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BASICS

THINGS YOU NEED TO KNOW ABOUT:

- Social Security
- Medicare
- In-Home Care
- Medicaid
- Medicare Supplement Insurance
- Long-Term Care Insurance
- Senior Housing

CSA
Society of Certified Senior Advisors

CSA

Certified
Senior Advisor (CSA)

What is a Certified Senior Advisor (CSA)®?

CSAs are specialists in aging — professionals who have supplemented their expertise with knowledge about aging and health, social and financial issues important to many older adults.

CSAs are uniquely able to help you navigate your individual experience of aging and benefit from its opportunities.

Your CSA will help you:

- Know what to expect and plan for as you age
- Integrate your needs and goals — health, social and financial
- Consider factors to make decisions in your best interests
- Select your best options and solutions
- Make adjustments as your needs change

Your CSA will also help you find services and supports for your aging needs, and refer you to other qualified professionals with complementary expertise.

All CSA candidates must pass a certification exam and criminal background check, and agree to uphold the highest ethical standards for the benefit and protection of older adults. Also, every three years CSAs must fulfill continuing education requirements, verify their compliance with laws and regulations, and reaffirm their pledge to follow the *CSA Code of Professional Responsibility*.

Introduction

In America today, aging means more complication. Whether it is dealing with the details of Medicare or the challenges of Medicaid, or whether it is determining the “if” and “when” of long-term care insurance or the “how” of home care, aging poses its own unique requirements either on ourselves or on the older adults we care about.

This brochure answers some of the most frequently asked questions about Social Security, Medicare, Medicare Supplement Insurance, Medicaid, Long-Term Care Insurance, In-Home Care, and Senior Housing. It does not cover every subject you need to know, but it covers some of the subjects you should know.

The idea for this brochure originated from our Certified Senior Advisors (CSAs) who have taken the time to learn about the complexity of aging and how to help older adults find the tools to navigate that journey. A CSA may not have the immediate answer to your question, but they can promptly access their colleagues who do. So no matter what information you may need, a professional who holds the CSA credential is always a highly valuable source.

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SOCIAL SECURITY

The Social Security Retirement Program, was started in 1935, and was designed as a financial "safety net" for retired workers and their families. There are five major components: Retirement, Disability and SSI, Survivor's Benefits, and Medicare.

Retirement

When people reach retirement age, Social Security income provides a foundation on which they can build a secure retirement. It is intended to supplement other income sources including work income, pensions, savings and investment gains.

Many financial advisors recommend that, at retirement time, people have about 70 percent of their preretirement income in order to maintain their standard of living. For the average worker, Social Security benefits replace approximately 40 percent of pre-retirement income. Social Security retirement income is the entire source of income for one out of five older adults and about 96 percent of all workers are covered by Social Security.

The benefit comes from the Old-Age, Survivors, and Disability Insurance (OASDI) funds through the federal government. The Social Security retirement program has undergone important changes and it is anticipated that further changes will be necessary to keep the system solvent and functioning. No one knows at this time what those changes might be, but this guide explains the program as it currently exists.

How do I qualify for Social Security?

To qualify for Social Security benefits, a worker earns credits when he or she works in a job and pays Social Security taxes. The number of credits required to receive retirement benefits depends on when you were born. If you were born in 1929 or later, you need 40 credits.

Credits are calculated as follows: one credit is earned in covered employment, for a maximum of four credits per year. With four credits per year for 10 years (40 credits) the worker is "fully insured."

If workers stop working before they have enough credits to qualify for benefits, the credits remain on their Social Security record. If they return to work later, more credits can be earned to qualify. No retirement benefits can be paid until they have the required number of credits.

When workers reach full retirement age, they can receive full retirement benefits. The full retirement age used to be 65, but now it varies based on the year of birth.

Birth Year	Full Retirement Age
1937	65
1938	65 & 2 months
1939	65 & 4 months
1940	65 & 6 months
1941	65 & 8 months
1942	65 & 10 months
1943-1954	66
1955	66 & 2 months
1956	66 & 4 months
1957	66 & 6 months
1958	66 & 8 months
1959	66 & 10 months
1960+	67

Reduced retirement benefits can be collected as early as age 62 (with 40 credits), and benefits will be approximately 25% less. If benefits are collected later than full retirement age, they will be increased slightly.

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A spouse who has not worked or who has low earnings can be entitled to as much as one-half of the retired worker's full benefit. If you are eligible for both, your own retirement benefits and for benefits as a spouse, Social Security will always pay your own benefits first.

It is important to remember that although Social Security retirement age now varies depending on your birth year, Medicare eligibility remains at age 65.

Are my retirement benefits figured on my last five years of income?

No. Retirement benefits are calculated on earnings during a lifetime of work under the Social Security system. For most current and future retirees, your 35 highest years of earnings will be averaged. If you have fewer than 35 years of earnings, years of zero earnings are averaged in to bring the number of years to 35.

How can I find out how much Social Security income I will receive?

The benefit computation is complex and there are no simple tables that tell you how much you will receive. However, there are several ways to determine an estimate of your retirement benefits:

1. Social Security sends a yearly Social Security Statement to everyone age 60 or older who has paid Social Security taxes and has not yet received benefits and to those who do not yet have a secure online "My Social Security account." A Social Security statement should arrive about three months before your birthday each year.

   Statements can be requested by calling the Social Security Administration and asking for a form SSA-7004, Request for Social Security Statement, or by downloading the form at:

   www.ssa.gov/forms

You can also use the online Benefits Planner to estimate your benefits at:

www.ssa.gov/planners

2. Read "Your Retirement Benefit, How it is Figured," a publication that walks you through the formula for computing your retirement benefit. You can view this publication online at:

www.ssa.gov/pubs/EN-05-10070.pdf

Do I have to apply for Social Security benefits?

Yes. Apply for benefits about three months before the date you want your benefits to start. Most information can be obtained over the phone by calling 800-772-1213 or by visiting the Social Security Administration website:

www.ssa.gov

Can I still receive my benefits if I am working?

If you reached your Full Retirement Age, you can earn any amount and receive full Social Security retirement benefits.

If you are under the Full Retirement Age when you start receiving Social Security payments, $1 in benefits will be deducted for each $2 you earn above the annual limit. The earnings limit changes yearly.

In the year you reach your Full Retirement Age, $1 in benefits will be deducted for each $3 you earn above a different limit, but only counting earnings before the month you reach Full Retirement Age. The earnings limit changes yearly.

Does my investment income count toward earnings?

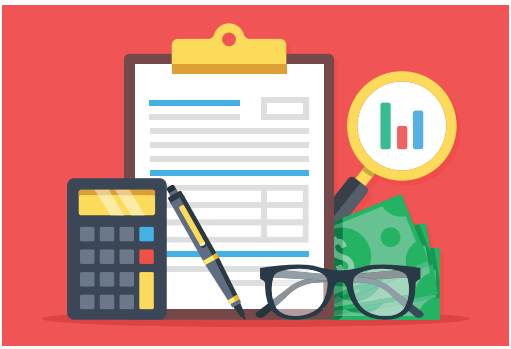
Non-work sources of income do not count as wages for the earnings test. Non-work sources of income include:

- Inheritance payments
- Pensions
- Income from investments
- IRA distributions
- Interest
- Other sources as determined by the Social Security program

The only criterion for Social Security eligibility is the loss of earnings, not the failure to have investment income.

Does my investment income count toward earnings?

Some people have to pay federal income taxes on their Social Security benefits. This usually happens only if you have other substantial income (wages, self-employment, interest, dividends, and other taxable income that must be reported on your tax return) in addition to your benefits. No one pays federal income tax on more than 85 percent of his or her Social Security benefits based on Internal Revenue Service (IRS) rules.



If you:

- **File a federal tax return as an "individual" or file a joint return and have combined income:**

    1. Between the annual limits (see www.ssa.gov for annual changes), you may have to pay income tax on 50 percent of your benefits.

    2. Higher income levels, may have up to 85 percent of your benefits be taxable.

- **Are married and file a separate tax return, you probably will pay taxes on your benefits.**

Each January you will receive a Social Security Benefit Statement (Form SSA-1099) showing the amount of benefits you received in the previous year. You can use this Statement when you complete your federal income tax return to find out if your benefits are subject to tax.

Although you are not required to have federal taxes withheld from your Social Security benefits, you may find it easier than paying quarterly estimated tax payments. For more information about your taxes, see Internal Revenue Service (IRS) Publication 554, "Tax Information for Older Americans," and Publication 915, "Social Security Benefits and Equivalent Railroad Retirement Benefits." Both publications have worksheets to help you figure out whether your benefits would be taxable. You can call the IRS at 800-829-3676 to ask for copies of these publications.

*Combined income is the sum of your adjusted gross income on your 1040 tax return, plus nontaxable interest, plus one-half of your Social Security benefits.

Disability and Supplemental Security Income (SSI)

This benefit is a distribution of cash in the event of interruption of employment, including disability and unemployment, when people become severely disabled and are unable to perform substantial work. The benefit is based on the beneficiary's work record only. The beneficiary must be "fully insured" under Social Security rules.

There is a five-month waiting period for Social Security disability benefits and the benefits will continue until a beneficiary is able to return to work or until retirement age if the individual cannot return to work.

For more information, call 800-772-1213 or contact your local Social Security office for an appointment to apply.

Survivors Benefits

Are retirement benefits available to a surviving spouse, children, or a divorced spouse?

When a person who has worked and paid Social Security taxes dies, certain members of the family may be eligible for survivors benefits (a widow or widower, unmarried children up to 18, disabled children of any age, dependent parents at least age 62). Up to ten years of work is needed to be eligible for benefits, depending on the person's age at the time of death.

- You can work and still collect survivor's benefits, depending on your age and income.
- Social Security survivor's benefits can be paid to:
  - A widow or widower - full benefits at full retirement age, or reduced benefits as early as age 60.
  - A disabled widow or widower - as early as age 50.
  - A widow or widower at any age if he or she takes care of the deceased's child who is under the age of 16 or disabled and receiving Social Security benefits.
  - Unmarried children under 18, or up to age 19 if they are attending high school full time. Under certain circumstances, benefits can be paid to stepchildren, grandchildren or adopted children.
  - Children at any age who were disabled before age 22 and remain disabled.
  - Dependent parents age 62 or older.

Resources:
Social Security Administration website, www.ssa.gov; Working with Older Adults, Society of Certified Senior Advisors® (2015)

MEDICARE

Medicare is the health insurance program, administered by the federal government, for people 65 years of age and older, certain younger people with disabilities, people with end stage Renal Disease (ESRD), and people with Lou Gehrig's Disease (Amyotrophic Lateral Sclerosis, ALS).

Get the most from your Medicare benefits by learning what Medicare covers and by taking advantage of all the benefits that Medicare has to offer.

Medicare Part A (Hospital Insurance)

Helps cover most medically necessary inpatient hospital care. Part A also helps cover skilled nursing facility care (following a three night hospital stay and discharge to a Medicare approved skilled nursing facility). Medicare also covers home health and hospice care, if certain conditions are met.

Medicare Part B (Medical Insurance)

Helps cover most medically necessary doctors' services, durable medical equipment, lab tests, x-rays, mental health care, some home health ambulance services, and hospital outpatient care. Part B also covers many preventative services to help maintain health and to keep certain illnesses from progressing.

Medicare Part C (Medicare Advantage Plans)

Part A, Part B, and sometimes Part D (prescription drug) coverage. Part C, most commonly called Medicare Advantage Plans, are health plans offered by private companies and approved by Medicare. It is important to note that a Medicare Advantage Plan replaces Original Medicare {Parts A and B}.They must offer at least the same benefits as Original Medicare, but can do so with different rules,

costs, and coverage restrictions.

Medicare Advantage Plans always cover emergency and urgent care, and all services that original Medicare covers except hospice care. (Original Medicare covers hospice care even if you have a Medicare Advantage Plan.)

Medicare Advantage Plans may also offer extra coverage such as vision, hearing, dental, and/or health and wellness programs. Each plan can charge different out-of-pocket costs and may have different rules for how to get service.

Medicare Part D (Outpatient Prescription Drug Coverage)

Enrollment for prescription drug coverage is optional for people who receive Medicare benefits. Eligible individuals without creditable drug coverage are subject to late enrollment penalties, you must clarify you already have creditable coverage (as good as Part D).

Part D drug plan covers most brand name and generic drugs. Like other insurance, you pay a monthly premium, a deductible, and a share of the costs of your prescriptions. Monthly premiums and annual deductibles vary depending on the plan.

After you satisfy your deductible, you pay a percentage of your drug costs up to a certain amount. After that amount, you pay 100% of your drug costs until you have spent a certain yearly total. After that annual total is met, for the rest of that year, you will pay a minimal percentage of your drug costs. Cost maximums, yearly maximums, and percentages may change; go to www.medicare.gov for updated information.

Medicare eligibility is not based on income or resource levels. Your Medicare eligibility will not be affected by how much income you earn after retirement.

Medicare Part B Premium Payment

Part B premiums are deducted monthly from your Social Security, Railroad Retirement, or Civil Service Retirement check. Premium amounts can change yearly; you can verify premium amounts at www.medicare.gov.

If you do not receive monthly payments from Social Security, Railroad Retirement, or Civil Service Retirement, then Medicare will send you a bill every three months.

Long Term Care Benefit

Medicare pays only for medically necessary skilled care. It does not pay for non-skilled custodial care in your home or a facility. Custodial care is defined as personal care that provides help with (1) the Activities of Daily Living such as bathing, dressing, eating, transferring (getting in or out of a bed or chair), toileting or maintaining continence or (2) the effects of a cognitive impairment such as Alzheimer's or dementia, when the person is no longer safe to be unsupervised.

To qualify for Medicare coverage in a skilled nursing facility, you must first meet the qualifications of a three night hospital stay. After admission to a skilled facility, the care must be short-term, up to 100 days for recovery or rehabilitation. After the initial 20 days in a skilled facility, the patient will be responsible for part or all of the costs.

Medicare Enrollment and Medicare Due to Disability

If you are receiving Social Security benefits when you turn 65, Medicare Part A starts automatically.

If you are not collecting Social Security, you need to sign up for Medicare during the seven-month period that includes about three months before you reach age 65. You are eligible for premium-free Part A if you are 65 or older and you or your spouse worked and paid Medicare taxes for at least 10 years.

If you are covered by an employer group health insurance plan, you might want to delay enrollment into Medicare Part B. If you elect to delay enrollment in Part B, you can sign up later during a Special Enrollment Period or a General Enrollment Period. You will want to consult with Social Security prior to deferring your enrollment and when your employment coverage ends.

Medicare Advantage Plans

There are several different types of Medicare Advantage Plans including:

- Health Maintenance Organizations (HMO)
- Preferred Provider Organizations (PPO)
- Private Fee-for-Service (PFFS)
- Medicare Medical Savings Account (MSA)
- Special Needs Plan (SNP)
- Point of Service (POS)
- Provider Sponsored Organizations (PSOs)

It is important to know that Medicare Advantage Plan benefits can change annually and, if needed, you can go back to original Medicare.

Resources:
www.cms.hhs.gov (Centers for Medicare and Medicaid Services); www.medicare.gov (Medicare website); www.aarp.org (American Association of Retired Persons); Working with Older Adults, Society of Certified Senior Advisors® (2015);); www.medicareinteractive.org

MEDICARE SUPPLEMENT INSURANCE

Original Medicare pays for many, but not all health care services and supplies. A Medigap, or Medicare Supplemental, policy sold by private insurance companies can help pay some of these costs ("gaps") that Original Medicare does not cover, such as copayments, coinsurance, deductibles, and medical care when you travel outside the U.S. If you have Original Medicare and you buy a Medigap policy, both plans will pay their share of Medicare approved amounts for covered health care costs. Medicare does not pay any of the costs for a Medigap policy.

Buying Medigap insurance is an important process which should include weighing your priorities, comparing policies, and balancing coverage with affordability.

How do I know if a Medigap policy is legitimate?

Every Medigap policy must follow federal and state laws designed to protect you, and it must be clearly identified as "Medicare Supplement Insurance." Medigap insurance companies can sell you only a "standardized" Medigap policy identified in most states, except Massachusetts, Minnesota, and Wisconsin, by ten letters, Plans A, B, C, D, E, F, G, H, I, J, K, L, M and N. All plans offer a different set of standardized benefits. Premiums vary depending on the plan you choose and the insurance company you buy it from. It is important to review the various Medigap plans to match a plan with your health needs and budget.

Do I need Medicare to get a Medigap Policy?

You must have Medicare Part A (hospital coverage) and Part B (medical insurance) in order to purchase a Medigap policy, but you cannot purchase a Medigap policy if you have Medicare Part C, commonly called a Medicare Advantage plan.

Can my Medigap be canceled if I have a lot of health problems?

As long as you pay your premium, your Medigap policy is guaranteed renewable. It is automatically renewed each year and will continue, as long as your premium is paid. Premiums may increase each year.

Can I get a Medigap policy that also covers my spouse?

If married, you and your spouse must buy separate Medigap policies. Your Medigap policy will not cover any health care costs for your spouse.

Why should I buy a Medigap policy?

Medigap policies can lower your out-of-pocket medical costs and can provide increased health coverage beyond that provided by Medicare.

What are some examples of things not covered by Medigap policies?

Medigap policies do not cover things such as custodial care (long-term care), routine vision or dental care, hearing aids, and private-duty nursing.

How much do Medigap policies cost?

Each insurance company sets its own premiums and the cost of Medigap policies can vary widely. There can be big differences in the premiums that insurance companies charge for the same letter plan coverage, primarily due to different ways insurance companies set their prices. Although initial price is important, you should ask how long a plan has been available when choosing a plan. Newer plans may cost less initially but there may be significant renewal rate increases. Investigate carefully and thoroughly when choosing a Medigap plan.

When should I buy a Medigap policy?

It is important to buy a Medigap policy during your Medicare Open Enrollment Period, which starts on the day you are covered under Medicare Part B, or the first of the month you turn age 65 if you are already on Medicare Part B.

During the six-month Open Enrollment Period, an insurance company cannot:

- Deny you any Medigap policy it sells.
- Make you wait for coverage to start.
- Charge you higher premiums because of health problems.

Further, if you buy a Medigap policy during the open enrollment period and you had health insurance coverage for at least six months

prior, the company cannot apply a pre-existing condition waiting period to you.

You can submit an application for a Medigap policy prior to your Medicare Part B effective date or prior to turning age 65. In most states, you can apply up to 90 days ahead of the requested effective date. Some states allow you to apply up to six months ahead of that time.

Where can I go for more information?

For additional information on Medigap policies, how to enroll, or what policy is best for you, contact your State Health Insurance Assistance Program (SHIP). You can find the number of your SHIP by visiting www.shiptacenter.org. You can also contact your State Department of Insurance to get additional information on Medigap Ploicies in your state.

Additional links:

www.medicare.gov

www.medicarerights.org

www.aarpmedicaresupplement.com

Resources: www.healthinsuranceindepth.com; www.medicare.gov; www.aarp.org; "Choosing a Medigap Policy: A Guide to Health Insurance for People with Medicare. (www.nied1care.gov); Working with Older Adults, Society of Certified Senior Advisors® (2015)

Many people confuse Medicare and Medicaid. Medicaid was established in 1965 at the same time as Medicare under Title XIX of the Social Security Act. It was designed to assist low-income families in providing health care for themselves and their children. It also covers certain other individuals who fall below the federal poverty level. It covers hospital and doctor's visits, prenatal care, emergency room visits, prescription drugs, and other treatments. Medicaid also pays for custodial long-term care where Medicare does not.

Who Benefits from Medicaid?

Medicaid is a "means-tested program," available to those who meet their state's general, medical and financial eligibility requirements. It provides medical care to the poor-adults, children, and pregnant women living under the federal poverty level. It is funded jointly by the states and the federal government. Low income is only one test for Medicaid eligibility; assets and resources are also tested against established thresholds.

Within broad national federal guidelines, each state:

- Establishes its own eligibility standards.
- Determines the type, amount, duration, and scope of services.
- Sets the rate of payment for services.
- Administers its own program.

Medicaid & Long Term Care

Medicaid is the biggest financer of long-term care in the U.S. More than two-thirds of Medicaid spending for long-term care is on institutional services (nursing homes). The Deficit Reduction Act of 2005 made it more difficult for people with higher incomes and assets to become eligible for Medicaid benefits for long-term care.

Finacial Planning

While Medicaid provides a critical safety net for many older adults, the decision to rely on Medicaid entails some risks. Good financial planning can help the family determine if Medicaid funding for long-term care is a reasonable alternative to purchasing an appropriate long-term care insurance policy. A long-term care insurance policy can provide peace of mind while permitting the older person to remain at home for care or go to a facility and not erode the principal of their estate assets.

Older adults who fall below the federal poverty level (in both assets and income) usually do not have the income or the assets to purchase long-term care insurance or pay the costs of long-term care on their own. Those who qualify for Medicaid benefits through a "medically needy" determination face medical bills, including long-term care expenses, in excess of their ability to pay. An attorney who understands planning for the possibility of needing Medicaid benefits should be consulted.

Assets & Eligibility

Medicaid does not count all assets when determining eligibility. Older adults may keep some assets. These assets are called "non-countable assets" and include a home if a healthy spouse or disabled dependent child is living in the home. If not, then the home must be counted under a set value as determined by each state. Medicaid does not count the value of basic household furnishings, a car, or burial plots. A Medicaid beneficiary cannot keep other assets which are considered countable assets, such as stocks, bonds, investments, and retirement plan assets. According to federal law, an unmarried applicant for Medicaid may retain "non-countable assets" plus no more than a minimal amount in countable assets (determined by each state). Before Medicaid benefits begin, an applicant must consume or eliminate the amount of countable assets above this limit.

Each state has different income eligibility requirements. Medicaid counts Social Security income, defined benefit pensions, alimony, and income from immediate annuities as income. Most income counted by Medicaid will be applied toward nursing home and other care costs. Medicaid then makes up the difference between the total cost and available income.

Medicaid & Couples

Income decisions are complicated for married individuals, and some states set an individual income threshold for Medicaid eligibility.

Importance of Legal Advice

Families who face long-term care decisions, and wonder how to pay the high costs of care, may be able to transfer countable assets so they are inaccessible to both the Medicaid applicant and the Medicaid program by either giving them away or placing them in a trust. Medicaid will look back to review all financial transactions to determine eligibility. An elder law attorney should be consulted to assist in making good decisions.

Federal law requires states to seek recovery for Medicaid benefits by placing a claim against the probate estate of the deceased beneficiary. States may also seek to recover non-countable assets (such as the home) and/or non-probate assets such as jointly owned property, living trusts, etc. For these reasons, it is extremely important for the family to obtain competent legal advice about how assets can be affected by the Medicaid program.

Various financial tools, such as irrevocable trusts and some annuities (where the beneficiary is the state), can be used to preserve assets. Effective and safe use of these measures requires the assistance of a knowledgeable professional. Successful Medicaid planning should include documenting and executing powers of attorney (financial and medical) in case an older adult were to suddenly become incapacitated.

Medicaid may pay for some home health care services, depending on the type of needed care and the requirements of the state in which you reside.

Resources:
www.medicaid.gov;
Working with Older Adults, Society of Certified Senior Advisors® (2015)

LONG-TERM CARE INSURANCE

Long-term care is a family issue. When someone needs care, multiple family members typically are involved in the major decisions about where care will be given, by whom, and how to pay the cost. Long-term care insurance may be an option for providing an income stream to pay for the cost of care and care management.

Long-term care insurance provides an income stream to pay for services to help people who are unable to perform certain Activities of Daily Living (ADLs) without assistance. Long-term care insurance is available as individual insurance or through an employer-sponsored or association plan. The applicant must be healthy to apply, and the premiums are based on the applicant's gender, marital status, health, and age at the time of the application.

The decision of whether you or someone you love needs long-term care is made by a health professional who certifies that care is needed due to the inability to perform any of the ADLs without assistance.

ADLs include:

- Transferring from a chair or bed (Sometimes called mobility)
- Toileting and associated hygiene
- Bathing
- Dressing
- Eating
- Maintaining continence (Control of bowel or bladder)

The inability to perform the ADLs may be the result of an accident, illness, or cognitive impairment. Cognitive impairment is the deterioration or loss of intellectual capacity that requires continual supervision. Some such causes are Alzheimer's disease, Parkinson's, or dementia.

Long Term Care Insurance will begin to pay for the cost of care if the medical professional certifies that the policy holder cannot perform two of the six ADLs, or has a cognitive impairment that has an expectation of lasting at least 90 days.

Long-term care insurance plans generally address choices of where care will be given: at home (mostly by family members with paid professionals assisting), in adult day care, in an assisted living facility, or in a nursing home. The choice for the location of care is made at the time care is needed with guidance from a care coordinator, nurse, or social worker. This is an important benefit of the insurance plan because expert guidance may be necessary.

Long-term care plans are designed with only a few decisions to be made, and a licensed insurance professional can guide you. Knowing the cost of home care and facility care in your community before you purchase insurance will be helpful as you design a long-term care plan.

Some of the decisions you may have to make include the following:

- Most carriers offer an Elimination Period or Waiting Period the first time you access your policy benefits. This means you are responsible for long-term care costs until after the period is over. It is similar to a deductible on other types of insurance and will keep the cost of premiums at an affordable level. A period of 60-90 days of care is common, although, they can be as much as 360 days or as short as 0 days.
- Once the Elimination Period has been satisfied, the plan will pay a daily, weekly, or monthly maximum amount for your care, depending on the policy. This maximum will be deducted from a lifetime maximum pool of money in your plan, based on the amount chosen. Generally, the pool of money is hundreds of thousands of dollars for you to use right away or in the future.
- The cost of care at home or in a facility is continuing to rise and there is often an inflation protection feature offered in the insurance plans to give you a more meaningful benefit in the future. This feature adds to the premium cost.

Other riders or options may include:

- Individual plans offer spouse discounts when one or both are approved.
- Those individuals with good health ratings may be offered plans at a discount.
- Bed reservation is common (this will hold a bed in a facility when you are temporarily away).
- The option to get a return of premiums you have paid. This option may be available for an additional premium cost in order to provide money (amount based on premiums paid in) to your estate if your policy is still in force at the time of your death – it can be expensive and most advisors will not recommend it.

Currently, most long-term care insurance policies must cover Alzheimer's and other organic cognitive disabilities which occur after the policy becomes effective. An insurance company will not issue a new long-term care insurance policy to someone already suffering from Alzheimer's.

The younger you are when you buy a policy, the lower your annual premium will be. Insurance companies can raise rates, but only for everyone in the same pool of insured. The company cannot target individual policy holders for special rate increases despite the number of claims an insured person may make. Policies are "guaranteed renewable" which means that you cannot be cancelled because your health deteriorates or you make claims. The only reason the insurance company can cancel a policy is if the premium is not paid.

Long-term care insurance policies do not cover hospital stays. Rather, they are designed to pay for custodial, long-term care at home or in a facility.

Long-term care insurance policies do have exclusions and generally will not cover certain disorders such as alcohol or drug addiction or care necessitated by an act of war or self-inflicted injury. Some policies have limited international coverage.

Once you are approved, there are no pre-existing conditions. The Outline of Coverage that is yours to keep will explain, in detail, the coverage included in your policy.

Consult with a trusted insurance professional who has knowledge about long-term care planning and understands the health care community. You want one who will assist you in designing a plan that will offer protection today and peace of mind in the years to come.

Resources:
AHIP. (2013). Guide to Long-Term Care Insurance [Brochure]. Author. Retrieved June 15, 2017, from https://www.ahip.org/wp-content/uploads/2014/02/LTC_Guide.pdf;
www.pueblo.gsa.gov/cic_text/health/ltc/t_ guide.htm;
Working with Older Adults, Society of Certified Senior Advisors® (2015)

IN-HOME CARE

The term “aging in place” refers to remaining in the home of your choice for as long as you would like instead of relocating to an assisted living community, nursing home, or other facility. This is possible because the services needed to live a safe and secure life are now available at home. Many older adults want to remain at home as long as possible, and planning ahead is a good idea for them and their families.

Oftentimes decisions must be made quickly and sooner than expected because of an accident or an unexpected illness. Short or long-term in-home care by a family member or friend may be required and means a change in how individuals and families function in their daily lives. The good news is that if this happens, you aren’t alone. There are individuals and organizations qualified to provide advice or in-home care to assist your family. Your local Area Agency/Council on Aging can provide you with a list of services that are available in your area.

The National Association of Area Agencies on Aging (N4A) is the umbrella organization for the 622 Area Agencies on Aging (AAAs) in the United States. The fundamental mission of the N4A (www.n4a.org) is to provide services that make it possible for older individuals to remain in their homes.

Home health care may include medical care following surgery or rehabilitation, therapies, and may involve helping with activities of daily living such as bathing, dressing, and eating. Research data provides evidence that when medical care is provided in the home, some patients may heal faster and many risks, such as infection, can be minimized. Patients who stay at home can continue their customary daily routines and their own physician continues to oversee their care.

The majority of in-home care (commonly referred to as 'home care') is provided by informal caregivers, usually family and friends. Home care can also be provided through non-medical staff contracted from home care agencies. Most of the care is non-skilled, custodial long-term care. This level of care is designed to provide assistance with things such as meals, transportation, medication management, paying bills, shopping, housework, laundry, bathing, dressing, transferring and help with toileting. Other non-medical services such as companion care and personal care may be available from local home care agencies.

Medicare covers some home health care if all of the following conditions are met:

- A doctor must decide that the patient needs medical care in the home.
- The patient must require at least one skilled service on a part-time or intermittent basis (skilled nursing care, physical therapy, speech language pathology services, or continuing occupational therapy).
- The patient must be homebound; this means that leaving home takes considerable and taxing effort. A person may leave home for medical treatment or short, infrequent, absences for non-medical reasons, such as a trip to the barber or to attend religious service. (It is important to note that a need for adult day care does prohibit one from getting home health care).
- Medicare must approve the home health agency caring for the patient.

Medicare does not cover the following home care services:

- 24-hour-a-day care at home.
- Prescription drugs.
- Meals delivered to the home.
- Home support services like shopping, cleaning, and laundry.
- Personal or companion care, such as bathing, dressing, and using the bathroom, when this is the only care needed (custodial care).

It is important to consider the needs of the caregiver and the level of care needed. Caregivers may not be able to care for you 24 hours a day, every day. They may need help so they can provide you with the best possible care on an ongoing basis.

The cost of home health care varies across and within states. In addition, costs will fluctuate based on the type of health care professional required. Services can be paid directly by patients and their families or through a variety of public and private sources including Medicare, Medicaid, the Older Americans Act, the Veterans Administration, private health insurance, and long-term care insurance. Most home care agencies have a minimum per-visit rate which usually covers a few hours per visit.

Resources:
www.medicare.gov;
http://www.ageinplace.org/Portals/0/pdf/aging_in_place_planning_guide_final_8-14-1.pdf;
http://www.longtermcare.gov/costs-how-to-pay;
Working with Older Adults, Society of Certified Senior Advisors® (2015)

SENIOR HOUSING

There may be a time when you will need to consider alternative housing. Having the right information about the options can make all the difference in whether you or someone you care about transitions successfully.

It is important to find the right senior housing option as this allows an older adult to have the appropriate level of support and care. Factors such as health and financial situation are critical to this decision since there are many different levels of care, each with different service and payment options. Finding the right place begins with assessing the older person's health condition, determining the level of care needed both now and in the future, and matching that with the services offered at the facility.

A major factor in determining the level of care needed is the older person's ability to perform the Activities of Daily Living (see page 21). Another criteria for determining appropriate level of care is the ability to perform a set of tasks known as the Instrumental Activities of Daily Living (IADLs). The IADLs include the ability to use a telephone (look up numbers, dial, answer); travel by car or public transportation without issue; shop for food or clothes; prepare meals; prepare and take the correct dose of medication; and manage money (such as writing checks and paying bills).

For a thorough assessment, a General Practitioner, Geriatrician, (Nurse Clinical Specialist) APRN, Social Worker for care planning, Geriatric Care Manager, or other specialist can make a professional assessment of the needed level of care.

Another factor for living arrangement consideration is the older person's financial situation. Understanding the costs, what personal funds are available, what options are covered by

Medicare/Medicaid or long-term care insurance are critical factors in making decisions about senior housing options.

Depending on circumstance, there are a variety of different options available for senior housing.

Options include:

Independent Living

Active Lifestyle Communities, Retirement Communities, and Senior Living Communities - these types of housing are for independent and active adults interested in recreational and social opportunities, and who have few or no health care needs and can perform their own ADLs. Built to accommodate an active adult lifestyle, these properties offer many amenities and are constructed for a physically safer environment such as handrails in the bathrooms and 24-hour emergency response systems. Services for home care may be available on site. These facilities are most commonly paid for by private funds, but subsidized programs may be available. These communities are not licensed or regulated by federal or state agencies.

Continuing Care Retirement Communities (CCRCs)

These are campus-style communities which offer all levels of senior housing on one property - independent living, assisted living, personal care, and skilled nursing facilities. As an individual's healthcare needs change, he or she can remain on the same property but transfer to the next level of care needed, allowing a person to "age in place." Such residences are also referred to as Life Care Communities or Life Services Communities. The most common form of payment is private funds. Some communities require a non-refundable entrance fee or equity payment. With the exception of independent living, each level of care at a CCRC is regulated.

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It should be noted that levels of care/housing and the associated terms vary from state to state.

Assisted Living

Assisted living facilities are for people who do not need care 24 hours a day, but who require some assistance with activities such as bathing and dressing. They do not provide complex medical care. Typically, the home environment includes bedrooms, kitchenettes and living areas. Paid for most often by private funds, long-term care insurance may cover this living situation. In a few states, Medicaid funds could be available. Assisted living is regulated at the state level, but those standards vary from state to state.

Skilled Nursing/Nursing Home

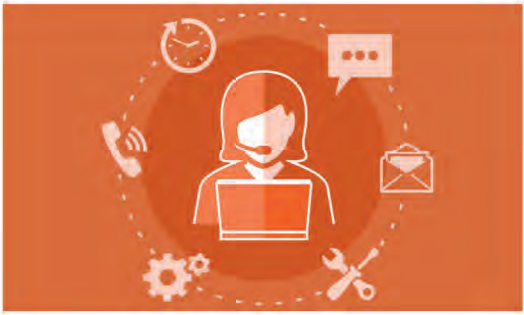
Skilled nursing is for individuals requiring long-term, 24-hour care from a licensed nurse and possible short-term rehabilitation services. It also provides the services offered at the assisted living level. Private funds, Medicaid and long-term care insurance are most common in covering the costs. Medicare may cover some costs for a short-term rehabilitation stay following an illness, accident or surgery. These facilities are regulated at the state and federal levels and licensed at the state level. They are certified by both Medicare and Medicaid. The staff and administrators must conform to licensing standards.

Alzheimer's and Dementia Care

A few options exist for patients with Alzheimer's or other types of dementia. Many assisted living and skilled nursing facilities have programs devoted to the needs of memory care individuals. Additionally, facilities designed for providing care specifically for patients dealing with memory issues are also an option. When considering a facility for quality dementia care, safety, supervision, and structured activity

offerings should be assessed. Payment options vary depending on which level of care is chosen. Private funds and long-term care insurance most commonly cover the costs. It is possible that Medicaid may be available to assist with payment as well. Visit the Alzheimer's Association website (www.alz.org) for more information. When evaluating skilled nursing facilities for potential placement of a loved one, look for those which are "Medicare certified". These facilities are required to be in compliance with the Medicare/Medicaid programs laws and regulations.

The state is responsible for certifying that a facility is in compliance and recommends appropriate enforcement. The Centers for Medicare and Medicaid Services (CMS) regional offices determine a facility's eligibility to participate in the Medicare program based on the state's certification of compliance and a facility's compliance with civil rights requirements.



Resources:
www.assistedlivinginfo.com; www.medicare.gov; www.stronghealth.com; www.alz.org; www.healthcare.uci.edu; Working with Older Adults, Society of Certified Senior Advisors® (2015)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About the Society of Certified Senior Advisors®
Society of Certified Senior Advisors (SCSA) is the premier membership organization for professionals who serve older adults. SCSA's Working with Older Adults program provides a standardized education in key aging issues.
Founded in 1997 with the input of health, social, financial, legal and other experts, SCSA believes that growing older is an experience to be valued and supported with the right kind of planning, recommendations and referrals for people's unique situations.
CSA Is Dually Accredited
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