ESSENTIAL PLANNING GUIDE FOR FAMILIES DEALING WITH DEMENTIA

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Elder Law • Special Needs Planning • Estate Planning
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NOTE: The materials in this publication have been prepared for the purpose of providing accurate general information regarding the subjects covered. The information herein is not intended or offered as legal advice, nor may it be construed as such by any person. The reader should seek competent professional advice from an attorney before applying any information in this guide to his or her personal situation.

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About The Author

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An alumnus of Mississippi College and the University of Mississippi School of Law, Rick is the first attorney in Mississippi to have received the designation of **Certified Elder Law Attorney** by the American Bar Association-accredited National Elder Law Foundation. He is a former Assistant Dean and Adjunct Professor of Law of the Mississippi College School of Law and Adjunct Professor of Law at University of Mississippi School of Law. Rick is a Fellow and past Director of the National Academy of Elder Law Attorneys; the Real Property, Trusts and Estates Law Section of the American Bar Association; the Trusts and Estates Section of the Mississippi State Bar (Past Chair), and the Mississippi Estate Planning Council. Rick is past President of the Special Needs Alliance, Inc., a national organization of special needs planning attorneys and is a Fellow in the American College of Trust and Estate Counsel.

Mr. Courtney and his law firm possess the highest "AV Preeminent" rating by Martindale-Hubbell, the leading national lawyer rating service. Mr. Courtney has also been selected annually since 2006 as a Mid-South Super Lawyer (among top five percent of Arkansas, Tennessee and Mississippi attorneys) by peer review survey of Mississippi attorneys and professional evaluation process. In 2009, Rick was awarded the 15th Annual Theresa Award by the New York-based Theresa Foundation, for community service and professional advocacy on behalf of children and adults with special needs. He is a member in the Council of Advanced Practitioners of the National Academy of Elder Law Attorneys, and is named among Best Lawyers in America in elder law and trusts and estate planning.

Rick has been active in the community as President and Director of the Cerebral Palsy Foundation of Mississippi, Inc., President of the Advisory Board of Hospice Ministries Inc., a Director of the Heritage School for children with learning disabilities, member of the Occupational Therapy Council of Advisors for the Mississippi State Department of Health, President of the Mississippi Elder Justice Center Advisory Board, and member of the Alzheimer's Association-Middle Mississippi Chapter. He has published numerous articles and educational materials and has delivered many presentations for lawyers and other professionals on a variety of elder law, estate planning and special needs planning subjects. He frequently speaks to church and community groups on topics of interest to senior adults, caregiver children and spouses, and families with special needs.

Statement of Purpose: *Legal Solutions for Lifetime Health and Wealth – Families, Older Adults, and Persons with Disabilities.*

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Introduction

A diagnosis of dementia can be devastating for the person receiving the diagnosis and his or her family. Early medical intervention and proper treatment may assure many years of continued independence and quality of life with such a condition. It is important that persons with dementia take action promptly, not only to get good medical intervention, but also to implement their legal plans for future care and financial security. Where a person with dementia no longer has the capacity to take such action, the family must be informed about steps they can take to assure these future needs of their loved one and themselves will be met.

This guide (and our firm) places the primary focus on the person with dementia – helping him or her achieve the right care with the right supports, provided by the right people, at the right times and in the right ways, with all available resources. An additional focus is on the family members and caregivers of such persons, who seek to help their loved ones experience the highest possible quality of life but often do not know where to find the help or resources needed to do so.

The purpose of this guide is to help persons with dementia, their family members and caregivers become more:

- **educated** about the legal, financial and health-care planning options and resources available;
- **empowered** to carry out planning steps to ensure effective management of care and resources for the best interest of the person with dementia;
- **encouraged** to plan in order to maximize the benefits and effectiveness of such plans for the person with dementia and other family; and
- **enabled** to advocate more effectively for the rights and care of the person with dementia.

ABOUT DEMENTIA

Dementia is a mental disorder characterized by the loss of the ability to think, reason and remember. Of the elder population in the United States, it is estimated that up to 8% of those age 65 to 74 have some type of clinical dementia. The percentage increases dramatically as age progresses. Of those elders that are 85 years and older, it has been estimated that 25% to 50% suffer from some form of dementia. Progressive dementia will eventually become severe enough to interfere with work performance, social activities and daily functioning.

There are many sources of good information about dementia. The website of the Mayo Clinic (www.mayoclinic.com) contains much helpful and easy to understand explanation about the types of dementia, their causes and cures, treatments, and the importance of specific diagnosis. Some of the information found there is summarized and cited in the following section.

The Alzheimer's Association website lists what it calls the **Ten Signs of Alzheimer's** – symptoms of the disease that go beyond the effects of normal aging. The listing of these signs is:

1. Memory loss that disrupts daily life
2. Challenges in planning or solving problems
3. Difficulty completing familiar tasks at home, at work or at leisure
4. Confusion with time or place
5. Trouble understanding visual images and spatial relationships
6. New problems with words in speaking or writing
7. Misplacing things and losing the ability to retrace steps
8. Decreased or poor judgment
9. Withdrawal from work or social activities
10. Changes in mood and personality

More can be learned about these signs, including a course that expands on each symptom, online at **http://www.alz.org/10-signs-symptoms-alzheimers-dementia.asp.**

While Alzheimer's disease is the most common cause of dementia, many other conditions also cause these symptoms. Some of these disorders get worse with

time and cannot be cured. Other types can be treated and reversed. The three most common forms of dementia are Alzheimer's disease, vascular dementia and Lewy body dementia. Sometimes, a person can have more than one of these problems at the same time.

Alzheimer's disease is caused by the development of "plaques" and "tangles" of nerve cells in the brain. It usually begins with forgetfulness and, as it progresses, affects language, reasoning and understanding, and ultimately the loss of ability to care for oneself.

Vascular dementia occurs when arteries feeding the brain become narrowed or blocked. While the symptoms may manifest abruptly, often after a stroke, some forms of vascular dementia progress slowly, making them difficult to distinguish from Alzheimer's disease. A person may have Alzheimer's and vascular dementia at the same time. Symptoms include problems with thinking, language, walking, bladder control and concentration. Preventing additional strokes by treating underlying diseases, such as high blood pressure, may halt the progression of vascular dementia.

Lewy body dementia, the second most common type of progressive dementia after Alzheimer's disease, causes a progressive decline in mental abilities. It may also cause visual hallucinations, which may take the form of seeing shapes, colors, people or animals that aren't there or, more complexly, having conversations with deceased loved ones. Another indicator of Lewy body dementia may be significant fluctuations in alertness and attention, which may include daytime drowsiness or periods of staring into space. And, like Parkinson's disease, Lewy body dementia can result in rigid muscles, slowed movement and tremors. In Lewy body dementia, abnormal round structures — called Lewy bodies — develop in regions of your brain involved in thinking and movement.

Several less common brain disorders also can result in dementia.

Frontotemporal dementia. Usually appearing between the ages of 40 and 65, this disease affects the lobes of the brain that are responsible for judgment and social behavior, often resulting in impolite and socially inappropriate behavior. The disease seems to run in families.

Huntington's disease. This is a hereditary disorder, typically beginning between the ages of 30 and 50. Symptoms that begin as mild personality changes may progress to the development of involuntary jerky movements, muscle weakness and clumsiness. Dementia commonly develops in the later stages of the disease.

Parkinson's disease. People with Parkinson's disease may experience stiffness of limbs, shaking at rest (tremor), speech impairment and a shuffling gait. Some people with Parkinson's develop dementia late in the disease.

Creutzfeldt-Jakob disease. This extremely rare and fatal brain disorder belongs to a family of human and animal diseases known as the transmissible spongiform encephalopathies. A new variety of Creutzfeldt-Jakob disease has emerged — particularly in Great Britain. It's believed to be linked to the human consumption of beef from cattle with mad cow disease (bovine spongiform encephalopathy).

According to the Mayo Clinic website, "[M]any other conditions, some reversible, can cause dementia or dementia-like symptoms."

Reactions to medications. Some medications have side effects that mimic the symptoms of dementia. A single medicine may trigger such a reaction in an older person or in someone whose liver fails to eliminate the drug properly. Interactions among two or more drugs may lead to reversible symptoms of dementia as well.

Metabolic abnormalities. Decreased thyroid function (hypothyroidism) can result in apathy, depression or dementia. Hypoglycemia, a condition in which there isn't enough sugar in the bloodstream, can cause confusion or personality changes. Pernicious anemia — an impaired ability to absorb vitamin B-12 — also can cause personality changes.

Nutritional deficiencies. Chronic alcoholism can result in deficiencies of thiamin (vitamin B-1), which can seriously impair mental abilities. Severe deficiency of vitamin B-6 may lead to pellagra, a neurological illness with features of dementia. Dehydration also can cause confusion that may resemble dementia.

Emotional problems. The confusion, apathy and forgetfulness associated with depression are sometimes mistaken for dementia, particularly in older individuals.

Infections. Meningitis and encephalitis, which are infections of the brain or the membrane that covers it, can cause confusion, memory loss or sudden dementia. Untreated syphilis can damage the brain and cause dementia. People in the advanced stages of AIDS also may develop a form of dementia.

Dementia isn't always due to Alzheimer's. It is essential that family members obtain a thorough, expert medical evaluation to determine the underlying cause of symptoms such as memory loss and confusion. Even if the evaluation uncovers no underlying condition that, with treatment, can reverse dementia, options may be available for easing its symptoms. Knowing the likely cause of dementia, however, is the essential first step toward managing it.

Progression and Effect of Dementia. While the progression of dementia is unique in each patient, there are five stages commonly recognized in the medical literature:

- **Mild cognitive impairment.** The person may experience some memory problems but can continue to live independently.

- **Mild dementia.** The person may experience impaired memory and thinking skills, may no longer be able to live completely independently, and may require assistance with finances, grooming and dressing, and meal planning and cooking. The individual may also become confused when in public. The patient may: appear more apathetic; lose interest in hobbies and activities; be unwilling to try new things; be unable to adapt to change; show poor judgment and make poor decisions; be slower to grasp complex ideas and take longer with routine jobs; blame others for "stealing" lost items; become more self-centered and less concerned with others and their feelings; become more forgetful of details of recent events; be more likely to repeat themselves or lose the thread of their conversation; be more irritable or upset if they fail at something; have difficulty handling money.

- Moderate dementia. The person may experience severe memory impairment and difficulty in communicating. He or she can't live alone and needs help with almost every basic activity. The person can go out in public only with assistance. Among the practical effects of moderate dementia the patient may: be forgetful of recent events, with seemingly better memory for the distant past; be confused regarding time and place; become lost if away from familiar surroundings; forget names of family or friends, or confuse one family member with another; forget saucepans and kettles on the stove, and leave gas unlit; wander around streets, perhaps at night, sometimes becoming lost; behave inappropriately, for example going outdoors in nightwear; see or hear things that are not there; become very repetitive; be neglectful of hygiene or eating; become angry, upset or distressed through frustration.

- Severe dementia. The person experiences severe problems with communication, frequent incontinence and requires constant care. He or she needs hands-on assistance with dressing and eating and is too impaired to go out in public. The person with severe dementia may: be unable to remember, for even a few minutes, that they have had, for example, a meal; lose their ability to understand or use speech; be incontinent; show no recognition of friends and family; need help with eating, washing, bathing, using the toilet, dressing; fail to recognize everyday objects; be disturbed at night; be restless, perhaps looking for a long-dead relative; be aggressive, especially when feeling threatened or closed in; have difficulty walking, eventually perhaps becoming confined to a wheelchair; have uncontrolled movements.

- Profound dementia. At this end stage, the person usually is bedridden. Though much is lost during the progression of dementia, it is important to remember that someone suffering from dementia retains their sense of touch and hearing as well as their ability to respond to emotion.

  Because no two patients experience precisely the same process, it is also important to remember that each patient's ability to handle tasks will be unique, and a diagnosis of dementia need not prevent the patient from developing a lawyer-client relationship nor from completing estate planning, health care and/or Medicaid long-term care planning in

individual cases. Finally, the differing progression and multiple causes of dementia make it critically important that each patient have a competent, thorough medical evaluation and diagnosis. (Robert B. Fleming, *A Lawyer's Guide to Recognizing, Understanding and Coping with Dementia in Clients*, 2003 Advanced Elder Law Program, Atlanta, GA)

TERMINOLOGY

Throughout this material, the following terms will carry the stated meanings unless otherwise noted in specific situations:

- Agent – A person who acts for a person with dementia in some *voluntarily* established legal capacity (such as Attorney-in-Fact under a durable power of attorney, health-care proxy or agent under Advance Health-care Directive)
- Dementia – Any type of condition which causes a progressive or significant loss of capacity to remember, think or reason, as well as related physical disabilities
- Person with Dementia (or PWD) – Any person who has received a diagnosis of dementia. [Note: We specifically use and encourage "People First" language that focuses on the *person* first, *then* the condition which limits abilities or capacity. The fact that one has dementia (or any other type of disability) does not mean that he or she is less a person or entitled to less respect because of it.]
- MCA – The abbreviation "MCA" will designate a section of the Mississippi Code Annotated, the statute laws of Mississippi.
- USC – Refers to a section in the United States Code, the federal statute laws.
- CFR – Refers to the Code of Federal Regulations, those federal regulations that explain how the statute laws must be carried out.

ABOUT "CAPACITY"

Historically, both medical and legal communities have referred to the **abilities to think, reason and act in one's own best interest** as "competence" of the person. One who lost these abilities was called legally or medically "incompetent". More recently, the possession of such abilities has come to be called "capacity," and the loss of such abilities is referred to as "incapacity." There are differences between the diagnostic approach of the medical community and the functional evaluation imposed by the legal community, but in most cases, proof of legal capacity will rely heavily on medical evaluations of competency. Legal standards of capacity tend to be somewhat absolute (that is, if one is deemed to lack capacity to execute a valid complex last will and testament, she would also be deemed to lack capacity to execute a valid simple will). Case law also recognizes that capacity may ebb and flow and that a person may have a **"lucid moment"** or **"lucid interval"** during which he has the required level of capacity, even though this interval is preceded and followed by periods of unbroken incapacity.

Standards of Capacity. It is also clear that there are different **levels of capacity** to make different kinds of decisions. "Capacity" can mean different things depending on the type of legal action contemplated for an individual. Among the more common types of capacity that must be considered:

- Testamentary Capacity. In order for one to be able to make a valid will or power of attorney, that person (called the "testator") must be able to (i) "understand and appreciate the nature and effect of his act" in signing the will, (ii) understand and recognize "the natural objects or persons to receive his bounty (property)" and their relationship to him, and (iii) be "capable of determining what disposition he desires to make of his property". *Dowdy v. Smith*, 818 So.2d 1255 (Miss. 2002) If a person has this level of capacity at the time she executes a last will and testament, the will is valid even though the maker was incapacitated for some time prior to or after such execution. This rule was upheld in *In re Estate of Byrd*, 749 So.2d 1214 (Miss. 1999). The court case of *Lee v. Lee*, 337 So.2d 713 (Miss. 1976) ruled that, even though a person is found to be unable to manage his property due to incapacity and a conservator is appointed for him, he may still have the level of capacity necessary to execute a valid will. The same level of capacity needed to establish a valid will or power of attorney is required to revoke it.

- General Contractual Capacity. The law generally recognizes that a person does not have the capacity to enter into a valid contract if he does not have "sufficient mental capacity to understand the nature and effect of the particular transaction." *McElroy v. Mathews*, 263 S.W.2d 1 (Mo. 1953). This means the person must understand the performances that each party to the contract is obligated to render and the benefits to each. This is a higher standard than testamentary capacity. A person who has had a conservator appointed for him cannot legally enter into any contract without court approval.

- Advance Directives. The Mississippi Uniform Health-Care Decisions Act (MCA §41-41-203(d)) defines decision-making "capacity" for health-care as "an individual's ability to understand the significant benefits, risks and alternatives to proposed health care and to make and communicate a health care decision."

- Informed Consent. In order to be able to validly consent to particular medical treatment for oneself, the individual must be able to "understand the diagnosis, the nature of the proposed treatment, the risks inherent in it, the prognosis if the proposed treatment is not undertaken, and the alternative methods of treatment, if any". Regan, John J, Morgan, Rebecca C. and English, David M., *Tax, Estate & Financial Planning for the Elderly*, §14.03 (LexisNexis 2005) This is called "informed consent."

PRE-INCAPACITY PLANNING

The materials in this section explain how a person with a diagnosis of dementia who **still retains legal capacity to act on his or her own behalf** can plan in the areas of Health-Care Decision-making (Section I), other Personal Affairs and Financial Decision-making (Section II), and Estate Planning and Asset Disposition (Section III). Some planning options may not apply to the person's particular situation, and the only way to be sure which options are the best is to consult with an expert elder law attorney.

I. Health-Care Decision-making.

Any adult in Mississippi who has the capacity to make an advance directive (as noted above) may authorize another to obtain medical information about, and make health-care decisions for, that person. Every adult should execute an Advance Health-Care Directive to

ensure that, in the event he becomes incapacitated and needs medical treatment, the person most desirable to make such decisions will have been designated and given written guidance based on the maker's personal values.

A. "Living Will". Prior to 1998, Mississippi law contained a statute entitled "Declaration for Withdrawal of Life-Sustaining Mechanisms". This was commonly known as the "living will" law, and the "living will" document stated that the signer did not want heroic life-support mechanisms employed to prolong life if that person became terminally ill. Since the repeal of this law in 1998, these documents are no longer prescribed by state law, although "living wills" that were validly executed prior to repeal remain valid for the limited purpose described.

B. Health-Care Power of Attorney. Prior to 1998, our state statutes recognized a power of attorney that designated another to make health-care and medical treatment decisions for the maker. This Act was repealed when the Mississippi Health-Care Decisions Act was enacted in 1998. However, health-care powers of attorney that were validly made prior to repeal remain valid today.

C. Advance Health-care Directive. The Uniform Health-Care Decisions Act of Mississippi (MCA §41-41-201, -209) prescribes the "Advance Health-Care Directive" (AHCD) as the instrument by which a **person with capacity can designate an agent** who will be able to make health-care decisions for the maker. An adult in Mississippi is entitled to make his own medical treatment and health-care decisions, and maintain the privacy of his own medical information, unless someone else has legal authority to do so. This includes the right to implement, alter and refuse medical treatment for oneself. However, one may lose this capacity through illness or injury, and medical providers will be reluctant to render non-emergency treatment without consent of someone with lawful authority to approve such measures. The AHCD allows one to control and direct personal health-care decisions after the onset of any future incapacity.

Section 1 of the AHCD is the health-care power of attorney, in which one or more persons may be listed in the maker's order of choice and designated as agents to make *medical and health-care treatment* decisions for the maker.

The maker can select whether the agent may make such decisions without prior determination of the maker's incapacity, or whether one or more doctors must first determine the maker's incapacity before the agent can make decisions for her. In Section 2, the maker can state any personal health-care decisions, such as about keeping or removing life-support treatments or tube-fed food and liquids in the event of terminal illness, and other choices concerning medical treatment based on the maker's own personal choices. In the optional Section 3, the maker may list the name and contact information for her personal physician. Section 4 is an authorization for organ donation if the maker desires.

In light of the stringent privacy regulations under the Health Insurance Portability and Accountability Act (HIPAA) governing the release of personal medical information, it is wise to include specific language in the AHCD that identifies the agent as your "personal representative" who is entitled to request and receive your medical information for HIPAA purposes.

D. HIPAA Authorization.

In April 2005, the federal Health Insurance Portability and Accountability Act (HIPAA) implemented stringent privacy regulations governing the release of personal medical information by all types of health care providers. As a result of these regulations and the penalties they impose for improper release of such personal medical information, many doctors, hospitals and other health care providers are reluctant to release health care information without strict compliance with HIPAA. The HIPAA Privacy Rule regulations, in 45 CFR §164.502(a)(2), require a "covered entity" (that is, a hospital, clinic or other health-care provider covered by the Act) to disclose protected personal health information *to the individual* upon request by her. Section 164.502(g) provides that a covered entity must treat a **"personal representative"** as the individual and can therefore disclose protected health information of an adult to a person who has lawful authority to act on behalf of that adult in making health-care decisions. Such authority can be given by a **written authorization** from the individual approving certain health-care action by the representative. 45 CFR §164.508(c) sets out the requirements for such a written authorization, which should be drafted by a knowledgeable attorney.

Do the HIPAA rules permit a doctor to discuss a patient's health status, treatment, or payment arrangements with the patient's family and friends?

The answer is "Yes." The HIPAA Privacy Rule, at 45 CFR §164.510(b), specifically permits covered entities to share information that is directly relevant to the involvement of a spouse, family members, friends, or other persons identified by a patient, in the patient's care or payment for health care. If the patient is present at the time of disclosure, or is otherwise available prior to the disclosure, and has the capacity to make health care decisions, the covered entity may discuss this information with the family and these other persons if the patient agrees or, when given the opportunity, does not object. The covered entity may also share relevant information with the family and these other persons if it can reasonably infer, based on professional judgment, that the patient does not object. Under these circumstances, for example:

- A doctor may give information about a patient's mobility limitations to a friend driving the patient home from the hospital.
- A hospital may discuss a patient's payment options with her adult daughter.
- A doctor may instruct a patient's roommate about proper medicine dosage when she comes to pick up her friend from the hospital.
- A physician may discuss a patient's treatment with the patient in the presence of a friend when the patient brings the friend to a medical appointment and asks if the friend can come into the treatment room.

In addition, the Privacy Rule expressly permits a covered entity to use professional judgment and experience with common practice to make reasonable judgments about the patient's best interests in allowing another person to act for the patient to pick up a filled prescription, medical supplies, X-rays, or other similar forms of protected health information. For example, when a person comes to a pharmacy requesting to pick up a prescription for an individual he identifies by name, a pharmacist, based on professional judgment and experience with common practice, may allow the person to do so.

E. Family communication about health-care decisions.

It is not enough to have a health-care directive or authorization document signed. Personal values and choices about end-of-life and other health-care issues should be discussed with loved ones who will be expected to make such decisions. The law generally requires that a health-care agent,

to the extent she has reason to know the decision that the principal would make for himself under the circumstances, must make that decision also. This is called the **"substituted judgment"** rule, because the judgment of the incapacitated principal must be substituted for the independent decision of the agent. If the agent has no basis to know what the principal would choose in the situation, then the agent must act in the best interest of the principal (the **"best interest"** rule). Therefore, the principal must communicate his values and choices about medical care and end-of-life treatment to the agent before the need to use the directive arises**.** (This failure to clearly communicate personal wishes and values in end-of-life situations to her spouse and family was the greatest problem for Terri Schiavo, the severely brain-injured young Florida woman who remained on life support for over 15 years while family members fought in court to determine whether her life support should be removed.) Our firm provides some very **helpful tools and checklists** to assist an individual in selecting an appropriate health-care agent and communicating personal values about medical care and end-of-life treatment, as well as guidelines to help the agent understand how to make health-care decisions in the event of the principal's incapacity.

II. Personal Affairs and Financial Decision-making

The Constitution of the United States and the privacy laws that have emanated from its protections guarantee the right of each competent adult to act in her own behalf regarding all personal and property matters. Just as with health-care decision-making, it is essential that individuals establish appropriate plans for others to make personal business and financial decisions for them if they become unable to do so for themselves. Such authority may be given in a variety of ways, with the **Durable Power of Attorney** being a **recommended basic component** of every good plan. Other methods include joint ownership of assets, trusts and representative payee status for Social Security payments.

A. Durable Power of Attorney ("DPOA").

A durable power of attorney is a written document in which the "principal" appoints another as the principal's agent (or "Attorney-in-Fact") and gives that agent the authority to carry out the principal's non-medical affairs on the terms stated in the DPOA. ***Note:*** A power of attorney **must** contain a statement to the effect that "This power of attorney shall not be affected by the subsequent disability or incompetence of the Principal." If such a statement is included,

then the power of attorney is considered "durable" and the Attorney-in-Fact will continue to have the power to act for the principal even after the principal becomes incapacitated. (Without such a statement, the power of attorney becomes void after the principal's incapacity.) The DPOA may give the Attorney-in-Fact all the powers over the principal's affairs and property that the principal would have (a "general" power of attorney), ***or*** it may be limited to certain powers, such as the power to sell real property or create a trust for the principal (a "limited" power of attorney). It may allow the Attorney-in-Fact to act as soon as the principal has signed the document (an "immediate" power) ***or*** it may state that the Attorney-in-Fact may only exercise the powers after some future event, such as one or more physicians certifying that the principal has become incapacitated (a "springing" power). An immediate DPOA does **not** take away or affect the principal's right to continue to make such decisions or control her property and affairs as long as she has capacity to do so. A DPOA should be customized for the principal's personal circumstances, and is best done by an experienced elder law attorney who understands these issues. A power of attorney that lacks important statements of intended powers or that unduly restricts certain types of powers will hamper the actions of the agent when it becomes necessary to use it.

Under a Mississippi law, a married person must specifically name someone other than his or her spouse to have power to deed or transfer any interest in the principal's residence property. The spouse is not legally able to do so.

The primary reasons for a DPOA are: (a) to plan for a substitute decision-maker in the event of your future incapacity; (b) to personally select the person(s) who may be appointed conservator for you if required (rather than having the Court approve someone undesirable); (c) to authorize the Attorney-in-Fact to take necessary actions to conduct your affairs and protect your assets as part of your estate plan. If you become incapacitated without a DPOA, a court will have to appoint a conservator to handle your affairs and assets. (See Conservatorship below.)

B. Joint Ownership.

A person may be given access and control over certain types of assets (such as bank and financial accounts) by making him a "joint owner" of the account. Each joint owner has access to jointly-owned bank accounts; therefore, another joint owner can freely withdraw jointly-

owned funds, possibly leaving the PWD without funds for self-support. Also, both living joint owners of real property must sign any deed or mortgage to obtain money from the property, and a conservatorship may be required for a joint owner who becomes mentally incapacitated in order to sell or mortgage the property.

C. Trusts. Individuals who utilize revocable living trusts (see Section III following) to hold and manage property and assets for the benefit of themselves and their spouses may name a Co-Trustee and direct in the trust that the Co-Trustee may take certain actions with trust assets (such as disbursing funds to pay bills) without the PWD joining in the action. This would permit continued management of those trust assets if the trust maker becomes incapacitated. Also, an individual creating a trust may designate a third party "Trust Protector" who will have authority to appoint a successor Trustee in the event the initial Trustee/trust creator becomes incapacitated.

D. Representative Payee for Social Security payments. Every recipient of Social Security payments has the right to receive and manage her own benefits. However, if the Social Security Administration receives adequate evidence that it is in the recipient's best interest (regardless of the recipient's competency), it may appoint another as "representative payee." 42 USC §405(j); 20 CFR §§404.2001-2065. SSA is required to first verify the new payee's Social Security number and determine whether the applicant has been convicted of certain crimes or been previously terminated or suspended as a payee. The recipient may inform the SSA as to his preference for a particular representative payee to be appointed for him. Additional information and help with designation of a representative payee is available on-line at www.ssa.gov/payee.

E. Driving. The subject of driving should be discussed by a PWD and his family, since a decline in judgment and physical abilities will endanger both him and others. If possible, the PWD should consider drafting an "Agreement With My Family about Driving." Such an agreement may be simple and stand-alone, such as the following sample agreement provided, with other suggestions, by The Hartford in "Alzheimer's, Dementia & Driving." (2000)

I have discussed with my family my desire to drive as long as it is safe for me to do so. When it is not reasonable for me to drive, I would like (person's name) or (person's name) to tell me that I should no longer drive. I wish for (person's name) to assist by consulting with my physician or a driving rehabilitation specialist about my ability to drive safely.

If I am unwilling or unable to surrender my driver's license after a professional concurs that I am unable to drive safely, I agree that the following steps may be initiated by (person's name):

[_____] he/she may contact my physician so that he/she may alert the state department of motor vehicles, or she/he may do so directly.

[_____] she/he may take possession of my car keys.

[_____] he/she may take possession of my car.

[_____] she/he may sell my car and use the proceeds to pay for alternative transportation.

III. Estate Planning and Asset Disposition.

Every adult should implement a plan for lifetime ownership and ultimate distribution of his or her assets to intended family or charities. What alternatives are available to help one plan for intended disposition of assets to family members or others?

A. Outright gifts. You may give money or assets to others. ***Advantages:*** (i) Gifts remove assets from the estate of the giver for estate tax purposes (note: consult an experienced elder law or estate planning attorney to see if this applies to you); (ii) ensures that assets go to the intended recipient. ***Disadvantages:*** (i) May create an obligation to file a gift tax return if over $15,000 per person per year*; (ii) gifts prior to Medicaid application may delay eligibility; (iii) gifted assets become subject to the bankruptcy, divorce, debts and liabilities of the recipient. **Caution:** Assets essential for a senior's self-support should never be given away unless the senior is certain their needs will be met without those assets.

*(and if the giver's estate exceeds $11.18 million)

B. Joint ownership. Property owned jointly with someone else as joint tenants "with rights of survivorship" will **automatically pass to the surviving owner** at the death of either owner. Joint property **will not pass according to the terms of your will or trust.** If you own real property with others and the deed does not say "joint tenants with rights of survivorship", then your share of the property will not pass automatically to the surviving co-owner but will pass through probate under the terms of your will, or to your heirs if you have no will. Jointly-owned bank and financial accounts will automatically pass to the surviving owner of the funds at your death. However, if the account documents do not state that there is a right of survivorship and if your name is the primary name on the account, your estate may have to be probated at your death to pass the funds to your heirs. ***Advantages:*** (i) The jointly-owned assets pass automatically to the surviving owner at death without probate. (ii) The other joint owner has access to jointly-owned bank accounts in the event you become incapacitated. (iii) The surviving joint owner may inherit the assets with an advantageous tax basis. ***Disadvantages:*** (i) The other joint owner can freely withdraw jointly-owned funds, leaving you without funds for self-support. (ii) Jointly-owned assets may become subject to the judgments, lawsuits, divorce or bankruptcy of any joint owner. (iii) Full ownership of the assets will pass to the other joint owner at your death, without any legal requirement that she share them with other children or family members. (iv) Both living joint owners of real property must sign any deed or mortgage, and a conservatorship may be required for a joint owner who becomes mentally incapacitated in order to sell or mortgage the property.

C. Deed land and reserve life estate. You may deed land to another (the "remainder owner") and retain in the deed the right to use, enjoy and occupy it during your lifetime (as "life estate" owner). The land passes directly to the remainder owner at your death and does not pass through will or probate at death (similar to joint ownership). The property is not subject to Medicaid's payback claim at your death, but both owners must sign a deed in order to sell or mortgage the property. Therefore, a conservatorship may be required for a life estate owner who has no durable power of attorney and becomes mentally incapacitated in order to sell or mortgage the property. Also, transfer of property by any type deed *may* create a period of ineligibility for Medicaid within five years after the date of the deed. You should consult an elder law attorney before doing such a transaction.

D. Designated beneficiary.

Life insurance policies, retirement plans, annuities, and "pay on death" (POD) and "transfer on death" (TOD) accounts will pass automatically to the persons named as "designated beneficiaries" of those benefits, not under the terms of your will or trust. (If no beneficiary is named on the account or policy, then the benefits will pass by will or inheritance through the probate estate of the owner.) One or more secondary beneficiaries should be named in case the primary beneficiary dies first. Consult an elder law or estate planning attorney for help in drafting custom beneficiary designations for specific situations.

E. Last Will and Testament.

A "will" (more formally known as a Last Will and Testament) is a document in which the person making the will (the "testator") states how and to whom she wants her assets to pass at death. The **primary purposes** of a will are: (i) To name future guardians for minor or disabled adult children at the parent's death; (ii) to designate the people who you wish to receive your assets (without a will, state inheritance law will decide); (iii) to prevent the need for court-supervised guardianship or conservatorship by appointing a Trustee to hold and distribute assets for minor or disabled children or an incapacitated spouse after your death (see "Special Needs Trusts" below); (iv) to protect assets from an heir's debts and liabilities by leaving those assets in a trust for the benefit of that heir; and (v) to prevent payment of estate taxes by use of tax-saving trust provisions in the will.

All financial accounts, real property and personal property that you own in your name **and** that will not pass "outside" your Will by joint ownership or remainder ownership (Sections B and C above) or to "designated beneficiaries" (Section D above) will pass **through your will** to your designated heirs.

A will does not affect assets until death, and any executor or trustee named in the will has no power until after your death. A will can be revoked or amended at any time prior to death. A will must be ***probated*** in court in order to transfer the estate in accordance with its terms. ***Probate*** is the process where the "executor" named in a will hires a lawyer to file the original will with the court clerk of the county where the testator (deceased person) resided. A petition to open the probate is filed and the executor is given a document called "Letters Testamentary" which authorizes him

to collect all the testator's assets, pay any creditors who file claims with the court, and ultimately distribute all remaining assets to those people or charities named in the will. The executor is then relieved from his responsibilities. Probate will take at least four months after the testator's death. This is because it will usually take a month or so to obtain a death certificate and have the petition for probate filed. A notice is then published in the newspaper giving creditors 90 days from the date of the notice to file any claims. Only after this 90-day period has expired can the estate be closed. A similar process is used to probate the estate of a person who dies without a will. A **properly drafted will** can prevent the filing of personal assets information in the probate case and thereby **keep personal financial information private.**

F. Revocable Living Trust. An alternative to a will is the revocable living trust. The trust document contains similar provisions to a will, but it becomes effective immediately after it is signed. The person setting up the trust, called the "grantor," can also act as trustee or appoint another person or financial institution to serve as trustee. The trustee must manage the trust assets and make payments from the trust in accordance with the desires of the grantor. The grantor must then transfer his/her assets to the trust to manage (by changing the names on bank accounts, stocks, real estate, etc.). At the grantor's death, a new trustee may continue to hold the trust assets for, or will distribute the trust assets to, the persons named as the remainder beneficiaries (usually the grantor's heirs). No probate is required to permit the trust to continue or to transfer ownership of assets to the remainder beneficiaries. However, **assets that are <u>not</u> titled in the trust** (and are not passing to others by joint ownership or as designated beneficiaries) **will require a probate** to pass such assets to the grantor's heirs. For this reason, a simple will called a "pour-over" will should always be prepared along with a revocable trust. This will states that any assets that were not placed in the trust prior to the grantor's death are to be put ("poured over") into the trust by probating the pour-over will. A revocable living trust will allow persons who own real property in more than one state to avoid the necessity of probates in all those states upon death.

Note: Medicaid does not count (for eligibility determination) the value of a residence owned by the disabled person, but counts the full value if the residence is owned by a revocable trust. Also, a "special needs trust"

for a spouse must be established in the healthy spouse's will and not in a revocable trust. **You should consult an experienced elder law attorney to determine whether a will or living trust plan is best for you.**

G. Special Needs Trusts. The primary purpose of a special needs trust ("SNT") is to hold assets for the benefit of a spouse or child with a disability who receives or may become eligible for Medicaid or SSI benefits so that the trust assets are not counted as assets of the PWD and do not disqualify him or her for SSI or Medicaid. Such a trust will also name a trustee who will be able to effectively manage and disburse trust funds for the disabled beneficiary's needs. There are **two basic types of SNTs** based on who is placing assets in the trust.

- Third party SNT (or "Estate Planning SNT"). Spouses of disabled adults, or parents and grandparents of disabled children, who have no will or who leave assets through their wills or trusts to their spouse or children, will thereby disqualify the disabled spouse or child for Medicaid or SSI assistance. The inherited funds will be counted as assets of the disabled spouse or child by SSI and Medicaid rules. Likewise, *guardianship* or *conservatorship* funds held for a child or adult are deemed to be resources of that child or adult. It is imperative that families of children or adults with disabilities craft an estate plan which will provide access to all available resources, including Medicaid benefits, for the disabled person's future needs. **A Special Needs Trust** may be set up in the Last Will and Testament **of the healthy spouse, to establish a fund for the care of the spouse with dementia.** The assets in this type trust will not be counted as assets by SSI or Medicaid and will be used for the disabled beneficiary's needs during his lifetime, and the assets remaining in the trust at the death of the beneficiary will be distributed to the persons and in the manner prescribed in the trust (such as to other children or family members, non-profit groups, etc.). This trust can be established in the will of the healthy spouse, and parents may establish such trusts for disabled children separate from the will and fund them during life and/or at death. Medicaid will not be entitled to claim any of the funds or assets in this type trust.

- Self-settled SNT. A **"self-settled"** special needs trust may be created to hold the **assets already owned** by the person under age 65 with a disability ("beneficiary"), or that the beneficiary is entitled to receive

through a **lawsuit settlement or inheritance.** Federal law states that the assets of a disabled person placed in such a properly established trust are not to be counted as assets of the beneficiary for SSI or Medicaid purposes. At the beneficiary's death, **Medicaid must be first in line** to recover from the trust assets the amount Medicaid has paid for the beneficiary's medical care. Any remaining balance in the SNT can be paid to those persons (the "remainder beneficiaries") designated by the creator of the trust.

H. Irrevocable Trust. If an individual (the "grantor") wishes to gift assets to the grantor's family but wants to protect them from the liabilities and creditors of those family members, the grantor may place those assets in an irrevocable trust. This trust may provide that the grantor will receive income from those assets, which would be counted for Medicaid eligibility purposes. However, the assets themselves would pass to the grantor's family members at the grantor's death without probate. If the grantor's residence is placed in such a trust, the property tax and income tax advantages of the grantor's ownership may be retained. (There would also be an ineligibility period for nursing home Medicaid for five (5) years from the date of transfer of assets into such a trust.)

(NOTE: "Self-settled trusts" are trusts created by a grantor for her own benefit and funded with the grantor's own assets. Only a "Qualified Disposition Trust" can protect the grantor's assets from future claims of grantor's creditors.)

POST-INCAPACITY PLANNING

National legal surveys have determined that approximately 65% of American adults have no written estate plan of any type. For this reason, many persons with dementia reach a point of incapacity without having implemented any of the planning strategies (such as a will, durable power of attorney, advance health-care directive, etc.) mentioned in the Pre-Incapacity Planning section above. The materials in the following section explain how the caregivers of a person with dementia who **no longer has legal capacity to act on his or her own behalf** can plan in the areas of Health-Care Decision-making (Section I), other Personal Affairs and Financial Decision-making (Section II), and Estate Planning and Asset Disposition (Section III). Again, consultation with an expert elder law attorney is the only way to be sure which options are the best for the person's particular situation.

I. Health-Care Decision-making. Once a person has lost the capacity to make personal health-care and medical treatment decisions, he may no longer establish the terms and limitations on those decisions that will be made for him. Others may be able to make such decisions under involuntary legal processes as outlined below.

A. HIPAA. Even when the patient is not present, or emergency circumstances or the patient's incapacity may prevent the covered entity from asking the patient's consent to discuss her care or payment with a family member or other person, HIPAA permits a covered entity to share this information with the third person when, in exercising professional judgment, it determines that doing so would be in the best interest of the patient. See 45 CFR §164.510(b). Thus, for example:

- A surgeon may, if consistent with such professional judgment, inform a patient's child, who accompanied her parent to the emergency room, that the patient has suffered a heart attack and provide periodic updates on the patient's progress and prognosis.
- A doctor may, if consistent with such professional judgment, discuss an incapacitated patient's condition with a family member over the phone.

B. Health-care Surrogate. Section 41-41-211 of the Uniform Health-care Decisions Act of Mississippi allows a third party (known as a health-care "Surrogate") to make health-care decisions for one who is unable to make such decisions for himself, where no health-care agent or guardian has been appointed for the patient or, if appointed, is not reasonably available. The Surrogate must be within the designated classes of persons authorized to act as Surrogate, which are in order of priority: (i) spouse, unless legally separated; (ii) adult child; (iii) parent; (iv) adult brother or sister; or (v) an adult who has exhibited special care and concern for patient, who is familiar with patient's personal values, and who is reasonably available to act. A Surrogate must make any health-care decision for the patient in accordance with the patient's individual instructions, if any, and other wishes to the extent known to Surrogate ("substituted judgment" test); otherwise, the Surrogate will make the decision in accordance with Surrogate's determination of the patient's best interest, taking into consideration the patient's personal values to the extent known

to the Surrogate. Since a medical provider has the right to require **written evidence** of such surrogate status, our firm has developed and can prepare a written **Declaration of Health-Care Surrogate** for such situations.

C. Conservatorship. If a PWD has no health-care directive and is unable to manage her own affairs, a family member may seek to be appointed **"conservator"** of the person for the PWD. The conservatorship statutes, found at MCA §93-13-251, refer to the person with incapacity as the **"ward."** If a person is "incapable of managing his own estate" due to "advanced age, physical incapacity or mental weakness," that person, a friend or relative may file a petition in the Chancery Court to appoint a conservator of the financial estate, the person, or both. The petition must include written certificates of at least two licensed physicians (or one physician and one psychologist) stating that they have examined the ward and that, in their opinion, she is unable to manage her own affairs and is in need of a conservator. The petition is filed, a copy of the petition must be personally delivered to the ward and at least one spouse or next of kin or caretaker, and a court hearing may be set not less than 5 days later.

Once appointed, the conservator will have authority to direct the health-care of the ward as her personal representative under HIPAA. Also, the conservator must file a petition for court permission to move the person and/or property of the ward to another county, or to move the person and property of the ward out of state, by obtaining an insurance bond conditioned on the conservator qualifying in the other state.

Note: A conservatorship may be used (with the help of an experienced elder law attorney) to remove assets from the ownership of an incapacitated spouse in order to provide for the financial security of the healthy spouse and ***obtain or protect nursing home Medicaid eligibility for long-term care for the spouse with dementia.***

The **legal standard** for appointment of a conservator is the **inability to manage** his property **or person** due to "advanced age, physical incapacity or mental weakness." The Mississippi case of *Harvey v. Meador,* 459 So.2d 288 (Miss. 1984) established several legal propositions pertaining to conservatorship: (i) advanced age or physical incapacity alone does not necessarily justify appointment of a conservator; (ii) mere lack of good business judgment, not amounting to some degree of wasted or dissipated

property, is not sufficient basis for appointment of a conservator; and (iii) the test of "management competency" is met by assessing factors including ability to manage, improvident disposition, dissipation of property, susceptibility to undue influence or deception by others, and similar factors. In the 2003 case of *In Re Conservator for Demoville*, 856 So.2d 607, rehearing denied, cert denied 866 So.2d 473 (Miss. 2003), the court ruled that if at least one of the factors of the "management competency test" is established, appointment of a conservator may be justified. In *Demoville*, the court refused to appoint as conservator the daughter of a woman with severe dementia, where the daughter had transferred large sums of money from the mother's funds to her own benefit. The court held that a person with such a conflict of interest with the incapacitated person cannot serve as conservator.

D. Emergency Commitment. Where a person is believed to be incapacitated by mental illness and is a danger to himself or others, is uncooperative with psychotropic medications, or is unable to care for himself (such as, bathe, eat, etc.), then the individual may be involuntarily committed for mental treatment. A family member may go to the Chancery Clerk, sign an Affidavit, and pay a filing fee for a court-appointed attorney, doctor, etc. The court will set a hearing date promptly, and the alleged incapacitated person will either voluntarily attend the hearing, or be picked up by the sheriff for the hearing. The person signing the affidavit must attend the hearing and prove the grounds for commitment. If commitment is ordered, the individual is committed to Mississippi State Hospital at Whitfield or, if his family can arrange admission to another facility, can be transferred to another hospital or nursing home pending a bed becoming available at Whitfield. If no bed is available at the State Hospital and no other facility admission can be arranged, the alleged incapacitated person may be sent home until a bed becomes available and must go to outpatient treatment. If he fails to go to treatment, he can be picked up and confined involuntarily.

II. Personal Affairs and Financial Decision-making

The primary method for third-party decision-making **for a person who has done no planning** for that circumstance is establishment of a **conservatorship**, although there are other actions that can be taken to assume control of the actions of an incapacitated PWD.

A. Conservatorship. If a PWD has no power of attorney and is unable to manage her own affairs and/or financial assets, a family member may seek to be appointed **"conservator"** of the PWD. The conservatorship statutes, found at MCA §93-13-251, refer to the person with incapacity as the **"ward."** If a person is "incapable of managing his own estate" due to "advanced age, physical incapacity or mental weakness," that person, a friend or relative may file a petition in the Chancery Court to appoint a conservator of the financial estate, the person, or both. The petition must include written certificates of at least two licensed physicians (or one physician and one psychologist) stating the results of their personal examination of the ward and that, in their opinion, she is unable to manage her own affairs and is in need of a conservator. The petition is filed, a copy of the petition must be personally served on the ward and at least one spouse or next of kin or caretaker, and a court hearing may be set not less than 5 days later.

Once appointed, the conservator may only use the ward's funds for the ward's benefit as allowed by Court orders. The conservator may be required by law to purchase an insurance bond which would replace any money that the conservator might steal or misuse. Conservators must file an initial inventory of the ward's assets and annual accountings of the income and disbursements of the conservatorship. Also, the conservator must hire a lawyer to file a petition for court permission to: spend the money for the ward's needs; create or renew a mortgage or encumbrance on the ward's property; purchase or sell real estate for the ward; sell personal property of the ward; retain securities and investments received for the ward by inheritance; sell or compromise debts and claims due the ward; move the person and/or property of the ward to another county; or move the person and property of the ward out of state, by posting an insurance bond here conditioned on the conservator qualifying in the other state.

A conservatorship may be used (with the help of an experienced elder law attorney) to remove assets from the ownership of an incapacitated spouse in order to **provide for the financial security of the healthy spouse** and obtain or protect nursing home Medicaid eligibility. So long as there is a duly appointed conservator, the ward may not enter into valid contracts or convey title to property on his own.

As noted above, the **legal standard** for appointment of a conservator is the **inability to manage** one's property or person due to "advanced age, physical incapacity or mental weakness." The Mississippi case of *Harvey v. Meador,* 459 So.2d 288 (Miss. 1984) established several legal propositions pertaining to conservatorship: (i) advanced age or physical incapacity alone does not necessarily justify appointment of a conservator; (ii) mere lack of good business judgment, not amounting to some degree of wasted or dissipated property, is not sufficient basis for appointment of a conservator; and (iii) the test of "management competency" is met by assessing factors including ability to manage, improvident disposition, dissipation of property, susceptibility to undue influence or deception by others, and similar factors. In the 2003 case of *In Re Conservator for Demoville,* 856 So.2d 607, rehearing denied, cert denied 866 So.2d 473 (Miss. 2003), the court ruled that if at least one of the factors of the "management competency test" is established, appointment of a conservator may be justified. In *Demoville*, the court refused to appoint as conservator the daughter of a woman with severe dementia, where the daughter had transferred large sums of money from the mother's funds to her own benefit. The court held that a person with such a conflict of interest with the incapacitated person cannot serve as conservator.

B. Removing Driving Privileges.

When a PWD is not willing to voluntarily discontinue driving, and continuation of such activity has become dangerous to her or others, then steps should be taken to limit driving and protect the PWD. As noted at the Mayo Clinic website, the focused concentration and quick reaction time needed for safe driving tends to decline with age. Alzheimer's disease accelerates this process dramatically . . . A driver who has Alzheimer's may also have trouble prioritizing visual cues. (*Alzheimer's: When to stop Driving*; http://www.mayoclinic.org/healthy-lifestyle/caregivers/in-depth/alzheimers/art-20044924) Caregivers should evaluate whether decline in any of the following abilities is likely to cause a driving danger: Coordination; judging distance and space; engaging in multiple tasks; staying alert to what's happening nearby; making decisions and solving problems. **Warning signs of unsafe driving** include: Forgetting how to locate familiar places; failing to observe traffic signals; making slow or poor decisions; driving at an inappropriate speed; becoming angry and confused while driving.

Some protective steps to take when driving becomes unsafe:

Obtain a 'do not drive' recommendation from the doctor. Sometimes it helps if an authority figure — physician, lawyer, insurance agent — tells your loved one to stop driving. Having something in writing can be a useful reminder.

Request a new driving test. The state Highway Patrol may, upon notice from a family member of unsafe driving activity, be willing to contact the older driver and request that he take a new driving test. Failing such a test will result in loss of driver's license and driving privilege.

Control access to the car and keys. In many cases, it's a simple matter of "Out of sight, out of mind." Parking the car around the corner may be enough. Some caregivers sell the family car and buy one that's a different color so that the person with Alzheimer's thinks it belongs to the neighbors. If your loved one insists on carrying a set of car keys, you can replace them with keys that don't work.

Disable the car. Removing a battery wire will stop the car from starting. Or a mechanic can install a "kill switch" that must be engaged before the car can start.

Ease the transition. Arrange for alternate transportation, perhaps via the city bus service or a senior van route. You may be able to establish a payment account with a taxi service so that your loved one won't have to handle money. Many items, such as groceries, meals and prescriptions, can be delivered. Some barbers and hairdressers can make house calls. Whether your loved one stops driving all at once or in stages, he or she will probably grieve this loss of independence. Be as patient as you can throughout this process, but remember to stand firm. Arguments and explanations rarely make it easier to accept.

These and other resources addressing driving problems – including video conversations – can be found at the **Alzheimer's and Dementia Caregiving Center** (www.alz.org/care/alzheimers-dementia-and-driving.asp)

III. Estate Planning and Asset Disposition

Even after a PWD has become incapacitated or died, certain planning options are available to affect the transfer and disposition of her assets and property.

A. Joint Ownership. As noted above, each joint owner of financial accounts has continued access to such jointly-owned accounts and can use them for the support of the person with dementia. In certain circumstances, such as joint ownership of assets by an incapacitated person and his spouse, it may be advisable to remove the assets from the joint account and re-deposit them in the sole ownership of the healthy spouse. This strategy, combined with a new will and special needs trust by the healthy spouse, can keep the assets available for the support of the spouse with dementia without conservatorship or Medicaid disqualification in the event the healthy spouse dies first.

B. Disclaimer. Where property is passing to a person at the death of another, by will or inheritance without a will, the recipient may "disclaim" all or part of those assets. This will force the disclaimed assets to pass as they would have if the disclaiming party had predeceased (died before) the owner of the assets. The disclaimed assets will pass to the next level of heirs stated in the will or inheritance law. Disclaimer may be used to achieve estate tax savings for the deceased person's estate. Such a disclaimer must be executed in strict compliance with IRS Code §2518 and state law requirements. MCA §89-21-1 et seq. ("Uniform Disclaimer of Property Interests Law") requires that a disclaimer must be in writing and delivered to the executor or administrator of the deceased person or filed in her estate not later than nine (9) months after the death of the deceased owner. A surviving joint owner may disclaim any property or interest in property passing to him by right of survivorship. The disclaiming party may not direct where the assets go and may not accept the property or the benefits of the disclaimed assets before executing the disclaimer. Two examples of when a disclaimer might be used are the following:

- A child who has substantial wealth of his own may elect to disclaim his interest in his parent's estate so that the property will pass to other family members; or
- Children might elect to disclaim their father's bequests to them, thus increasing the assets passing to their mother

C. Renunciation by Surviving Spouse. When a married person dies and makes no provision or inadequate provision for his spouse in his last will and testament, Mississippi law allows the surviving spouse to challenge the will and inherit an equal share of the deceased spouse's estate along with children of the deceased spouse (up to a maximum of one-half the total estate). The surviving spouse may "renounce" the will under MCA §91-5-25 or -27. The renunciation must be in writing and filed in the Chancery Court where the deceased spouse's will is probated not later than ninety (90) days following the probate filing. (**Note,** however, that this 90-day requirement will not be applied to a surviving spouse who is incapacitated, and her renunciation will be allowed after that time whenever her conservator or legal representative gets court approval to file it.)

PAYING FOR MEDICAL CARE

I. Medicare

Medicare is a medical insurance-type program developed to pay medical costs for retired or disabled persons who have paid into the Social Security system. Medicare **Part A** pays for hospitalization costs and **Part B** pays for doctor visits, outpatient therapies, medical equipment, home health care, etc. Any recipient of Social Security Retirement or railroad retirement benefits is eligible for Medicare Part A coverage beginning at age 65. The beneficiary should apply for Medicare and will elect either original Medicare or Medicare Advantage. Medicare Advantage allows eligible individuals to elect coverage from approved Medicare Advantage plans (HMOs, PPOs, etc.) as an alternative to traditional fee-for-service Medicare. A person who continues working past age 65 is still eligible for Medicare benefits provided a Medicare application has been filed. A person who does not apply for Social Security or Medicare Part A benefits until after age 65 is entitled to Part A (hospital) benefits retroactive for 6 months prior to the month of application. Medicare coverage is not dependent upon the income or assets of the recipient. Medicare Part B is a voluntary program for individuals who are eligible for Part A and who enroll in the program and pay the monthly premium ($134.00 in 2018; higher for income over $85,000 single/$170,000 couple). Delay in filing for Part B beyond age 65 may result in a higher monthly premium for lifetime.

Also, persons under age 65 who are receiving or are entitled to receive Social Security disability or railroad retirement disability benefits become eligible for Medicare benefits after they have received disability payments for 24 months.

Contrary to popular belief, Medicare does not pay a significant amount for nursing home care. Medicare pays only the first 20 days of nursing home care in full (if the individual is admitted to a Medicare-certified nursing home within thirty (30) days after a hospital stay of at least three (3) days), and Medicare will pay part of the next 80 days of nursing home care after the resident pays a daily co-payment ($167.50 per day in 2018). Medicare pays nothing after 100 days.

There are premiums, deductibles and co-payments for Medicare coverage. These premiums, deductibles and co-payments may be paid by Medicaid for individuals whose income and assets are below poverty level limits (known as "Qualified Medicare Beneficiaries" or "QMBs"), or by private "Medigap" insurance policies (see section on **Medigap Insurance** below).

The **Medicare Prescription Drug, Improvement and Modernization Act of 2003** implemented the new Medicare **Part D Prescription Drug Benefit**. On January 2006, the Medicare Part D drug benefit went into effect. Medicare recipients may voluntarily join a drug plan run by a private company. Those who do not sign up for a plan within 6 months after becoming Medicare-eligible will have to permanently pay a higher premium for late enrollment (1% increase for each month delayed). Each participant may pay a monthly premium for the plan (average approximately $35, set by each company). In 2018, the participant may then be required to pay a deductible not to exceed $405 in prescription drug costs during the year. After the plan and participant have paid $3,750 in drug costs, the participant must pay 100% of the cost (the "coverage gap" or "donut hole"). After the participant and plan have paid $5,000 in total out-of-pocket drugs costs (not including premiums), Medicare will then pay most drug costs (the "catastrophic benefit"), and the participant must pay the greater of 5% of cost or a $3.35 generic/$8.35 brand-name co-pay for each drug. Many plans charge co-payments instead of 25% coinsurance, and 40% of plans charge no deductible. Part D plans will receive a 50% discount on the total cost of their brand-name drugs purchased while in the donut hole, and enrollees will pay no more than 35% of the price for the brand-name drug in 2018. Medicare Part D beneficiaries who reach the donut hole will also pay a maximum of 44% co-pay on generic drugs purchased while in the coverage gap (a 56% discount). Contact

Medicare (800-633-4227), Mississippi Medicaid (800-421-2408), AARP (601-206-1848), or go to their websites (www.medicare.gov or www.aarp.org/prescriptiondrugs) for assistance to determine the best plan for you and to learn how to request an application form from the selected plan company.
Persons whose income is below $16,389 per year for a single person (or $22,221 for a married couple living together or even more with dependent children or grandchildren living with them), AND whose "countable" assets are below $9,060 for a single person (or $14,340 if married), may be entitled to get prescription drugs with reduced or no premium, no deductible, no coverage gap, and lower co-pays, and no co-pay if in a nursing home, and no copay over the catastrophic limit. "Countable" assets are generally all assets except the home, car, burial plot, $1,500 burial funds, term life insurance and cash value life insurance with a face value not more than $1,500.

II. Medigap Insurance

A Medicare Supplement (or "Medigap") insurance policy pays some or all of the Medicare deductibles and co-payments and may pay for some health services not covered by Medicare. Most Medigap policies require that the services be medically necessary, and they pay only up to the amounts approved by Medicare. There are ten standardized plans of coverage, designated by various letters A through N, with varying combinations of coverage. Medigap insurers are permitted to sell only these packages. Prices for the packages may differ from one insurer to another, and not all policies may be available in all states. (See http://www.medicare.gov/find-a-plan/questions/medigap-home.aspx)
NOTE: Insurers are prohibited from checking on the health of applicants age 65 or older during the first six months after they apply for Medicare Part B. Therefore, persons with existing medical problems should consider purchasing Medigap insurance within six months after enrolling in Medicare Part B, which typically occurs at age 65. These persons cannot be denied or charged more for Medigap coverage if they act within this time frame, nor can subsequent claims for benefits be denied due to preexisting conditions. The 2018 Medicare guidebook entitled *"Choosing a Medigap Policy"*, may be found at www.medicare.gov/Publications/.

III. Long-term Care Insurance

For persons whose health and financial status allows them to qualify for long-term care insurance, such coverage is an excellent way to protect family assets from the costs of long-term care and possibly provide payment for at-home

services not covered by Medicaid. You must consider the long-term affordability of such a policy, since the premiums will not go down even after you may have lost income from retirement or otherwise. The cost of such insurance varies based on the features of the policy chosen. You should seek a knowledgeable long-term care insurance agent who will discuss your personal needs and find the right policy with the right mix of features for you. Among the terms to address in reviewing a policy are:

A. Type of policy: The options are individual, joint or life insurance with long-term care attached. With joint policies, couples may choose between a single policy with two owners sharing single pool of funds, or two policies with a sharing provision, allowing one spouse to use the other spouse's benefits when his run out. Life insurance can be purchased with a long-term care insurance rider that allows policyholders to access a certain percentage of the death benefit each month.

B. What the policy should cover: Skilled (nursing home), intermediate and custodial care are usually covered. Home care, adult day care and assisted living – often not covered. Since you never know where you may need care, should consider buying a comprehensive policy that covers home care, adult day care, assisted living and nursing home care.

C. Triggering events: When does the policy take effect? Triple trigger may be best: Cognitive impairment (e.g., Alzheimer's), **or** Medical necessity, **or** impairment in 2 of 6 ADLs (activities of daily living – Eating, toileting, transferring, bathing, dressing & continence)

D. The daily benefit: May want to insure for the maximum daily benefit one might need in a local nursing home, minus the amount you are able to pay per day from other sources ("coinsurance"). Is there a lesser rate payable for home care?

E. Benefit period: How long will the benefits last? Most policies have a ten-year maximum coverage term. The average claim is less than 36 months, so a four- or five-year benefit may make most sense unless there is a history of Alzheimer's or you have sufficient funds to buy more.

F. How the policy pays: Is the plan "reimbursement" or "indemnity"? Reimbursement pays claims submitted by nursing home, home health, etc. and is least expensive option (used by 70 - 80 percent of policyholders.) Indemnity pays set cash benefit, and policyholder keeps the difference if daily benefit exceeds claims. Indemnity is generally more expensive.

G. Elimination period: This is the waiting period before benefits kick in. Sets forth the number of days you will pay the bill yourself. Same idea

as deductible, only measured in days, not dollars. May be mistake to buy a 90-day elimination period because the period is not based on calendar days but on days of reimbursable service, which can get very complicated. May want shorter period of 0 or 30 days. Some carriers offer 0 on home care but 90 days for nursing home care.

H. Inflation protection: A specified factor or index or an option to purchase additional coverage. Policyholders under age 62 or 63 may want "compound" inflation protection. Otherwise, "simple" inflation increases are adequate, since compound increases will more than double the premium.

I. Is there a waiver of premium? Not having to pay while receiving benefits under the policy.

J. Repeat stays in nursing home: Is there an elimination period – a certain number of days required between stays? Possibly best to have a single, accumulated number of days over life of policy

K. Preexisting conditions: What is excluded from coverage?

IV. Medicaid

Medicaid provides payment of medical expenses for persons age 65 or over or disabled (in accordance with Social Security disability definitions), who also qualify in terms of limited assets and income. Medicaid is administered by the state Division of Medicaid through the Governor's Office, under a federally approved medical assistance plan. For many disabled individuals who cannot obtain other medical insurance, Medicaid provides the only safety net for health care. In Mississippi, any recipient of federal Supplemental Security Income (SSI) benefits is automatically entitled to receive Medicaid benefits, and loss of SSI may result in loss of Medicaid eligibility. In Mississippi, there are a number of other Medicaid programs, including for nursing home care and home-and-community-based services, which are not tied to SSI eligibility and are available to non-SSI recipients. Medicaid coverage is dependent upon low income and assets.

The Medicaid program is a broad range of services provided to many different **"coverage groups".** A summary of these groups that apply to adults follows, along with statements for each group regarding the "income limit" (the maximum income a person can have to be eligible) and the "resources limit" (the maximum cumulative value of countable resources a person can own to be eligible) for each group.

- SSI-Eligible. Any Mississippi resident who receives any payment of SSI benefits is automatically eligible for Medicaid services. The income and resource limits of the SSI program apply.

- Qualified Medicare Beneficiary. An individual who is Medicare-eligible and whose income is below 100% of the federal poverty level + $50 ($1,062 individual / $1,422 couple) is eligible for this Medicaid program. Medicaid will pay the monthly Medicare Part B premium as well as other Medicare deductibles and co-payments for the individual.

- Home and Community-Based Services (HCBS) Waiver Programs. Mississippi has obtained federal waivers to use Medicaid funds to offer services in several "home and community-based" programs. These programs provide Medicaid-paid in-home attendant care, respite care, adult day care, nursing supervision and other services designed to help recipients avoid institutionalization and remain at home. These include: ***Elderly and Disabled Waiver; Physically Handicapped (Independent Living) Waiver; Intellectually Disabled/Developmentally Disabled (ID/DD) Waiver; Assisted Living Waiver;*** and ***Traumatic Brain Injury Waiver.*** There are other eligibility criteria, services and population limitations on these groups. The applicant's income in excess of the income "cap" ($2,250 in 2018) must be held to reimburse Medicaid. The resource limit is $4,000 and "spousal impoverishment" rules apply (see following section). There are often long waiting lists for these programs due to great demand.

- Long Term Care (or Nursing Home) Group. This coverage pays nursing home costs in excess of the Medicaid recipient's monthly share of cost. A Medicaid applicant may have countable asset of no more than $4,000 to qualify for Medicaid for LTC. In addition, under **"spousal impoverishment" rules** for married applicants, the at-home spouse ("community spouse" or CS) may keep all of his/her own separate income, plus enough of the applicant's income to get the CS's income up to the "minimum monthly needs allowance" of $3,090.00 if the CS's separate income is less than this amount. While the nursing home spouse may own no more than $4,000 of countable assets, the CS may own separate countable resources of up to $123,600 (the "community spouse resource allowance"). Assets may be transferred from the nursing home spouse to the community spouse to achieve these levels. The separate income (Social Security, etc.) of the applicant spouse that is not assigned to the CS as part of the minimum monthly needs allowance must be applied to pay nursing home cost as the applicant's "share of cost", but the community spouse's

income and assets do not have to be spent for this care. The applicant may keep $44 each month as a "personal needs allowance" and may pay a medical insurance premium.

There are many **misconceptions about Medicaid eligibility** for nursing home care. Medicaid will pay nursing home costs for persons who are disabled and whose "countable" income and assets are under certain limits. While these limits are low, a number of assets are excluded in determining "countable" assets and income.

A. Excluded Assets: A number of assets are **not counted** when determining eligibility for Medicaid. These include: the entire value of the residence (**unless** it is in a revocable living trust); all household furnishings; up to two automobiles; certain life estate or inherited interests in property; some income producing property; property used in trade or business for self-support; certain mineral and timber rights; certain life insurance policies; prepaid or designated funeral contracts and burial plots; and certain types of retirement or annuity funds.

B. The "Look-back Period": Many people have heard: "You have to wait 3 years after giving anything away to get Medicaid." The Truth: The Deficit Reduction Act of 2005 ("DRA") changed the look-back to five (5) years for transfers (gifts) made on or after February 8, 2006, the effective date of DRA. The new law requires disclosure of all transfers (gifts) made within five (5) years prior to Medicaid application, whether they were transferred to a trust or otherwise. Such transfers will cause an ineligibility period (described below), unless the transfer was to a spouse, blind or disabled child, or certain trusts for a disabled person.

C. Transfer Penalty: If assets were *given* away (that is, without any value in return) to persons other than a spouse or disabled child, and if the giver applies for Medicaid within 60 months after such gift, Medicaid will impose the following penalty on such gifts: Medicaid will refuse to pay the giver's nursing home care for a number of months based on the state average nursing home cost ($5,700 from January 2011 – June 2014, $5,920 from July 2014 – June 2015, $6,250 from July 2015 – June 2016, $6,405 July 2016 – June 2017, $6,619 July 2017 – June 2018). Under the DRA, the penalty period for gifts does not begin to run until the Medicaid Applicant has **both** entered a nursing home and is otherwise financially eligible for Medicaid. Therefore, if the applicant gave away $57,000 on June 1, 2014 and goes into a nursing home and applies for Medicaid December 1, 2018,

there would be a 10-month ineligibility period ($57,000 divided by $5,700 average cost in 2014 when transfer was made) before Medicaid will begin. Even though his assets are below the Medicaid eligibility limit ($4,000) when he applies for Medicaid, he must private pay for his nursing home for the additional 10 months of ineligibility.

The DRA has dramatically changed the Medicaid eligibility rules. Therefore, it is imperative that, if substantial gifts have been made, a Medicaid application must **NOT** be filed prematurely. ***Consult an experienced elder law attorney about any gifts and their effect on Medicaid eligibility.***

D. Estate Recovery: Federal law requires that each state Medicaid agency seek to recover reimbursement from the estate of each deceased Medicaid recipient for nursing home or home-and-community-based waiver services paid by Medicaid after the recipient was 55 years of age. This claim will be waived by Medicaid (a) if there is a surviving spouse; or (b) if there is a surviving dependent who is under the age of twenty-one (21) years or who is blind or disabled; or (c) as provided by federal law and regulation, if it is determined by Medicaid or by court order that there is undue hardship. A 2011 state court case also held that Medicaid has no claim against the Medicaid recipient's homestead property at death IF the Medicaid recipient is survived by a spouse, child or grandchild who would take the residence as an inheritance. Estate of Darby v. Stinson, 68 So.3d 702 (Miss. App. 2011), rehearing den. May 31, 2011, cert. den. Sept. 1, 2011. A 2015 Attorney General's Opinion affirmed that Medicaid will not have a recovery claim against homestead property owned by the Medicaid recipient at his/her death, and such property will descend to that person's surviving spouse, child(ren) or grandchild(ren). Mississippi AGO No. 2015-304 (Dec. 23, 2015)

E. General Planning Strategies: There are numerous planning strategies that can be accomplished within the rules and regulations of Medicaid and can be effective in (a) passing assets to other family members or (b) establishing Medicaid eligibility by converting countable assets to income or non-countable assets. The common objective of such strategies is to prevent the necessity of having to "spend down" all personal assets to the Medicaid limits before qualifying for Medicaid. **NO** Medicaid planning strategies should be undertaken without full consultation and assistance by an elder law attorney familiar with the applicable laws and regulations of the Medicaid and SSI programs.

V. Veterans' Benefits to Pay for Care at Home

The Veterans' Administration estimates that approximately 11.5 million veterans and 23.5 million spouses of veterans, or about 33% of all seniors in this country, could qualify for up to $2,170 (2018) a month in additional income from the Department of Veterans Affairs. This money can be used to pay just about anyone to provide elder care services at home, including children, other relatives, friends, home care companies, or domestic workers. Adequate documentation and evidence must be provided in order to receive these benefits.

The **Veteran's Pension** is available to veterans who served on active duty during a period of war. A **Death Pension** is available to un-remarried widows of deceased veterans who met the criteria below. An additional monthly payment available to more seriously disabled veterans or their widowed spouses is the **"Aid and Attendance"** benefit. Veteran households with income or assets above certain levels will not qualify for the benefit. Applicants with significant long-term care costs, such as home care, assisted living or nursing home care, are often eligible for VA pension or assistance benefits. The pension benefit is paid to a veteran who: (a) is age 65 or older, or permanently and totally disabled not due to his/her own misconduct; (b) was discharged from service under conditions other than dishonorable; (c) served at least 90 days of active military service, one day of which was during a war time period (at least 24 months if you entered active duty after September 7, 1980); and (d) has family "countable income" below a yearly limit set by law. ***"Countable income"*** includes income received by the veteran and his or her dependents, if any, from most sources (earnings, disability and retirement payments, interest and dividends, net income from farming or business) but excludes public assistance such as Supplemental Security Income (SSI). "Unreimbursed medical expenses" (including Medicare and medical insurance premiums and co-payments, home health, assisted living, nursing home costs) paid by the claimant are deducted from income to arrive at the countable income.

Net worth, or the net value of the **assets** of the veteran and his or her dependents, is also considered. It includes such assets as bank accounts, stocks, bonds, mutual funds and any property other than the veteran's residence and a reasonable lot area. There is no set limit on how much net worth a veteran and his dependents can have, but net worth cannot be excessive and the general rule is less than $80,000 for a couple. The decision as to whether a claimant's net worth is excessive depends on the facts of each individual case.

Your annual pension payment is calculated by first totaling all your countable income, then subtracting any deductions from that total. The remaining countable income is deducted from the appropriate "maximum annual pension rate" (based on the veteran's marital and dependent status). The resulting amount is then divided by 12 and rounded down to the nearest dollar to give you the amount of your monthly payment. In **2018,** the **maximum annual pension rate** for a veteran with no dependents is $13,166 ($1,097 per month), and $17,241 ($1,437 per month) for a veteran with one dependent. The the **maximum annual pension rate** for a surviving spouse with no dependents is $8,830 ($736 per month).

Veterans or spouses who are more seriously disabled may qualify for **Aid and Attendance or Housebound** benefits in addition to monthly pension. This benefit **may not** be paid without eligibility for pension. A claimant may be eligible for A&A when (a) the veteran requires the aid of another person in order to perform personal functions required in everyday living, such as bathing, feeding, dressing, attending to the wants of nature, adjusting prosthetic devices, or protecting himself/herself from the hazards of his/her daily environment; **or** (b) the veteran is bedbound, in that his/her disability or disabilities requires that he/she remain in bed apart from any prescribed course of convalescence or treatment; **or** (c) the veteran is a patient in a nursing home due to mental or physical incapacity; **or** (d) the veteran is blind, or so nearly blind as to have corrected visual acuity of 5/200 or less, in both eyes, or concentric contraction of the visual field to 5 degrees or less.

Housebound assistance is paid in addition to monthly pension. A veteran may be eligible for Housebound benefits when (a) the veteran has a single permanent disability evaluated as 100-percent disabling AND, due to such disability, he/she is permanently and substantially confined to his/her immediate premises, or (b) the veteran has a single permanent disability evaluated as 100-percent disabling AND, another disability, or disabilities, evaluated as 60 percent or more disabling.

In **2018**, the maximum annual **Aid & Attendance** benefit (includes pension) is $21,962 ($1,830 per month) for a veteran with no dependents, and $26,036 ($2,170 per month) for a veteran with one dependent. The maximum annual **Housebound** benefit is $16,089 ($1,341 per month) for a veteran with no dependents, and $20,166 ($1,681 per month) for a veteran with one dependent. The maximum annual Aid & Attendance benefit for a widowed spouse is

$14,113 ($1,176 per month) for a claimant with no dependents, and $16,837 ($1,403 per month) for a claimant with one dependent child. The maximum annual Housebound benefit for a widowed spouse is $10,792 ($899 per month) for a claimant with no dependents, and $13,514 ($1,126 per month) for a claimant with one dependent child. A claimant cannot receive both Aid and Attendance and Housebound benefits at the same time.

How to Apply for Aid and Attendance and Housebound:

You may apply for Aid and Attendance or Housebound benefits by filing an application with the VA regional office that serves your area of residence. You should **include copies of any evidence,** preferably a report from an attending physician validating the need for Aid and Attendance or Housebound type care. The report should be in sufficient detail to determine whether there is disease or injury producing physical or mental impairment, loss of coordination, or conditions affecting the ability to dress and undress, to feed oneself, to attend to sanitary needs, and to keep oneself ordinarily clean and presentable. In addition, it is necessary to determine whether the claimant is confined to the home or immediate premises. Whether the claim is for Aid and Attendance or Housebound, the **report should indicate how well the individual gets around,** where the individual goes, and what he or she is able to do during a typical day. You can apply on line at the VA web site: http://vabenefits.vba.va.gov/vonapp/main.asp. You may download and fill out VA Form 21-526, Veteran's Application for Compensation and/or Pension. Make sure you download all parts of the application as well as the instructions for filling out the forms. If available, attach copies of dependency records (marriage & children's birth certificates). You must send the completed application and any copies of other documents to the VA Jackson Regional Office at 1600 E. Woodrow Wilson Avenue, Jackson, Mississippi 39216, phone 800-827-1000. You may also contact a Veterans Service Officer (VSO) from a veterans service organization, who are located in each county in Mississippi. You may call the toll free number, 1-800-827-1000, for the location of the VSO nearest you.

RESIDENTIAL HOUSING OPTIONS

The term "long term care" includes medical and non-medical care provided to an individual who cannot live independently. Such care must be delivered in the person's own home or in some other residential setting where the individual's

needs can be met. Some of the options for such residential care settings include the following:

I. In-Home Care By Relatives. As people age and begin to develop physical problems, initial care may be provided by family members – usually a spouse or child. In the early stages of care-giving this is a practical, inexpensive solution. Factors affecting the ability of family to provide care include the health and work schedules of the care-giving family members along with their own additional responsibilities.

II. In-Home Care By Paid Caregivers. When family members cannot provide the level or amount of care needed, paid caregivers can be brought in to assist the family. In some cases, Medicare will fund a limited number of home visits following a surgery or critical care episode (the "home care benefit"), or when hospice care is appropriate. Some long-term care insurance policies will also pay for a specified amount of professional care-giving service. The Medicaid home-and-community-based waiver programs discussed in this section also provide some care-giving services. Much of the time, however, this becomes a responsibility which must be paid by the individual and their family.

III. Medicaid Waiver Programs. Several Medicaid Waiver programs provide a variety of services for elderly or disabled clients in their homes. These are statewide programs designed to offer assistance to qualified Medicaid beneficiaries in lieu of institutional care. Determination of appropriate services is made by an evaluation process and may be affected by the amount of available funding. In some areas of the state, there are waiting lists for these programs. Not all services will be deemed appropriate for all clients. (See the Medicaid section above for a list of these programs.)

IV. Adult Day Services. Some communities have adult day service programs. These are facilities which provide day-long supervision, meals, and activities for elderly clients for a fee. They provide a safe, comfortable and stimulating environment and permit the care-giver(s) to go to work or care for their other family needs. Adult Day Services generally have broad criteria for clients who enter their programs. Programs are available for full or half days and clients may come once a week or five days a week. Some of these facilities

offer specialized Alzheimer's units. Adult Day Services may be paid by certain Medicaid programs (such as the Elderly & Disabled Waiver program) or by the Veterans' Administration.

V. Continuing Care Retirement Communities.

A new trend in long term care is the Continuing Care Retirement Community. It is estimated that more than 2,100 CCRC's are open nationally, with twenty more opening each year. These offer apartment or one-story living accommodations plus common rooms, dining halls, exercise facilities, transportation, etc. They also offer on-site assisted living or skilled nursing care. These usually require a significant entrance fee plus a monthly charge. There are no federal regulations on CCRC oversight, but some of these communities have been accredited by the Continuing Care Accreditation Commission. (We can help our clients evaluate such facilities.)

VI. Assisted Living Facilities.

These are facilities that house residents who cannot live independently but who do not require nursing facility care. An assisted living setting should provide or coordinate personal services, 24-hour supervision and assistance, activities, and health related services. They are designed to accommodate the individual resident's changing needs and preferences, to maximize their dignity, autonomy, privacy, independence and safety and to minimize the need to move to a skilled nursing facility. They also encourage family and community involvement. They provide such services as meals, housekeeping and laundry assistance, and personal care assistance. Assisted Living Homes are certified and licensed by the state Department of Health. Residents are generally expected to be able to take their own medications and to be ambulatory, although the issue of ambulation (and wheelchair use) is coming under some review. This category also includes personal care homes and boarding homes. These facilities are not regulated by the Mississippi Department of Health, although some voluntarily obtain certification. They are less expensive than Assisted Living Facilities and generally do no offer the same range of services.

VII. Skilled Nursing Facilities (Nursing Homes).

Skilled Nursing Facilities (nursing homes) are licensed and certified by the State Department of Health to provide nursing care to their residents who are no longer able to live independently. Generally, nursing home residents enter

skilled nursing care when their medical condition is severely compromised either by a catastrophic event like a stroke or from progressive deterioration due to conditions such as Alzheimer's disease, Parkinson's disease, or just the effects of aging. Nursing home residents' care must be supervised by a physician. All nursing homes which accept Medicare and/or Medicaid reimbursement are required to conform to the Nursing Home Reform Law (OBRA '87) which judges the nursing home not on its capacity to provide care, but on whether residents actually receive needed care. You may compare the quality assessments of nursing homes online at www.medicare.gov/NHcompare.

VIII. Hospice. Hospice care is designed to meet the needs of persons with terminal illness and their families. Hospice patients must be referred to the service by their physicians, generally at a point when they are not expected to live more than six months. Services can help a patient remain at home with appropriate medical support, and end-of-life care can include moving a patient to a hospice facility or increasing the nursing support at home. Hospice does not provide caregivers, but works with the caregivers and family members to meet their needs, including medical equipment, nursing care, and counseling.

NURSING HOME RIGHTS, PROCEDURES AND PROTECTIONS

The federal Nursing Home Reform Act (NHRA) of 1987 establishes rights of residents in nursing homes that accept Medicare and Medicaid. Nursing facilities must provide services that attain and maintain the highest practicable mental, physical, and psychosocial well being of each resident using a written plan of care.

I. Residents' Bill of Rights. Each resident must be informed, at admission and upon later request, of the resident's rights (1) to choose a physician and participate in establishing a care plan, (2) to full information from the health care provider about medical status, residents' rights, grievance procedures, and available benefits, (3) to privacy about medical treatment and during personal communications and the right to authorize access to medical records to family or others, (4) to decline to participate in social activities and to have family visitors at any time and nonfamily visitors during reasonable visiting hours, (5) to prior notice of any discharge or transfer, (6) to review all

transactions made on his/her behalf and to keep independent bank accounts, (7) to be free from abuse and unprescribed restraints, (8) to receive services with reasonable accommodation of individual needs and preferences and notice before a room or roommate of a resident is changed, (9) to voice grievances regarding treatment or care without discrimination, and (10) to examine the most recent facility survey and any plan of correction for it.

II. Discharge/Transfer Rules. NHRA permits discharge of a resident only if the resident (1) no longer needs nursing home care, (2) presents a danger to the health and safety of others, (3) fails to pay, or the facility (4) cannot meet the resident's needs or (5) closes. A facility must have a post-discharge plan of care, developed with the participation of the resident and his/her family, which will assist the resident to adjust to his/her new living environment. 42 CFR 483.20(1)(3)

III. Older Americans Act. Each state must establish an Office of The Ombudsman, to investigate nursing home activities and help residents resolve complaints. The Ombudsman is located in the local Area Agency on Aging office (see Appendix).

ABUSE OF THE ELDERLY

According to an April 2006 Houston Chronicle article: "The National Center on Elder Abuse, a Washington, D.C. clearinghouse for elder rights advocates, estimates there may be as many as 5 million victims of elder abuse a year. But it acknowledges no one knows for sure because there is no comprehensive data collection nationwide and because many seniors suffer in silence." Eileen Alt Powell, Associated Press, *"Financial abuse grows as elderly become targets / With population aging, more scams aimed at seniors"*, The Houston Chronicle (April 17, 2006). The Mississippi Vulnerable Persons Act (MCA §43-47-1, -7) requires that any person, care facility or professional employee who has knowledge of or reasonable cause to believe that a "vulnerable adult" has been the victim of abuse, neglect, or exploitation shall report the information to the Mississippi Department of Human Services (for home health agency reports) or the Mississippi Department of Health (for other care facility reports or reports by private persons). There are criminal penalties for such acts, and protective services may be obtained for adults who lack capacity to understand and consent to such services.

What is a "vulnerable person"?

- Any person (child included) whose ability to perform the normal activities of daily living or to provide for his/her own care or protection is impaired due to a mental, emotional, physical or developmental disability or dysfunction, or brain damage or the infirmities of aging.
- Includes all residents or patients of a care facility.

How does the law protect vulnerable adults?

The Act defines the crime, provides for mandatory reporting, and provides for protective services

What is the crime?

It is unlawful for any person to abuse, neglect, or exploit any vulnerable adult.

What is abuse?

- The willful or non-accidental infliction of physical pain, injury or mental anguish
- The unreasonable confinement of a vulnerable adult, by physical or drug-induced confinement
- The willful deprivation by a caretaker of services which are necessary to maintain the mental and physical health of a vulnerable adult
- Includes sexual abuse
- Does not mean conduct which is a part of the treatment and care of, and in furtherance of the health and safety of a patient or resident of a care facility.
- Includes, but is not limited to, a single incident.

What is neglect?

- The inability of a vulnerable adult who is living alone to provide for himself the food, clothing, shelter, health care or other services which are necessary to maintain his mental and physical health.
- The failure of a caretaker to supply the vulnerable adult with the food, clothing, shelter, health care, supervision or other services which a reasonably prudent person would do to maintain the vulnerable adult's mental and physical health.
- Includes a single incident.

What is exploitation?

- The illegal or improper use of a vulnerable adult or his resources for another's profit or advantage with or without the consent of the vulnerable adult, and includes acts committed pursuant to a power of attorney.
- Includes a single incident.

What is the punishment?

Misdemeanor Abuse – (contributes to, tends to contribute to or results)

- Fine up to $1,000
- Imprisonment up to 1 year in the county jail, or
- Both fine and imprisonment

Misdemeanor Neglect –

- Fine up to $1,000
- Imprisonment up to 1 year in the county jail, or
- Both fine and imprisonment

Misdemeanor Exploitation – (value exploited less than $250.00)

- Fine up to $5,000
- Imprisonment up to 1 year in the county jail
- Both fine and imprisonment

Felonious Abuse –

- Imprisonment in the State Penitentiary up to 20 years
- Fine up to $10,000

Felonious Exploitation – (value exploited more than $250.00)

- Imprisonment in the State Penitentiary up to 10 years
- Other charges can be used as well (i.e., forgery, embezzlement, rape, etc.) depending on the facts of the case.

Who has to report?

General Public

- Any person who knows or suspects that a vulnerable adult has been or is being abused, neglected or exploited.
- Including, but not limited to, the following:
    - Attorney, physician, medical examiner, chiropractor or nurse engaged in the admission, examination, care or treatment of a vulnerable adult;

- Health professional or mental health professional not otherwise specified;
- Practitioner who relies solely on spiritual means for healing;
- Social worker or other professional adult care, residential or institutional staff;
- State, county or municipal criminal justice employee or law enforcement officer;
- Human rights advocacy committee or long-term care ombudsman council member; or
- Accountant, stockbroker, financial advisor or consultant, investment advisor or consultant, insurance agent or consultant, financial planner, or any officer or employee of a bank, savings and loan, credit union or any other financial service provider.

Care Facilities

- Any person who within the scope of his employment at a care facility or his professional or personal capacity who has knowledge of or a reasonable cause to believe that any patient or resident of a care facility has been the victim of abuse, neglect or exploitation.

What has to be reported?

The facts of what you know or suspect.

Who receives the reports?

In Private Homes:

- The Department of Human Services (800-222-8000) or Attorney General's Vulnerable Adult Unit (601-359-4158)
- Local law enforcement

In Care Facilities:

- The Medicaid Fraud Control Unit of the Attorney General's Office (800-852-8341)
- The Division of Health Facilities Licensure and Certification of Department of Health (800-227-7308)
- Long-term Care Ombudsman Program (800-948-3090 or 800-345-6347)

What is the punishment for not reporting?

General Public

- Misdemeanor punishable by a fine up to $500 and/or imprisonment up to 6 months in the county jail

Health Care Facilities

- Misdemeanor punishable by a fine up to $500 and/or imprisonment up to 6 months in the county jail

What can happen to me if I make a report?

- Nothing. If you report, investigate, testify, you are **immune from liability,** civil or **criminal**, that might otherwise be incurred or imposed.
- The suspect/perpetrator is not immune.
- Intentional false reporting is not protected.

What kind of protective services are available?

Private Homes

- DHS investigates/makes a preliminary report to AG's Office within 48 hours
- DHS prepares a plan of services for the vulnerable adult
- DHS can ask court to order the provision of protective services
- A court can authorize an evaluation by a qualified third party upon a showing of probable cause, i.e., mental evaluation, financial records, etc.
- Local law enforcement and/or the AG's Office can take action through criminal prosecution

Care Facilities

- AG's Medicaid Fraud Unit investigates/prosecutes criminal acts
- Department of Licensure takes licensure actions

CARING FOR THE CAREGIVER

Caregiver Stress: The Importance of Taking Care of Yourself

Caring for a loved one can be a strain on even the most resilient individuals. If you're a caregiver, take steps to preserve your own health and well-being.

A caregiver is anyone who provides help to another person in need, whether that's an ill spouse or partner, a disabled child, or an aging relative. More than 65 million Americans provide care to a loved one. If you're among them, you know that taking care of someone who needs your assistance can be very rewarding. But it can also exact a high toll, and caregiver stress is common. Caregiver stress is the emotional and physical strain of caregiving. Individuals who experience the most caregiver stress are the most vulnerable to a decline in their own health.

Many caregivers fall into the trap of believing that they have to do everything by themselves. Don't make that mistake. Take advantage of the many resources and tools available. Remember, if you don't take care of yourself you won't be able to care for anyone else.

Signs of Caregiver Stress

As a caregiver, you may be so focused on your loved one that you don't realize that your own health and well-being are suffering. Watch for these signs of caregiver stress:

- Feeling tired most of the time
- Feeling overwhelmed and irritable
- Sleeping too much or too little
- Gaining or losing a lot of weight
- Losing interest in activities you used to enjoy

Too much stress, especially over a long time, can harm your health. As a caregiver, you're more likely to experience symptoms of depression or anxiety. In addition, you may not get enough physical activity or eat a balanced diet, which only increases your risk of medical problems, such as heart disease and diabetes.

Tips for Dealing With Caregiver Stress

The emotional and physical demands involved with caregiving can strain even the most capable person. That's why it's so important to take advantage of available help and support. These tips have helped others deal with caregiver stress:

- Accept help. Be prepared with a list of ways that others can help you and let the helper choose what he or she would like to do. For instance, one person might be happy to take the person you care for on a walk a couple of times a week. Someone else might offer to pick up groceries for you.

- Don't give in to guilt. Feeling guilty is normal, but understand that no one is a "perfect" caregiver. You're doing the best you can at any given time. Your house does not have to be perfect, and no one will care if you eat leftovers three days in a row. And you don't have to feel guilty about asking for help.
- Get informed. Organizations such as the Red Cross and the Alzheimer's Association offer classes on caregiving, and local hospitals may have classes specifically about the disease your loved one is facing.
- Join a support group. A support group can be a great source for encouragement and advice from others in similar situations. It can also be a good place to make new friends.
- Stay connected. Make an effort to stay in touch with family and friends. Set aside time each week for socializing, even if it's just a walk with a friend. Whenever possible, make plans that get you out of the house.
- Commit to staying healthy. Find time to be physically active on most days of the week, and don't neglect your need for a good night's sleep. It's also crucial to eat a healthy diet.
- See your doctor. Get recommended immunizations and screenings. Make sure to tell your doctor that you're a caregiver. Don't hesitate to mention any concerns or symptoms you have.

Alzheimer's Mississippi has a wonderful **Caring for Yourself** tips guide online at www.alzms.org/wp-content/uploads/2016/10/ALZMS_CaregivingTips_CaringforYourself-01-1.pdf, along with a variety of helpful resources to help the stressed-out caregiver deal specifically with feelings of being overwhelmed, withdrawal from social contacts, worry, financial anxiety and many other effects of such stress.

Respite Care

It may be hard to imagine leaving your loved one in someone else's care, but taking a break is one of the best things you can do for yourself as well as the person you're caring for. Most communities have some type of respite care available, such as:

- Adult care centers. Many adult care centers are located in churches or community centers. Some care centers provide care for both elderly adults and young children, and the two groups may spend time together.
- Day hospitals. These hospitals provide medical care during the day. In the evening, your loved one returns home.
- In-home respite. Health care aids come to your home to provide companionship, nursing services or both.
- Short-term nursing homes. Some assisted living homes, memory care facilities and nursing homes accept people needing care for short stays while caregivers are away.

The Caregiver Who Works Outside The Home

Two-thirds of caregivers work outside of the home. Juggling work responsibilities and caregiving isn't easy, and employed caregivers experience high levels of caregiver stress. If you're in this situation, try these tips for balancing your work and personal responsibilities:

- Learn to delegate. Share your work — and home — responsibilities with others.
- Ask your human resources department about resources your company offers, such as support lines or referral services. Then make use of these assistance programs.
- Keep an open line of communication with your supervisor and co-workers.
- Ask your loved one's doctor to send a letter to your company explaining the seriousness of your loved one's condition.

You Aren't Alone

If you're like many caregivers, you have a hard time asking for help. Unfortunately, this attitude can lead to feeling isolated, frustrated and even depressed. Rather than struggling on your own, take advantage of local resources for caregivers. To get started, contact your local Area Agency on Aging (AAA) to learn about services in your community. You can find your local AAA office information in the back of this guidebook or online at the Mississippi Department of Human Services Division of Aging and Adult Services, at http://www.mdhs.state.ms.us/for-adults/#seniors.

CONCLUSION

Mark Twain once said: ***"The secret of getting ahead is getting started. The secret of getting started is breaking your complex overwhelming tasks into small manageable tasks, then starting on the first one."***

Personal and family legal planning, and particularly dealing with the difficulties of dementia, may seem overwhelming. Your first "small manageable task" in putting a good legal plan in place for personal and family security, or planning to help a loved one with incapacity, is **to call our office** for a conference. We can identify the particular issues you face, suggest and implement planning options, and provide on-going assistance to help you achieve your estate planning, decision-making, Medicaid, long term care, special needs planning, or other goals. By putting a good plan into place, you and your family will have peace of mind and rest secure knowing that you have taken full advantage of the resources and opportunities available to you.

At Courtney Elder Law Associates, we provide:

Legal Solutions for Lifetime Health and Wealth:
Families, Older Adults, and Persons with Disabilities.

OTHER HELPFUL RESOURCES

Alzheimer's Mississippi, Inc.

855 S. Pear Orchard Rd., Ste. 501, Ridgeland, MS 39157, 601-987-0020, toll-free 877-930-6190, www.alzms.org.
(find many great caregiving tips on the *"Caregiver Topic Sheets"* page under *Information & Resources*.)

Alzheimer's Disease Education and Referral (ADEAR) Center

800-438-4380 (toll-free) http://www.nia.nih.gov/alzheimers
(download or order free booklet *"Home Safety for People with Alzheimer's Disease"*)

Family Caregiver Alliance

800-445-8106 (toll-free) www.caregiver.org
(download free *"Handbook for Long-distance Caregivers"*)

Aging Life Care Association

520-881-8008 www.aginglifecare.org
(for information about and help locating a Geriatric Care Manager)

Mississippi Department of Human Services Division of Aging and Adult Services

(601-359-4929 800-948-3090 (toll-free)
http://www.mdhs.ms.gov/adults-seniors/

Alzheimer's Association / Mississippi Chapter

232 Market Street, 2nd Floor, Flowood, MS, 39232, 228-437-0650,
24/7 Helpline 800-272-3900
https://www.alz.org/ms/

Area Agency on Aging	Director	Contact Information	Counties Served
Central MS Area Agency on Aging	Chelsea Crittle	P.O. Box 4935 Jackson, MS 39296 (601) 981-1516 1-888-995-9925	Copiah, Hinds, Madison, Rankin, Simpson, Warren, Yazoo
East Central Area Agency on Aging	Rosie Coleman	P.O. Box 499 Newton, MS 39345 (601) 683-2401 1-800-264-2007	Clarke, Jasper, Kemper, Lauderdale, Leake, Neshoba, Newton, Scott, Smith
Golden Triangle Area Agency on Aging	Bobby Gann	P.O. Box 828 Starkville, MS 39760-0828 (662) 324-4650 (662) 332-2636 (toll free within a 55-mile radius) 1-888-324-9000	Choctaw, Clay, Lowndes, Noxubee, Oktibbeha, Webster, Winston
North Central Area Agency on Aging	Darlena Allen	711-B South Applegate Winona, MS 38967 (662) 283-2675 (662) 283-2771 (toll free within a 55-mile radius) 1-888-427-0714	Attala, Carroll, Grenada, Holmes, Leflore, Montgomery, Yalobusha
North Delta Area Agency on Aging	Roderick Gordon	P.O. Box 1488 Batesville, MS 38601-1488 (662) 561-4100 1-800-844-2433	Coahoma, Desoto, Panola, Quitman, Tallahatchie, Tate, Tunica
Northeast MS Area Agency on Aging	Jane Perrigo	P.O. Box 600 Bonneville, MS 38829 (662) 728-7038 1-800-745-6961	Alcorn, Benton, Marshall, Prentiss, Tippah, Tishomingo

Area Agency on Aging	Director	Contact Information	Counties Served
South Delta Area Agency on Aging	Sylvia Jackson	P.O. Box 1776 Greenville, MS 38702-1776 (662) 378-3831 1-800-898-3055	Bolivar, Humphreys, Issaquena, Sharkey, Sunflower, Washington
Southern MS Area Agency on Aging	Robert Moore	9229 Highway 49 Gulfport, MS 39503 (228) 868-2326 1-800-444-8014 (nationwide) www.smpdd.com	Covington, Forrest, George, Greene, Hancock, Harrison, Jackson, Jefferson Davis, Jones, Lamar, Marion, Pearl River, Perry, Stone, Wayne
Southwest MS Area Agency on Aging	Yolanda Campbell	100 South Wall Street Natchez, MS 39120 (601) 446-6044 1-800-338-2049	Adams, Amite, Claiborne, Franklin, Jefferson, Lawrence, Lincoln, Pike, Walthall, Wilkinson
Three Rivers Area Agency on Aging	Joseph Cleveland	P.O. Box 690 Pontotoc, MS 38663 (662) 489-2415 (662) 489-6911 (toll free within a 55-mile radius) 1-877-489-6911 (statewide) www.trpdd.com	Calhoun, Chickasaw, Itawamba, Lafayette, Lee, Monroe, Pontotoc, Union

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