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Affordable and Accessible Hearing Health Care: Responding to a Public Health Concern
by Mary Helen McNeal

Editor’s Note: With the Affordable Care Act’s (ACA) future uncertain under a Trump administration, this article, authored in late 2016, sits in ambiguous territory. That said, regardless of how the ACA fares, the insight into advocacy for those with hearing loss in need of assistance and the overview of recommendations for the future presented by this article are valuable. Part I of this article outlines legal arguments for those in need of an affordable mechanism to obtain hearing assistance, particularly in light of the ACA. Part II summarizes recent recommendations from the National Academies of Science, Engineering and Medicine to expand access to, and the affordability of, hearing aids and other hearing health care.

Introduction
Age-related hearing loss is the third most prevalent chronic medical condition impacting older adults, with the incidence increasing with age. And yet, there is very little insurance coverage to pay for the cost of hearing aids; in fact, Medicare statutorily excludes coverage for hearing aids. The dearth of insurance coverage is of particular concern given the mounting evidence of the relationship between age-related hearing loss, called presbycusis, and other medical conditions, including increased falls and hospitalizations, depression, isolation, and diminished cognitive abilities. As the evidence mounts regarding the medical and social consequences of untreated hearing loss, hearing health professionals and advocates are exploring options for increased access to affordable hearing assistance.

Although past efforts to amend the Medicare statute to provide for hearing aid coverage have failed, the Affordable Care Act (ACA)\(^1\) provides a lens through

which one can reexamine this issue. Part I of this article outlines legal arguments for those in need of an affordable mechanism to obtain hearing assistance, particularly in light of the ACA. Part II summarizes recent recommendations from the National Academies of Science, Engineering and Medicine to expand access to, and the affordability of, hearing aids and other hearing health care.²

The Problem

Hearing loss affects an estimated 48 million people,³ with the prevalence of hearing loss rising steeply with age. It affects an estimated 49% of adults ages 60-69,⁴ an estimated 63% of those 70 and older,⁵ and an estimated 80% of those 80 and older.⁶ Presbycusis causes hearing loss at higher frequencies, which include most consonant sounds and sounds in higher octaves, resulting in an inability to distinguish words. Because presbycusis develops gradually over time, it often goes undetected and untreated for many years.

Recent medical research documents the significant medical consequences of untreated hearing loss. A connection between hearing loss, cognitive function, and dementia has been identified in various studies,⁷ although it remains uncertain whether or not it is a causal relationship. One study found that the risk of dementia increased with the severity of hearing loss, although the nature of the relationship remains unclear.⁸ Those with dementia and hearing loss have been found to experience more rapid cognitive decline.⁹ Another study found that those with greater hearing loss performed more poorly on tests measuring memory and executive function¹⁰ and another, that those with hearing loss had diminished

² Nat’l Acads. of Scis., Eng’g, and Med., Hearing Health Care for Adults: Priorities for Improving Access and Affordability (The National Academies Press 2016) [hereinafter Report]. This Report was developed based on the work of the Committee on Accessible and Affordable Hearing Health Care for Adults, which was comprised of audiologists, physicians, public health experts, academics, lawyers and other professionals, assisted by the staff from the National Academies of Sciences, Engineering and Medicine. Id.
⁸ See Lin et al., supra note 6. See also Chris J. D. Hardy et al., Hearing and Dementia, 263 J. NEUROL. 2339 (2016) (noting that although evidence of a relationship between hearing loss and cognition is “robust,” the mechanism for this is unclear).

Despite the prevalence of [hearing loss] and its medical consequences, an estimated 67-86% of those who could benefit from hearing aids do not use them. Although a myriad of factors contribute to this phenomenon, undoubtedly one is cost.
recall.\textsuperscript{11} Additionally, hearing loss can result in depression and increased isolation,\textsuperscript{12} an increase in falls,\textsuperscript{13} and an overall reduced quality of life.\textsuperscript{14}

Despite the prevalence of this condition and its medical consequences, an estimated 67\textendash{}86\% of those who could benefit from hearing aids do not use them.\textsuperscript{15} Although a myriad of factors contribute to this phenomenon, undoubtedly one is cost. In 2013, hearing aids cost, on average, $4,700 a pair.\textsuperscript{16} The costs of hearing aids are often “bundled” and include assessments, fittings, programming, adjustments, and routine maintenance, resulting in concerns that this pricing model offers some consumers services they do not need and fails to provide other consumers with services they do need.\textsuperscript{17} Most seniors are forced to pay for the hearing devices out-of-pocket.

Medicare, enacted in 1965, specifically excludes coverage of “routine physical checkups, eyeglasses . . . [and] hearing aids or examinations.”\textsuperscript{18} Although there is little relevant legislative history, most suspect these items were excluded due to potential costs and the view that providing seniors with coverage for major health care expenses would enable seniors to cover the costs of these “routine” items.\textsuperscript{19} All attempts to amend the statute to include coverage of hearing aids have failed. A number of bills were introduced in the 114\textsuperscript{th} Congress that would have provided avenues for reducing out-of-pocket costs, including one providing for coverage in the Medicare program.\textsuperscript{20} However, there was no significant movement on any of the proposed legislation.

Other types of insurance may provide some coverage for hearing devices, but rarely at a level sufficient to cover the costs of a hearing aid. Medicare Advantage Plans, which vary by region and type, provide some assistance for the costs of a hearing aid. Some employer-sponsored plans provide limited coverage for retirees, but increasingly fewer seniors have such coverage. While some seniors purchase Medigap policies to supplement their Medicare coverage, such plans are expensive and also typically do not cover hearing aids. For the very poor, Medicaid is an option for hearing aid coverage, but coverage is limited and varies by state.

**New Perspectives**

**Utilizing the ACA**

The ACA’s preventive care focus provides opportunities to argue that current Medicare policy is antiquated and inconsistent with contemporary thinking on the provision of health care and insurance coverage. Examples of that orientation include a provision that every senior receive a “Welcome to Medicare” visit that includes certain mandatory screenings and services. Each senior also receives an “annual wellness visit,” also required to include certain components, and a personalized preventive plan. These, and the preventive services required for all populations, are provided at no cost to the patient, including no


\textsuperscript{13} Derrick Lopez et al., *Falls, Injuries from Falls, Health Related Quality of Life and Mortality in Older Adults with Vision and Hearing Impairment—Is There a Gender Difference?*, 69(4) *Maturitas* 359, 359 (2011).

\textsuperscript{14} Bamini Gopinath et al., *Hearing Handicap, Rather than Measured Hearing Impairment, Predicts Poorer Quality of Life Over 10 Years in Older Adults*, 72 *Maturitas* 146, 146 (2012).


\textsuperscript{16} Letter from President’s Council of Advisors on Science and Technology to Barack Obama, President of the United States (Oct. 2015), https://www.whitehouse.gov/sites/default/files/microsites/ostp/PCAST/pcast_hearing_tech_letterreport_final3.pdf [https://perma.cc/3243-7EJF].

\textsuperscript{17} Id.

\textsuperscript{18} 42 U.S.C.A. § 1395y (a) (7).

\textsuperscript{19} Hearing Loss, Hearing Aids, and the Elderly: Hearing before the Subcomm. on Consumer Interests of the Elderly of the Special Comm. on Aging, 90th Cong. 309–10 (1968) (statement of Robert M. Ball, Comm’r on Soc. Sec.).

deductibles and no co-pays. The ACA is replete with additional programmatic changes focusing on preventive care, including opportunities for the Secretary of Health and Human Services (Secretary) to pilot innovative programs that enhance efficient delivery of health care services while reducing costs. Advocates interested in reforming Medicare hearing aid coverage policies should utilize the preventive care philosophy embodied in the ACA to argue for repeal of the statutory exclusion. Additionally, they should argue that hearing exams and treatment should be addressed as part of the mandatory depression screenings, and advocate that both regular hearing screenings and treatment, even for asymptomatic patients, be added to the list of mandated preventive services. Representatives of individual Medicare recipients should advocate for coverage under various existing ACA provisions. For example, arguably hearing aid coverage should be included as part of the “Welcome to Medicare” and wellness visit provisions described above. Another argument is that hearing aids are themselves preventive services given the adverse medical conditions that can result from untreated hearing loss, and therefore should be covered. Advocates can similarly argue that these ACA provisions require coverage under the Medicaid program. Advocates also can utilize the ACA’s provisions permitting innovative pilot projects to encourage the Secretary to implement a project providing Medicare coverage of hearing devices. Such a project would enable CMS to evaluate the impact of appropriate treatment for hearing loss on overall patient health and on health care costs.

Finally, the ACA requires each state to offer plans on the health exchange, in the non-grandfathered small group market, and in their expanded Medicaid programs (should they choose to expand) that include “essential health benefits.” The “essential health benefits” package is required to include coverage of “rehabilitative and habilitative services,” terms not defined in the ACA itself. These terms are defined in a glossary which insurance plans are required to reference. The glossary defines “habilitative/habilitation services” as “health care services that help you keep, learn or improve skills and functions for daily living.” It defines “rehabilitative services” as “health care services that help a person keep, get back or improve skills and functioning for daily living that have been lost or impaired because a person was sick, hurt or disabled.” The inclusion of these services as “essential health benefits” provides additional advocacy opportunities.

Coordinated advocacy efforts are necessary to accomplish these changes. Hearing health professionals from various disciplines and other advocates should set aside profession-specific goals and work together to increase insurance coverage for the benefit of seniors and others facing hearing loss. Efforts are needed at the federal legislative and regulatory levels, particularly as regulations implementing the ACA continue to be refined. Seniors and their advocates can challenge insurance coverage restrictions relying on these ACA provisions. Similar efforts can be initiated on the state level, promoting legislation mandating coverage of hearing devices in the private market, employer-sponsored plans (where permitted), retiree insurance, the “essential health benefits package,” and state Medicaid programs.

“Hearing Health Care for Adults: Priorities for Improving Access and Affordability”

The National Academies of Science, Engineering and Medicine issued a report in June of 2016 that similarly called for changes in insurance coverage

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22 42 U.S.C.A. § 1315a (a)(1) (West 2015) (“The purpose of the CMI [Center for Medicare and Medicaid Innovation] is to test innovative payment and service delivery models to reduce program expenditures under the applicable subchapters while preserving or enhancing the quality of care ….(4)(A).”).
26 Id.
of hearing devices, as well as a wide array of other recommendations. It convened an interdisciplinary committee of 17 experts (hereinafter “the Committee”) to examine the state of hearing health in the United States, exploring in particular access and affordability issues. In its comprehensive, 350-plus page report, “Hearing Health Care for Adults: Priorities for Improving Access and Affordability,” the Committee offers wide ranging proposals too numerous and varied to address here. This section will provide an overview of the Committee’s most significant recommendations, and a preliminary analysis of those ideas.

The Report acknowledged the many problems within the current hearing health care system. As noted previously, many seniors in need of hearing devices do not use them, there is insufficient insurance coverage, there is a dearth of information about hearing health, and the hearing health care delivery system is not user-friendly. It notes that for seniors, all of these problems are compounded by the known health effects caused or exacerbated by untreated hearing loss.

A primary Report recommendation is expanded insurance coverage of hearing services and devices. Acknowledging the current statutory restriction on Medicare coverage, the Report recommends that CMS evaluate options to render treatment of hearing loss affordable for Medicare beneficiaries. The Report further recommends that state Medicaid agencies, employers, private health insurance plans, and Medicare Advantage plans do the same.

The National Academies of Science, Engineering and Medicine issued a report in June of 2016 that similarly called for changes in insurance coverage of hearing devices, as well as a wide array of other recommendations. ... In its comprehensive, 350-plus page report, “Hearing Health Care for Adults: Priorities for Improving Access and Affordability,” the Committee offers wide ranging proposals...

27 Report, supra note 2.
28 Id. at 228.
29 Id. at 228.
waives that requirement. In contrast, PSAPs are not considered medical devices, are unregulated, and therefore currently cannot be marketed for the purpose of treating impaired hearing.\textsuperscript{34}

Because PSAPs are affordable and accessible, many seniors, however, are purchasing them to address their hearing loss. Unlike hearing aids, which can control sound, pitch, and direction, often digitally, PSAPs only amplify sound. There are no design, technical or performance standards, and no labeling requirements. The Report suggests that the establishment of a new category of over-the-counter devices would acknowledge the rapid technological changes occurring, better protect consumers, and offer more options for informed consumer choices. The Report recommends that such devices be subject to certain technical standards similar to those of hearing aids but that the devices be approved through a streamlined process and, depending on the technology used, potentially exempt from pre-market review.\textsuperscript{35}

The consequences of this proposal are unknown. It acknowledges the current reality, i.e. consumers purchasing PSAPs not labelled to assist with hearing impairment but using them precisely for that purpose. The proposed changes would require labelling, instructional materials, maximum sound output limitations, and other protections for quality control, safety and effectiveness.\textsuperscript{36} The regulatory review would assure a degree of quality control currently absent, and protect users from further hearing damage due to unsafe sound output or other problems.

However, subjecting these devices, essentially a subset of the current PSAPs, to even minimal regulation would likely increase manufacturing and distribution costs.\textsuperscript{37} Although intended only to address mild to moderate hearing loss, such OTC devices could be purchased by those with more serious hearing impairments. If the devices proved ineffective for them, the users could become even more reluctant to purchase hearing aids that could improve their hearing. The opposite may be true as well, with seniors who had good experiences with PSAPs potentially moving to more powerful devices as their hearing deteriorates. Although such OTC devices would undoubtedly be cheaper than hearing aids, it is unlikely that they would be covered by insurance.

The Report also recommends the development of standards insuring that all hearing devices are compatible with other electronic devices and use an “open platform,” enabling hearing health care professionals to program all devices. Other recommendations include the following: 1) Discussion of hearing issues integrated into regular and wellness visits; 2) Greater transparency in hearing aid fee structures; 3) Health care outreach to educate the public about hearing loss and its consequences; 4) Increased education of medical professionals, particularly primary care physicians, about hearing loss and treatment; 5) Outreach to those in communities of color and in rural areas who are less likely to receive hearing services; and 6) Patient education and assistance during annual wellness visits.\textsuperscript{38} Finally, consistent with the proposal outlined above, the Report also recommends that CMS “prioritize and fund demonstration projects and studies, including randomized clinical trials, to improve the evidence base for current and innovative payment and delivery models for treating hearing loss.”\textsuperscript{39}

The Committee was particularly interested in a demonstration project evaluating the impact of a “direct access” model enabling patients to go directly to an audiologist without first obtaining a physician’s referral.\textsuperscript{40} After weighing the increased burden on patients to secure the currently required referral with the benefit of coordinated care and screening for other diseases when the referral is required, the Committee could not reach consensus on this issue.\textsuperscript{41} It recommended a demonstration project testing the direct access model and generating evidence of its impact.\textsuperscript{42}

\textsuperscript{34} Report, supra note 2, at 8. See also Regulatory Requirements for Hearing Aid Devices and Personal Sound Amplification Products—Draft Guidance for Industry and Food and Drug Administration Staff, FDA (Nov. 7, 2013), http://www.fda.gov/medicaldevices/deviceregulationandguidance/guidancedocuments/ucm373461.htm [https://perma.cc/5BGR-R4P6] (explaining that the FDA “regulates electronic products that emit sonic vibrations, such as sound amplification equipment”).

\textsuperscript{35} Report, supra note 2, at 189-90.

\textsuperscript{36} Id. at 191-95.

\textsuperscript{37} Id.

\textsuperscript{38} Id. at 1-16.

\textsuperscript{39} Id. at 229.

\textsuperscript{40} Id. at 127-129.

\textsuperscript{41} Id. at 130.

\textsuperscript{42} Id. at 228-229.
Conclusion

The inability to hear adequately diminishes the quality of life for many seniors, limiting their ability to communicate with loved ones and caregivers, participate in activities, and obtain professional guidance on medical, legal and other issues. Additionally, it has serious medical consequences, including an effect on cognitive function, increased depression and isolation, greater risk of falling, more hospitalizations, and potentially, increased risk of dementia.

Many of those with presbycusis are unable to afford hearing aids that would enable them to remain engaged well into old age, and to potentially avoid other health problems. The ACA provides a lens to reexamine Medicare’s failure to cover these devices, and to argue for deletion of this statutory exclusion. Its preventive care philosophy also supports the expansion of other health insurance coverage of hearing devices. If implemented, the various recommendations of the Committee on Accessible and Affordable Hearing Health Care for Adults, including the creation of a new category of OTC wearable hearing devices, will likely enhance seniors’ access to hearing health care. Some seniors will be assisted with these relatively inexpensive over-the-counter products. Others, however, particularly as their hearing continues to decline with age, will require more sophisticated and personalized devices. Policy changes, particularly in the Medicare program, are necessary to assure that those who need these devices can secure them affordably. The ACA and the preventive care philosophy embedded within it and the many recommendations in the Institutes of Medicine Report offer arguments to assist in this advocacy and in the development of sound public policy.

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Ten Legal Tips for Caregivers

Family caregivers face a surprising mix of legal, financial, and practical issues every day. A new flyer from the Commission outlines ten tips to help you understand and manage those issues.

1. Understand Decisional Capacity
2. Know What Legal Authority You Have
3. Appoint a Health Care Agent
4. Complete a Financial Power of Attorney
5. Manage Social Security/Veterans Benefits
6. Know Your Rights of Access to Health Information
7. Know the Signs of Abuse, Neglect, and Exploitation
8. Know Your Rights if You Face Family Responsibilities Discrimination (FRD)
9. Understand your rights under the Family and Medical Leave Act (FMLA)
10. Consider a Personal Care Agreement

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Adult guardianship can remove important, fundamental rights – and also can subject individuals to a loss of privacy about financial, health, mental health, and other sensitive personal information. Guardianship is a court proceeding – and as such, hearings and records are open to the public unless there are provisions to protect privacy. Without such protections, court information may be available for public consumption – opening the door to possible identity theft, scams, and fraud – particularly with the potential for putting more guardianship information and documents online. Moreover, allowing strangers access to personal information adds trauma to an already incredibly trying situation. Thus, it is important to provide for protection of information about an individual subject to the guardianship process. As with other elements of guardianship law, the lack of uniformity makes assessment of privacy protections difficult.

This article is a summary of research examining statutes, court rules, and administrative rules. The survey focuses on statutory provisions and attempts to draw a distinction between those privacy provisions found within guardianship statutes themselves, and those found within rules. The survey covers four categories, including privacy provisions in statutes which provide complete protection, provisions which provide partial protection, and provisions which provide protections for hearings. Finally, this article examines relevant administrative and court rules which may supplement a state’s guardianship statutes.

**Full Protection**

These protections typically seal any record of the guardianship in its entirety. This includes any documents or records of the hearings. Currently, only thirteen states have statutory provisions providing this level of protection. Often, these provisions are conditioned upon a finding that the guardianship is unnecessary, or that a proceeding to institute guardianship was malicious. Florida, Tennessee, and Vermont each have similar provisions requiring sealing the record if no guardian is appointed. Only a few states have statutes which call for a sealing of the record.

**Examples**

Upon finding that a petition under this chapter was malicious, frivolous, or without just cause, the court may order that all information contained in the
court records relating to the proceeding be sealed and that the information be disclosed only upon court order for good cause shown. Alaska Stat. Ann. § 13.26.013(b).

Upon filing of a petition requesting appointment of a guardian or conservator, all pleadings, exhibits and other documents contained in the court file shall be considered confidential and not open for public inspection, either during the pendency of the case or after the case is closed. The protected person, and his or her attorney, may inspect or copy the file. Another party may file a petition... and, upon good cause shown, the court or mental hygiene commissioner may authorize the party, or his or her attorney, to inspect and copy the file. W. Va. Code Ann. § 44A-2-5.

Partial Protection
Rather than sealing a record in its entirety, these types of provisions make certain parts of the record confidential. Conversely, these provisions may allow public access to only orders of appointment acknowledging guardianship. Roughly half the states have some provision limiting public access to the record. Documents typically included in these provisions are medical records, visitor's reports, orders of appointment, annual reports, and financial reports. In California for example, reports recommending guardianship and annual status reports are confidential except to parties and their attorneys.

Examples
All the records relating to any minor or adult guardianship or conservatorship that is granted under this title shall be kept sealed, except for a record of the names and addresses of the minor, ward, and guardian or conservator and their legal counsel of record and the date of filing, granting, and terminating the guardianship or conservatorship. Ga. Code Ann. § 29-9-18(a).


Hearings Protection
Most states also provide privacy protection for any hearings held under guardianship statutes. In nearly all states, the hearing to determine guardianship may be closed at the request of the respondent, their attorney, or guardian ad litem. The hearing may also be closed, and opened only upon request.

Examples
The issue [of the person’s incapacity] may be determined at a closed hearing if the person alleged in need of protection or that person’s counsel so requests. 20 Pa. Stat. and Cons. Stat. Ann. § 5511(a).

The hearing may be closed to the public and without a jury unless the alleged incapacitated person or his counsel objects. The hearing shall be closed and with or without a jury if the person alleged to be incapacitated or his counsel so requests. Ariz. Rev. Stat. § 14-5407(D).

Rule-Based Protection
Finally, many privacy protections exist within court rules or administrative rules. Protection provided by rules varies from redaction of basic personal information to complete exemption from state public access laws. Thirty-three states currently have some form of rule-based protection, making rule-based privacy provisions the most common of the types of provisions discussed in this article. Typically, basic redaction rules cover information such as Social Security numbers, financial account numbers, birthdates, and other identifying information. However, these rules may not be strictly enforced, and usually parties bear the responsibility of ensuring this information is redacted. Rule-based protections may also provide the type of partial protection above, including privacy of medical records, visitor's reports, and other select documents from guardianship proceedings. In a few states, guardianship statutes are exempted from public access entirely. Examples of this diverse coverage of rule-based protections include Hawaii, Delaware, Colorado, and Indiana.

Examples
Matters docketed as Civil Miscellaneous (C.M.) actions including, but not limited to, guardianships, and associated miscellaneous petitions are confidential and not subject to public disclosure or access by the general public. Del. Ch. Ct. R. 90(a).

For good cause shown, the court may order a file to be placed under security, in which event the clerk of the court shall maintain it in an appropriate security file. Files kept under security may be examined only

Conclusion

It seems that guardianship statutes have yet to modernize. While clear privacy provisions regarding hearings, medical evaluations, and visitor’s reports may have been adequate in the analog age, widespread mandatory use of electronic filing systems within the courts has changed the way the public accesses information; easy access to court documents creates a significant privacy concern for protected individuals. States have developed a complex relationship of statute and rule to address this concern, and several states have filing rules which directly address privacy in guardianship proceedings. Guardianship is very jurisdictional, and the protection available depends on the state. A uniform privacy provision would address the lack of substantive privacy provisions within statutes themselves, and avoid any potential confusion arising from the scattered sources of privacy protections. Still, given the states’ panoply of approaches, adoption of a uniform provision is unlikely. Practitioners should conduct a thorough review of a state’s statutes and rules to provide those facing guardianship the most comprehensive privacy protection possible. Due diligence will go a long way in providing the dignity and respect that every person, protected or otherwise, deserves.

To access a reference chart of the individual state provisions discussed in this article, including citations for each provision, visit the Commission’s website at http://ambar.org/guardianship.

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