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CPA eldercare : a practitioner's resource guide;

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American Institute of Certified Public Accountants

AICPA

AICPA Practice Aid Series

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NOTICE TO READERS

CPA ElderCare: A Practitioner's Resource Guide presents the views of the authors and others who helped in its development. This publication has not been approved, disapproved, or otherwise acted upon by any senior technical committees of the American Institute of Certified Public Accountants. Therefore, the contents of this publication, including recommendations and suggestions, have no official or authoritative status.

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1 2 3 4 5 6 7 8 9 0 AAG 0 9 8 7 6 5 4 3 2

Table of Contents

PREFACE

The publications that constitute the AICPA Practice Aid Series have been designed to address a broad range of topics that affect today's CPA. From enhancing the efficiency of your practice to developing the new skill sets required for a successful transition to meet the challenges of the new millennium, this series provides practical guidance and information to assist CPAs in making sense out of a changing and complex business environment. The talents of many skilled professionals have been brought together to produce what we believe will be valuable additions to your professional library.

This *CPA ElderCare: A Practitioner's Resource Guide* answers your questions about offering CPA ElderCare services to your elderly clients and their families, as well as provides the fundamentals of getting started in the area.

The guide has several sections that provide background information, resources, federal and state program information, and sample documents for you and your staff to use as you develop your practice. A PowerPoint presentation CD is included for use when introducing CPA ElderCare services to your clients. In addition to making your job easier, the presentation helps standardize both the description and information provided to the public about these services. Even though you may feel you have limited need for some of the material provided, we suggest that practitioners study each section of the manual. To a great extent, your ability to provide appropriate services and assistance depends on a high level of knowledge about the aging network within the United States.

The ElderCare Service Development Task Force of the American Institute of Certified Public Accountants has worked diligently to consider the opportunities for growth as well as concerns about entering this area of practice. The services you provide reflect your firm's skill, knowledge, and ability. We challenge you and your staff to offer only the highest standard of service and to commit to affiliating with other licensed professionals to maintain a cohesive standard of excellence throughout the industry. Thank you.

AICPA Accounting and Auditing Publications Team

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CHAPTER 1:

CPA ElderCare Services and the AICPA

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CPA ElderCare Services and the AICPA

DESCRIPTION AND DISCUSSION OF CPA ELDERCARE SERVICES

What Are CPA ElderCare Services?

As an accounting professional, you have probably been reading and hearing about the AICPA's interest in and commitment to the developing practice area of CPA ElderCare services. The AICPA's Special Committee on Assurance Services identified ElderCare as an assurance service CPAs can provide.

As stated in the AICPA's *Report of the Special Committee on Assurance Services*[1] (the Report), the population of the United States is aging. The United States Bureau of the Census estimates that approximately 17 million people in the country are 75 years of age or older. This expanding elder segment of the population requires care and assistance in living in their own homes or in institutional care homes. In today's society, the younger generation is providing care and assistance less and less due to various reasons, including time constraints and geographic distances between grown children and their parents and older relatives. Governmental agencies cannot provide the care and assistance needed by elderly people, as it is not the role of government to fulfill those responsibilities.

What is needed is private initiative, and CPAs can help assure that elderly persons are receiving the care and assistance they need. As stated in the Report, CPAs can provide a valuable service to family members by providing assurance that care goals are achieved for elderly family members no longer able to be totally independent. This service relies on the expertise of other professionals, with the CPA serving as the coordinator and assurer of quality of services determined by the customer. The purpose of CPA ElderCare services is to provide assurance in a professional, independent, and objective manner to third parties (children, family members, or other concerned parties) that the needs of the elderly person are being met.

Why Does a Consumer Need Exist?

The client for CPA ElderCare services is the elderly person who requires care and assistance. A typical client for ElderCare Services is someone without an adequate local system of support. This may be because the spouse is deceased or incapacitated, or because the children living in the area are incapable of, or unwilling to, assist the parent. In some cases, there will be children who could care for the parent, but the elderly person wishes to remain independent.

The elderly population is growing dramatically. Elders need a wide variety of assistance to help them live happy lives while living in their own homes or in institutional care. Given the aging population and the amount of wealth concentrated among the elderly, a demand exists for specialized care.

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[1] This report can be found at the AICPA's Web site at www.aicpa.org/assurance.

What Does the Target Market for These Services Look Like?

Some clients pay for CPA services directly or through a trust account. In other cases, the client's child or relative pays for the services and receives periodic reports. Therefore, CPA services have three market segments: the elderly, the adult children or relatives of the elderly and families of special needs individuals.

The family or the elderly person has to have sufficient income or resources to pay for ElderCare services. As a rule of thumb, anyone who needs estate-planning services (that is, assets of $1.35 million or more) would likely have the resources to afford ElderCare services. It is difficult to set guidelines for targeting clients based solely on income levels, however, because the purchasing power of income varies widely by region. For instance, an income of $100,000 is considered substantial in one area of the country and strictly middle class in other parts of the country. Generally, whatever income level is considered to be upper-middle class and above would be the income level of this target market.

The question of how to profile the adult children is more difficult to answer. Individual children may not have enough in resources, but if they pool their resources, CPA ElderCare Services may be affordable. Also, if this high level of care and the parent's ability to stay home is an adult child's top priority, then that child may be more willing to allocate income to pay for this service. Because of this, targeting adult children by income level alone may be too restrictive.

AICPA market research indicates that there is likely to be a tremendous market for reasonably priced, independent, and objective CPA ElderCare services. The marketplace views the CPA as being independent, objective, honest, and reliable. Physically distant family members can be assured that their loved ones are being properly cared for, for a reasonable fee. ElderCare services are based on the application of CPAs' traditional measurement and reporting skills. CPAs could be seen as preferred providers of the service. However, CPAs are generally considered "numbers people," which could impede a practitioner's progress in developing ElderCare services. Welfare agencies, geriatric specialists, trust officers, lawyers, and others provide some ElderCare services today. However, none of them has demonstrated the ability or willingness to expand or dominate the market. It appears that this is an area without any established competition.

For those CPAs who want to research the size of the potential market for CPA ElderCare services in their practice area, the U.S. Census Bureau's Web site (www.census.gov) has always offered a wealth of information. In the past, however, finding the most pertinent information was not always easy, and sometimes using the data was complicated. Now, the U.S. Census Bureau's Web site has been completely redesigned to provide users with easier and faster access to the information they need. Information has been reorganized on the site. The most attractive new tool on the Web site is the "State Fact Finder," which allows you to quickly view data by state and by county.

The basic Census data (population, race, age [only over and under 18 years old]) and the "Census Brief on Age 65 and Over" are available on the Census Bureau's Web site. In addition to the Centennial Census, the Census Bureau regularly undertakes studies of the population that provide insight on American demographics. Examples of Web site information are provided in Chapter 2, in the section titled "The Older American Demographic."

Understanding Aging and Old Age

Before developing your CPA ElderCare services practice, you should have a basic understanding of aging and old age. First, review several important definitions.

- *Aging* is a multidisciplinary field that integrates information from several areas of study. Psychology, biology, and sociology are considered the core areas, with contributions from such other areas as economics, humanities, and public policy.
- *Gerontology* is the study of the aging processes as individuals grow from middle age through old age. Gerontology includes the study of physical, mental, and social changes of elderly people as they age, as well as investigation of changes in society that result from the aging population and the application of this knowledge to policies and programs. Professionals who study aging from many diverse fields and perspectives are known as gerontologists.
- *Geriatrics* is the study of health and disease in later life. This term is usually used when describing the medical or physical aspects of aging.

Practitioners advising elderly clients and their families should be familiar with the following areas:

- *Aging and the aging network.* The practitioner should have extensive knowledge of the aging organizations, agencies, programs, service availability, and trends in their own communities as well as where individuals can seek other information or assistance. The success of your ElderCare practice depends on, among other things, your ability to access information, services, and resources for elderly clients.
- *Medicare.* The practitioner should have adequate, timely knowledge of how this system operates, what is covered in its various component parts, how appeals are handled, and anticipated program changes in the near future.
- *Medicaid.* The practitioner should have adequate knowledge of how this program operates, individual states' eligibility criteria for health care, community-based long-term care, nursing home coverage, and possible criminal penalties for Medicaid planning activities.
- *Social Security.* The practitioner should have a working knowledge of qualifications and requirements for the program, and Social Security disability benefits.
- *Other public programs and benefits.* The practitioner should have a working knowledge of appropriate federal, state, and community programs and services available to elderly individuals; eligibility criteria; and application procedures.
- *Legal issues.* The practitioner should have extensive knowledge of gift and estate tax laws to facilitate appropriate planning activities. Professionals advising elderly clients should also have adequate knowledge of powers of attorney, living wills, the health care power of attorney, and other advanced directives. In addition, the practitioner should have a working knowledge of the laws and implications of appointment and regulation of guardians and conservators.
- *Nursing homes.* The CPA should have a general knowledge of the federal and state laws that regulate nursing homes and other care facilities. In addition, the practitioner should become well versed in the laws and policies related to admissions, discharge, quality of care, required services, documentation, and ombudsmen programs in the CPA's particular state.

- *Additional areas.* The CPA providing ElderCare services should acquire additional knowledge of retirement plans and taxation, Social Security benefit taxation, and income taxation of estates and trusts. Also, as practitioners join the increasing number of professionals who serve elderly individuals, they must develop an understanding of elder abuse, particularly as it relates to financial exploitation of resources.

Providing CPA ElderCare Services

People are living longer and are usually healthier than previous generations. The longer life span demands that individuals plan earlier and smarter for the later years of their lives. CPA ElderCare services are designed to provide assessment and planning assistance to assure a more secure old age as well as give confidence to family members and other responsible parties that the elderly person's needs are being met. For some clients, ElderCare services may be limited to only monthly bill paying when they are no longer able to do so. For others, these services can be offered as a comprehensive package that includes assessment, care planning and coordination, monitoring, accounting for the estate, tax planning, and financial planning.

Successfully providing CPA ElderCare services depends on (1) an appropriate plan that addresses the level of care or services required, (2) where the care or services will be provided, (3) who will provide the care or services, and (4) what resources will be available to pay for the needed care and services. ElderCare services challenge the practitioner to consider not only the elderly individual's financial needs, but also his physical, psychosocial, and environmental needs and the needs of the individual's family. Providing CPA ElderCare services broadens a practitioner's abilities and offers the opportunity for the practitioner both to become an integral part of America's professional network specializing in aging and to develop associations with other disciplines, such as medicine, law, social work and human services, insurance, and finance.

So you may better understand the history and development of CPA ElderCare services and their important relationship to the AICPA, a PowerPoint presentation CD titled *CPA ElderCare Services and the AICPA* is included with your guide. Copies of the presentation slides are included in the following section. Take time to review this information thoroughly before proceeding to the following chapters.

Topic Checklist for CPA ElderCare Services

In its efforts to continue the development of the service, the AICPA ElderCare Task Force has created an ElderCare topic checklist that allows the practitioner to identify information that is needed to provide aspects of CPA ElderCare services. This checklist is intended to be all-inclusive and will aid the practitioner in providing consulting, direct, or assurance services to older adult clients.

I. Standards and regulations
   A. How the standards apply to ElderCare
      1. Independence
      2. Conflicts of interest
      3. Loans, gifts, and bequests
      4. Confidentiality of information

5. Use of specialists

B. Professional standards
   1. AICPA Code of Professional Conduct
   2. Statements on Standards for Consulting Services
   3. Statements on Standards for Accounting and Review Services
   4. Statements on Standards for Attestation Engagements
   5. Statements on Auditing Standards
   6. Statements on Responsibilities in Tax Practice
   7. Statements on Responsibilities in Personal Financial Planning Practice
   8. Personal Financial Statements Guide

C. Federal and state regulations
   1. Tax law
      a.) Federal and state laws and reporting requirements
      b.) Individual income taxes
      c.) Estate and gift taxes
      d.) Trusts
   2. Employment law
      a.) Federal and state laws and reporting requirements
      b.) Legal vs. illegal workers
      c.) Employees vs. independent contractors
   3. Securities regulations
      a.) Federal and state laws and reporting requirements
      b.) Special regulations for investment advisers
      c.) General concepts of state securities regulation
      d.) State accountancy licensing and regulation
   4. Long-term care regulations
      a.) Federal and state laws and reporting requirements

II. Interpersonal knowledge and skills

A. Communication
   1. General communication styles
   2. Communicating about and dealing with sensitive issues
   3. Effective communication techniques
      a.) Listening
      b.) Congruent message sending
      c.) Asking questions correctly
      d.) Mirroring

e.) Silence

4. Obstacles to communication
5. Verbal and nonverbal cues

B. Familial relationships
1. Caregivers
2. Spousal relationships
3. Sibling issues
4. Marriage and divorce

C. Conflicts
1. Conflict analysis
2. Dispute and conflict resolution
a.) Negotiation
b.) Mediation
c.) Cooperative problem solving
3. Gaining closure on agreements

D. Social relationships
1. Independence vs. isolation
2. Social support networks
3. Purposeful activities
4. Identifying community resources that enhance social relationships for the older person

III. Governmental benefit programs for older adults
A. Basic understanding of programs available to older adults
1. Federally administered programs and state administered programs
2. Entitlement programs and need-based programs

B. Social Security system and benefits
1. Benefits available
2. Eligibility
3. Analyzing payment stream options
4. Limitation on earnings
5. Current and proposed regulations

C. Veterans benefits
1. Eligibility
2. Benefits available

D. Medicare
1. Traditional Medicare
a.) Part A services

b.) Part B services
c.) Costs
d.) Eligibility
e.) Election periods
f.) Benefits
g.) Medicare claims administration
h.) Medicare appeals process

2. Medicare + Choice
a.) Health maintenance organizations (HMOs)
b.) Preferred provider organizations
c.) Provider-sponsored organizations
d.) HMO withdrawals
e.) Beneficiary rights
f.) Medical savings accounts

3. The need for Medical Supplemental Insurance (Medigap)

E. Medicaid
1. Eligibility
a.) Residency requirements
b.) Resource and income eligibility
c.) Spend-down vs. income cap states
d.) Look-back period

2. Determining includible assets
a.) Exempt vs. nonexempt assets
b.) Joint assets
c.) Spousal impoverishment

3. Medicaid recovery
4. Medicaid waiver programs
5. Medicaid appeals process

IV. Planning for the costs of aging
A. Basic concepts of personal financial planning
1. Understanding the need for personal financial planning
2. Establishing financial objectives and identifying constraints
a.) Qualitative
(1) Client goals and preferences
(2) Life cycle considerations
(3) Client's personality, health, and lifestyle
(4) Time horizon

b.) Quantitative
   (1) Financial statement analysis and inventory of assets
   (2) Current income and spending patterns
   (3) Cash flow planning and budgeting
   (4) Financial independence

3. Investment planning for older adults
   a.) General considerations about the older client
   b.) Investment considerations
      (1) Risks
      (2) Preferences
      (3) Asset allocation
      (4) Investment strategies
      (5) Forms of ownership
      (6) Tax implications
   c.) Cash and cash equivalents
   d.) Fixed income investments
   e.) Equity investments
   f.) Mutual funds
   g.) Real estate
   h.) Other assets or income streams
4. Personal income tax planning for older adults
   a.) Fundamental rules
   b.) Income splitting
   c.) Gift-giving
   d.) Charitable trusts
   e.) Income and deduction timing
5. Financial risk management planning for older adults
   a.) Assessing risk
   b.) Self-insuring
   c.) Life insurance
   d.) Property and casualty insurance
   e.) Long-term care insurance
   f.) Medicare Supplemental Insurance (Medigap)
      (1) Eligibility and enrollment elections
      (2) Plans available
      (3) Evaluating plans and carriers
      (4) Coordination of benefits

6. Evaluating retirement plan distributions
   a.) Tax and economic considerations
   b.) Estate planning considerations
   c.) Noneconomic considerations
7. Estate planning
   a.) Property ownership and asset titling
   b.) Determining cash needs
   c.) Probate estate
   d.) Tools and techniques
      (1) Wills
      (2) Gifting
      (3) Annual exclusion
      (4) Present vs. future interests
      (5) Generation-skipping tax
      (6) Gifts to dependents
      (7) Gifts to charities
      (8) Trusts
      (9) Inter vivos and testamentary
      (10) Revocable vs. irrevocable
      (11) Charitable
      (12) Life insurance
      (13) Marital deduction
      (14) Instruction letters
      (15) Life insurance

B. Emerging and alternative techniques for paying for long-term care
   1. Long-term care insurance
      a.) Policy types
      b.) Qualified vs. nonqualified plans
      c.) Covered services
      d.) Special features
      e.) Evaluating plans
      f.) Evaluating carriers
      g.) Hybrid plans
      h.) Other issues
   2. Reverse mortgages
      a.) Evaluation of lender
      b.) Payment streams
      c.) Valuation issues

d.) Liens
e.) Effect on eligibility for entitlement programs
f.) Tax issues

3. Viatical settlements
a.) Evaluation of settlement companies
b.) Valuation issues
c.) Payment streams
d.) Tax issues
e.) Effect on eligibility for entitlement programs

V. Legal issues of aging
A. Powers of attorney
1. Definitions and importance
2. Types
3. Timing and jurisdiction
4. Choosing the attorney in fact
5. What is covered by the power of attorney

B. Medical self-determination
1. Patient Self-Determination Act
2. Right to die laws
3. Advance directives
a.) Living wills
b.) Health care proxies or powers of attorney

C. Guardianships
1. Definition and importance
2. Determining competency
3. Types
4. Responsibilities of the guardian
5. Determining powers to be granted

D. Trusts
1. Basic terminology
2. Advantages of trusts
3. Revocable vs. irrevocable trusts
4. Inter vivos vs. testamentary trusts
5. Trusts for special situations
a.) Marital deduction and by-pass trusts
b.) Life insurance trust
c.) Crummey trust
d.) Charitable lead trust

e.) Charitable remainder trust
f.) Qualified terminable interest in property trust (QTIP)
g.) Personal residence trust
h.) Generation-skipping trust
i.) Medicaid trusts
j.) Special needs trusts

6. Implications for the practitioner
7. Beneficiary considerations

E. Wills
1. Legal benefits of last will and testament
2. Testamentary substitutes
3. Providing for estate distribution without the need for probate

VI. Medical issues of aging
A. Assessment of care needs
1. Activities of daily living (ADLs)
2. Instrumental ADLs
3. Implications for the practitioner

B. Normal aging process
1. Typical degenerative disorders
2. Medication complications
3. Compensatory techniques
4. Implications for the practitioner

C. Cognitive disorders
1. Normal forgetfulness
2. Reversible dementias
3. Irreversible dementias
4. Delirium
5. Implications for the practitioner

D. Emotional disorders
1. Depression
2. Anxiety
3. Sleep disturbances
4. Alcohol and drugs
5. Suicide
6. Implications

E. Coordinating care resources
1. Developing an inventory of services
2. Identifying the needed health care professionals

VII. Issues of daily living
  A. Cultural and social issues
    1. Fear of poverty
    2. Cultural and ethnic prejudices
    3. Lack of financial sophistication
    4. Life experiences
    5. Implications for the practitioner
  B. Housing
    1. Household management, security, and safety
    2. Housing options and alternatives
      a.) Nursing facilities
      b.) Assisted living facilities
      c.) Continuing care retirement communities
      d.) Adult day care
      e.) Respite care
      f.) In-home care
      g) Board and care
      h.) Hospice care
    3. Evaluating housing options
      a.) Personal preference
      b.) Community and family support network
      c.) Financial resources
    4. Oversight
      a.) State surveys and licensing
      b.) Accrediting bodies
      c.) Trade organizations
  C. Signs of abuse, neglect, and exploitation
    1. Types of abuse
    2. Recognition of potential abuse situations
    3. Appropriate action
    4. Implications for the practitioner
  D. Snowbird issues
    1. Tax and estate issues
    2. Residency
    3. Insurance
    4. Practical issues
    5. Implications for the practitioner

E. Practice issues for the 21st century
   1. Longevity and demographics
   2. Trends in health care
   3. Trends in senior housing
   4. Trends in financing long-term care
   5. Implications for the practitioner

VIII. Engagement management
   A. Categories of service
      1. Consulting services
      2. Direct services
      3. Assurance services
   B. Understanding the care needs assessment
      1. Financial
      2. Nonfinancial
   C. The multidisciplinary team
      a.) Members of the team
         (1) Financial
         (2) Legal
         (3) Health care
         (4) Social services
      b.) Licensing and credentialing
      c.) Structuring the team
      d.) Referrals
   D. Developing an ElderCare plan
      a.) Establishing performance measures for service providers
      b.) Developing meaningful, objective, measurable criteria
   E. Engagement letter
      a.) Identification of client
      b.) Emergency clauses
      c.) Requests for additional services
      d.) Termination of the engagement
   F. Implementing the ElderCare plan
      a.) Establishing protocols
      b.) Monitoring the plan
      c.) Feedback and follow-up
   G. Documentation and reporting

IX. Practice management
  A. Risk management
    1. Identification of potential liabilities
    2. Domestic and international legal and legislative environment
    3. Determination of firm's level of risk exposure
    4. Measures to reduce or mitigate risk
      a.) Insurance coverage
      b.) Bonding
      c.) Client acceptance procedures
      d.) Engagement letters
  B. Financial recordkeeping
    1. Internal control
    2. Segregation of client accounts
    3. Safeguarding of assets
    4. Medical claim forms
  C. Filing and safekeeping of ElderCare client records
    1. Confidentiality issues
    2. Disclosure of information
      a.) Financial
      b.) Nonfinancial
    3. Record retention policies
  D. Office design
    1. Office environment
    2. Reading material
    3. Aural considerations
  E. Marketing
    1. Determining the target market
      a.) Characteristics of clientele
      b.) Income
      c.) Net worth
      d.) Age
    2. Developing a marketing plan
      a.) Settling realistic goals and objectives
      b.) Determining appropriate media, tools, and techniques to achieve goals
    3. Obtaining firm buy-in to the marketing plan
    4. Measuring the results of the plan
    5. Monitoring the achievement of goals and objectives

F. Technology
   1. Using software tools in an ElderCare engagement
   2. Performing Web searches
   3. Using online resources in an ElderCare engagement
      a.) Public resources
      b.) Private resources

POWERPOINT PRESENTATION FOR PROFESSIONALS

The PowerPoint presentation included with this Practice Aid titled *CPA ElderCare Services and the AICPA* is to be used to familiarize CPAs and other professionals in a multidisciplinary team with the development of CPA ElderCare services and the AICPA ElderCare Service Development Task Force. Presented on the following pages are copies of those presentation slides. The CD-ROM containing the PowerPoint presentation is included with your guide.

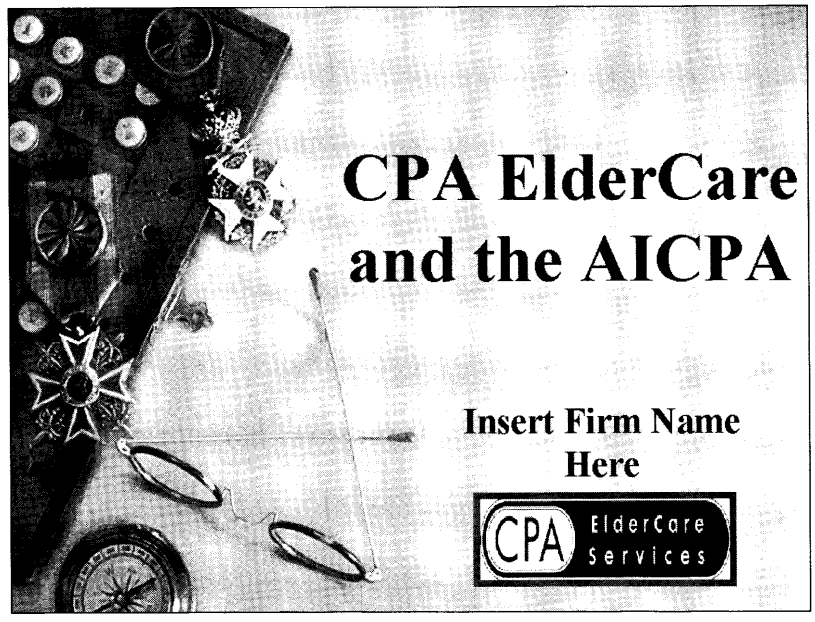
Personalizing Your Presentation

Follow these steps to personalize the ElderCare presentation with your firm name:

1. Open Microsoft PowerPoint and insert the CD-ROM into your computer's CD-ROM drive.
2. Go to the FILE menu and select OPEN.
3. Select the "CPA ElderCare Services and the AICPA" file from your CD-ROM drive.
4. Click OPEN.
5. On the first slide, move the cursor to "Insert Firm Name" and double click.
6. Delete the row of letters and type in your name and your firm's name.
7. Click outside the box when finished.
8. When complete, click on FILE.
9. Click on SAVE AS.
10. Select the desired location on your hard drive.
11. Click on SAVE.

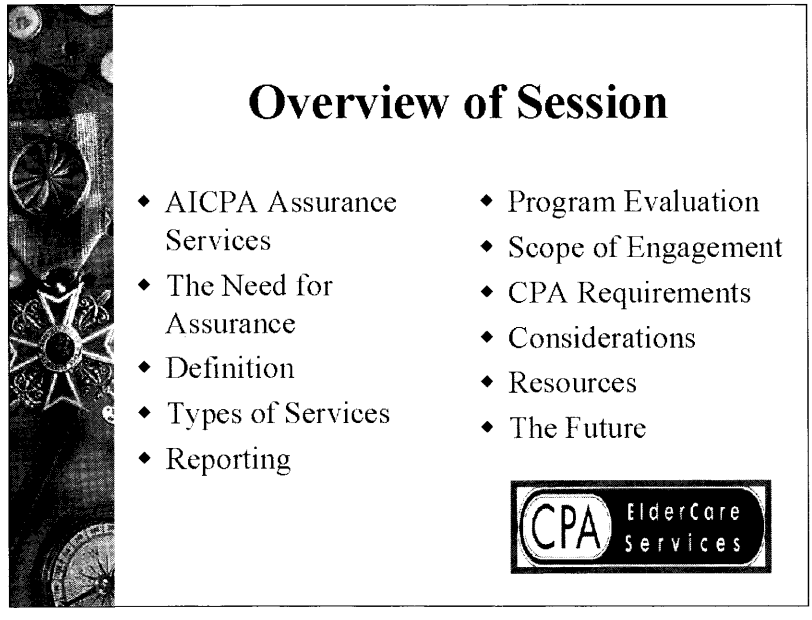
Slide 1

This slide begins your introduction to the concept of the relationship between the AICPA's CPA ElderCare services, the AICPA, and the practitioner. This presentation is used to familiarize CPAs with the development of ElderCare Assurance Services and the ElderCare Service Development Task Force.



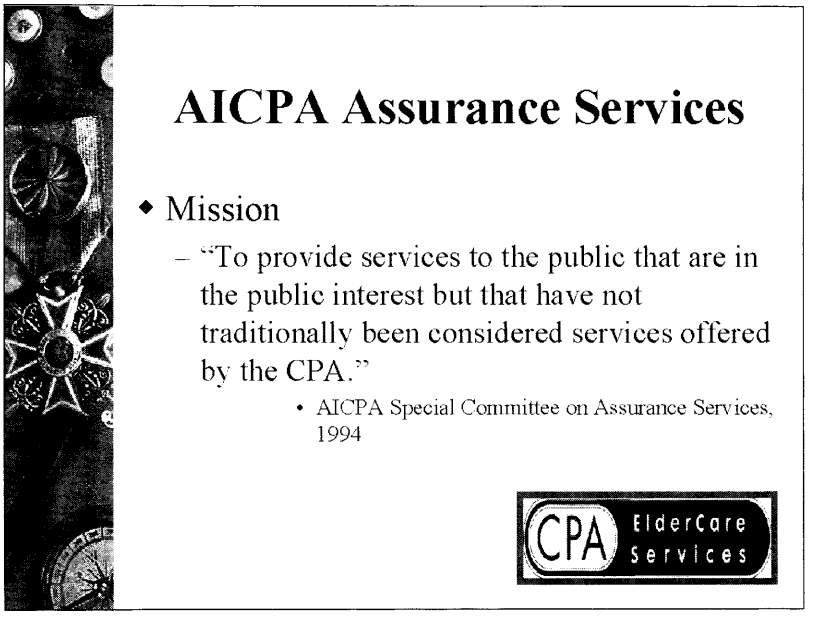
Slide 2

The presentation covers these topics that the task force considers important dimensions of CPA ElderCare services. These topics will be covered in more detail.



Slide 3

In 1996, the AICPA set up a Special Committee on Assurance Services (SCAS). This committee identified hundreds of potential assurance services and developed business plans for six areas of practice that were considered to have the most promise for the profession.

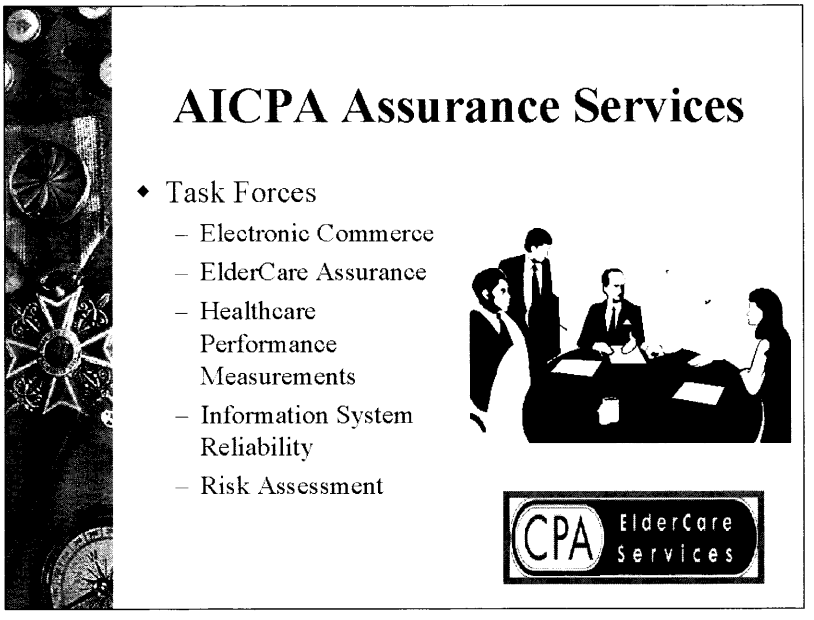


Slide 4

At the time of publication, the status of each task force is as follows:

Electronic Commerce. The Electronic Commerce Task Force continues its work on CPA WebTrust℠ service, which includes a Seal of Assurance designed to build trust and confidence among consumers and businesses purchasing goods and services over the Internet through independent verification by CPAs.

ElderCare. The ElderCare task force has developed educational programs, practice development tools, and a competency model for CPA ElderCare services. It is currently working on raising awareness of this service among practitioners, opinion leaders, decision makers, and consumers. In addition, the task force is working on the development of additional tools to assist the practitioner in the provision of this service.



Health Care Business Performance Measurement. The task force has published a practitioner's guide to providing performance measurement engagements and a related software tool designed to understand, measure, and communicate the operational performance and critical success factors of a client company.

Information Systems Reliability. The Systems Reliability Task Force has developed an assurance service, CPA SysTrust℠ service, to provide assurance on systems reliability. In addition to developing the principles and criteria that serve as the foundation of the service, the task force is developing training courses, a Practice Aid, and a competency model to equip the practitioner to perform SysTrust engagements.

Risk Assessment. This task force is completing a white paper for this service titled *Risk Management in the New Economy.*

Slide 5

This slide illustrates the need for CPA ElderCare services. Elderly clients and their families are in need of assistance with not only tax and estate planning issues but also care planning to optimize the latter years of the elderly client's life.

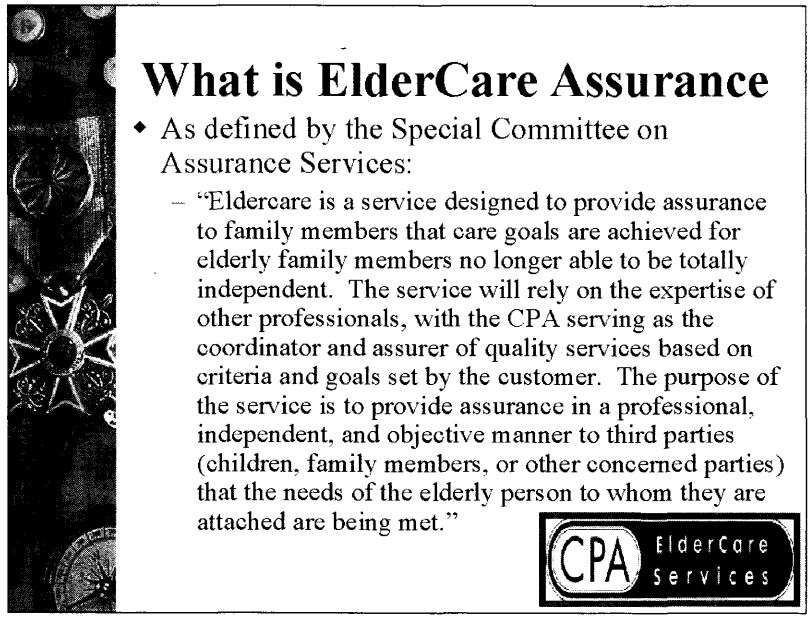
Approximately 16.6 million adults are over 75 years of age; approximately 20 percent will be 65 and over by the year 2020.

In the past, the configuration of a typical family resembled a pyramid shape, with fewer older relatives at the top to be cared for by a broader base of younger relatives. "Beanpole families" represent an elongated configuration, with possibly two or three generations of elderly people being cared for by a fewer number of younger individuals from subsequent generations.

It has been suggested that we will spend more time taking care of our parents than we spend parenting our children. Adults of all ages must begin to prepare for an extended life span.

Slide 6

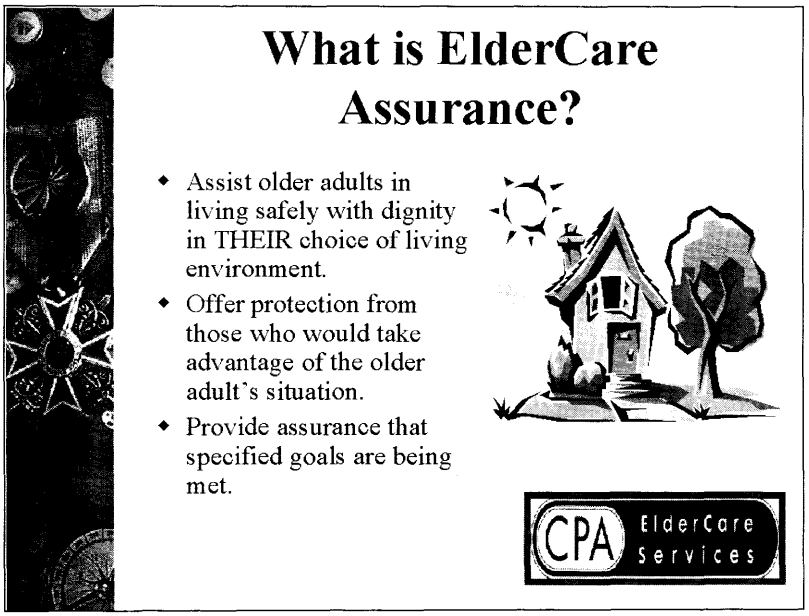
The SCAS provided this definition of ElderCare Assurance Services in 1996. This definition has been the springboard for the ElderCare task force's work since that time.



Slide 7

More simply stated, the goals of CPA ElderCare services are:

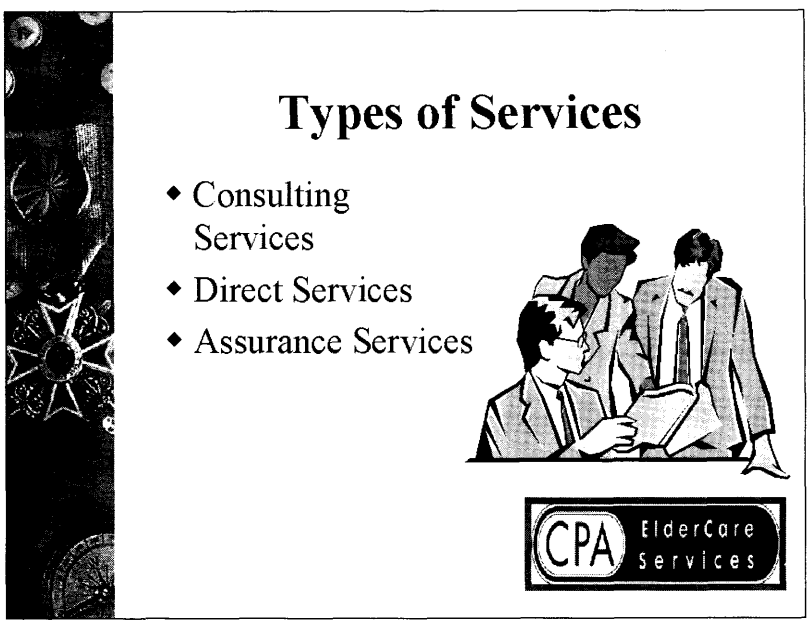
- Assist elderly persons to age in place or assist them in identifying another place (within their resources) in which they can live their lives in comfort and security
- Help protect the elderly persons and their assets
- Communicate the individual's goals for successful aging to members of a multi-disciplinary team of professionals, family members, and other responsible parties and provide assurance that specified goals are being met



Slide 8

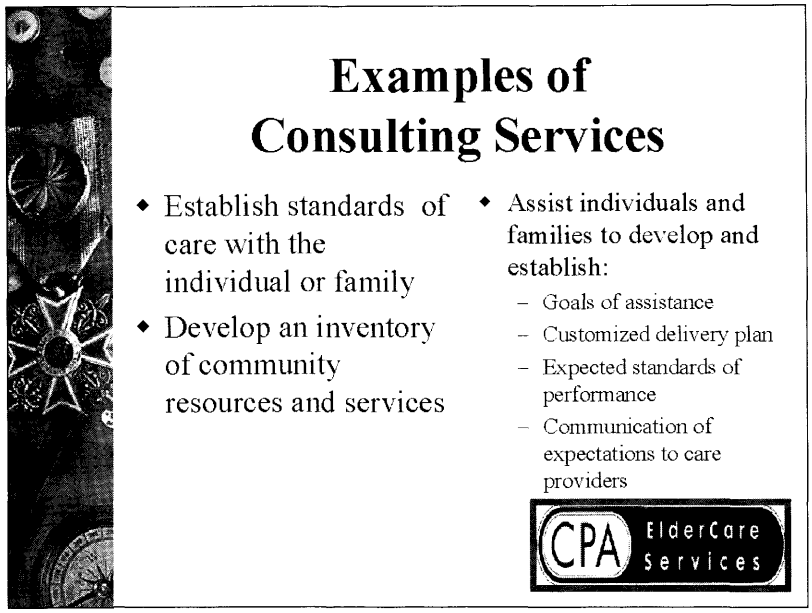
As described by the ElderCare task force, CPA ElderCare services are classified as:

- Consulting services
- Direct services
- Assurance services



Slide 9

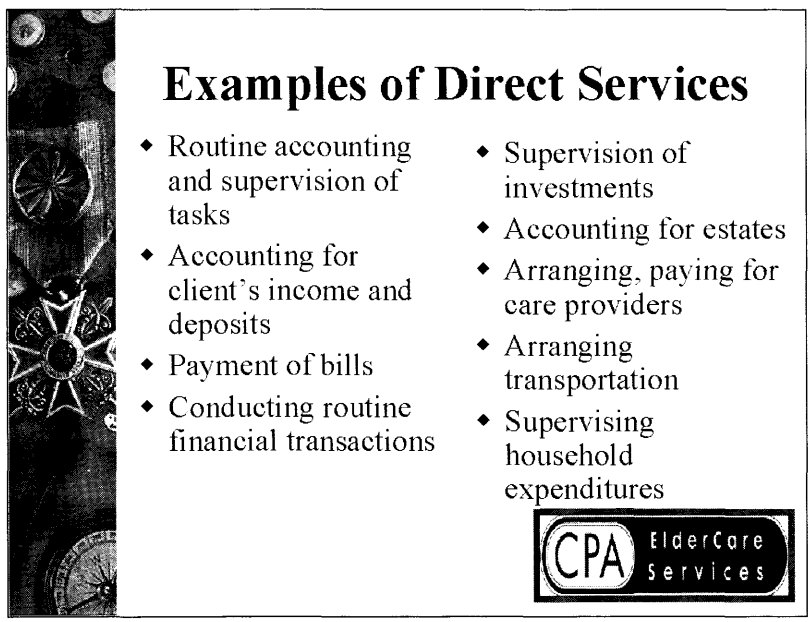
Consulting services establish the criteria and range of services required by the elderly person, through the use of comprehensive assessments prepared by members of the multidisciplinary team. Because the practitioner is working with individuals and families, each client's care plan should be customized. In addition, the practitioner should have a current knowledge of community resources so clients can be referred as needed. Following the assessment, an initial individual care plan is developed for the client.



Slide 10

Direct services are the hands-on services, some of which are already offered by CPAs. Whereas some clients may need assistance in paying bills, others may require extensive assistance with the activities of daily living (ADLs), such as personal care and shopping. The members of the multidisciplinary team should include licensed professionals who can assist the client as needed. These professionals include:

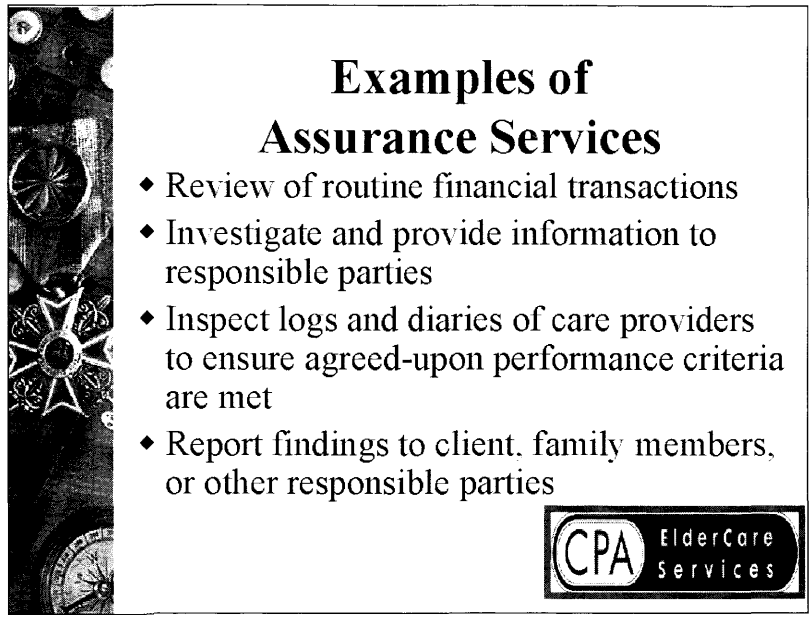
- Geriatric care manager
- Elder law attorney
- Insurance agent
- Stockbroker
- Physician
- Trust officers and financial planners



Slide 11

Assurance services describe the analytical services that are more closely related to the attest function that CPAs already provide. However, these services reflect assurance of services, not historical financial data.

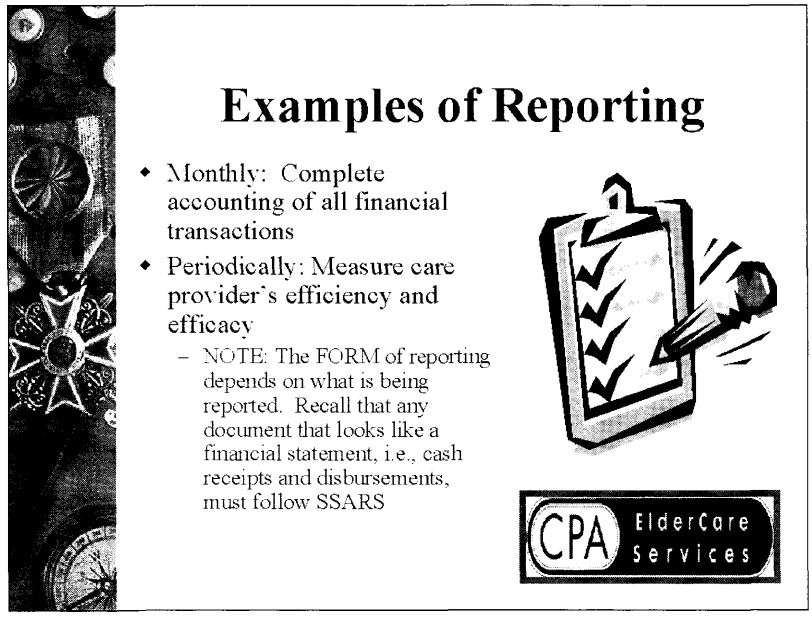
A word of caution on all ElderCare services: The CPA should demonstrate that all appropriate and acceptable professional standards are being followed.



Slide 12

In this area of practice, the individual may be compared to an individual business entity. Financial transactions (receipts, disbursements, and transfers) are reported on a monthly or quarterly basis.

As for care providers, CPAs must remain constantly aware of new services in the field of geriatrics. This is an important and developing field across the nation, with new services emerging. Results of caregivers' services should be provided as often as the clients and their families request. Because situations and circumstances change frequently, the CPA must continuously monitor the care provider or assign the task to another member of the team.

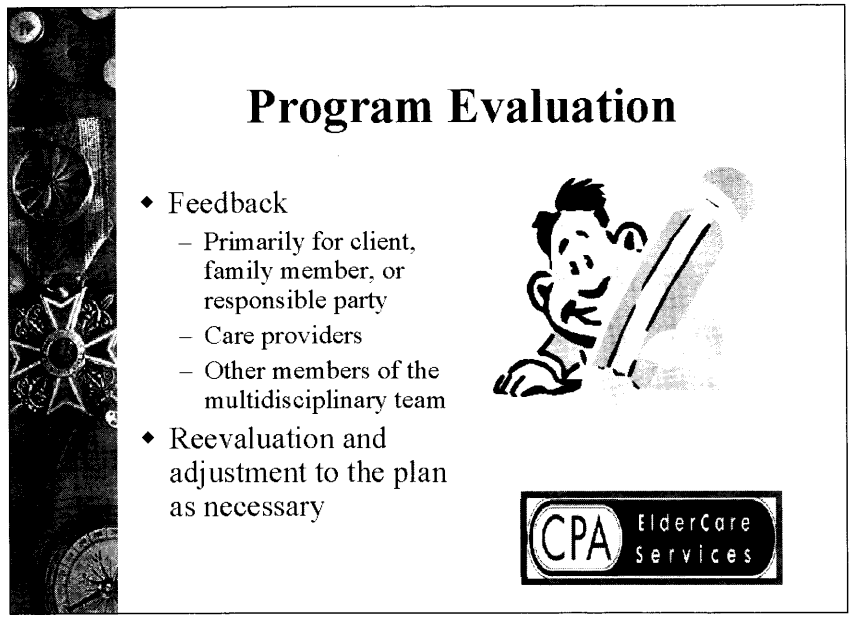


Slide 13

Program evaluations let the practitioners know how they are doing. They must expect and require regular feedback from:

- Clients
- Care providers
- Family members
- Other professionals in the multidisciplinary team

Clearly, because practitioners are dealing with human emotions and needs—and not simply financial statements—in this area of practice, the care plan will need to be updated on a continuous basis.

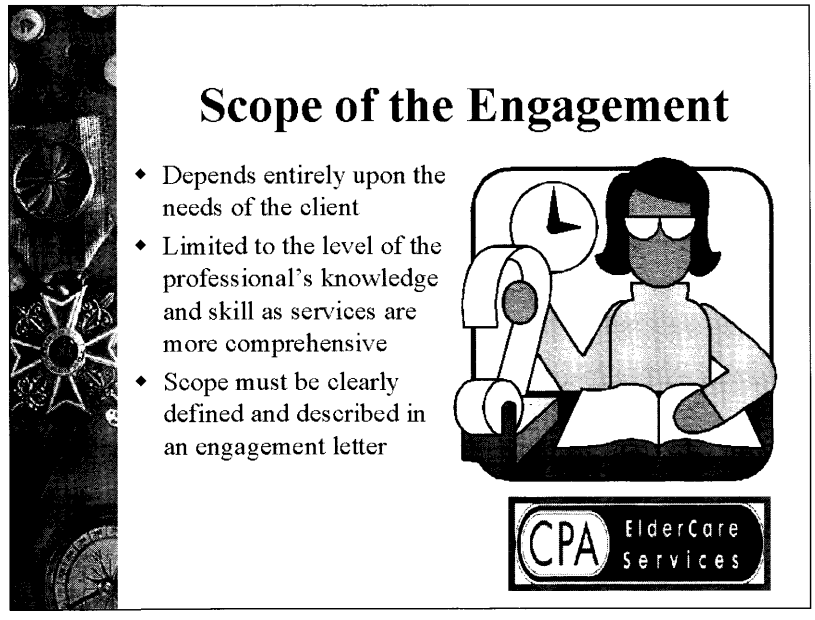


Slide 14

The scope of services offered to your clients varies with the needs of the individual. Some clients may need help only with bill paying; others may require daily assistance. The scope of service should be limited to the level of the practitioner's professional knowledge and skills. At a minimum, the practitioner needs a working knowledge of:

- Basics of normal and abnormal aging
- Medicare, Medicaid, and criminal penalties
- Insurance and long-term care
- Mediation and consultation skills
- Wills, trusts, and advance directives

In addition, each client should have an engagement letter. The task force recommends developing a letter that can be modified for each client.



Slide 15

Knowledge of the aging process is important. The CPA needs to be able to recognize the effects of normal aging on client functioning as well as the impact of abnormal aging.

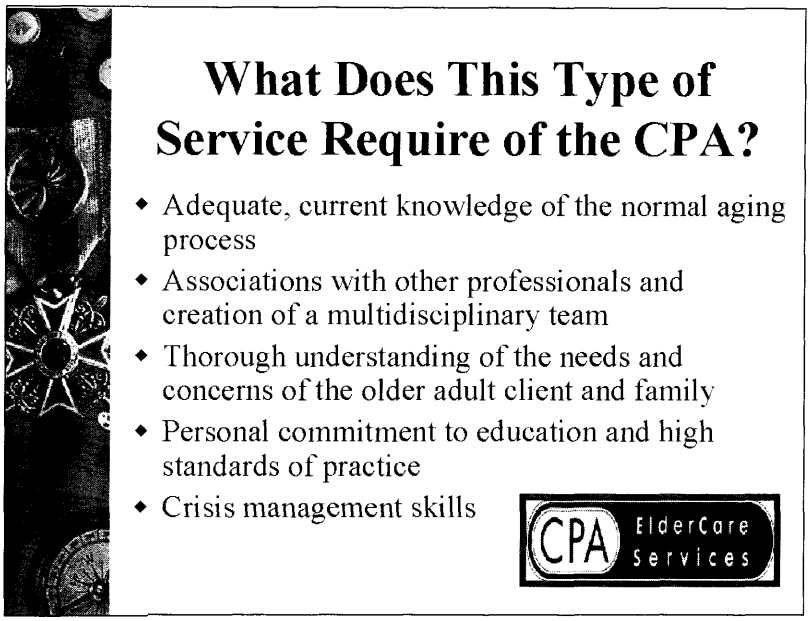
The practitioner needs a multidisciplinary team. No one can do it all.

Elderly individuals may:

- Be afraid that personal resources will run out.
- Experience significant losses of opportunities for socialization due to death of loved one, lack of transportation, or limited contacts.
- Be at higher risk for depression and depressive symptoms.

Elderly individuals:

- Are survivors (the Great Depression, wars, or loss of spouse, for example)
- Usually want to age in place in familiar surroundings
- Usually want to remain independent and self-reliant



Slide 16

Chemistry. Practitioners should ask themselves whether they really want to work with elderly individuals. Do they possess adequate patience to work with individuals who may need additional response time?

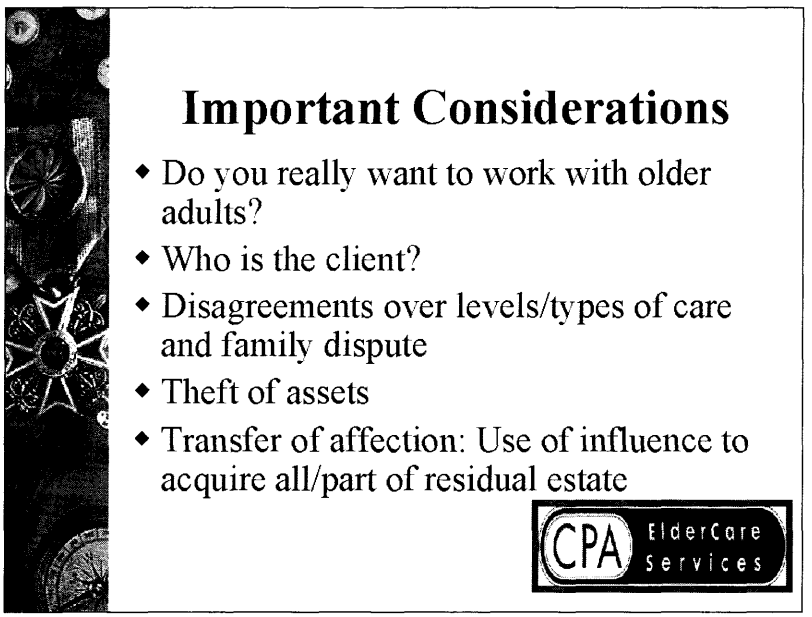
Staffing. Much of the work can be leveraged. However, because elderly people prefer to see the same individual, does the firm have adequate staff to cover this area of practice?

Family disputes. Who is the client? Can the practitioner remain an objective third party in conflicts among family members? What if an adult child wants something that is not in the best interest of the elderly parent? Does the practitioner possess adequate mediation skills?

Disagreements on levels and type of care. Who will decide the appropriate level of care for the individual? What is the practitioner's personal commitment to client self-determination?

Theft of assets. Who is responsible? CPAs must remain diligent in the protection of assets and report to clients or family members any problems noted.

Transfer of affection. The firm must have a policy stating that no one receives compensation or gifts from a client or client's estate for which the firm has provided ElderCare services.

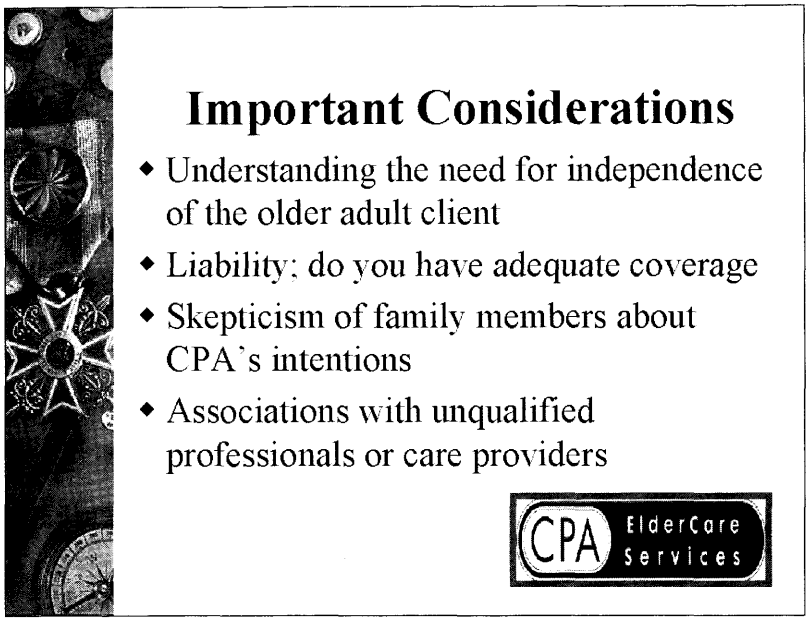


Slide 17

Need for independence. This is a paramount need for successful aging. Many elderly persons want to continue to live at home. This arrangement requires more planning, staffing, money, and patience. What is the practitioner's personal commitment?

Liability. Practitioners may encounter skepticism on the part of both the elderly person and family members about the CPA's intentions. Practitioners therefore must clearly describe their role. They should make sure their firm's liability policy covers the activities they perform for elderly people. Team members should be required to provide documentation of their own liability policy before their engagement.

Associations. This is the support team. Practitioners must be able to delegate responsibilities to qualified individuals. Require copies of appropriate licensure documentation before their engagement.

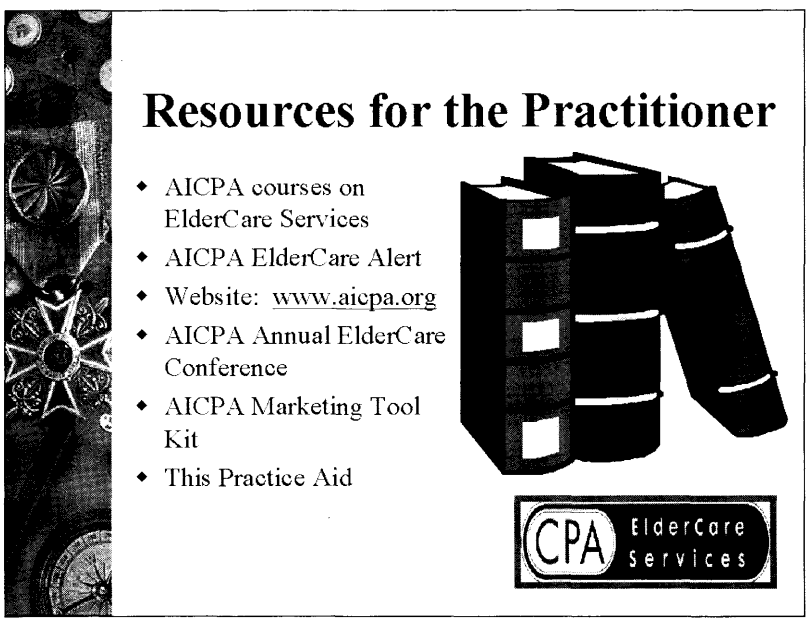


Slide 18

Many organizations and federal and state authorities can be used as resources for the practitioner. They include the following:

- National Association of Professional Geriatric Care Managers
- National Academy of Elder Law Attorneys
- National Aging Information Center
- American Association of Retired Persons
- Gerontological Society of America
- Health Care Financing Administration
- State insurance commissions
- State Medicare/Medicaid offices

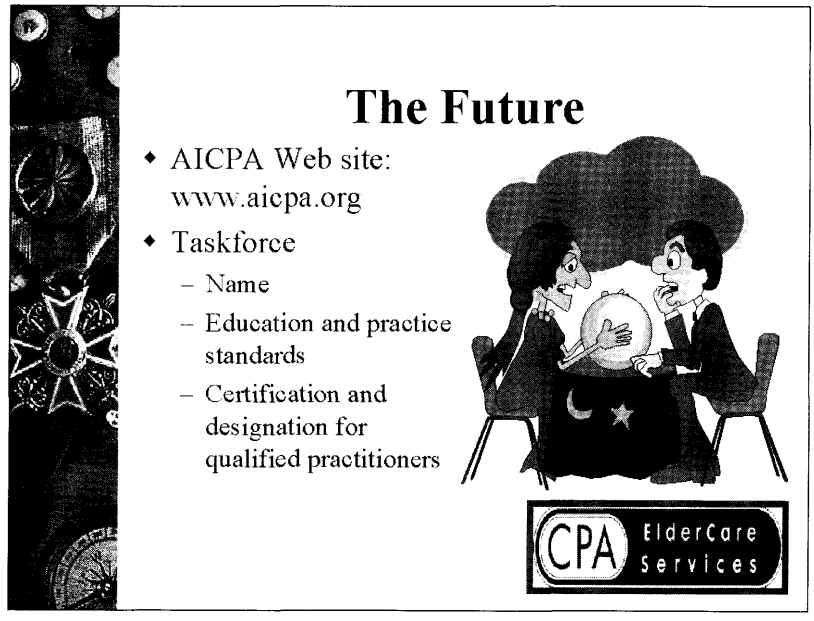
Addresses for these agencies are included in Chapter 10, "Associations, Organizations, Agencies, and Other Resources."



Slide 19

The ElderCare task force continues to work on issues, including the following:

- Awareness efforts
- Additional training and tools for the practitioner
- Referral network



CHAPTER 2:

Overview of Aging

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Overview of Aging

Test Your Knowledge of Aging

Test your knowledge of aging by answering the questions in Table 2.1 true or false.

Table 2.1 Aging Questionnaire

Source: Administration on Aging, 1996

1. Baby Boomers are the fastest-growing segment of the population.
   T F
2. Most elderly people do not have much contact with their families.
   T F
3. Everyone becomes confused or forgetful if they live long enough.
   T F
4. You can be too old to exercise.
   T F
5. Heart disease is a much bigger problem for older men than for older women.
   T F
6. The older you get, the less you sleep.
   T F
7. Most older people are depressed.
   T F
8. It is less important to screen older people for cancer because they cannot usually be treated if cancer is detected.
   T F
9. Older people take more medications than younger people.
   T F
10. People begin to lose interest in sex around age fifty-five.
    T F
11. If your parents had Alzheimer's disease, you will also get it.
    T F
12. Diet and exercise reduce the risk for osteoporosis.
    T F
13. As your body changes with age, so does your personality.
    T F
14. Urinary incontinence is a fact of life for most elderly people.
    T F

(continued)

15. Suicide is mainly a problem for teenagers and younger adults.
    T F
16. Everybody gets cataracts, eventually.
    T F
17. Extremes of heat and cold can be especially dangerous for elderly people.
    T F
18. You cannot teach an old dog new tricks.
    T F

Test Your Knowledge of Aging: The Answers

1. *False.* The population of people 85 and older is the fastest-growing age group in the country. There are more than 3 million Americans over the age of 85. That number is expected to quadruple by 2040, when there will be more than 12 million people in that age group.
2. *False.* Most elderly persons live close to their children and see them often. Many live with their spouses. An estimated 80 percent of men and 60 percent of women live in family settings. Only 5 percent of all elderly people live in nursing homes.
3. *False.* Confusion and serious forgetfulness in old age can be caused by Alzheimer's disease or other conditions that result in irreversible damage to the brain. Often, conditions can be treated, and the confusion they cause can be reduced or eliminated.
4. *False.* Exercise at any age can help strengthen the heart and lungs and lower blood pressure. Exercise also improves muscle strength and can reduce bone loss.
5. *False.* The risk of heart disease increases dramatically for women after they reach menopause. By age 65, both men and women have a one-in-three chance of developing heart disease. Diet and exercise can reduce the risk of heart disease.
6. *False.* During later life, the quality of sleep declines—not the total sleep time. Sleep patterns, also known as the circadian rhythms, change, and older people tend to take more naps during the day than younger individuals.
7. *False.* Most elderly people are not depressed. When depression occurs, it is treatable just as it is for younger persons. Physicians can determine whether depression is related to medication, physical illness, stress, or other factors.
8. *False.* Many elderly individuals can and do beat cancer, especially if it is detected early. More than one-half of all cancers occur in individuals 65 and over, which suggests that screening for cancer is extremely important.
9. *True.* Older adults often have a complex combination of conditions that require drugs. They consume 25 percent of all medications and have the highest rate of drug interactions.
10. *False.* Most older people can lead active, satisfying sex lives.
11. *False.* Clearly, the overwhelming number of people with Alzheimer's disease have not inherited the disease. Some families, however, seem to be at higher risk for the disease.
12. *True.* Women are at higher risk for osteoporosis. Proper diet and exercise can, however, prevent bone loss over the entire life span.
13. *False.* Research suggests that, except for persons suffering from Alzheimer's disease and other dementia disorders, personality is one of the few constants in life. Essentially, who we are as younger persons remains the same in old age.
14. *False.* Urinary incontinence is a symptom, not a disease itself. It usually results from changes in the body from infection, disease, and medications.
15. *False.* Suicide is most prevalent among people age 65 and over. Typically, white males who live alone are at the highest risk for suicide.

16. *False.* Although a great number of elderly persons get cataracts, not all older individuals do. Cataracts are usually successfully treated.
17. *True.* The body's thermostat functions less efficiently as we age, making the older person's body less able to adapt to heat and cold.
18. *False.* People at any age can learn new information and skills. Elderly individuals continue to obtain new skills and improve old ones.

The Older American Demographic

The population of senior citizens age 65 and over numbered 34.5 million in 1999, representing 12.7 percent of the U.S. population, or about one in every eight Americans. (Elderly women outnumbered elderly men by a ratio of 141 to 100, respectively.) Over the past decade, the elderly population has increased by 3.3 million or 10.6 percent.

Historical perspective. Since 1900, the percentage of senior citizens has more than tripled and their number has increased 11 times, from 3.1 million to 34.5 million. In 1999, the 65 to 74 age group was eight times larger than it was in 1900. Furthermore, the 76 to 84 group was 16 times larger, and the 85+ group was 34 times larger! Individuals reaching age 65 now have an average life expectancy of an additional 17.8 years (19.2 for females and 16.0 for males). A child who was born in 1998 will live approximately 76.7 years, about 29 years longer than his or her 1900 counterpart.

The future. The senior citizen population will continue to grow significantly. Almost 2 million people celebrated their 65th birthday in 1999, or 5,422 per day. In the same year, about 1.8 million persons aged 65 or older died, which resulted in a net 1999 annual increase to the over 65 demographic of approximately 200,000 individuals, or 558 per day.

The overall growth slowed somewhat during the past decade because of the relatively small number of babies born during the 1930s Great Depression. However, the older population is expected to explode between the years of 2010 and 2030, when the baby boomers reach age 65. It is estimated that the population will more than double, from 34.5 million in 1999 to 70 million in 2030 (13 percent to 20, respectively). Additionally, minority populations are projected to represent approximately 24.5 percent of the aged in 2030, up from 16.1 percent in 1999. Between 1999 and 2030, the population of Caucasian Americans is projected to increase by 81 percent, compared with a 219 percent increase for other minorities, including Hispanics (238 percent); African Americans (131 percent); American Indians, Eskimos, and Aleuts (147 percent); and Asian and Pacific Islanders (285 percent).

Family status. In 1999, men age 65 and older men were much more likely to be married than women, 77 percent compared to 43 percent, respectively. Almost half of elderly women in 1999 were widows and there were over four times as many widows as widowers. However, only 8 percent of all older persons were divorced or separated in 1999, approximately 2.5 million persons, compared to 1.5 million in 1990.

Home setting. Sixty-seven percent of older non-institutionalized elders lived in a family setting in 1998. This proportion tends to decrease with age (only 45 percent of those 85 or older live in family settings.) About 13 percent of older persons were not living with a spouse but were living with children, siblings, or other relatives.

About 31 percent of all non-institutionalized older persons lived alone in 1998. They represent 41 percent of women and 17 percent of older men. Living alone correlates with advanced age. For example, among women aged 85+, three of every five lived outside a family setting. Although a relatively small percentage (4.3 percent) of the population over age 65 lived in nursing homes, the percentage increased dramatically with age.

However, over the past few years, more alternatives have been available for seniors, including continuing care retirement communities, group homes, and assisted living facilities. Increasing numbers of seniors who are not able to live with family are still able to live outside of nursing homes.

Mobility. Activity limitation increases with age. Thirty percent of individuals 65 to 74 reported a limitation caused by a chronic condition. Over half of those 75 or older reported similar limitations. The majority of seniors reported having at least one disability and one-third reported having at least one severe disability. Approximately 14 percent reported difficulty in carrying out activities of daily living (ADLs), and 21 percent reported having difficulty with instrumental activities of daily living (IADLs). ADLs include bathing, dressing, eating, transfer, and locomotion/ambulation. IADLs include meal preparation, shopping, money management, telephone use, doing housework, and taking medications. The most common conditions were arthritis, hypertension, hearing impairments, heart disease, cataracts, orthopedic impairments, sinusitis, and diabetes. In 1998, older consumers averaged $2,936 in out-of-pocket health care expenditures, a 33 percent increase since 1990. Older Americans spent 12 percent of their income on health expense, approximately 3 times the percentage spent by younger consumers.

Geographic locations. In 1999, 52 percent of older Americans lived in only nine states.

California	3.6 million
Florida	2.7 million
New York	2.4 million
Texas	2.0 million
Pennsylvania	1.9 million
Ohio, Illinois, Michigan, and New Jersey	More than 1.0 million each

Older Americans were slightly less likely to live in metropolitan areas than younger persons. Fifty percent of seniors lived in the suburbs, 27 percent in central cities, and 23 percent in non-metropolitan areas. The elderly are less likely to change residence than any other age group. In 1998, only 4.6 percent of seniors had moved since 1997 compared with 17.5 percent of persons under 65. A large majority of these older adults (78 percent) had moved to another home in the same state.

Income. The median income of older persons in 1999 was $19,079 for males and $10,943 for females. Households containing families headed by persons 65 or older reported a median income of $33,148. Additionally, 46.9 percent had incomes of $35,000, 25 percent had incomes of $25,000 or more, and one of every nine family households with an elderly head had incomes of less than $15,000. Major sources of income included Social Security, asset income, public and private pensions, and earnings. Social Security benefits accounted for approximately 38 percent of the aggregate income of the older population. The bulk of the remainder consisted of earnings, assets, and pensions.

In 1999, 4.0 million Americans aged 65 and older were in the labor force, which represents approximately 3 percent of the U.S. labor force. About 21 percent of workers were self-employed—compared with 7 percent for younger workers—and over 70 percent of them were male.

Education level. The educational level of the older population has been steadily rising. Between 1970 and 1999, the percentage of high school graduates rose from 28 percent to 68 percent. The percentage of high school graduates varies considerably by race and ethnic origin, with 73 percent of Caucasians, 68 percent of Asian/Pacific Islanders, 45 percent of African Americans, and 32 percent of Hispanics finishing high school. (Approximately 15 percent of all seniors hold a bachelor's degree or higher.)

U.S. Census Bureau Data

The population age 65 and over is broken down by states and territories in Table 2.2.

Table 2.2 The 65+ Population for U.S. States: July 1, 1999

State or Territory	Population 65+	State or Territory	Population 65+
Alabama	567,952	Maryland	596,961
Alaska	34,750	Massachusetts	859,731
Arizona	628,633	Michigan	1,223,560
Arkansas	361,342	Minnesota	585,394
California	3,647,532	Mississippi	335,492
Colorado	407,773	Missouri	745,684
Connecticut	468,576	Montana	117,239
Delaware	98,135	Nebraska	228,286
District of Columbia	72,102	Nevada	207,412
Florida	2,741,849	New Hampshire	144,585
Georgia	761,143	New Jersey	1,108,257
Hawaii	161,889	New Mexico	199,974
Idaho	142,209	New York	2,429,632
Illinois	1,496,177	North Carolina	954,866
Indiana	743,020	North Dakota	92,383
Iowa	428,487	Ohio	1,511,136
Kansas	354,079	Oklahoma	448,698
Kentucky	493,154	Oregon	435,099
Louisiana	501,458	Pennsylvania	1,898,936
Maine	175,357	Rhode Island	154,348

(continued)

TABLE 2.2 (*CONTINUED*)

State or Territory	Population 65+	State or Territory	Population 65+
South Carolina	473,371	Virginia	774,885
South Dakota	105,442	Washington	657,312
Tennessee	680,954	West Virginia	272,896
Texas	2,016,497	Wisconsin	691,409
Utah	185,603	Wyoming	55,630
Vermont	72,916		

Source: Population Estimates Program, Population Division, U.S. Bureau of the Census, Washington, DC
See: www.census.gov/population/estimates/states/ST-99-08.txt
Table compiled by the U.S. Administration on Aging

COMMON MYTHS ABOUT THE ELDERLY AND AGING

Myth. Seniors tend to be very similar to one another.
Fact. Elderly individuals are a diverse group. Accumulation of experiences over their lives contributes to wide variation among this population.

Myth. Elderly people are usually alone and lonely.
Fact. Most elderly Americans remain in contact with family and friends.

Myth. Elderly individuals are generally frail, sickly, and dependent on others for their care.
Fact. Most elderly individuals live independently.

Myth. Elderly people get depressed more often than the rest of the population.
Fact. Elderly people who reside in the community have lower rates of depression than found in younger people.

Myth. As people age, they are harder to get along with.
Fact. A person's personality remains fairly stable over the course of one's life.

Myth. Many seniors cannot cope with the losses associated with the aging process.
Fact. Seniors adjust quite well to the challenges brought by the aging process.

Myth. Most elderly people experience senility.
Fact. Most elderly individuals do not experience significant decline in cognitive functioning. The usual declines do not cause severe problems.

COMMON AGE-RELATED CHANGES

Presented here are typical changes that occur as people age.

Personality. One's personality, demeanor, and coping styles usually follow lifelong patterns, even in old age. Seniors tend to value accuracy, avoid risk, and prefer certainty.

Hearing. Mild to moderate hearing changes occur in approximately half of individuals age 75 and over. As one ages, the ears become less efficient at funneling sound to the inner ear. Total loss or deafness is unusual, however; most common changes are loss of hearing in the higher frequency and tone ranges. Consonant sounds g, f, s, and z are harder for seniors to discriminate. When speaking to individuals with hearing loss, it is important that speakers use lower tones and slightly slow their rate of speech.

Vision. Older people require more time to adapt to changes in light levels and have more difficulty seeing in dim light. The ability to identify and discriminate between colors, especially blues and greens, becomes moderately more difficult. Due to the diminished elasticity, thickening, and yellowing of the eye lens and the reduction of pupil size, older individuals experience more difficulty focusing on objects and seeing small objects and details clearly. Mild to moderate changes in reading speed also occur as one ages.

Taste and smell. By age 70, most peoples' taste buds have decreased by 50 percent. As one ages, reduced sensitivity to smell occurs, which reduces one's ability to taste. Some illnesses and medicines cause a permanent loss of smell. These declines in smell and taste can lead to nutritional deficiencies and are a leading cause of food poisoning in the elderly, inasmuch as they may be unable to detect spoiled foods.

Touch. As one ages, the ability to tolerate extreme temperatures decreases. Seniors are often unable to maintain a comfortable feeling. Older people cannot recognize fine or rough textures as easily as younger people. Also, their sensation of pain is diminished, which increases the risk of being unaware of an injury one may have sustained.

Reaction time. Reaction time is typically slower in elderly people, particularly for more difficult tasks. The ability to learn new material may also be slightly slower; however, for most active, engaged individuals, there may be no change.

Changes in abilities to function. The proportion of adults needing personal assistance with everyday activities increases with age. A greater proportion of women than men experience loss of abilities after age 65.

Information processing. The ability to process information slows with age. This may suggest a slower learning rate or may simply reflect the individual's increased use of caution when making a decision or voicing an opinion. The ability to divide attention among several tasks declines also. Simple adjustments in the environment, such as eliminating background noise, permits enhanced functioning.

Short-term memory. This type of memory shows more age-related loss than long-term memory in most individuals.

Language. Most aspects remain normal; however, word finding, naming, and rapid word generation activities slow in some individuals.

Sleep. Older adults become polycyclic (that is, they usually get the same amount of sleep, but in increased intervals). It is easier to interrupt an older individual's deep sleep than a younger person's. To improve sleep quality, it is better to adjust one's sleep schedule than to use sleeping aids.

Coping Strategies for Normal Age-Related Changes

Many elderly people develop effective coping strategies and mechanisms that help them maintain their independence and functioning as they experience normal age-related changes. These include:

- Practicing memory strategies, such as doing crossword puzzles and playing cards, and maintaining a "use-it-or-lose-it" mentality
- Making lists and notes as reminders
- Participating in memory-training workshops and activities
- Modifying tasks or the environment to accommodate changes
- Seeking support from friends, family, and neighbors

DEMENTIA

(Adapted from publications of the U.S. Department of Health and Human Services, the National Institutes of Health, the National Institute on Aging, and the National Institute of Neurological Disorders and Stroke)

It is important for the Elder Care practitioner to have a working knowledge concerning the diseases of the elderly. You may be the first one to notice degeneration in an elderly individual because of the intermittent contact that you have with clients as well as the factual nature of questions posed in a CPA practice. The family may be too close either physically or emotionally to recognize changes in their loved one. Your independence in regard to family members can help those involved recognize and accept a potential health problem.

Alzheimer's Disease

Alzheimer's disease is the most common cause of dementia in the elderly, although its cause is still unknown. Dementia is a condition that disrupts brain functioning. Alzheimer's affects parts of the brain that control thought, memory, and language. Approximately 4 million people in the United States have been diagnosed with the disease. Alzheimer's usually begins after age 65 although it can begin as early as 40, and the risk of the disease increases with age. About 3 percent of persons age 65 to 74 have Alzheimer's, and nearly half of those age 85 and older have the disease. It should be noted, however, that the disease is not a normal part of the aging process.

Named for German physician Alois Alzheimer, this progressive disease causes noticeable changes to the brain. Abnormal clumps, called *senile* or *neuritic plaques*, and tangled bundles of fibers known as *neurofibrillary tangles*, are the hallmarks of Alzheimer's. In addition, affected brains suffer a loss of nerve cells in areas of the brain that are vital to memory and other mental abilities. The brain also has lower levels of the chemicals that carry complex messages back and forth between billions of nerve cells. Alzheimer's usually disrupts normal thinking and memory by blocking messages between these nerve cells.

Another hallmark of the disease is slow onset. The type, severity, sequence and progression of mental changes can vary widely from person to person. At first, the only symptom may be mild forgetfulness. Elderly persons with Alzheimer's have trouble remembering recent events, activities, or the names of familiar people or things. Simple

math problems and activities, such as subtracting checks in a bank book, become increasingly difficult to complete. Usually, these symptoms are not serious enough to cause alarm. However, as the disease progresses, symptoms are more easily noticed and become serious enough to cause persons with the disease or their family members to seek medical help. People with Alzheimer's may forget how to do simple tasks, such as brushing their teeth or combing their hair. They can no longer think clearly and they begin to have problems speaking, understanding, reading, or writing. In the later stages of the disease, people may become anxious, aggressive, or begin to wander away from home. Eventually, due to severe mental damage, patients require total care.

Some individuals may live with the disease for only five years, whereas others may survive it for as many as twenty years. Currently, there is no cure for Alzheimer's; however, for some people certain drugs (for example, tacrine, THA, Cognex, Aricept or Excelon) may alleviate some cognitive symptoms. Some medicines help control behavioral symptoms of the disease, such as sleeplessness, agitation, wandering, anxiety, and depression.

Doctors at specialized centers can diagnose probable Alzheimer's disease 80 percent to 90 percent of the time. The following is some of the information physicians use to make a diagnosis:

- *A complete medical history,* including general health and past medical conditions and problems with ADLs
- *Basic and advanced medical tests,* including blood and urine tests to eliminate other diseases, or a spinal tap
- *Neuropsychological tests,* such as tests of memory, problem solving, attention, counting, and language
- *Brain scans,* including computerized tomography (CT) scan, magnetic resonance imaging scan (MRI), or positron emission tomography (PET) scan to view abnormalities

The Alzheimer Association has extensive information. This organization as well as others, such as the National Institute of Neurological Disorders and Stroke, the National Institute on Aging, and the National Institute of Mental health, conduct and support research on Alzheimer's to improve diagnosis, treatment and prevention. You can contact these organizations to obtain up-to-date information for your clients. For more information see the list of contact information in Chapter 10.

The 10 Common Warning Signs of Alzheimer's Disease

1. *Recent memory loss that affects job skills and functioning.* Individuals may begin to forget assignments, names of colleagues, telephone numbers and even where and when to arrive at work. Dementia patients will typically forget things more often.
2. *Difficulty performing familiar tasks.* Individuals with AD might be able to go grocery shopping, but then forget to prepare a meal, or even forget how long it has been since last eating.
3. *Problems with language.* Alzheimer's patients may forget simple words or substitute inappropriate words causing the listener to misinterpret the meaning of a statement or sentence.
4. *Disorientation of time and place.* Individuals may become easily lost or disorientated in familiar places and may be unable to find their way home again.

5. *Poor or decreased judgment.* Alzheimer's patients may dress inappropriately for the season or current temperature; individuals may resist personal care activities.
6. *Problems with abstract thinking.* Balancing a checkbook may be difficult when a check goes unrecorded or if there are errors on a statement; however, for individuals with Alzheimer's, the names and meaning of numbers may be lost, so the task is impossible to complete.
7. *Misplacing things.* Individuals suffering from Alzheimer's may demonstrate rummaging behaviors as they try to find things they have misplaced. Often, items are placed in inappropriate places and simply cannot be located.
8. *Changes in mood or behavior.* Alzheimer's patients may be docile and compliant one moment and argumentative and combative the next. Rapid mood swings can become commonplace.
9. *Changes in personality.* Typically, our personality type and style remain constant over the course of our lifetime; however, Alzheimer's patients may demonstrate drastic changes and may become suspicious or fearful.
10. *Loss of initiative.* Individuals with Alzheimer's may become extremely passive and require prompts or cues from other persons to help start or remain on task.

Pick's Disease or Alzheimer's?

Pick's is a rare disease that has many characteristics and symptoms similar to Alzheimer's except for one major difference: a rapid onset. The brain rapidly deteriorates with severe memory deficits, disturbances in personality, behavior, and orientation. Pick's disease is typically diagnosed in individuals from 40 to 60 years old. If one has noticed a rapid onset of supposed Alzheimer's, ensure that your client is directed to a physician knowledgeable in all aspects of dementia.

Parkinson's Disease

Parkinson's is a slow, progressive disorder of the central nervous system that typically occurs in adults between the ages of 60 and 65, but occurs most frequently in individuals aged 75 and over. It is characterized by tremors, stiffness of the limbs and joints, speech impairment, and gait problems. Medications such as L-dopa (Levodopa) are used to improve the motor skills of Parkinson's patients; however, medications do not restore the mental and cognitive skills lost during the disease progression. Depression and dementia commonly occur with Parkinson's. Persons with the disease typically live an additional 14 years following diagnosis.

Dementia with Lewy Bodies

Dementia with Lewy Bodies (DWLB), the second most frequent cause of dementia in elderly adults, is a neurodegenerative disorder associated with abnormal structures (Lewy bodies) found in certain areas of the brain. Because these structures as well as many other symptoms of DWLB are associated with both Parkinson's and Alzheimer's, researchers do not yet know if DWLB is its own distinct clinical disease or a variant of Alzheimer's or Parkinson's.

Symptoms can range from traditional Parkinson's effects, such as rigidity, tremor, and loss of spontaneous movement, to effects similar to those of Alzheimer's disease (acute

confusion, memory loss, cognitive impairment). Visual hallucinations may be one of the first symptoms noted, and patients may suffer from other psychiatric disturbances (delusions, depression). Onset of the disorder usually occurs in older adults, although younger people can be affected as well.

Treatment for DWLB is symptomatic, often involving the use of medication to control the symptoms. The disease is slowly progressive and has no cure.

Multi-Infarct Dementia

A common cause of dementia in the elderly, Multi-Infarct Dementia (MID) occurs when blood clots block small blood vessels in the brain and destroy brain tissue. Probable risk factors are high blood pressure and advanced age. The disease can cause strokes, dementia, migraine-like headaches, and psychiatric disturbances. MID symptoms, which often develop in a stepwise manner, include confusion, problems with recent memory, wandering or getting lost in familiar places, loss of bladder or bowel control, emotional problems such as laughing or crying inappropriately, difficulty following instructions, and problems handling money. Usually the damage is so slight that the change is noticeable only as a series of small steps. Individuals with the disease may improve for short periods of time; however, over time, as more small vessels are blocked, the mental state gradually declines. MID, which typically begins between the ages of 60 and 75, affects men more often than women.

Currently, there is no treatment for MID that can reverse the damage that has already occurred. Treatment focuses on prevention of additional brain damage by controlling high blood pressure. Early treatment and management of blood pressure may prevent further progression of the disorder; however, the prognosis for patients with MID is generally poor.

Creutzfeldt-Jakob Disease

A rare, degenerative, invariably fatal brain disorder, Creutzfeldt-Jakob Disease (DJD) affects only 200 people in the United States per year. It appears in later life and runs a rapid course. Typically, onset of symptoms occurs around age 60, and about 90 percent of patients die within one year. In the early stages of the disease, patients may have failing memory, behavioral changes, lack of coordination and visual disturbances. As the illness progresses, mental deterioration becomes more pronounced and involuntary movements, blindness, weakness of extremities, and coma may occur. There is no successful cure. Direct or indirect contact with brain tissue and spinal cord fluid is the method of transmission. It cannot be transmitted through casual contact. The illness can be diagnosed by a combination of neurological tests (EEG, MRI).

Elder Abuse

What Is Elder Abuse?

Elder abuse is defined as the physical, psychological, or emotional abuse or financial exploitation of elderly people. Federal definitions of elder abuse, neglect, and exploitation appeared for the first time in the 1987 Amendments to the Older Americans Act. These definitions were provided in the law only as guidelines for identifying

problems and not for enforcement purposes. Currently, elder abuse is defined by state laws, and state definitions vary considerably from one jurisdiction to another in terms of what constitutes abuse, neglect, or exploitation. Researchers have used many different definitions to study the problem. Broadly defined, however, there are three basic categories of elder abuse: domestic, institutional, and self-neglect. In most cases, state statutes addressing elder abuse provide the definitions of these different categories of elder abuse, with varying degrees of specificity.

Depending on the statute of a given state, elder abuse may or may not be an official crime. However, most physical, sexual, financial and material abuses are considered crimes in all states. In addition, depending on the type of the perpetrator's conduct and its consequences for the victims, certain emotional abuse and neglect cases are subject to criminal prosecution. However, self-neglect is not a crime in all jurisdictions, and therefore some state laws do not address self-neglect.

Practitioners wishing to provide CPA ElderCare services to individuals and families must be familiar with activities that may constitute elder abuse. If any practitioner knows or suspects that an elderly person is at risk for becoming a victim of such abuse, he or she must be able to identify appropriate resources for intervention.

Abusers may be family members, caregivers, or persons well known to the victim. Victims may feel too ashamed or embarrassed to tell anyone about such abuse, or they may feel that telling will only make their situation worse. Some are scared that they will have nowhere else to go and no one to care for them if they report this activity.

In general, the three basic categories of elder abuse are as follows:

1. *Domestic abuse.* Generally refers to any of several forms of maltreatment of an older person by someone who has a special relationship with the elder, such as a spouse, sibling, child, friend or caregiver. Abuse can take place in the home of the elder or in the home of the caregiver.
2. *Institutional abuse.* Usually occurs in a residential facility or agency charged with the care of an elderly individual, such as nursing homes, foster homes, group homes, board and care and residential facilities. Perpetrators of institutional abuse usually are persons who have a legal or contractual obligation to provide elders with care or protection, such as paid caregivers, staff, and professionals.
3. *Self-neglect or self-abuse.* Characterized by behavior of elderly people that threatens their own health or safety, this is usually manifested as a refusal or failure to provide themselves with adequate food, water, shelter, personal hygiene, medications as prescribed, and safety precautions. The definition usually excludes a situation in which a mentally competent elderly person, who understands the consequences of hazardous decisions, makes a conscious and voluntary decision as a matter of personal choice.

Why Does Elder Abuse Occur?

Elder abuse, like other types of domestic violence, is extremely complex. Generally a combination of psychological, social, and economic factors, along with the mental and physical conditions of the victim and the perpetrator, contribute to the occurrence of maltreatment. Although the reasons listed in this section are not all-inclusive, they are common causes of elder maltreatment. Note that more than two thirds of elder abuse perpetrators are family members of the victims, typically serving in a caregiving role.

Caregiver stress. Caring for frail older people is a very difficult and stress-provoking task. This is particularly true when older people are mentally or physically impaired, when the caregiver is ill-prepared for the task, or when the needed resources are lacking. Under these circumstances, the increased stress and frustration of a caregiver may lead to abuse or willfull neglect.

Impairment of the dependent elder. Some research has found that elders in poor health are more likely to be abused than those in good health. They have also found that abuse tends to occur when the stress level of the caregiver is heightened as a result of the deteriorating health of the elder.

Familial cycle of violence. Some families are more prone to violence than others because violence is a learned behavior and is transmitted from one generation to another. In these families, abusive behavior is the normal response to tension or conflict because they have not learned healthy response mechanisms.

Personal problems of abusers. Studies have shown that abusers of the elderly (typically adult children) tend to have more personal problems than do non-abusers. Adult children abusers frequently suffer from such problems as mental and emotional disorders, alcoholism, drug addiction, and financial difficulty. Because of these problems, these adult children are often dependent on the elders for their support. Abuse in these cases may be an inappropriate response exacerbated by a caregiver's sense of inadequacy.

Characteristics of Victims

According to the National Center for Elder Abuse, the median age of elder abuse victims was 77.9 years in 1996. Of all elder abuse victims, 67.3 percent are women. Various sources report that self-neglect accounts for half of all elder abuse. The second most frequent type of elder abuse is domestic elder abuse. Adult children are the most frequent abusers of the elderly, comprising 36.7 percent of all perpetrators of domestic elder abuse in 1996. Spouses are responsible for 12.6 percent of all domestic elder abuse, and other family members were responsible for 10.8 percent.

There may be instances either during the process of accepting clients or during an ElderCare engagement when the practitioner or other member of the ElderCare services team becomes aware of signs of elder abuse. Every firm should have in place a policy that was developed in consultation with its attorney to outline the firm's responsibilities for reporting suspected cases of elder abuse. Having a policy in place helps the firm:

- Ensure that the suspicion is handled quickly and uniformly because the steps are laid out, each individual's responsibilities are clear, and decisions are made in advance.
- Ensure that it is in compliance with the elder abuse reporting regulations in its state or jurisdiction. (For example, the state of Illinois recently enacted legislation that makes it mandatory for CPAs, among other professionals, to report suspected cases of elder abuse.)
- Clearly communicate its policy on elder abuse to employees, team members, clients, and their families.

Possible Signs of Elder Abuse

Indications of physical abuse include:

- Injuries to the upper body, especially the face, neck, throat, chest, abdomen, or pelvic area.
- Bruises in the shapes of objects, such as belts, ropes or fingers
- Burns in unusual size, shapes or locations
- Black eyes, welts, lacerations
- Bone and skull fractures
- Broken eyeglasses, frames
- Previous injuries in different stages of healing (open wounds, cuts, punctures)
- Signs of being restrained
- Location of the bruising inconsistent with the patient's explanations
- Evidence of drug or alcohol abuse by victim or person accompanying the victim
- Repeated use of emergency room services, possibly in different facilities
- Delay between the incident causing the injury and presentation in the emergency room
- Changes in behavior, demeanor or activity level (either observed through ongoing contact or reported by the victim)
- Unwillingness to communicate
- The caregiver's refusal to allow visitors to see an elder alone
- Signs of sexual abuse include, but are not limited to:
  - — An elder's report of being mistreated
  - — Bruises around the chest, genitals and/or inner thighs
  - — Bloody or torn underclothes as well as unexplained genital bleeding
  - — Difficulty in walking or sitting without evidence of muscular-skeletal disease

Indications of psychological or emotional abuse include:

- Confusion or disorientation (which is not otherwise indicated by organic brain syndrome, malnutrition, dehydration, anesthesia, or inappropriate use of medication)
- Anxiety
- Fear
- Withdrawal, passivity, lack of communication
- Signs of depression, such as suicidal ideation, sleep disturbances, changes in appetite, psycho-motor agitation, and loss of interest in pursuing social contacts
- Denial or evasiveness

Indications of financial exploitation include:

- Credit card bills from clothing or electronic equipment suppliers not likely to be frequented by the elderly person
- Sudden changes in bank accounts or banking practices, including unexplained withdrawals of large sums of money
- Additional names on the bank signature card
- Unauthorized use of the elder's ATM card
- Sudden changes in a will, or other financial document

- Signatures that are possibly forged (i.e., that do not resemble the older person's signature—or that appear even when older person can no longer write)
- Unusual concern by family member or caregiver that an excessive amount of money is being expended on the care of the older person
- Sudden appearance of uninvolved relatives
- Inability to pay bills for shelter, food, appropriate clothing, or medications despite adequate income and resources
- Placement in nursing home or residential care facility that is not consistent with alleged size of the estate
- Lack of amenities such as TV, personal grooming items, and appropriate clothing that the estate can well afford
- Missing personal belongings, such as art, silverware, or jewelry
- Deliberate isolation of an older adult from friends and family, resulting in the caregiver alone having total control
- Anxiety about or lack of knowledge of personal finances
- Transfers of assets or other property to a family or nonfamilial person
- An elder's report of exploitation

Indications of neglect include:

- Dirt, fecal or urine smell, or other health and safety hazards in elder's living environment
- Rashes, sores, or lice
- Inadequate clothing
- Malnourishment or dehydration
- Untreated medical conditions
- Hazardous or unsafe living conditions
- An elder's report of being mistreated

Indications of self-neglect include:

- Inability to manage personal finances, for example, hoarding, squandering, giving money away, or failure to pay bills
- Inability to manage activities of daily living, including personal hygiene, appropriate clothing, shopping, meal preparation, and housework
- Suicidal acts, wanderings, refusal of medical attention, isolation, or substance abuse
- Hazardous and unsanitary living conditions: lack of or unsafe utilities (plumbing or wiring, toilet facilities), signs of animal infestation in living quarters
- Rashes, sores, fecal or urine smell, inadequate clothing, malnourishment, and dehydration
- Changes in intellectual functioning, for example, confusion, inappropriate or lack of any response, disorientation to time and place, memory failure, and incoherence
- Inability to keep medical appointments for a serious illness
- Lack of necessary medical aids

State and Local Agencies to Contact for Elder Abuse Protection

(Adapted from materials from the Administration on Aging National Center on Elder Abuse)

Many public and private agencies and organizations are involved in efforts to protect vulnerable elderly people from abuse, neglect, and exploitation. Specific organizations and information is supplied in this section.

- *Adult protective services units of state social service agencies.* In most states, the Adult Protective Services (APS) agency is the principal public agency responsible for both investigating reported cases of elder abuse and providing victims and their families with treatment and protective services. In most jurisdictions, the county departments of social services maintain an APS unit that serves the need of local communities.

  Although most APS agencies also handle abuse cases for clients between 18 and 59 years of age, nearly 70 percent of caseloads involve elder abuse. The APS community is relatively small compared with the groups working for other human service programs, but it is composed of a few thousand professionals, nationwide.
- *State unit on aging.* The State Unit on Aging is the agency designated by the governor and the state legislature as the focal point for all matters relating to the needs of older persons within the state. The State Unit on Aging is responsible for planning, coordination, funding and evaluating programs for older persons authorized by both state and federal government. Refer to your state government listings for your state's office on aging or department of human resources.
- *Area agency on aging.* Every area agency on aging operates an information and referral (I&R) line that provides referrals to a wide range of services. I&R services can be particularly helpful in locating services that can help prevent abuse and neglect.
- *State long-term care ombudsman's office.* Every state has a long-term care ombudsman program to investigate and resolve nursing home complaints. The program has also been working toward the extension of services to board and care facilities as well as home care. Check with the State Unit on Aging or Area Agency on Aging to see if the long-term care ombudsman program in your area can help in your specific practice care instance. Chapter 9, "Long-Term Care Insurance," contains a comprehensive directory of state ombudsman offices.
- *State Attorney General's Office.* Every State Attorney General's Office is required by federal law to have a Medicaid Fraud Control Unit (MFCU) to investigate and prosecute Medicaid provider fraud and patient abuse or neglect in health care programs that participate in Medicaid, including home health care service.
- *Elder facility licensing and certification agencies.*
- *Law enforcement agencies.* (Including police and sheriff departments, district attorney offices as well as the court system.)
- *Hospitals and medical offices.* (Including the medical examiner/coroner's office.)
- *Health agencies.*
- *Area mental health centers.*

Often, people who want to help older relatives and friends don't live near them. There is a nationwide toll-free Eldercare Locator number—(800) 677-1116—to locate services in the community where the elder lives.

Additionally, many states have instituted a 24-hour toll-free number for reporting abuse. Calls are confidential. Table 2.3 contains the phone numbers of state elder abuse offices.

TABLE 2.3 STATE-BY-STATE ELDER ABUSE TOLL-FREE TELEPHONE NUMBERS

Source: National Center for Elder Abuse

State	Domestic Elder Abuse	Institutional Elder Abuse	Accessibility
Alabama	(800) 458-7214	(800) 458-7214	AL only
Alaska	(800) 478-9996 (907) 269-3666	(800) 730-6393 (907) 269-3666	AK only Out of State
Arizona	(877) 767-2385	(877) 767-2385	AZ only
Arkansas	(800) 482-8049	(800) 582-4887	Nationwide
California	None Available	(800) 231-4024	CA only
Colorado	(800) 773-1366	(800) 238-1376	Nationwide
Connecticut	(888) 385-4225	(860) 424-5200	CT only
Delaware	(800) 223-9074	(800) 223-9074	DE only
District of Columbia	(202) 727-2345	(202) 434-2140	DC only
Florida	(800) 962-2873	(800) 962-2873	Nationwide
Georgia	(800) 677-1116	(404) 657-2567 or (404) 657-4076	GA only
Guam	(671) 475-0268	(671) 475-0268	
Hawaii	(808) 832-5115	Same (808) 243-5151 (808) 241-3432 (808) 241-3433 (808) 327-6280	Oahu Maui Kauai Hawaii West Hawaii
Idaho	(208) 334-2220	None Available	
Illinois	(800) 252-8966	(800) 252-4343	After hours, report domestic abuse at (800) 279-0400
Indiana	(800) 992-6978 (800) 545-7763, ext. 20135	(800) 992-6978	IN only Out of state
Iowa	(800) 362-2178	(515) 281-4115	Nationwide 800 number, IA only
Kansas	(800) 922-5330 (785) 296-0044	(800) 842-0078	KS only Out of state
Kentucky	(800) 752-6200	(800) 752-6200	KY only

(continued)

TABLE 2.3 (*CONTINUED*)

State	Domestic Elder Abuse	Institutional Elder Abuse	Accessibility
Louisiana	(800) 259-4990	(800) 259-4990	LA only
Maine	(800) 624-8404	(800) 624-8404	ME only
Maryland	(800) 91-Prevent (800) 917-7383	(800) 91-Prevent (800) 917-7383	MD only
Massachusetts	(800) 922-2275	(800) 462-5540	MA only
Michigan	(800) 996-6228	(800) 882-6006	MI only
Minnesota	(800) 333-2433	(800) 333-2433	Nationwide
Mississippi	(800) 222-8000	(800) 227-7308	MS only
Missouri	(800) 392-0210	(800) 392-0210	MO only
Montana	(800) 332-2272	None available	MT only
Nebraska	(800) 652-1999	(800) 652-1999	NE only
Nevada	(800) 992-5757	(800) 992-5757	Nationwide
New Hampshire	(800) 949-0470 (603) 271-4386	(800) 442-5640 (603) 271-4396	NH only Out of state
New Jersey	(800) 792-8820	(800) 792-8820	NJ only
New Mexico	(800) 797-3260 (505) 841-6100	(800) 797-3260 (505) 841-6100	NM only Albuquerque and out of state
New York	(800) 342-9871	None available	
North Carolina	(800) 662-7030	(800) 662-7030	NC only
North Dakota	(800) 755-8521	(800) 755-8521	ND only
Ohio	None available	(800) 282-1206	Nationwide
Oklahoma	(800) 522-3511	(800) 522-3511	OK only
Oregon	(800) 232-3020	(800) 232-3020	OR only
Pennsylvania	(800) 490-8505	(800) 254-5164	Nationwide
Puerto Rico	(787) 725-9788 or (787) 721-8225		
Rhode Island	(401) 222-2858, ext. 321	(400) 222-2858, ext. 321	RI only
South Carolina	(800) 868-9095	(800) 868-9095	SC only
South Dakota	(605) 773-3656	(605) 773-3656	
Tennessee	(888) 277-8366	(888) 277-8366	Nationwide
Texas	(512) 834-3784 (800) 252-5400	(512) 438-2633 (800) 252-5400	Out of state TX and contiguous states

TABLE 2.3 (*CONTINUED*)

State	Domestic Elder Abuse	Institutional Elder Abuse	Accessibility
Utah	(801) 264-7669 (800) 371-7897	(801) 264-7669 (800) 371-7897	 UT only
Vermont	(800) 564-1612	(800) 564-1612	VT only
Virgin Islands	None available	None available	
Virginia	(888) 832-3858 (804) 371-0896	(888) 832-3858 (804) 371-0896	VA only Out of state
Washington	(800) 422-3263	(800) 562-6078	WA only
West Virginia	(800) 352-6513	(800) 352-6513	WV only
Wisconsin	(800) 815-0015 (608) 266-2536	(800) 815-0015 (608) 266-8944	WI only Out of state
Wyoming	(307) 777-6137	(307) 777-7123	

Elder Abuse and the Law

Federal law. Federal laws on child and domestic abuse fund services and shelters for victims, but there is no comparable federal law governing elder abuse. The Federal Older Americans Act (42 U.S.C. (3001 et seq., as amended)) does provide definitions of elder abuse and authorizes the use of federal funds for the National Center on Elder Abuse and for certain elder abuse awareness, training, and coordination activities in states and local communities, but it does not fund adult protective services or shelters for abused older persons.

Federal ombudsman laws. Since the passage of the 1975 Older Americans Act, all states and the District of Columbia have laws authorizing the Long Term Care Ombudsman Program (LTCOP), which is responsible for advocating on behalf of long-term care facility residents who experience abuse, violations of their rights, or other problems. LTCOPs are mandated in each state as a condition of receiving federal funds under the Older Americans Act. LTCOPs are an integral part of the systemic response to institutional elder abuse. LTCOPs may discover an abusive situation when responding to complaints within a facility and then, if appropriate, make a referral to an APS program, a law enforcement agency, or the agency responsible for licensing and certifying such facilities. Moreover, in some states, the LTCOP actually fulfills the role of adult protective services and has the legal authority to investigate and respond to abuse.

State adult protective services (APS) laws. All 50 states and the District of Columbia have enacted legislation authorizing the provision of APS in cases of elder abuse. Generally, these APS laws establish a system for the reporting and investigation of elder abuse and for the provision of social services to help the victim and ameliorate the abuse. In most jurisdictions, these laws pertain to abused adults who have a disability, vulnerability or impairment as defined by state law, and not just to older persons. These statues may vary widely in the following areas.

- The age or circumstance under which a victim is eligible to receive protective services
- The definition of abuse
- Types of abuse, neglect and exploitation that are covered
- Classification of the abuse as criminal or civil
- Reporting requirements (mandatory or voluntary)
- Investigation responsibility and procedures
- Remedies for abuse

Some state APS laws relate only to individuals who reside in the community (domestic abuse), whereas other APS laws also include individuals who reside in long-term care facilities (institutional abuse). Each state defines long term care facility (LTCF) differently; moreover, some states include other types of institutions (such as mental health facilities) in their statutes also.

State institutional laws. In some states where the APS law only covers individuals who reside in the community, institutional abuse statutes exist to create a mechanism for reporting, investigating and addressing incidents of elder abuse that occur in LTCFs or other facilities covered under the law.

State criminal laws. An increasing number of states are passing laws that provide explicit criminal penalties for various forms of elder abuse. Legislatures are also signaling their intent that elder abuse be treated as a crime in other ways. For example, some APS laws include a provision stating that elder abuse may be prosecuted criminally, while others define certain acts (for example, sexual abuse) in the same words or by reference to definitions that are used in the criminal laws.

Even if there is not a specific statute or provision authorizing criminal prosecution for elder abuse, a jurisdiction's basic criminal laws (battery, assault, theft, fraud, rape, manslaughter, or murder) can be used to prosecute someone who has committed an act of abuse against an older person. Some legislatures have enacted enhanced penalties for certain crimes against older persons.

Other relevant laws. Other state laws may be pertinent in cases involving elder abuse, such as those including guardianship or conservatorship, durable powers of attorney, and domestic or family violence prevention.

Resources for finding state laws. A variety of resources exist that will enable you to research and obtain copies of state laws. Libraries and the Internet are the most available resources. If you are looking for the laws in your own state, the community public library may have a set of statutes. The community courthouse may have a law library open to the public that will also have statues.

If you are looking for the law of another state or if you have no access to statutes at any public or law libraries near you, your best option is to search the Internet. Here are some Web sites that will link you to state laws online.

- Thomas (U.S. Senate): www.prairienet.org/~scruffy/htm.
- U.S. House of Representatives: www.law.house.gov/17.htm
- American Law Sources on-line (ALSO) www.lawsource.com/also/
- Findlaw: www.findlaw.com/casecode/state.html

- National Association of Area Agencies on Aging www.n4a.org
- Senior Law: www.seniorlaw.com

A comprehensive list of ElderCare Web sites is located in Chapter 10.

Disabled Elders

In the Spotlight: The *Olmstead* Decision

In 1999, the Supreme Court affirmed that the unjustified segregation and institutionalization of people with disabilities constitutes unlawful discrimination in violation of the Americans with Disabilities Act (ADA). The *Olmstead* v. *L.C.* (527 U.S. 581 1999) decision supported two women with mental retardation and mental illness from Georgia who voluntarily admitted themselves to Georgia's state mental hospitals; however, the decision was not limited to people with similar disabilities. The *Olmstead* decision challenged states to prevent and correct inappropriate institutionalization of persons with disabilities and to review intake and admissions processes to assure that persons with disabilities are serviced in the most integrated setting appropriate. The principles set forth in *Olmstead* apply to all individuals with disabilities protected from discrimination by title II of the ADA. The ADA prohibits discrimination against "qualified" individuals with a disability.

To be considered a "qualified" individual with a disability, the person must meet the essential eligibility requirements for receipt of services or participation in a public entity's programs, activities, or services. Your elderly client may qualify as disabled, allowing ADA protection for your client.

The ADA defines disability as:

- A physical or mental impairment that substantially limits one or more of an individual's major life activities
- A record of such an impairment
- Being regarded as having such an impairment

To meet the definition of a disability, a physical or mental impairment must be serious enough to limit a major life activity. Examples of such activities include caring for oneself, walking, seeing, hearing, speaking, breathing, working, performing manual tasks, and learning. They also include such basic activities as thinking, concentrating, interacting with others, and sleeping. Each group of people at issue, including the elderly, must meet the same threshold definition of disability in order to be covered by the ADA. With respect to elderly persons, age alone is not equated with disability. However, if an elderly individual has a physical or mental impairment that substantially limits one or more of his or her major life activities, has a record of such an impairment, or is regarded as having such an impairment, he or she would be protected under the ADA.

Access to affordable housing is frequently a necessary but missing prerequisite for moving out of a nursing home or other institutional setting. Historically, the lack of accessible, affordable housing and necessary community-based services has been a major barrier to the integration of people with disabilities. The Departments of Health and Human Services and Housing and Urban Development reported that they were strongly

committed to assisting states in developing comprehensive working plans to strengthen community service systems and to actively involve people with disabilities and their families in the design, development, and implementation of such plans.

The *Olmstead* v. *L.C.* decision indicated that a court might find a state in compliance with the ADA integration mandate if it demonstrated that it had a "comprehensive, effectively working plan(s)" for providing services to individuals with disabilities in the most integrated setting, and a waiting list that moves at a reasonable pace not motivated by a desire to keep institutions full. Ideally, all people with disabilities would already be provided with services in integrated settings, thereby eliminating the need for planning. As a practical matter, however, many states, including those that have made significant investment in the development of community-based services, still face unmet needs. Developing and implementing the kind of plan described by the Supreme Court in *Olmstead* is a recommended step toward addressing those needs. While the court did not require states to undertake planning, professionals suggested that planning is essential for states to remain in compliance with the order.

Executive Order for Community-Based Alternatives for Individuals with Disabilities

Additionally, on June 19, 2001, President Bush issued an executive order for *Community-Based Alternatives for Individuals with Disabilities.* The order restated the nation's commitment to community-based alternatives for individuals with disabilities by effectively fostering independence and participation in the community for Americans with disabilities. The order requires that states must avoid disability-based discrimination unless doing so would fundamentally alter the nature of the service, program or activity provided by the state. The order further requires the federal government to assist states and localities to swiftly implement the *Olmstead* decision to help ensure that all Americans have the opportunity to live close to their families and friends, to live more independently, to engage in productive employment, and to participate in community life.

While termed by some as the "Magna Carta" of the disability community, it remains to be seen how much *Olmstead* will actually help individuals with disabilities live in communities of their choice, and to obtain decent, affordable housing of their choice.

CHAPTER 3:

How to Build an ElderCare Practice

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ElderCare services is an emerging market for CPAs. As with all new ventures, practitioners need time to develop the practice and clients. Practitioners cannot realistically expect ElderCare clients to flock to their practice simply because the practitioner has announced this new service. An individual using a CPA for ElderCare services is driven by the trust already developed with the CPA, as well as the CPA's reputation for integrity and independence. Consequently, the initial ElderCare service client will in all likelihood emerge from an existing client base. As the practitioner becomes known in this area for providing these services in a reliable and trustworthy manner, new clients will be attracted.

Generating Leads From Existing Clients

The existing client base is undoubtedly the best source of potential clients for CPA ElderCare services, whether they are elderly or the adult children of elderly parents. The practitioner can easily identify elderly clients, using the firm's internal client database, but it may be more difficult to identify the adult children of elderly parents. CPAs in the firm may be aware of these situations, and they should be encouraged to identify the adult children of elderly parents.

The most likely source of client information is the tax or financial planning staff, who have access to information that would help them identify potential clients. The tax checklist is an excellent device for gathering information about client needs. Also, some tax return items are excellent indicators of the need for ElderCare. For example, if someone is deducting medical expenses for the care of a parent, the parent is a potential ElderCare client.

Some questions practitioners might want to include in their tax or financial planning checklist are as follow:

- Have you planned for the potential costs of long-term care or eldercare for your parents?
- Have you planned for yourself?
- Have you set up a durable power of attorney and a health care power of attorney in case of disability or medical emergency?
- If you own a business, have you done any planning for the transfer of ownership at your retirement?
- Do you (or your parents) have long-term care insurance?

Client Referral Sources

Even though your own established clients can provide a base from which you can develop CPA ElderCare services, you should explore the many other sources that exist to expand your ElderCare practice.

Professional resources include the following:

- Physicians
  - — Geriatricians
  - — Neurologists
  - — Psychiatrists
  - — Nephrologists
  - — Ophthalmologists
  - — Pulmonary specialists
  - — ENTs
  - — Primary (family) care
  - — Internists
  - — Oncologists
  - — Urologists
  - — Cardiologists
  - — Orthopedic surgeons
  - — Dermatologists
- Attorneys
  - — Elder lawyers
  - — Tax and estate lawyers
  - — Family or divorce lawyers and mediators
  - — Family and probate judges
- Stockbrokers
- Trust officers
- Insurance agents
- Financial planners
- Other CPAs and accountants

Community resources include the following:

- Clergy and religiously affiliated senior organizations
- Human resource directors in business and industry
- Chambers of Commerce
- Care-giving support groups, such as Alzheimer's, ALS (Lou Gehrig's disease), Parkinson's, and Hospice groups
- Civic, service, and professional clubs, such as Junior League, Rotary, Kiwanis, Sertoma, Civitan, American Medical Association, American Bar Association, and American Psychological Association
- Local media
- Local chapters of the American Association of Retired Persons and National Association of Retired Federal Employees

- Other interest groups that use speakers, such as art associations, garden and book clubs, alumni groups, investment clubs, and travel clubs (Check with your local library or college to be placed on the Speaker's Bureau.)

Network resources on aging can also provide referrals, which are most likely to come from the professionals and administrators working in network programs who recognize the needs of elderly individuals and their families in the community. Network resources include the following:

- Seniors centers
- Shepherd's centers
- Community-based long-term care agencies (These agencies provide in-home care services and are available to Medicaid-eligible individuals only. However, such agencies receive many inquiries about the availability of other services. Chapter 10, "Associations, Organizations, Agencies, and Other Resources," contains a list of phone numbers of state offices on aging, which can provide information about community-based long-term care agencies.)
- Adult protective services, usually a division of the state's office on aging or department of health and human services (See chapter 10 for information on state offices on aging.)
- Nursing home and residential care facilities
- Hospital discharge departments (Discharge planning requires that a patient be discharged when appropriate care arrangements are in place. Therefore, CPA ElderCare services are of particular value to out-of-town and working families who may require additional support and services for their elderly relative.)
- Home health agency social workers and physical and speech therapists (These public and private agencies care for many of Medicare's homebound elderly patients. When the patient's case is closed to home health services, elderly individuals and families are often still in need of ongoing monitoring and care.)
- Adult day care programs (These are public and private services that provide daily care for elderly individuals who need assistance during the day when other caregivers are unavailable.)
- Police and sheriff's offices keep-check or elderwatch programs
- Community commissions and boards on the elderly (These governmental groups maintain rosters of community aging-related services and agencies.)

The firm's CPA ElderCare services should be represented at:

- Health fairs
- Business and community expositions and events
- Older Americans month (May) events
- Senior sporting events
- Professional meetings and conferences

Case Study

This section presents an example of how a CPA may become involved in providing CPA ElderCare services to an elderly client and what those services entail.

Mr. Vandelay, a 77-year-old widower, has been a client of the CPA's firm for nine years. A retired mechanical engineer, Mr. Vandelay has no children and only one sister, with whom he has had sporadic communication for the past 30 years. A very private person, Mr. Vandelay lives in a one-level home in a rural subdivision approximately five miles from the center of a small town. Until an automobile accident last year, he had adequate personal transportation; however, following the accident and his own recognition of the occurrence of memory problems, he voluntarily stopped driving. Public transportation is not available. The client has reported no chronic health problems (subsequently verified by a comprehensive health assessment) and has excellent vision and hearing. He rides a stationary bicycle for 45 minutes three times a week at the local senior center, where he also usually has lunch (he takes a cab to the center). Mr. Vandelay owns significant assets, has adequate health and long-term care insurance, and maintains an avid interest in current events and the stock market. Should it become necessary, however, adequate assistance is not available to the client, insofar as he has no family in the area, his church does not have any significant assistance programs, and he has no affiliation with any civic institutions.

The CPA began to notice changes in the client approximately a year ago, when Mr. Vandelay began to arrive for appointments in an unkempt manner and often forgot the items he had been instructed to bring. It was obvious that he was losing weight and he seemed unusually quiet and tense. He reported that he was having difficulty remembering things and was very frustrated by his continuous episodes of forgetfulness. Several times during the past year, a 67-year-old female friend, Miss Kimoto, accompanied Mr. Vandelay.

Miss Kimoto stated that she and the client had dinner together daily and that she drove him to appointments, out shopping, and on other errands. Even though Mr. Vandelay had been referred by a family physician to the local mental health clinic for depression, Miss Kimoto reported that he continued to lose weight and seemed even more depressed. Both the client and his friend responded positively when the CPA suggested that the client meet with the firm's geriatric care manager (GCM) to discuss his concerns.

The GCM met with Mr. Vandelay in his residence. During the assessment, the GCM observed numerous antidepressant prescriptions and sample packs in various locations in the home. In addition, the GCM noted significant amounts of the client's deceased wife's medication past its expiration date. Although the client was prescribed only small daily amounts of one antidepressant and one antianxiety medication, he was clearly confused when asked to explain his medication regimen. The GCM observed many foods past their "best before" dates in the refrigerator and pantry, and little fresh food available. Although the house was found to be in good repair, it was cluttered with empty boxes, old newspapers, and magazines. Smoke detectors were inoperable and lighting was poor.

After completing a comprehensive assessment, geriatric depression screening, and a short mental status exam, the GCM recommended that the client see a geriatric physicians group in a nearby city for a thorough evaluation. Once the appointment was scheduled, Miss Kimoto's attitude began to change. She suggested Mr. Vandelay not make the trip and suggested he would "just get better"—she would see to it that he ate more often. The client, however, was eager to visit the physician due to his increased memory loss and frustration with speech problems.

Two weeks before the appointment, Mr. Vandelay called the CPA to inform him that he and Miss Kimoto would be married the following week. When the CPA asked the client

about his interest in such a quick marriage, Mr. Vandelay stated that it was something Miss Kimoto wanted to do and he would go along. Although the CPA, GCM, and the client's power of attorney had reservations about the marriage, it was clear that the client intended to marry and was competent to do so. The client was encouraged to complete his will (which had never been executed) and advance directives.

Three days after the wedding, Mr. Vandelay called the CPA and disclosed that he had made a serious mistake and regretted his decision to marry. In addition, he reported that Miss Kimoto had remarked several times that now that they were married, half of everything was hers. The client disclosed that Miss Kimoto had been treated for manic-depression. He further stated that she was continuously yelling at him and that he needed to see the CPA as soon as possible. The CPA promptly gathered the client's attorney, power of attorney, and GCM to discuss the situation with Mr. Vandelay. It was determined that the client should immediately seek an annulment of the marriage. Miss Kimoto was advised to vacate the home and cease contact with the client.

When notified that Miss Kimoto had left the home, the GCM visited Mr. Vandelay and found him to be depressed and withdrawn. The client's physicians were immediately contacted and informed of the situation. During the next week, the GCM monitored his situation on a daily basis. With the departure of Miss Kimoto, the client had no transportation and was having difficulty preparing meals. He refused to attend the senior center. With the client's permission, the members of the multidisciplinary team initiated the following actions.

The CPA:

- Gathered and sorted mail and legal documents that had been neglected
- Paid outstanding bills and arranged for monthly drafts as appropriate
- Helped the client inventory his safe deposit boxes
- Assisted the client with brokerage accounts and monitored all financial transactions
- Evaluated insurance
- Disposed of the stored automobile
- Assisted the client at meetings with bankers, brokers, and agents to determine appropriate changes to accounts and policies

The GCM:

- Arranged for emergency meal service until a homemaker could be hired
- Provided transportation to appointments
- Coordinated home services
- Monitored medications
- Coordinated services with the senior center for paid transportation and supplemental meals
- Developed a care plan
- Provided ongoing monitoring

The attorney:

- Filed for annulment proceedings

- Drafted a will and advance directives

The physician:

- Assessed the client for depression
- Ordered comprehensive tests to determine etiology of weight and memory loss
- Adjusted the client's medicine regimen
- Assessed the client for nutritional deficiency

The client:

- Checks off daily calendar for medications and meals
- Continues to exercise
- Attempts additional memory-related tasks daily (for example, crossword puzzles, word games, and reading)
- Keeps important phone numbers posted in several locations in his home for quick access
- Sorts mail daily

The annulment proceedings were completed within 45 days. Mr. Vandelay's home was cleaned and small repairs made. All medical tests were completed with no unusual results. The client regained 13 of the 15 pounds lost and felt much improved. He started again to attend the senior center on a regular basis and investigated several retirement and assisted-living communities with the GCM. The client continued to have cognitive deficits related to his memory loss, but his abilities improved with enhanced nutrition and supplemental vitamins. He started to prepare his medications weekly (which were reviewed by the GCM). All old and unused medicines and samples were discarded. Comprehensive neurological testing was scheduled. Mr. Vandelay's plans were to remain in his home with assistance as long as possible. However, with the ElderCare services, he was able to recognize and accept that his needs would increase over time. He executed a will, advance directives, and health care power of attorney. He successfully adjusted to the loss of independence from not being able to drive and his optimism about life improved. Mr. Vandelay took some trips with a traveling senior group. His bills remained current, with his accounts monitored by the CPA. He was able to discuss his interests and concerns with the GCM. Mr. Vandelay remained a very private individual with a support system in place to assist him with independence in his own home.

Epilogue: Mr. Vandelay lived in his own home up until the last week of his life. He passed away peacefully knowing that his needs were met in accordance with his wishes and that his instructions at death were carried out. Miss Kimoto received none of his estate. Fifty percent was bequested to his sister, a small portion was set aside in a trust (with a neighbor as trustee) for the care of his cat, and the remainder was donated to the victims of September 11th. This case is an example of an ElderCare success story.

Kinds of Marketing Needed

To market this service effectively, you must first consider to whom you are going to market your service: the elderly person or their children. You can market to both client

groups, but you must develop two approaches to address the needs and perspectives of these different target markets.

To market to the elderly person, you could focus on independence issues; to market to the adult children, you could focus on peace of mind.

Once you have developed an overall approach to your marketing message, you need to develop a marketing plan for the service, which includes deciding which marketing and promotional vehicles will best help you get your message across to your prospective clients. This marketing plan should be updated on a regular basis, to reflect changes in your practice.

The following is a list of possible means of promoting your new service:

- Direct contact
- Requests for referrals
- Speeches
- Firm newsletter
- Brochures
- Individualized letters
- Advertising
- Public relations
- Web site
- Sales calls

Direct Contact

Personal relationships are likely to provide the best source of clients. Because of this, personal phone calls and meetings with existing clients and personal contacts should be used early. Invite contacts in for a free consultation or take them to lunch to explain your services.

Requests for Referrals

A rich source of clients is likely to be your referral network, especially the people in your referral network who have elderly clients. Make them aware of your services and ask them to identify those who might benefit from your services. This referral relationship can be almost as strong as the personal relationship you have with your own clients.

Speeches

Giving speeches to local groups is an effective way to establish name recognition in your community and to demonstrate your knowledge of issues relating to the elderly. Some local groups that you may want to consider are service organizations, such as the Rotary and Lions, and even the community outreach program of your local hospital.

Speaking to local chapters of professional groups is a useful way to make contacts with other professionals who serve this market. Members of such professional groups (physicians, lawyers, hospital discharge planners, and nursing home operators) require

training for maintaining licensure. Some possible topics to address to these groups would include paying for long-term care, deductibility of medical expenses, and estate planning.

Be sure to bring firm brochures, copies of recently published articles that you have written, as well as any other materials that can be imprinted with your firm name, address, and telephone number.

Firm Newsletter

Certainly, if your firm has its own newsletter, you should feature your ElderCare service prominently in one of the issues, particularly an issue that will be received in advance of tax time because it will put the service in the client's minds right before they meet with you.

Brochures

Brochures are a very useful tool to market this service because they can be mailed to existing clients and distributed to locations that are sources of potential clients, such as doctors' offices, banks, law offices, funeral homes (for surviving spouses and their families), hospitals, and nursing homes. They can be mailed in response to inquiries from potential clients and given to potential clients during tax time visits. A sample of a CPA ElderCare services brochure is included in Chapter 11, "Sample Documents and Checklists."

Individualized Letters

Letters can be used for promoting CPA Eldercare services to existing clients as well as to potential clients. Letters are not as visually appealing as brochures, but they offer more opportunity for you to customize your message, depending on whether the client is the elderly person, the adult child, an existing client, or a potential client. There is no end to the opportunity for customization with today's technology. The most important element of direct mailings is the development of a mailing list. Direct mail is very expensive on a per-unit basis, so identifying the correct profile of a potential client is very important when selecting your list. Look at your current client base and select potential clients based on such factors as age and income levels.

Advertising

Advertising on the local level may be an effective way to raise awareness of your CPA ElderCare service. ElderCare is clearly a service in which personal relationships are important, so impersonal communications are likely to be less effective than personal contacts and referrals.

It is important to decide whether you are trying to reach the elderly or their children when designing your ad. Avoid terms that are too technical and try to describe your service in simple terms. Although it is important to project a professional image, remember that this service is for consumers who may not be familiar or comfortable with technical accounting and health care jargon. Keep your message concise and remember to make the ad easy to read.

The AICPA has developed a marketing kit for practitioners, which includes brochures, advertisements, and direct mail pieces. Also included are marketing messages targeting

both the elderly and the adult children of the elderly. You can customize these pieces to incorporate your firm's name, logo, and services specifically provided. To order the marketing kit (product no. 022508), call the AICPA at (888) 777-7077 or visit www.cpa2biz.com.

Public Relations

Public relations can consist of a number of initiatives, including press releases, sponsorships of community events, or community service. Offering free tax advice at your local senior center might provide an introduction to some new potential clients and may increase the firm's name recognition among senior citizens in the community.

Writing a column on financial matters of interest to seniors in your local newspaper or newsletters of local organizations establishes name recognition and a reputation as an expert among your potential clients. Newspaper columns are typically 300 to 500 words long and should be written in clear, easy-to-understand language. If possible, get the publication to include your firm name and address. Remember to include your CPA designation, any special accreditation, and any memberships in professional organizations that would enhance your standing as an expert.

If you cannot get a column published, write letters to the editor of your local newspaper about local or national issues that affect the elderly. Be sure to identify yourself and your firm name. These letters should not be inflammatory in nature, but should take a factual approach to solving a situation. For example, if an article in your local paper discusses changes to the Medicare program, you could write a letter to the editor that further explains the ramifications of the changes that were noted in the article.

Web Site

If you use a Web site, you should be sure to prominently feature your CPA ElderCare services practice on this site. This type of advertising is particularly effective for marketing to distant adult children who have an elderly parent in your area.

Sales Calls

This is the most costly way to market the service. You should limit sales calls to following up on initial contacts or use them only in cases where the potential client cannot visit your office because of physical disability or hospitalization.

Client Retention

The very nature of an ElderCare practice dictates that client turnover will be much more rapid than your traditional areas of practice. For this reason, a continuing marketing effort is needed to maintain your client base.

How to Generate Internal Enthusiasm for the Service

Depending on the size of the firm, often the hardest part of developing an ElderCare practice is convincing your partners to devote internal resources to it. Obviously, this is a more important issue for multipartner firms. Initially your clients will probably be

derived from your existing client base, so it is critical that everyone in the firm is aware of the service and recognize the value to the client and the firm.

Your internal sell depends on the circumstances of your particular firm—its risk tolerance and willingness to try new services and new ways of doing business. A successful proposal must be tailored to your specific firm, but should demonstrate that, at a minimum:

- You have done research on the market need in your area and the need exists.
- You have considered what resources the firm will have to devote to the development of this practice area.
- You have developed a reasonable timeline for the development of this service, including milestones to reach to continue supporting the service.
- Your firm's client base includes potential clients for this service.

You should undertake efforts to increase the awareness and understanding of the service by all the firm's staff. This may take the form of training sessions, internal communications, or even informal, one-on-one "pitches."

You will probably need to educate partners and staff about the issues and costs of ElderCare for them to understand and appreciate why these services could be valuable to their clients.

How to Approach a Potential Client

People are generally very sensitive about their ability to do things on their own and their dependence on others for taking care of some of their daily needs. Often, if you ask adult children of the elderly how their parents are faring on their own, you will get a markedly different response than if you ask the elderly directly. So talking about ElderCare with a potential client can often be a tricky proposition.

An indirect approach is often the best one when dealing with the elderly. Focus on the benefits of having some of their more worrisome responsibilities taken care of for them instead of on the fact that they may not be handling these responsibilities well anymore. For example, no one enjoys having to remember to make estimated tax payments during the year. Focus on how your handling of this responsibility during the course of the year will free them from thinking about paying taxes throughout the year.

When selling to the adult children of the elderly, focus on how the service will alleviate some of their worries about their parents' ability to cope with the financial and other burdens of everyday living. Also, the service can help to assuage the adult children's guilt about not having enough time to spend on taking care of their parent. They can feel secure that they are giving their parents the best care that money can buy.

Price Comparison Worksheet

The Monthly Price Comparison worksheet in Chapter 11, "Sample Documents and Checklists," can be used as a planning tool and also as a marketing tool, when a potential client is convinced that it is too expensive for them to provide ElderCare for their parent or to pay for it themselves. In some areas, the cost of living in an institutionalized setting may be much less than of living independently, but in many areas the cost will not vary

widely from an institutionalized setting to living at home with CPA ElderCare services. Complete a sample worksheet based on average costs in your area, and if the difference is negligible, do include a sample comparison as one of your marketing tools.

Networks and Strategic Alliances

Many other professionals are targeting elder adults as their clients. You can develop strong networks with these professionals, which can lead to client referrals. In addition, you may form strategic alliances with these individuals, which will include the multidisciplinary team approach with the client.

You may consider starting a more formal network of these professionals and include periodic meetings with these individuals in your community. This may also position you as a leader in this area. Be sure to exercise due care in selecting those professionals to whom you choose to refer clients.

Also, do not ignore other CPAs in your area. Not all CPAs will be willing to provide ElderCare services, but many will have elder clients.

Consider forming networks with the following professionals:

- Investment advisers
- Bank managers
- Trust officers
- Long-term care insurance providers
- Elder law attorneys
- Estate planning attorneys
- Nursing home administrators
- Home health agencies
- Funeral home directors
- Insurance agents
- Hospital discharge directors
- Geriatric psychiatrists
- Geriatric physicians
- Geriatric care managers
- Social workers

How to Market Long Distance

The adult children of the potential ElderCare client may live a considerable distance from their parents. This presents a unique marketing issue: how to reach these potential interested parties. Marketing to adult children who do not live in your geographic area will be difficult. One approach would be to develop relationships with elderly people in the area, then try to get introduced and communicate with the children who live elsewhere. For example, you could ask to meet with the children of your elderly clients to try to establish a closer relationship with them. Another approach would be to interact

with older people in the community through programs delivered to service organizations and retirement communities, then invite them to include their adult children in meetings or programs you sponsor.

It may be possible to use a direct mail campaign to adults who still have parents in your area by using alumni directories or subscription lists from local newspapers.

The AICPA is developing Web-based resources for the development of ElderCare. The project, or phase of service development, will be on the AICPA's site and is intended for practitioners. This project will provide resource information and will also include listings of those practitioners interested in providing CPA ElderCare services. This will provide a vehicle for practitioners to network with other CPAs interested in providing ElderCare and also could be used by CPAs to refer the adult children to CPAs providing ElderCare services in the area where their parents live. The second project will be a Web site, geared specifically to consumers, to explain ElderCare services and provide listings of CPAs nationwide that provide these services. This will allow consumers to select ElderCare service providers for either themselves or their parents.

Business-to-Business

An emerging trend is for employers to assist employees with the responsibilities of taking care of parents. Many large corporations are now recognizing the cost of absenteeism and lost productivity due to adult children taking care of their elderly parents. Many corporations are now including some type of assistance to their employees as part of their employee benefit packages.

This trend may present a CPA with a new market base for CPA ElderCare services. In particular, CPAs at larger firms that have large corporate clients can offer consulting services to their corporate clients' employees under an employee benefit plan.

CHAPTER 4:

Understanding With the Client, Engagement Letters, and Planning

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Understanding With the Client, Engagement Letters, and Planning

Understanding With the Client and Engagement Letters

Although AICPA professional literature does not require the use of engagement letters in any type of engagement, the auditing, attestation, and accounting and review standards require that you have an understanding with the client. Furthermore, the auditing and attestation standards require you to document that understanding.

Specifically, Chapter 1, "Attest Engagements," of Statement on Standards for Attestation Engagements No. 10, *Attestation Standards: Revision and Recodification* (AICPA, *Professional Standards,* vol. 1, AT sec. 101.46), and Statement on Auditing Standards (SAS) No. 1, *Codification of Auditing Standards and Procedures* (AICPA, *Professional Standards,* vol. 1, AU sec. 310.05, "Appointment of the Independent Auditor"), require an understanding to be established with the client and documented for attestation and audit engagements, respectively. Statement on Standards for Accounting and Review Services No. 1, *Compilation and Review of Financial Statements* (AICPA, *Professional Standards,* vol. 2, AR sec. 100.08), requires an understanding with the client to be established for compilation and review engagements, and Statement on Standards for Consulting Services (AICPA, *Professional Standards,* vol. 2, CS sec. 100.07), requires an understanding with the client to be established for consulting engagements.

CPAs are strongly advised to document all CPA ElderCare engagements through a written communication with the client (an engagement letter). A well-written engagement letter is for the CPA's protection as well as for the client's benefit.

Both the elderly client and the responsible family members, if appropriate, should agree to the terms of the engagement. If that is not possible because of the elderly client's incompetence, the engagement letter should be addressed to, and signed by, the person legally responsible for the elderly client—presumably the person named as attorney-in-fact in a durable power of attorney, with copies, if appropriate, to the elderly client or other close family members.

In drafting ElderCare engagement letters, practitioners should avoid boilerplate letters and should carefully tailor every letter to the individual client. Engagement letters should be very specific about the matters for which the practitioner will be responsible and actions that should be taken by the practitioner in unforeseen or unusual situations.

Engagement letters should be reviewed and revised regularly, but no less than at least once every year. The needs of an elderly person change, sometimes rapidly. If the mental or physical condition of the ElderCare client changes, the practitioner should review and revise the engagement agreement to reflect the change in his or her responsibilities to the ElderCare client. Those responsibilities will change over time in response to the changing

needs of the elderly person. Unless the matter involves a threat to the health or safety of the elderly person, the practitioner should not undertake additional responsibilities until the engagement letter has been amended to include those additional matters.

Unique Situations

Virtually every ElderCare engagement presents the practitioner with a number of unique situations and demands for services that are well beyond the scope of the examples in the sample engagement letters provided in this Practice Aid in Chapter 11, "Sample Documents and Checklists." Goals for assistance are as varied as are the individuals requiring assistance. Each engagement or plan must be tailor-made to fit the particular needs of the elderly person and his family.

Practitioners must also be aware that engagements may be framed in an environment fraught with animosity. There might be estrangement between the elderly client and various children, among the children themselves, or among other family members. If the acceptance of such an engagement is contemplated, the practitioner may wish to consult with his or her attorney on crafting an engagement letter.

Finally, the elderly client is likely to be experiencing mental changes that adversely affect memory and perception of reality. They may often shift alliances among various competing interests for no apparent reason. The practitioner must be careful not to become a convenient scapegoat for disaffected family members or even for the client.

For all of these reasons, practitioners must ensure that the terms of understanding of the engagement are clear, unambiguous, and as comprehensive as possible. Be fully descriptive of the services to be provided, and lay down clean lines of responsibility for providing the services.

Elements of the Understanding With the Client and Engagement Letters

The items to be included in the understanding with the client will depend on the kind of engagement to be performed, and the respective professional standards that the engagement may be performed under. As mentioned previously, this understanding should be documented through a written communication with the client (an engagement letter).

What the Professional Standards Require in the Understanding

Attestation Engagements. Chapter 1 of Statement on Standards for Attestation Engagements No. 10 (AT sec. 101.46) states that the understanding should include the engagement's objectives, client's responsibilities, the practitioner's responsibilities, as well as limitations of the engagement. In addition, if the engagement is an agreed-upon procedures engagement and the understanding is documented through the use of an engagement letter, Chapter 2, "Agreed-Upon Procedures Engagements," of SSAE No. 10 (AT sec. 201), the following matters (listed in subsection AT sec. 201.10) might be included in such an understanding:

- Nature of the engagement
- Identification of the subject matter (or the assertion related thereto), the responsible party, and the criteria to be used
- Identification of specified parties

- Specified parties' acknowledgment of their responsibility for the sufficiency of the procedures
- Responsibilities of the practitioner
- Reference to attestation standards established by the AICPA
- Agreement on procedures by enumerating (or referring to) the procedures
- Disclaimers expected to be included in the practitioner's report
- Use restrictions
- Assistance to be provided to the practitioner
- Involvement of a specialist
- Agreed-upon materiality limits

Compilation and Review Engagements. If the engagement is performed under the accounting and review services standards, those standards require that the understanding include a description of the nature and limitations of the services to be performed and a description of the report the practitioner expects to render. The understanding should also provide (a) that the engagement cannot be relied on to disclose errors, fraud, or illegal acts and (b) that the practitioner will inform the appropriate people of any material errors that come to his or her attention and any fraud or illegal acts that come to his or her attention, unless they are clearly inconsequential (AR sec. 100.08).

Consulting Engagements. If the ElderCare engagement is performed under the AICPA's consulting services standards, the understanding should include the responsibilities of the parties and the nature, scope, and limitations of services to be performed (CS sec. 100.07).

Auditing Engagements. It is unlikely that an ElderCare engagement would be performed under the AICPA's auditing standards. Nevertheless, if the auditing standards do apply, Statement on Auditing Standards (SAS) No. 83, *Establishing an Understanding With the Client* (AICPA, *Professional Standards*, vol. 1, AU sec. 310.06-.07), as amended, sets out the items that would generally be included in the understanding related to an audit of financial statements.

Recommended Topics to Include in an ElderCare Engagement Letter

In addition to the matters described above, the ElderCare engagement letter should address the following topics.

Identification of the Client. In some cases, a child or other party may be engaging the CPA to perform work on behalf of the elderly person. Because the older adult is always considered to be the client in an ElderCare engagement, it may be possible that practitioners address the engagement letter to someone other than the client. Be sure to spell out who the client is (always the elder), and what responsibilities the other party may have. If at all possible, the elderly person should sign a copy of the engagement letter, even when another party is paying for the service.

Description of Services to Be Provided. The engagement letter should include a paragraph identifying the services that practitioners will be performing for the client. Even though it may be difficult at first, practitioners should try to be as specific as possible in outlining what they will be doing. They should not leave an implication that they will be doing more than they actually anticipate performing.

Staffing of the Engagement. In such a highly personalized service, it is important to identify all the staff members who will be handling parts of the engagement. This is important because clients may be expecting the partner to be handling all aspects of their engagement and may become confused when contacted by other individuals from the firm. It is also important to underline at the start of the engagement that this service uses a team approach that will be coordinated by the partner in charge of the engagement. If staff members are named in the engagement letter and there is a subsequent change in the staffing of the engagement, a follow-up letter should be sent to the client documenting this change.

Designation of Client Contacts. Occasionally during an ElderCare engagement, the elderly person is unable to make his or her own decisions about care or finances, so a contact person should be designated who can make these decisions on the client's behalf. A hierarchy of contacts may be necessary in case of emergency. These contacts should hold a power of attorney that would allow them to act on the client's behalf in cases of mental or physical incapacity.

Description of Client Responsibilities. Although the CPA and other team members have specific responsibilities in an engagement, the client also has responsibilities to provide information needed by the CPA to render services. The client should be informed of the scope and timing of these responsibilities. For example, the practitioner should list legal documents such as powers of attorney, trust documents, waivers, or any other documents that the client is responsible to provide that are necessary to the performance of the practitioner's duties.

Family Conflicts. Disputes between family members regarding the care of an older adult are a common situation. The engagement should document the firm's policy on how conflicts between the elderly client and responsible family members will be handled.

Emergency Clauses. The engagement letter should describe actions that are to be taken in emergency situations, for example, who is to take what action in the event of an emergency or who is to be notified. Try to create a hierarchy of contacts in the event of an emergency.

Requests for Additional Services. Over time, the CPA develops a close relationship with the ElderCare client, and as a result, the client sometimes may become confused about the role of the CPA and simply assume that the CPA has undertaken additional responsibilities. The engagement letter should address the issue of how requests for additional services will be handled.

Client Communications. Describe the type of reports to be issued as part of the engagement, the frequency of these reports, and what professional standards apply to these reports.

Disclosure to Others. Because ElderCare will frequently involve many family members and team members, the engagement letter should contain the authorization to release information to specific other parties. This will limit distribution of any reports resulting from the engagement and can also help the firm's staff in maintaining confidentiality. See the discussion of Gramm-Leach-Bliley Act in Chapter 6, "Engagement Services, Professional Standards, and Reporting," and the new privacy notice requirements and distribution form located in Chapter 11, "Sample Documents and Checklists."

Provisions to Resolve Potential Ethical Conflicts. Despite stringent client screening procedures, conflicts of interest can and do arise after engagements begin. To avoid potential client misunderstanding, it is helpful to explain in the engagement letter any potential for conflicts that currently exist and any circumstances under which the firm may become required to suspend services or resign from the engagement.

Records Retention Policy. Clients need to agree to be bound by the firm's policy on retention of both firm workpapers and the client's records. The firm may want to develop a records retention policy specific to ElderCare services. If a separate policy is developed, it should be clearly stated in the engagement letter and adhered to by all staff providing ElderCare services.

Other Parties or Providers. If the elder client will hire other providers (such as home health agencies and sitters) or if other professionals are providing services to the older adult, practitioners should describe the responsibilities of each professional or provider in the engagement letter. Also, other individuals or family members may be involved in the engagement, such as the person granted a durable power of attorney. Detail their duties and responsibilities in the engagement letter, and what the CPA's relationship with each individual should be.

Termination of Engagement. Describe in the engagement letter how either party can terminate the engagement. This will include a description of the firm's policy on termination of ElderCare engagements. Although professional standards indicate that the practitioner has to abide only by the conditions for termination set forth in the engagement letter, it is often not possible for a practitioner to terminate an engagement according to his or her usual terms of termination. For example, the termination of the CPA's services may` have a negative effect on the health and welfare of the elderly client, or the CPA's continued involvement on the engagement may increase the risk of litigation or legal exposure. In these instances, it would be prudent to obtain legal consultation before terminating the engagement.

Explanation of Billing Practices and Payment Terms. The engagement letter should explain the estimate of anticipated client fees and costs and the method of billing. Outline payment terms in accordance with the firm's policy.

Engagement Letter Updates. Provide a means by which the engagement letter can be updated, if the ElderCare situation substantially changes and changes in service level are required.

Disclaimer. Include a statement that the firm's staff and all members of the ElderCare team that the firm hires directly have signed an agreement disclaiming all gifts, loans, or bequests that may be offered by the client during the engagement.

Some Final Points on the Understanding With the Client and Engagement Letters

ElderCare engagements are fluid and dynamic. Clients' needs can change quickly over a short period of time. As such, practitioners must be prepared to review the terms of the engagement at least annually, and in many cases, more often than that to ensure all understandings are properly reflected in writing.

Finally, due to broad variations in laws in different jurisdictions and the wide scope of service possibilities, practitioners should consider having elements of the engagement letters reviewed by legal counsel periodically to ensure that all interests are protected.

Sample Engagement Letters

Even though every ElderCare engagement is different, sample engagement letters will be helpful. Chapter 11, "Sample Documents and Checklists," includes sample engagement letters for use in the ElderCare practice.

The Planning Process

When performing CPA ElderCare services, the CPA should gather all available information regarding the client's health, previous estate-planning efforts, health insurance, life insurance, assets, debts, estate plan, monthly income and expenses, and family support system. Valuable information is contained in the client's most recent tax return, copies of powers of attorney and advanced directives, recent bank statements, Social Security and pension information, and copies of deeds to real estate. The CPA should gather information on accounts, documents, and properties that may be held with other parties. Additionally, maintaining a comprehensive list of the client's physicians, family members, and emergency contact numbers is essential. Chapter 11 contains a Sample Client Intake Form, Sample Client Information Form, and a Sample Client Assessment Form to aid the CPA in gathering client information.

Whereas some clients and their family members may be able to complete some of the aforementioned forms before meeting the CPA, the practitioner may find it helpful to complete the task with the client and family during an initial conference. This permits the client and family to provide additional important material and allows the practitioner to observe the client's level of functioning, orientation, and understanding. Before the meeting, the practitioner should review the section in this chapter titled "Creating an Inviting Environment for Your Elderly Clients."

During meetings with the elderly client, the practitioner may observe what has been called "delayed response to stimulus." This phenomenon is demonstrated by elderly people when, during the discussion of a topic, a previously discussed (and usually concluded) topic again surfaces for further comment by the elderly person. The delayed response occurs as the elderly person's brain continues to gather stored material related to the previous topic. The practitioner should be prepared for these events and simply permit the client to continue the thought. The delayed response to stimulus is a normal part of the aging process and should be expected and appropriately handled by the ElderCare CPA.

To make the elderly client more comfortable discussing personal information, the CPA should assure the client that confidentiality will be maintained. Individuals may be reluctant to discuss pertinent information if they feel it will be relayed to their adult children or other responsible parties without their permission. Because the competency level of an adult may be determined only by a court, the practitioner must make every effort to maintain confidentiality. Written information release forms, signed by the client, are recommended before the CPA provides any other party with confidential documents or communications.

After gathering the important information and documents related to the client, and by considering additional client information provided by members of the multidisciplinary team, the CPA can begin the planning process.

The steps of planning may include:

1. *Determining the goals of the elderly person.* Why has the client or client's family requested the practitioner's services? What is the primary goal of this activity? Clearly define what the client and family hope to accomplish by engaging the CPA to perform ElderCare services.
2. *Assessing the client's health and care needs.* The CPA's association with a geriatric care manager (GCM) will be valuable in this task. Usually conducted in the client's home, the assessment offers the clearest picture of client-family functioning that cannot be gained in an office setting. This assessment should include physical, psychosocial, and environmental functioning as well as determining the level of family or other support available to the client. The care manager should possess a current knowledge of community resources that are available to satisfy an elderly client's needs.
3. *Assessing the client's financial resources.* What are the client's financial needs and are resources available? Does the client have adequate health and long-term care insurance? Does the client qualify for public programs of assistance? Asset preservation and Medicaid issues should be considered with the input of an experienced elder law professional. The Medicaid section of Chapter 7, "Federal and State Programs for the Elderly," presents additional information in this area.
4. *Presenting the plan.* Prepare an engagement letter and written service plan, and give them to the client and his or her family, if applicable. All meetings, conversations, and authorizations for services should be documented. Examples of a service plan and engagement letter are presented in Chapter 11.

STAFFING

Because CPA ElderCare engagements differ from many other engagements, practitioner involvement with the client is usually on a much more personal basis than a normal accounting engagement. And although the ultimate goal of an ElderCare engagement is the comfort, safety, and well-being of the client, practitioners also want the engagements to be profitable for their firm. This section discusses some of the potential staffing issues in the CPA ElderCare engagement.

Willingness to Work With Older Adults

One of the first requirements for staffing ElderCare engagements is to assign personnel to the engagements who are willing to work with elderly clients. Some practitioners are comfortable in dealing with the elderly, and others do not have the patience or other such attributes that such engagements sometimes require. Certainly, if a staff member assigned to an ElderCare engagement is not at ease around an elderly person, he should not be assigned duties that require direct contact with the elderly person.

An individual who has had exposure to older adults would likely be well suited for an ElderCare engagement. Care has to be taken to remain in a professional relationship and avoid excessive emotional attachment to the elderly client. One of the dangers of dealing

with ElderCare clients is that the relationship often ends because the client dies. This loss can be emotionally disturbing to a practitioner who is not accepting of this inevitability.

Chemistry

The relationship between the elderly person and the practitioner should be such that the elderly person feels comfortable discussing a range of issues from financial to personal. This relationship is built on trust and respect between the elderly person and the practitioner. If an elderly person dislikes the staff person assigned to the engagement, the staff person can probably never satisfy the demands of the elderly client regardless of the quality of care and attention devoted to the engagement.

If the practitioner receives complaints from an ElderCare client regarding the staff person assigned to the engagement, the complaints should be investigated to see if the staff person is truly not serving the best interests of the client. In some cases, the staff person is not performing as required and appropriate action can be taken. In other cases, the staff person is performing properly but there is a lack of positive chemistry between the elderly person and the staff person. The decision must then be made about whether to assign the engagement to another staff person who will be more accepted by the elderly client or to simply continue monitoring the engagement to make sure that the level of service being provided by the staff person is proper.

Age and Gender Considerations

The age of the staff person may also be a consideration in staffing ElderCare engagements. In most cases, an elderly person will be more receptive to a staff person who has some amount of life experience. Although there may be exceptions, such as a young staff person who has significant experience with the elderly, most young persons will not have the emotional maturity required to deal with some of the issues involving elderly clients. Therefore, practitioners should probably assign more experienced staff people to ElderCare engagements where they will be interacting with the elderly client.

Be aware of gender when assigning staff to ElderCare engagements. The gender of the ElderCare staff person could be an element in the success of the engagement. A man or a woman, depending upon the individual client's preference, could be more successful in dealing with the ElderCare client. Because of the wide variety of services involved in ElderCare, the client needs to be comfortable discussing financial and personal issues with the staff person. This comfort level may depend upon the gender of the client and the staff person.

Continuity of Staff

An elderly person develops a feeling of trust and familiarity with the ElderCare staff person assigned to the engagement. Removal of the assigned staff person can be upsetting to the elderly person. Therefore, as much as possible, practitioners should make sure that the same staff person is assigned to a particular ElderCare engagement. Frequent rotation of staff members defeats their ability to detect physical and mental changes in the elderly person. In addition, the elderly person has to redevelop with each new staff person the "chemistry" noted earlier.

Use of Specialists

CPA ElderCare services may often require the use of specialists, such as GCMs or licensed social workers (LSWs), to perform engagement tasks that are outside the competencies of the practitioner (see the section in this chapter titled "The Multidisciplinary Team"). When practitioners start a CPA ElderCare practice, questions often arise about whether to refer to specialists, when to subcontract with specialists, and when to employ specialists on staff.

The answer to this question depends on the number of ElderCare clients that the firm currently has and the involvement required of a specialist in those engagements. If there are only a few ElderCare clients, and a GCM or LSW would be required only periodically, a referral or subcontract with the specialist would probably be the most cost-effective approach. As the CPA ElderCare practice grows and the need for the specialist increases to full time, consideration should be given to hiring a specialist as a member of the staff. Before making any employment decisions, the practitioner should contact the firm's insurance carrier or broker to assess whether insurance coverage should be changed as a result of this hire.

Supervision

Practitioners should make sure that any employees of the firm working on CPA ElderCare engagements are properly supervised. Internal controls can be instituted in the firm when the practitioner or the staff has signature and bill-paying authority over a client's accounts.

The quality control standards of the CPA firm should establish the protocols to be followed in ElderCare engagements. Among the issues to be addressed would be the type and amount of documentation required in ElderCare engagements. These will vary depending on the nature of the engagement. In addition, guidelines should be established concerning when the staff member assigned to the engagement should seek consultation with senior personnel of the firm and when and in what format the staff person should report to supervisory personnel.

The main point to remember is that any engagement requires proper supervision and documentation concerning actions taken and information developed.

Training

Persons involved directly with the ElderCare client need the same type of ElderCare training, whether the person is the engagement partner or a staff person assigned to the engagement. Support staff involved only in the financial aspects of the engagement may not need such extensive ElderCare training. Most of their work will be at the direction of the engagement partner, performing such tasks as preparing financial statements or, in some cases, paying bills and making deposits.

The AICPA, in cooperation with state societies, is offering a number of courses to help the practitioner understand the needs of elderly persons and how best to serve those needs. In addition, other professional organizations, such as elder law attorneys, GCMs, and long-term care insurers, offer continuing education that may be helpful to the CPA ElderCare practitioner. There is also a great deal of information available in books and at various Web sites. Refer to Chapter 10, "Associations, Organizations, Agencies, and Other

Resources," of this Practice Aid for more information about ElderCare training and information resources.

Practitioners who are going to be directly involved with ElderCare clients should have as much training as possible on issues involving the elderly. The practitioner generally does not deliver social, medical, or legal services directly to the elderly client. Practitioners do need to understand the issues involved in each of these disciplines to understand how to deal with those problems, and when and what specific specialists should be consulted from time to time.

The Multidisciplinary Team

CPA ElderCare services offer the client an innovative approach to financial- and care-management planning. Normally, the CPA assembles a multidisciplinary team of professionals who use their unique areas of expertise to serve the elderly client's needs.

The CPA may serve as the coordinator of planning, may direct the process from its inception, or may choose to be involved in a limited number of activities. The practitioner's level of involvement should be guided by his or her knowledge; commitment to the process; and ability to adapt to constantly changing, complicated circumstances. The decision to participate as an integral player in a multidisciplinary team must be made with thoughtful consideration and a realistic assessment of the practitioner's interest, available staff and resources, and commitment to continuing education and high standards of professional practice. The decisions made may very well affect an elderly client's well-being.

Whenever specialists are involved, practitioners should obtain reasonable assurance about the specialist's competence in his or her field. Such factors as years of experience, professional certification and licensing are relevant in making these initial assessments. When there are few objective criteria available (which will be the case for non-professionals) the prudent practitioner will check references and possibly go as far as obtaining a background check.

Practitioners are not expected to possess the same knowledge of subject matter elements as the specialist, but they do need to have sufficient knowledge to:

- Define the objectives of the work assigned to the specialist and how this work relates to the objectives of the engagement
- Consider and conclude on the reasonableness of the assumptions, methods, and source data used by the specialist
- Consider and conclude on the reasonableness and significance of the specialists' findings in relation to the objectives of the engagement

When specialists are used on an ElderCare engagement, they should be identified in the engagement letter, and their responsibilities as part of the engagement team should be explained in the letter.

Members of the Multidisciplinary Team

Possible members of the multidisciplinary team include the following.

The Geriatric Care or Case Manager

As professionals who specialize in assisting elderly people and their families with long-term care arrangements, geriatric care or case managers (GCMs) have master's degrees in gerontology, social work, nursing, or counseling. A GCM may:

- Identify problems that are affecting the elderly client
- Determine the client's need for services
- Determine the client's eligibility for assistance
- Screen, arrange, and monitor in-home help and services
- Provide resources and referrals to community agencies and services
- Provide crisis intervention
- Act as a liaison between the client and distant family members
- Assist with alternative living arrangements
- Provide education services and advocacy
- Offer counseling and support

The inclusion of a GCM not only provides an advocate for the client, but also supplies each discipline (for example, legal or financial) with valuable additional information that is used during planning. The care manager conducts a comprehensive home assessment to ascertain the level of client functioning, support system, and client needs. In accordance with confidentiality mandates and with the client's permission, the care manager can convey information to members of the team. A comprehensive financial and care plan can then be developed that adequately meets the client's long-term needs.

The National Association of Professional Geriatric Care Managers (NAPGCM), was established in October 1986. The association has established membership criteria and consists of individual persons who fulfill the membership requirements and are current in their membership dues. All members must comply with all relevant state and professional licensing and certification requirements.
The levels of membership in NAPGCM are as follows:

- *Associate*—Bachelor's degree in nursing, gerontology, psychology, social work, health and human services, or other related field of human service delivery; primarily engaged in direct practice, administration, or supervision of client-centered services to the elderly and their families; at least two years of supervised experience in gerontology
- *Professional*—Master's or doctorate degree in same disciplines as above
- *Advanced Professional*—Same as Professional; with at least two years of supervised experience in gerontology
- *Fellow*—Same as Advanced Professional; credentialed as a certified GCM through GCM Board-approved program; provided documented evidence of professional leadership; completed peer review process through the Association
- *Affiliate*—Does not meet criteria of the other designations but has an interest in gerontology

The NAPGCM has established standards of practice for professional geriatric care managers, as follows:

- The primary client is the elderly person; all others affected by his or her care needs are considered part of the "client system."
- To the greatest extent possible, the GCM should foster self-determination on the part of the elderly person.
- The GCM should respect the elderly person's right to privacy.
- The GCM should clearly define his or her role to the family and other professionals.
- The GCM should provide quality care using a flexible care plan developed in conjunction with the older person and others involved in care.
- The GCM should act in a manner that ensures his integrity as well as integrity of the client system.
- All fees should be discussed before the initiation of services.
- Advertising should be conducted in accordance with guidelines of professional management services.
- The GCM should avoid situations that would cause a conflict of interest.
- The GCM should be familiar with laws relating to employment practices.
- The GCM should provide full disclosure regarding business, professional, or personal relationships with recommended businesses, agencies, or institutions.
- The GCM should participate in continuing education programs.
- The GCM should never exploit professional relationships with clients and families for personal gain.

For the names of GCMs in your area, contact the NAPGCM at (520) 881-8008. Contact information is provided in Chapter 10. If you are unable to locate a GCM in your area, you can contact a licensed social worker about performing these functions.

The Elder Law Attorney

An elder law attorney's expertise can encompass a wide spectrum of issues, including:

- Governmental benefits, such as Social Security, supplemental security income, Medicare, and Medicaid
- Private retirement plans
- Guardianship and conservatorship
- Advance directives, such as living wills, health care power of attorney, and durable power of attorney
- Estate planning, including tax planning, wills, gifts, and trusts. Note: Trust officers may also be a consideration for a multidisciplinary team
- Review of care contracts with, for example, retirement communities, assisted living facilities, and nursing homes
- Elder abuse and neglect issues, including physical, psychological, and financial issues; patient rights; disability law; and discrimination in housing and work laws

Physicians and Other Health Professionals

It is likely that the GCM or family members will be in contact with the elderly client's physicians. Notwithstanding, the CPA must be familiar with the client's health condition, available resources, and kinds of insurance. In addition, the practitioner should have a working knowledge of Medicare, Medicaid, health insurance, and current health care trends. The professional should be able to identify geriatric physicians or geriatric assessment units at local hospitals or universities that provide current information on aging issues, treatments, and research.

Insurance Agents

Because clients often invest significant resources in insurance protection, the practitioner must be aware of the policies currently in force, coverage and benefits available, and needs for additional coverage. Many elderly clients request information on long-term care insurance plans, annuities, and life and health coverage. The CPA who has knowledge of insurance products and terminology provides a valuable additional service to the client. Chapter 9, "Long-Term Care Insurance," presents information regarding insurance.

Creating an Inviting Environment for Your Elderly Clients

Effective communication with your elderly clients is essential for a positive outcome. When interacting with elderly clients, you may want to modify your office environment, modify the way you speak and listen, and make other accommodations to address the unique needs of elderly clients. Accommodations include the following:

- Create a well-lighted and quiet environment. Eliminate background noise and reduce glare from windows and lights. Piped-in music may prevent clear sound discrimination. Glare from windows distorts sight and may be physically painful.
- Arrange the office space to accommodate a wheelchair or walker.
- Offer firm-backed chairs with arms for ease of access.
- Remove throw rugs from the office, because they can easily cause falls.
- Use high-visibility colors, such as yellow and red, in documents and in the office, and avoid blue and green because they are poorly visible.
- Avoid elaborate patterns in carpeting, especially on stairs.
- Confirm the appointment and remind the individual to bring requested documents and such items as eye glasses and hearing aids. Provide simple directions to the place of business and offer to meet the client in the parking area if accessibility is difficult.
- Greet the elderly client with respect. A warm handshake or touch on the shoulder may help the client feel at ease.
- Slow your rate of speech slightly and speak in lower tones. This is particularly important for women practitioners, who naturally speak in the higher ranges.
- Always speak while facing the individual. Your facial cues and gestures will help communicate your message if the client has hearing loss.
- Ask only one question at a time and wait for a response. Speak in clear, simple language and do not shout—a higher pitch results, which is more difficult to understand. Do not be surprised if the individual returns to a subject you considered

closed; this represents a delayed response to stimulus and should be expected. In addition to the time needed for an aging brain to retrieve information, elderly persons may prefer to more thoroughly respond and clarify a subject.

- Use large print (fourteen-point font or larger) on printed materials. Black type on white paper permits the greatest contrast and is easiest to read. Use matte finish papers; glossy finishes distort the text.

CHAPTER 5:

Quality Control, Best Practices, and Risk Management

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Quality Control, Best Practices, and Risk Management

Quality Control

The AICPA principles of professional conduct provide, among other things, that "members should practice in firms that have in place internal quality-control procedures to ensure that services are competently delivered and adequately supervised." Because of the public interest in the services provided by and the reliance placed on the objectivity and integrity of CPAs, a CPA firm shall have a system of quality control for its accounting and auditing practice. Accounting and auditing practice refers to all audit, attest, accounting and review, and other services for which standards have been established by the AICPA Auditing Standards Board or the AICPA Accounting and Review Services Committee under Rule 201, *General Standards* (AICPA, *Professional Standards*, vol. 2, ET sec. 201), or Rule 202, *Compliance With Standards* (AICPA, *Professional Standards*, vol. 2, ET sec. 202), of the AICPA Code of Professional Conduct. Standards may also be established by other AICPA senior technical committees; engagements that are performed in accordance with those standards are not encompassed in the definition of an accounting and auditing practice.

When ElderCare services you perform are services that are within the scope of Statements on Standards for Attestation Engagements (SSAEs), Statements on Standards for Accounting and Review Services (SSARSs), or Statements on Auditing Standards (SASs), you need to have a system of quality control in place for those services in accordance with the AICPA Quality Control Standards.

It is highly recommended that you develop a system of quality control that encompasses all of your ElderCare services, not just those that fall under the purview of the SSAEs, SSARSs, and SASs. By having an overall system of quality control in place, you increase the likelihood that your services will be competently delivered and your ElderCare practice will be successful. Moreover, the nature of ElderCare engagements will likely change over time, encompassing a different mix of services that may require a system of quality control. If you have a system of quality control in place from the beginning, you will not have to handle the difficulties of establishing a system of quality control in the future to accommodate the new mix of services.

The elements of a system of quality control for ElderCare services are the same as with other accounting and auditing services. The five key components are as follows:

1. Independence, integrity, and objectivity
2. Personnel management
3. Acceptance and continuance of clients and engagements
4. Engagement performance
5. Monitoring

You should read the AICPA *Guide for Establishing and Maintaining a System of Quality Control for a CPA Firm's Accounting and Auditing Practice* to gain a full description of the five components of a system of quality control. This guide can be obtained by calling the AICPA Order Department at (888) 777-7077 and asking for product number 067020.

Independence, Integrity, and Objectivity

A firm's success is based on achieving and maintaining professional relationships with its clients. Professional staff members (and their families) are to be independent, in fact and in appearance. The firm policy manuals and employment contracts should reflect this. The professional staff is expected to know the firm's policy on independence and objectivity and to comply with it. With respect to conflicts of interest, the firm should never knowingly be in a position where there is a perceived obligation to one client that is directly inconsistent with an existing obligation to another client. It is important that this be remembered when staff is servicing the CPA ElderCare engagement. It is important at all times that the professional and administrative staff keep the affairs of the ElderCare client confidential.

Personnel Management

The most important resource of a public accounting firm is its professional personnel. The success of a firm is directly related to how well it manages its staff. Open and honest communication with all levels of staff will contribute to the overall quality control system and ongoing maintenance of a quality control system in an ElderCare practice. Assignment of engagement personnel must meet the service needs of the CPA ElderCare client on a timely basis. Performance evaluations of staff should be carried out by designated reviewers on a periodic basis. The dynamics of an ElderCare practice require continuing professional development and attendance at outside development courses; these should be encouraged. Professional staff members are prohibited from providing services to a CPA ElderCare client on their own account.

Acceptance and Continuance of Clients and Engagements

Before a CPA ElderCare engagement is accepted, consideration has to be made of the firm's ability to provide the specified service in conducting the engagement in accordance with professional standards without incurring an unacceptable level of risk. Communication with predecessor CPAs should be made to determine if there are any reasons or circumstances for not accepting the engagement.

Engagement Performance

It is important that an engagement letter be prepared for every CPA ElderCare engagement assignment. This should be reviewed annually or when the nature of the ElderCare services changes. The engagement letter should be signed in the firm's name, on firm's letterhead, and the ElderCare client should receive a written acknowledgment. For further information on ElderCare engagement letters, refer to the section later in this chapter "Managing Professional Liability Risk". For additional information, see the section titled "Documents and Checklists" in Chapter 11 "Engagement Letters" and the section titled "Engagement Issues" in Chapter 13 "Frequently Asked Questions."

In the planning of a CPA ElderCare engagement and its execution, as with other public practice areas, professional judgment plays an important role in determining the extent of the documentation. Documentation should be maintained for service provider tests, recording of meetings both on the telephone and in person, listing of financial information and compilation of monthly reporting. Separate files should be maintained for every CPA ElderCare engagement and retained in accordance with the AICPA's recommendations. All professional staff on an ElderCare engagement must have an assigned superior and partner responsible for the overall conduct in completion of the engagement. If more than one professional staff member is assigned to a CPA ElderCare engagement, team consultation is necessary. Additionally, the team should document the progress and uncertainties about engagement issues. Statement on Standards for Attestation Engagement SSAE No. 11, *Attest Documentation* (AICPA, *Professional Standards*, vol. 1, AT secs. 101-701), provides documentation requirements for attestation engagements.

Monitoring

The objective of the monitoring element of a system of quality control is to provide the firm with reasonable assurance that the policies and procedures relating to the other elements of quality control are suitably designed and being effectively applied. Monitoring is an ongoing consideration and evaluation process.

Best Practices

Certainly, CPAs are aware of the need for internal control in any organization. However, practitioners have not always regularly provided the types of direct financial services that may be part of ElderCare services. Their internal control may be sufficient for their current activities but may not provide adequate control over client assets in regard to ElderCare services. You should review and assess the firm's current internal control to ensure its adequacy for these services.

Presented in the following sections are processes, controls, and practices that are recommended to be implemented in your ElderCare practice.

Practice Administration

Only the partner should have the authority to sign the firm name on correspondence. Professional administrative staff must not use firm letterhead for personal matters. CPA ElderCare engagement files and related documentation should be protected from unauthorized access, and the ElderCare partner must approve all requests for review of engagement documentation. Engagement documentation should not be made available to third parties unless the ElderCare client has authorized disclosure in writing or there is a professional duty to disclose information, as in the case of judicial process.

ElderCare documentation should not be left unattended. All records on computer equipment should be maintained and security protected. CPA ElderCare services should be monitored to the extent of timely delivery of information, billings, and reliability.

Documentation is required on a CPA ElderCare engagement when circumstances involving conflict arise. These include the following:

- Defalcations or other similar irregularities

- Questions about service provider's integrity
- Third-party claims against the ElderCare client
- Change in key service providers
- Issues of abuse of the ElderCare client, including financial, mental or physical abuses

Financial Recordkeeping

It is important to institute appropriate internal and quality controls in the financial recordkeeping operations. This is needed to ensure that the transactions are properly recorded and that the opportunities for fraud and misappropriation of the CPA ElderCare client's assets are eliminated or reduced.

The extent and complexity of the controls will depend on the size of the CPA firm and its assignment of staff to the engagement. Smaller firms may appear to need less formal controls because staff assignments and activities can be closely monitored. However, you should attempt segregation of duties wherever practical.

You should discuss both the controls already in place as well as controls to be implemented, with the firm's errors and omissions insurance carrier, the insurer of any fidelity bond, and comprehensive business liability insurer, to determine if the firm needs to establish any additional specific quality or internal controls. Such conversations can also help you identify risk factors in this area of practice.

Control of Cash

The CPA may be engaged as a "home office" to receive and deposit revenues and to pay bills on behalf of the ElderCare client. Even though the CPA may feel uniquely qualified to provide this service, you should evaluate a number of considerations even before the acceptance of the responsibility of collecting cash receipts on behalf of a client and recording of transactions.

You should always check with your insurance carrier to understand the terms and conditions concerning coverage with respect to involvement with cash transactions before accepting this component of a CPA ElderCare engagement.

Handling of Currency

You should attempt to avoid, as much as possible, the handling of currency for the CPA ElderCare client. If currency is required to be handled, such as to pay a housekeeper, strict controls must be enforced. The receiver of any currency should be required to sign a formal receipt to evidence the payment and receipt of the currency. You might want to consider having two individuals present anytime currency is handled.

Cash Receipts

It is good practice to have a staff person (perhaps a receptionist, secretary, office clerk, or mailroom clerk) open all mail and record all incoming checks on a log. This process provides a source document, independent of the bookkeeping function, that can be delivered to the engagement supervisor. The person opening the mail and preparing the log should ideally also have a "for deposit only" stamp for ElderCare clients' checking

accounts. This individual would stamp each check "for deposit only" before it is delivered to the bookkeeper or other recorder of transactions.

Other personnel, such as bookkeepers or accounting staff, can then prepare the deposit slips for the clients. A copy of the checks being deposited should be attached to the office copy of the deposit slip. The bookkeeper should then prepare a journal entry or make appropriate data processing entries into the computer system to record the cash receipt transaction for the deposit. The entries should be coded to provide the ElderCare client with the information needed, for example, information necessary to facilitate preparation of the personal income tax returns.

Cash Disbursements

A sound practice is to make sure that checks are drawn in payment of bills after approval by a supervisor. However, certain recurring payments may not have an invoice, such as recurring payments for a housekeeper or for other periodic service providers. A methodology should be established, with the approval of the CPA ElderCare client, to make certain that such payments are made on a timely basis and with appropriate approvals by a responsible person. It should be the client's responsibility to advise of changes in these recurring payments. Making this point clear in the engagement letter is effective risk management control.

The appropriate coding for the payment should be made at the time the payment is recorded.

You should have a clear understanding with the ElderCare client, preferably in writing, of check-signing authority. If the client does not sign checks, appropriate procedures must be put in place to protect both you and the client. For example, the firm could require dual signatures for checks above a threshold amount. If there are multiple partners in the firm, two partners might, for example, be required to sign checks in excess of $1,000. There may be acceptable exceptions to this procedure for such items as mortgage payments, which are not likely to vary but which might exceed the ElderCare client's comfort threshold for the signing of checks.

Partners or other equity owners of the CPA firm should be the only individuals given check-signing authority. Rare exceptions to this recommendation would be to give authority to a trusted employee who has been with the CPA firm for many years. However, the CPA should recognize that such exceptions should be rare.

You should consider discussing with the CPA ElderCare client the feasibility and practicality of having a third party (for example the ElderCare client) receive the bank statements and cancelled checks directly from the depositories. This might provide a higher degree of comfort to the client who may fear turning over cash control to a third-party CPA.

Account Transfers

There may be occasions when the practitioner transfers cash from a checking account to another account established for, say, investment purposes. It is recommended that transfers be made only to other financial accounts in the name of the ElderCare client.

Bank Reconciliations

The timely preparation of bank reconciliations is a necessity. Preferably, these bank reconciliations should be performed by someone other than the person responsible for recording transactions for more effective control. If a third party receives the bank statements and cancelled checks, the records should be delivered to the CPA for this procedure to be performed.

Bookkeeping Systems

Practitioners need to determine how the recording of transactions shall be maintained. In a small firm performing the occasional ElderCare engagement, a simple manual system may suffice. However, larger offices or practice units with a higher volume of CPA ElderCare client engagements are likely to find computerized systems more efficient. Turnkey computer systems are available that enable separate recordkeeping for multiple clients, with multiple users. These systems provide automatic check printing and encoding from blank check stock. The cash disbursement transactions are concurrently recorded in the books and records of the client upon printing the checks. Cash receipts and other transactions are also recorded into the systems. These systems also enable users to select from an array of different financial reports and formats. They can also accommodate customized reports as well. Such systems can be remarkably affordable considering the options they present, if there is a significant ElderCare practice.

Medical Claim Forms

If the practitioner is responsible for filing medical claims, it is recommended that checks to medical service providers not be issued until the practitioner is satisfied that the applicable insurance claim forms have been prepared and filed. Anecdotal experience suggests that the failure to establish strict control of this process results in claim forms being delayed or, worse, neglected altogether. Follow-up on the processing of the claims and reading the Explanations of Benefits (EOBs) also requires a follow-up system and procedure.

The Bookkeeping Records

The question of ownership of bookkeeping records may come up on occasion. When practitioners perform bookkeeping services for a CPA ElderCare client, awareness of the legal and ethical rules about ownership of the records is important. In virtually all cases in the United States, the following original documents and records belong to the ElderCare client:

- Bank statements
- Cancelled checks
- Records of deposits
- Paid invoices for goods and services
- Books of original entry, such as
  - — Cash receipts journals
  - — Cash disbursements journals
  - — General ledgers

- Payroll journals and records
- Original records of investments
- Original wills, trusts, and other dispositive documents
- Original insurance policies and any claims records pertaining thereto

The above list is not meant to be all-inclusive. Practitioners in doubt about to whom certain records belong should seek legal counsel to avoid breaches of laws and rules of professional ethics. Practitioners may want to reproduce copies of these records sufficient to support the work performed if asked to return records to the ElderCare client.

Computer Records

The CPA ElderCare client's records that are stored on computer disk or other electronic media also belong to the client. If the CPA provides the ElderCare client with "hard-copies" of such files, the obligations to the client are likely fulfilled. However, there may be times when copies of such records are requested to be transmitted by computer disk or other electronic media. The CPA should be vigilant when transferring copies of computer files to make certain that there is no inadvertent transfer of records or files belonging to other clients. Those files that qualify as CPA work product are governed by the appropriate rules of professional ethics, accountancy laws, and regulations pertaining thereto.

Filing and Safekeeping of CPA ElderCare Client's Records

Security of the ElderCare client's records must be maintained. Checks received should be deposited on a timely basis. If deposits cannot be made the same day they are received, they should be locked in a safe or other secure location. If there are preprinted checks belonging to the ElderCare client in the practitioner's possession, it is essential to have a storage place in which to lock the checks for security purposes.

Fidelity Bonds

Practitioners may want to consider obtaining a fidelity bond covering the firm and its employees who will have access to ElderCare clients' cash and other tangible assets. Such insurance may be able to be obtained as an endorsement to the firm's office package policy. (Some office packages may have fidelity coverage built in. However, the limit should be assessed for sufficiency.) However, it is important to determine if such coverage will extend to professional acts of employees with respect to client services. If such coverage cannot be obtained through the office package policy, it may be able to be obtained from the firm's errors and omissions insurance carrier, by endorsement. If that is not an option, then a stand-alone insurance policy will have to be obtained to protect the CPA firm and the client.

CPA ElderCare Risk Management

Following the quality control standards and the best practices already discussed in this chapter helps reduce liability risk for your firm. The following section will address specific risk exposures you may face and how to address them when delivering service to your clients. For example, some of the risk management approaches will involve communications with your client. Engagement letters and the concept of full disclosure

are important considerations. Other tactics involve risk transfer techniques such as commercial insurance. You need to protect yourself and your associates in a way that allows you to focus on practicing your profession in a manner satisfactory to both you and your client. It is impossible to extract all risks from your CPA practice; however, many risks can be mitigated so that you can concentrate on delivering your best service to your client. The very act of providing excellent service is a core risk management strategy for any firm.

The Roles of an Insurance Agent

An insurance agent becomes more crucial if a firm expands to include an ElderCare practice. First, just as a geriatric care manager is crucial to your practice in ElderCare management, an insurance agent is equally crucial for providing customer services. There are many insurance issues that concern your client and you will need the resources of an insurance expert. These include such diverse matters as the amount of long-term care insurance owned by the elderly person and whether the workers caring for the elder in the home have appropriate workers' compensation insurance. Evaluating these matters and advising the client are within the professional scope of an insurance agent. If someone in your firm is not a licensed insurance professional, you should treat the referral to such a person as you would any other referral involving the elder.

Second, the role of your firm's insurance agent is expanded because an ElderCare practice may expand traditional insurance risks as well as adding potential new exposures. A knowledgeable insurance agent is necessary for you to obtain the necessary comprehensive coverage for your firm.

How ElderCare Affects Traditional Property and Casualty Risks

You may already be quite familiar with the risks associated with the traditional practice of any business. What you may not know is that ElderCare brings into play some new exposures that are unprecedented. The new exposures may already be covered under some of your firm's existing insurance policies. Therefore, you should consider existing as well as new insurance issues to have a comprehensive evaluation of your developing practice in order to set up an appropriate risk management strategy.

Among your exposures as a CPA are property loss from fire and theft and the liability arising out of bodily injury to others that occurs in your office or company-owned vehicle. Still other risks involve economic loss to your firm arising from the death or disability of your partners or employees. A good place to find inventories of these exposures is in articles on starting a CPA practice. One such article is on the Web site of the AICPA Insurance Program administrator, Aon Insurance Services. (The URL is www.cpai.com/busneeds/syocpa.php#ic). It focuses on many issues including professional liability, employment practices and life insurance. The following is a listing of general business insurance and its related exposure. It was developed by Aon Association Services and is excerpted here. The list is on the Web at www.asae-aon.com/askdetail.php. Your insurance agent may also have such a tool for your use. We have listed how practicing ElderCare affects the following insurance areas:

General Business Insurance and Related Exposure	ElderCare Effect on Practice
Building insurance. Coverage should be for risks of direct physical loss on a replacement cost basis (no deduction for depreciation)	Your ElderCare practice will not change this insurance exposure unless you simply grow and require more space.
Contents insurance (business personal property). Coverage is for risks of direct physical loss on a replacement costs basis (no deduction for depreciation). Coverage is purchased to cover your office furnishings and equipment, improvements, and betterments.	No effect. Equipment in your office is probably not unique to your ElderCare practice.
Computer equipment. Coverage is for computer hardware and software. It can also be amended to cover your extra expenses needed to continue your computer-based operations following a covered loss.	No effect.
Valuable papers and records. Coverage is available for reimbursement of the costs to reproduce information found within books of accounts, mailing lists, and other business records damaged or destroyed by a covered loss. This is a very important consideration for all aspects of your practice.	Your records will become more imperative if you keep wills and other documents on file for your ElderCare clients.
Business income. This provides coverage for your loss of net profit/income as a result of a covered loss at your premises. For example, a fire that destroys your office would curtail your ability to realize revenue.	Affects necessary coverage insomuch as ElderCare increases your profits/losses.
Extra expense. Insurance that provides reimbursement of those expenses necessarily incurred to keep your office functioning at its fullest capacity after an insured loss. This coverage can also be combined with business income insurance.	No effect.
Accounts receivable. If your billings and records of accounts receivable were destroyed, you would indeed be at a loss. Accounts receivable insurance would reimburse you for the outstanding accounts you would not be able to collect.	No effect.
Inland marine floaters. Insurance available to cover camera equipment, valuable works of art in your offices and other property you take away from your office premises.	No effect.
Crime insurance. Crime protection is available in several different forms and can be tailored to cover your particular situation. Employee dishonesty (fidelity) insurance provides	If you have employees who visit your ElderCare clients at their residences and/or who handle client assets, you need to consider this insurance. You may purchase it as a stand-alone

(continued)

General Business Insurance and Related Exposure	ElderCare Effect on Practice
coverage for you in the event of a sustained loss resulting from the fraudulent or dishonest acts of an employee.	bond or as an endorsement on your professional liability insurance policy. (Professional liability is discussed in the next section of this chapter.)
Commercial general liability. Insurance protection is available against third-party bodily injury and property damage claims arising from your premises or operations. It is important to note the focus on "bodily injury and property damage." This is discussed later in the chapter. A commercial general liability policy has many parts:	Affects ElderCare practice in individual areas, as specified below.
• *Personal injury* provides protection against claims involving false arrest, detention, malicious prosecution, libel, slander or defamation of character.	No effect.
• *Products/completed operations* protects against claims arising from the selling, distribution, serving, or giving away of any type of product.	No effect.
• *Fire legal liability.* protects you if you do not own the building you occupy in the event you are held legally liable for fire damage to the premises.	No effect.
• *Medical payments* will provide for the reimbursement of medical expenses for a third-party injury on your premises, regardless of your legal liability.	More necessary due to frailty of your elderly clients.
Other important considerations with regard to commercial general liability coverage are as follows: • Your employees and volunteers should be included as additional insureds. • If you lease, the lease agreement may require that the landlord be named as an additional insured. • Claims arising out of "professional services" are normally excluded.	
Non-owned and hired automobile insurance. This is protection for the firm if employees or other persons are involved in an accident while using their own automobiles on your business or cars rented in your name for business trips. The injured party may very well name your firm as a party to the suit.	If you or your employees transport your elder clients, you need this coverage. From a liability perspective, transporting clients is a high-risk activity.
Owned automobiles or long-term leased automobiles. This is insurance for any automobiles owned or leased by your firm.	No effect.
Workers' Compensation. Mandatory coverage for work-related injuries sustained by your employees.	Since your employees may be visiting your ElderCare client's home, and the home may be not in good condition, this coverage may become more crucial with the addition of an ElderCare practice

General Business Insurance and Related Exposure	ElderCare Effect on Practice
Umbrella liability. This is additional liability coverage over and above your primary commercial general liability, automobile liability and employer's liability (under workers' compensation). It increases the limits available to you on each underlying policy without otherwise changing the coverage.	See individual categories, above.

Managing Professional Liability Risk

In addition to the traditional risks listed above that are a part of any business, you also have a professional liability exposure related to your special expertise and the duty owed to your clients and third parties. For example, audit engagements present an elevated risk of malpractice claim. Tax work is fraught with technical challenges that, if not handled properly, can result in interest and penalties for which your client may hold you responsible. The risk of a professional liability claim against you and your firm will be the subject of the remainder of this chapter.

Much of your professional liability risk can be managed through common sense. If you were to stop and think, you would easily identify some of the best risk management ideas. Be technically proficient; be thorough and careful, keep good records, communicate often with your client, and disclose every relationship that might be viewed as a potential conflict of interest. You might even see that you should have a comprehensive letter of agreement for every engagement, spelling out the scope of the work and the mutual understandings and expectations of all parties. There are certainly many other risk management principles, some of which may occur to you. See Chapter 11, "Documents and Checklists" for sample engagement letters and Chapter 13, "Frequently Asked Questions" for engagement letter advice and additional professional liability information.

The Importance of Communication

One of the most important issues in ElderCare engagements is communication. Your elder client may have diminished mental capacity. Does the client understand your recommendations? There may be others involved in the care of the elder—relatives living at a distance from the elder person, for example. How will they know what you will be doing (and not doing) and what to expect? Consider these thoughts paraphrased from "Effective Communication: The Best Medicine to Avoid Litigation?"—an article by John McFadden and Joseph Wolfe, risk management consultants with the underwriter of the AICPA Professional Liability Insurance Program, CNA.[1] (Also, see the section titled "The AICPA Professional Liability Insurance Program," in this chapter for further information.)

- Don't send the engagement letter through the mail. Before the work starts, meet with your client, explain its contents, and give the client an opportunity to ask questions.
- Before the work starts, meet with your client and explain your plan for the engagement. When will it start? How will it progress? When do you plan to finish? Explain what you'll need from the client and when.

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- Periodically throughout the assignment, meet with the client to report on the status of the engagement. Provide the client the opportunity to comment on how things are going. It's easier to address and fix problems if they are identified early.
- Don't just mail or deliver a tax return or a written report. Meet with the client and explain the contents. Provide information to the client to explain any unexpected, special, or unusual circumstances that may have been encountered.
- Ask the client if the work went satisfactorily. Provide an opportunity for the client to ask questions and comment on the assignment. Keep the lines of verbal communication open.

(The complete article can be found at www.cpai.com/newsletter/newsletter_indexadmin.-php?id=31.)

Entire books have been written about engagement letters. The AICPA program provides guidance to its insured firms on this subject. See the Program Web site at URL www.cpai.com, in the Policyholder Resource Center. Furthermore, via a Program hotline available to policyholders, (800) CNA-8060, experienced risk managers can be consulted on the specific issues peculiar to the engagements of insured firms.

Tailor your letter to the engagement. Do not simply use a "boiler-plate" engagement letter. Tailoring will help minimize the risk of fuzzy understanding by the client about the work. They will appreciate it. See the sample engagement letters and instructions in Chapter 11, "Sample Documents and Checklists."

You may employ the best risk management practices and still get sued. If that occurs, you will quickly discover that maintaining appropriate professional liability insurance is very important. Experienced claim professionals will investigate the claims made and assign skilled defense counsel to protect your interests. Claims professionals are specialists and will move the process along as expeditiously as possible. Then, you can get on with your practice. You should, of course, stay involved in the claim process. However, your representation by experts reduces the pressure on you and your firm.

Case Studies: Exposure Issues Specific to ElderCare

Beverlee Burrows, an accountants professional liability program manager with CNA, has studied the special risks associated with ElderCare services.[2] In her article, "ElderCare Exposure Analysis," Burrows presents four case studies with ascending professional liability exposure. The four are paraphrased here. The entire article can be found on the AICPA Insurance Programs Web site at www.cpai.com/newsletter/newsletter_indexadmin.php?id=24.

Case Study 1

This hypothetical firm provides services to elderly clients. Services include paying bills, balancing checkbooks, tax planning, tax return preparation and financial planning.

Exposure Analysis: These services are not new to accountants. When the practitioner assumes responsibility for conducting routine financial transactions and performing bank account reconciliations on the client's behalf, there is a possibility that the elder or a family member might feel uncomfortable. Requiring dual signatures on checks over a given threshold may alleviate concerns about

[2] Excerpted by permission of Continental Casualty Company, one of the CNA insurance companies. © 2001, Continental Casualty Company. All rights reserved.

oversight. Alternative approaches could include having banks send statements directly to the elder or family member or forwarding invoices to the elder or family member for approval prior to payment by the practitioner. Providing financial information to the elderly client's family member raises questions about the confidentiality of client information. The engagement letter should specifically address permission to provide confidential client information to family members of the elder.

CPAs routinely face these exposures in their day-to-day practice. The services provided meet the definition of professional services included in the AICPA program policy. Be sure to check with your carrier for its position.

Case Study 2

This hypothetical firm provides the same services listed in Case Study 1. In addition, the firm provides services geared toward elderly clients who want to remain in their homes, but require some assistance. The client is the elderly person. Determination of the type of services to be provided to the elder begins with a needs assessment. When it is completed, the client and practitioner agree upon the services to be provided. An engagement letter is prepared and signed by the client.

The practitioner assists the client in locating service providers in the community, for example, basic transportation or legal advice. The CPA assists the client by providing a short list of qualified providers for the client's selection. The client enters into a contract with the service provider. In addition, the CPA, addressing the services being provided by other vendors, provides assurance services. For example, the CPA may provide assurance that a new roof placed on the home used the quality of materials specified in the contract.

Exposure Analysis: These areas of practice present a higher level of risk than contemplated in Case Study 1. In Case Study 2, the practitioner assists the client in selecting independent contractors or outside professional service providers. CPAs who recommend service providers to clients and fail to issue an engagement letter or contract that establishes their lack of an agency relationship with the recommended provider are exposed to claims of vicarious liability. In addition, claims may be made alleging negligent referral and failure to investigate the background and experience of the professional recommended. A consistent and careful screening of all service providers prior to recommending them will help to reduce this risk. CPAs should verify that such providers maintain adequate liability insurance and fidelity bond coverage prior to recommending them to clients. Thus, the firm will avoid being exposed to claims arising out of their services simply because the CPA firm is viewed as a "deep pocket."

The services performed by the CPA firm in this example meet the definition of professional services included in the AICPA Professional Liability Insurance Program policy. Claims made against the CPA firm for negligent referral or vicarious liability are covered under the policy.

Case Study 3

Services provided by this hypothetical firm include the services listed in Case Study 1 and Case Study 2. In this example, the family of the client wishes to become more involved in the care for their loved one whose health is failing. The elder resides in a

nursing home. With the consent of the elderly client, the firm provides the family with copies of its reports. The CPA firm provides assurance regarding the frequency of visits by the nurse and physical therapist and verifies the daily visits of a paid companion. The CPA firm also makes periodic visits to the nursing home to ensure that agreed upon care standards are being met. Criteria for such standards of care are agreed upon in advance and documented in an engagement letter.

Exposure Analysis: These areas of practice present a higher exposure to risk than contemplated in both Case Study 1 and Case Study 2. In this example, the practitioner is providing assurance services regarding the timeliness and consistency of care the client receives in a nursing home. The practitioner may fulfill the engagement as agreed, but if the elder is injured at the nursing home, the CPA firm could still be sued under a theory of negligent supervision, breach of an implied warranty, or failure to comply with professional standards in performing assurance services. If the firm also recommended the nursing home to the client, additional claims alleging negligence in making the recommendation could be anticipated. Risk in such situations can be managed by issuing carefully drafted engagement letters. Additionally, the firm can reduce risk by being careful to avoid subjective responses to open-ended questions from family members, such as "Is Mom okay?"

Client selection is also an important factor in controlling the exposure in this engagement. The firm must assess the mental capabilities of the individual client as well as the dynamics of the relationship between the elder and his or her family. Situations that appear to be fraught with family conflicts present higher risk. Another risk presented by this example is that the elder may become emotionally dependent upon the practitioner due to continuing contact. As a result, the elder's family members may feel that they are being estranged from the elder and may also become suspicious of the CPA's motives in making recommendations regarding the elder's situation. This could result in claims alleging alienation of affection or fraud.

The scope of an ElderCare assurance services engagement does not contemplate observing and reporting upon the client's medical condition or the quality of medical treatment at a nursing home. This would require subjective analysis as well as medical training. However, CPAs will in fact see the elder and sometimes be present when medical treatment is provided, and they will form their own opinions about the elder's condition and care. It will be difficult for CPAs to avoid discussing this with the client's family members. CPAs who do so may be more directly exposed to claims seeking recovery of damages for emotional distress and bodily injury.

Some of the exposures presented by this hypothetical case may not be covered by the AICPA Professional Liability Insurance Program policy. In general, recoverable amounts in professional liability claims against accountants are limited to economic damages. This has been well established by case law, and in some jurisdictions, by statute. Courts have rejected recovery for property damage or bodily injury in lawsuits against accountants acting within the scope of their traditional service areas. Plaintiffs may argue that some of the services discussed above are not traditional accounting services, and the courts may be receptive to this argument. In this case, a coverage question would exist based on the wording of the professional services definition in the program's policy. In addition, the policy specifically excludes coverage for claims of bodily injury or for damage to, destruction of, or loss of use of tangible property. Finally, alienation of affection claims seek recovery of damages for emotional distress. Emotional distress is not

covered under the AICPA program policy. CPAs may be asked to become a conservator or guardian for the elder. The policy excludes coverage for services rendered as a conservator or guardian of an individual.

Case Study 4

In this hypothetical example, the firm provides direct services by hiring or entering into contractual relationships with other professionals such as social workers, geriatric care managers, and respite providers. A social worker is an employee of the CPA firm, and a geriatric care manager is an independent contractor working for the CPA firm. The firm's marketing materials introduce both individuals and list their credentials. The client is not given a list of possible care providers to choose from. Both the social worker and the geriatric care manager provide services to the elder. With this exception, the services rendered by the firm are the same services as provided in Case Studies 1, 2 and 3.

Exposure Analysis: In addition to the exposure issues already discussed, this firm is liable for the actions of its employees. The AICPA Professional Liability Insurance Program policy defines professional services, in part, as those services "performed in the practice of public accountancy by you for others, including but not limited to those services of consulting or personal financial planning."

Services rendered to clients by the CPA acting as a social worker or a geriatric care manager do not qualify as professional services under the definition in the AICPA Professional Liability Insurance Program policy. Additionally, the geriatric care manager would not qualify for coverage under the policy as an independent contractor because he or she is not an accountant, and thus would not meet the definition of "you" and "your." Nevertheless, the CPA firm would still be exposed to claims for negligent referral and supervision, and breach of contract. Coverage for such claims would be dependent upon the specific facts of the claim. Techniques the firm could use to lower its exposure in this situation are to require the geriatric care manager to engage directly with the client as an independent contractor, and to verify that the geriatric care manager maintains applicable and adequate insurance.

These case studies depict that exposure is not simple. The potential for bodily injury and emotional distress claims is real. General liability policies normally provide coverage for bodily injury and emotional distress claims but exclude coverage for claims arising out of professional services. Unless an endorsement is added to your professional liability insurance policy to provide coverage for bodily injury and emotional distress, you will be unnecessarily exposed.

Guardianships

It is important to reiterate Burrows's admonition regarding guardianships. In an ElderCare practice, you may be confronted with a request to become a legal guardian for an elderly person. This responsibility is great. Depending on the laws of your state, you would likely be held responsible for the physical well-being of the individual. Such responsibility is not to be taken lightly. From a risk management perspective, you are well advised to decline any request to become a guardian for one of your clients. It would put you too close to the client and possibly impair your objectivity. Furthermore, this responsibility is definitely not within the practice of accountancy. As such, it will not be a covered service in the accountant's professional liability insurance policy. Do not expect your policy to provide coverage.

Trusteeships

Some professional liability policies, the AICPA program included, provide coverage for serving as a trustee for personal trusts, that is, trusts established for the benefit of an individual or set of related individuals. The AICPA Program also includes in that category IRS-defined charitable remainder trusts. As an estate planning or succession planning strategy, many individuals establish trusts and ask their CPA to serve as trustee. Trustees assume a fiduciary duty to the beneficiaries of the trust. If estate planning or succession planning services are requested in conjunction with an ElderCare engagement, consider carefully how, in hindsight, the trust beneficiaries may view your objectivity in performing these services if you are responsible for managing the assets of the trust upon the death of your client. Under most circumstances, it is prudent to either assist the client with estate planning or serve as the trustee of their trusts rather than agreeing to perform all these services together.

Be sure to check your policy coverage before agreeing to serve as a trustee. Read the definition of a trust or trustee in the policy and/or consult your insurance agent or broker.

The AICPA Professional Liability Insurance Program

The AICPA established the Accountants Professional Liability Insurance Program in 1967 so that quality professional liability insurance would be available to AICPA members. With the high cost and serious consequences of a professional liability lawsuit, comprehensive protection is especially important for CPA firms today.

The overall management of the AICPA Program is guided by the AICPA Professional and Personal Liability Insurance Programs (PLIP) Committee, comprising CPA practitioners. The PLIP Committee meets regularly with Aon Insurance Services, the National Program Administrator, and Continental Casualty Company, the program underwriter and one of the CNA insurance companies, to oversee all aspects of the coverage.

The Professional Liability Insurance Program features plans that provide comprehensive coverage tailored to meet the diverse needs of CPA firms of all sizes and areas of practice. More accountants get their professional liability insurance from the program than from any other sponsored plan. The plans are on the cutting edge of CPA needs (some plans now include bodily injury for ElderCare exposure and provide options relating to your risk in working with other professionals, for example, geriatric care managers and social workers.)

The plans available are:

- *The CPA Value Plan* is for firms with up to three accounting professionals and annual revenues of up to $300,000
- *The Premier Plan* is for firms with unique coverage needs or more than three accounting professionals and annual revenues in excess of $300,000. This plan also provides coverage for other professionals in the firm, such as ERISA plan fiduciaries, life insurance agents, real estate agents and registered representatives.
- *The Large Firm Unit Plan* is for the top 100 firms (excluding Big 5) and firms with specialized needs.

The AICPA Professional Liability Insurance Program can help you address the aforementioned exposures you face when performing CPA ElderCare services. If you are

insured with another company, be sure to speak with your agent about your exposure and how coverage will apply.

For more information about the AICPA Professional Liability Insurance Program, call your local representative or, if you prefer, Aon Insurance Services at (800) 221-3023.

As you develop your ElderCare practice, be certain you have considered the exposures associated with this service area, some of which ordinarily do not arise in the practice of public accountancy. Recognize you will be working with professionals outside the accounting profession who are not bound by similar rules of ethics. They may relate to clients differently. Some of the exposures associated with ElderCare are unprecedented in the world of public accounting and must be addressed with your insurance agent and carrier. You can protect yourself, however, and engage in rewarding relationships with all your CPA ElderCare Services clients.

CHAPTER 6:

Engagement Services, Professional Standards, and Reporting

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Engagement Services, Professional Standards, and Reporting

CPA ElderCare Engagement Services

ElderCare services can involve three kinds of services: direct services, assurance services, and consulting services. Direct services entail the more traditional aspects of accounting and financial services. Assurance services involve measurement and reporting on prescribed goals against stated criteria. Consulting services include planning and evaluation of client needs.

Listed in the following sections are some of the potential services under each of the three categories.

Direct Services

Direct services are the hands-on services, some of which are already offered by CPAs. Whereas some clients may need assistance in paying bills, others may require extensive assistance with the activities of daily living (ADLs), such as personal care and shopping. The members of the multidisciplinary team should include licensed professionals who can assist the client as needed.

Direct services may include:

- Financial services. Practitioners:
  - — Receive, deposit, and account for client receipts
  - — Ensure expected revenues are received
  - — Make appropriate disbursements
  - — Submit claims to insurance companies
  - — Confirm accuracy of provider bills and appropriate reimbursements
  - — Protect elderly from predators by controlling checkbook and other assets
  - — Conduct income tax planning and preparation
  - — Prepare gift tax returns
  - — Prepare employment tax returns for caregivers and household help
- Nonfinancial services. Practitioners:
  - — Help arrange for transportation, housekeeping, and other services
  - — Manage real estate and other property
  - — Visit and report on elderly on behalf of children in distant locations

Assurance Services

Assurance services describe the analytical services that are more closely related to the attest function that CPAs already provide. However, these services reflect assurance of services, not historical financial data.

Assurance services may include:

- Financial services. Practitioners:
  - — Review and report on financial transactions
  - — Test for asserters' adherence to established criteria
  - — Review investments and trust activity
  - — Audit third party calculations, such as pension, insurance, and annuity payments
  - — Review reports from fiduciaries
- Nonfinancial services. Practitioners:
  - — Measure and report on care provider performance against established goals
  - — Evaluate and report on the performance of other outside parties, such as contractors

Consulting Services

Consulting services establish the criteria and range of services required by the elderly person, through the use of comprehensive assessments prepared by members of the multidisciplinary team. Because practitioners are working with individuals and families, each client's care plan should be customized. In addition, practitioners should have a current knowledge of community resources so clients can be referred as needed. Following the assessment, an initial individual care plan is developed for the client.

Consulting services may include:

- ElderCare planning. Practitioners:
  - — Plan for housing and support service needs
  - — Plan for declining competency
  - — Plan for death or disability of one or both spouses
  - — Evaluate alternative costs of retirement communities and other housing
  - — Evaluate housing and care alternatives
  - — Provide inventory of services available in the community
  - — Provide estate planning
- Planning for fiduciary needs. Practitioners evaluate the need for:
  - — Financial power of attorney
  - — Health care power of attorney
  - — Guardianship
  - — Trusteeship
  - — Living wills
  - — Advanced medical directives

- Evaluation of financing options. Practitioners explore:
  - — Medicare and Medicaid
  - — Long-term care insurance
  - — Medigap insurance
  - — Health maintenance organizations
  - — Annuities
  - — Viatical insurance settlements
  - — Reverse mortgages
  - — Sale or leaseback of home
  - — Flexible spending accounts
- Family facilitation. Practitioners:
  - — Mediate or arbitrate family disputes
  - — Provide objectivity for highly emotional issues
  - — Act as intermediary between parent and child
- Coordination of support and healthcare services. Practitioners can act as the "quarterback" on the team that consists of health care, legal, and other professionals
- Other consulting services. Practitioners:
  - — Help family monitor care
  - — Establish standards of care expected
  - — Communicate expectations to care providers
  - — Establish performance measurement systems

Professional Standards and Reporting

Since ElderCare involves a range of services, from consulting to attestation (assurance) to direct provision of services, practitioners need to follow the appropriate professional standards for the type of service being rendered. Regardless of the level of service, they are bound by the AICPA Code of Professional Conduct (the Code). These ethical standards are what set the CPA profession apart from other professions and are the basis upon which CPA ElderCare Services are being developed. In addition to following the Code, a member who performs auditing, review, compilation, management consulting, tax, or other professional services must comply with standards promulgated by bodies designated by the AICPA Council. In other words, practitioners entering ElderCare specialty must follow the requirements of the Code and the requirements of the specific standards that apply to the specific kinds of services they are performing.

AICPA Code of Professional Conduct

The Code was adopted by the membership to provide guidance and rules to all members—those in public practice, in industry, in government, and in education—in the performance of their professional responsibilities.

The Code governs the performance of professional services by members. ElderCare practitioners should be familiar with the Code and adhere to all of its relevant provisions. In particular, they should be familiar with the following principles and rules of the Code.

Objectivity and Independence

A member should maintain objectivity and be free of conflicts of interest in discharging professional responsibilities. A member in public practice should be independent in fact and appearance when providing auditing and other attestation services. The principle of objectivity imposes the obligation to be impartial, intellectually honest, and free of conflicts of interest. Independence precludes relationships that may appear to impair a member's objectivity in rendering attestation services.

Independence is the hallmark of the CPA profession. In cases where the ElderCare service being provided is an assurance service (an attestation or agreed-upon procedures engagement), independence is required. A lack of independence would preclude members from providing such assurance services.

Interpretation No. 101-11, modified application of Rule 101 for certain engagements to issue restricted-use reports under the Statements on Standards for Attestation Engagements of ET section 101 (AICPA, *Professional Standards*, vol. 2, ET sec. 101.13), provides guidance for attestation engagements when the report will be restricted to identified parties.

Practitioners assessing independence issues in ElderCare engagements should refer to the full text of this Interpretation. Also, practitioners can get help with independence, or other ethics-related questions by calling the AICPA Ethics Hotline at (888) 777-7077.

Compilation. If compiled financial statements, as defined in Interpretation No. 15, "Differentiating a Financial Statement Presentation From a Trial Balance," of Statement on Standards for Accounting and Review Services (SSARS) No. 1, *Compilation and Review of Financial Statements* (AICPA, *Professional Standards*, vol. 2, AR sec. 9100.54-.57), and paragraph 4 of SSARS No. 1 (AICPA, *Professional Standards*, vol. 2, AR sec. 100.04), are issued, independence is not required, but any lack of independence must be disclosed in your compilation report.

Consulting. If the ElderCare service is a consulting engagement that has no assurance component—that is, it is not performed under the SASEs—you are not required to be independent. Nevertheless, a conflict of interest may exist, as described in Rule 102, *Integrity and Objectivity* (AICPA, *Professional Standards*, vol. 2, ET sec. 102), and its Interpretations (ET sec. 102). If you believe that the professional service can be performed with objectivity, and the relationship is disclosed and consent is obtained from the client or other appropriate parties, the rule will not prohibit the performance of the professional service. When making the disclosure, you should consider Rule 301, *Confidential Client Information* (AICPA, *Professional Standards*, vol. 2, ET sec. 301).

Conflicts of Interest. Interpretation No. 102-2, "Conflicts of Interest," of ET section 102, *Integrity and Objectivity* (AICPA, *Professional Standards*, vol. 2, ET sec. 102.03), defines conflicts of interest in part as follows:

> A conflict of interest may occur if a member performs a professional service for a client or employer and the member or his or her firm has a relationship with

> another person, entity, product, or service that could, in the member's professional judgment, be viewed by the client, employer, or other appropriate parties as impairing the member's objectivity.

Example. If you refer your elderly client to a doctor who is a tax client of yours, this may or may not be a conflict of interest. If the doctor is only a tax client, a conflict of interest would probably not exist. If, however, the doctor owns several businesses, which are also your clients and generate significant fees for you, a conflict of interest may very well exist. That relationship could impair your objectivity, if other doctors are available in the community with similar abilities.

What to Do If a Conflict of Interest Occurs. If a conflict of interest occurs, decide whether you can perform the service with objectivity. If you cannot, then do not perform the service. If you decide you can, disclose the relationship and get consent from the client and other appropriate parties.

Recipient of the Residual Estate. You should not allow yourself, or your representative, to be named as a recipient of some or all of your elderly client's residual estate. Moreover, you and your staff should not accept loans or gifts from clients. It is quite possible that an elderly client may change the will to include you, as a result of a close ongoing relationship that may have evolved between the client and yourself as his ElderCare CPA. If practitioners become recipients of the residual estates of their elderly clients—to the detriment of family members or other heirs—people may look unfavorably upon the CPA profession.

To avoid this situation:

1. Your engagement letter should include language specifying actions that will be taken, such as notification of the responsible family member and refusal to accept, if the elderly person attempts to change the will to include you.
2. You should obtain written confirmation from staff assigned to the ElderCare engagement that they will abide by the same provisions concerning residual estates.

Professional Competence

Members should undertake only those professional services that they or their firms can reasonably expect to complete with professional competence. A member's agreement to perform professional services implies that the member has the necessary competence to complete those professional services according to professional standards, applying his or her knowledge and skill with reasonable care and diligence, but the member does not assume a responsibility for infallibility of knowledge or judgment.

Competence to perform professional services involves both the technical qualifications of the member and the member's staff and the ability to supervise and evaluate the quality of the work performed. Competence relates both to knowledge of the profession's standards, techniques, and the technical subject matter involved, and to the capability to exercise sound judgment in applying such knowledge in the performance of professional services.

Due Professional Care

A member should exercise due professional care in the performance of professional services.

Planning and Supervision

A member should adequately plan and supervise the performance of professional services.

Sufficient Relevant Data

A member should obtain sufficient relevant data to afford a reasonable basis for conclusions or recommendations in relation to any professional services performed.

Confidential Client Information

A member in public practice shall not disclose any confidential client information without the specific consent of the client.

Most CPAs are well attuned to the absolute necessity to respect the utmost secrecy of any confidential information concerning their clients and former clients. There will be situations when disclosures must be made to carry out the terms of their engagement properly. The engagement letter should clearly specify what type of information could be disclosed, to whom it might be disclosed, and under what circumstances the disclosures may be made. There should be an understanding about who has authority to release information in circumstances when the client may be unavailable or incapable of acting. There may be ongoing instances (for example, sending monthly reports to children or guardians) that can be spelled out in the engagement letter. Separate waivers should be obtained in all other cases whenever information is released to third parties. Once again, it is important that all agents, employees, and colleagues are aware of confidentiality considerations. Legal counsel may be needed to determine whether practitioners are violating any privacy laws.

In spite of the obligations described in this section, however, there will, as in all professional engagements, be situations in which the practitioner may be compelled to release information to a court or a competent authority. This is sometimes permissible under the rules of the profession, but legal advice should be sought in these cases.

New privacy regulations are now in effect as a result of the passage of the Gramm-Leach-Bliley Act. The Act is discussed in detail at the end of this chapter.

Compilations and Reviews

If you are issuing a report on unaudited financial statements or you are submitting such financial statements to your client or others, you must comply with the provisions of the SSARS. According to Interpretation No. 15 of SSARS No. 1, financial statements generally contain titles that identify the presentation as one intended to present financial position, results of operations, or cash flows. Typical titles for financial statements include:

- Balance sheet
- Statement of income
- Statement of cash flows
- Statement of assets and liabilities
- Statement of revenue and expenses
- Statement of cash receipts and disbursements

You should use judgment and consult the SSARS when determining whether the financial presentation constitutes a financial statement. When making this determination, you should consider the preponderance of the attributes of the financial presentation.

Attestation Services and Applying Agreed-Upon Procedures

An attest engagement is an engagement in which a practitioner is engaged to issue or does issue an examination, a review, or an agreed-upon procedures report on subject matter, or an assertion about the subject matter, that is the responsibility of another party. When a practitioner performs an attest engagement, the engagement is subject to the AICPA SSAEs.

Specifically, you will need to comply with the provisions of SSAE No. 10, *Attestation Standards: Revision and Recodification* (AICPA, *Professional Standards*, vol. 1, sec. AT secs. 101-701), as amended by SSAE No. 11, *Attest Documentation* (AICPA, *Professional Standards*, vol. 1, AT secs. 101-701). Depending on the kind of attestation work you are performing on your ElderCare engagement, you can consider the following:

Chapter 1, "Attest Engagements," of SSAE No. 10 (AT sec. 101)

Chapter 2, "Agreed-Upon Procedures Engagements," of SSAE No. 10 (AT sec. 201)

Chapter 3, "Financial Forecasts and Projections," of SSAE No. 10 (AT sec. 301)

Chapter 6, "Compliance Attestation," of SSAE No. 10 (AT sec. 601)

Agreed-Upon Procedures Engagements

An agreed-upon procedures engagement is one in which a practitioner is engaged by a client to issue a report of findings based on specific procedures performed on subject matter. The client engages the practitioner to assist specified parties in evaluating subject matter or an assertion as a result of a need or needs of the specified parties. Because the specified parties require that findings be independently derived, the services of a practitioner are obtained to perform procedures and report his or her findings. The specified parties and the practitioner agree upon the procedures to be performed by the practitioner that the specified parties believe are appropriate. Because the needs of the specified parties may vary widely, the nature, timing, and extent of the agreed-upon procedures may vary as well; consequently, the specified parties assume responsibility for the sufficiency of the procedures since they best understand their own needs. In an agreed-upon procedures engagement performed under Chapter 2 of SSAE No. 10, the practitioner does not perform an examination or a review, as discussed in Chapter 1 of SSAE No. 10, and does not provide an opinion or negative assurance. Instead, the practitioner's report on agreed-upon procedures should be in the form of procedures and findings.

As a consequence of the role of the specified parties in agreeing upon the procedures performed or to be performed, a practitioner's report on such engagements should clearly indicate that its use is restricted to those specified parties.

Consulting Services

Many of the services you perform as part of your ElderCare engagement will probably be considered consulting services (see the list at the beginning of this chapter under "CPA

ElderCare Engagement Services"). Consulting services differ fundamentally from the CPA's function of attesting to the assertions of other parties. In an attest service, the practitioner expresses a conclusion about the reliability of a written assertion that is the responsibility of another party, the asserter. In a consulting service, the practitioner develops the findings, conclusions, and recommendations presented. The nature and scope of work is determined solely by the agreement between the practitioner and the client. Generally, the work is performed only for the use and benefit of the client.

You should follow the provisions of the AICPA's Statement on Standards for Consulting Services, *Consulting Services: Definitions and Standards* (AICPA, *Professional Standards*, vol. 2, CS sec. 100), when performing consulting services as part of your ElderCare engagement.

Auditing Services

Financial statements on which the practitioner issues an auditor's report would seldom arise as a CPA ElderCare engagement. If by some rare chance an audit were required as a part of an ElderCare engagement, you would need to comply with the requirements of the AICPA's Statements on Auditing Standards.

Reporting and Report Examples

When issuing your report and communicating with your client, you should follow the guidance presented on such matters in the professional standards that apply to the services you are reporting on (see previous sections in this chapter).

When the ElderCare practitioner is providing direct services to the client other than financial services, the type of report and information to be included in the report depends on the terms of the engagement. Such a report may simply be a narrative recitation of activities that have occurred during the reporting period or of any other information requested by the responsible parties. Separate reports would, in this case, be issued for financial information and nonfinancial information.

Some practitioners feel that such reports are best communicated orally so that the person(s) to whom reporting is being done may ask questions and discuss matters or comments of interest to them. If reporting is done orally, a memo should be prepared for the file after each such oral report setting forth the date and time of the report, the items discussed, and any conclusions or recommendations made or reached.

In drafting narrative, nontraditional reports, the practitioner should be careful to avoid the use of phrases that are vague or subject to interpretation, such as "good condition" and "looks fine." Rather, the recitation should be as factual as possible. The following are some examples.

The wrong way. I visited your mother on Monday afternoon, July 10. She was in good spirits and seemed to be having a great time. She looked great and carried on a lively conversation with the sitter and me.

A better way. I visited your mother at 5 p.m. on Monday afternoon, July 10. She was smiling, her makeup had been applied for the day, and her clothing was pressed and neat. She participated freely in the conversation with the sitter and me, although some of her responses to questions were not to the point of the inquiry. The sitter reported to me that the geriatric care manager you employed had indicated that such behavior was normal for your mother during the late afternoon.

Report Examples

Sample reports are contained in Chapter 11, "Sample Documents and Checklists."

Where to Obtain the Professional Standards

To obtain the professional standards discussed in this chapter, call the AICPA Order Department at (888) 777-7077 or visit www.cpa2biz.com.

The Gramm-Leach-Bliley Act

The Gramm-Leach-Bliley Act and the related Federal Trade Commission (FTC) regulations contain restrictions on the disclosure of personal financial information of certain individual clients and also require the distribution of privacy notices to those clients. You are subject to these provisions if you are significantly engaged in providing clients with nonbusiness financial products or services. More specifically, these are products or services for personal, family, or household purposes and can encompass a broad spectrum. Many ElderCare practices provide nonbusiness financial products and services to their clients, such as individual tax return preparation, tax and retirement planning, and home care consulting.

What Is Required?

You are required to provide notices regarding your privacy policy to the clients for whom you are providing the financial products or services. In addition, you are prohibited, with certain exceptions, from disclosing to a nonaffiliated third party any nonpublic personal information regarding those clients. The following exceptions to the nondisclosure rule are likely to apply to practicing CPAs:

- To effect or administer the transaction requested by the client—for example, disclosure to a tax return processor for purposes of preparing the client's return.
- To participate in a peer review
- To comply with federal, state, or local laws—for example, in response to a summons or subpoena.

When Is It Required?

The new privacy requirements were effective July 1, 2001, and existing clients were required to be sent the notice on or before that date. For individual clients acquired after July 1, 2001, you must provide the initial notice no later than the acceptance of the client relationship. Going forward, you must give the notice on an annual basis to continuing clients for whom a notice is required. In most cases, you should be able to accomplish this by including the notice with client billings or engagement letters. Note that after the initial notice, the first annual notice must be provided to continuing clients before January 1, 2003, and each subsequent annual notice must be provided within 12 months of that notice.

What Will Be the Effect on Your Practice?

Other than the notice requirement, these provisions should have no effect on your practice. As a CPA, you are already bound by your state ethics requirements. Also, AICPA members are bound by Rule 301 of the AICPA Code of Professional Conduct, which is even more restrictive than the provisions of the Gramm-Leach-Bliley Act and the FTC.

Subject to certain exceptions, Rule 301 generally prohibits you from disclosing confidential client information without the specific consent of the client. In addition, subject to certain exceptions, Internal Revenue Code (IRC) section 7216 makes it a misdemeanor for a paid income tax return preparer to disclose tax return information other than in connection with the preparation of the return.

What Should Be Included in the Privacy Notice?

For information on inclusion requirements and a sample privacy notice, see Chapter 11, "Sample Documents and Checklists."

CHAPTER 7:

Federal and State Programs for the Elderly

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Federal and State Programs for the Elderly

MEDICARE

Medicare, the nation's largest health insurance program, is nationally managed by the Health Care Financing Administration (HCFA), a federal agency in the Department of Health and Human Services. Medicare provides health insurance to people age 65 and over, to those who have End-Stage Renal Disease (ESRD), and to certain people with disabilities.

Medicare currently provides federal health insurance coverage for approximately 39 million elderly Americans—and that number is growing. Medicare beneficiaries (your clients) will face significant challenges coping with the potential changes that may affect the Medicare program in the future. Clients will ask you for your opinion about how these changes will affect their financial and health security.

- They may ask, "How is the Medicare + Choice option different from the traditional plan? Can I afford to keep a Medigap policy? Where can I get additional information?"
- Your staff may ask, "Here is another statement from Medicare for Mrs. Richardson—her claim was denied. What do I do now?"
- A frazzled adult child may tell you his or her parent will be in a nursing home for about three months. How much money will the family need to cover their portion of the bill?
- You may be acting as the responsible party making program decisions for your elderly client. Can you make the best choice for your client?

You, as the CPA ElderCare services practitioner, must be prepared to either provide the assistance clients and staff require or be able to direct them to other knowledgeable resources and professionals. Your ability to advise your clients appropriately in a timely manner as an ElderCare practitioner will provide added value for your clients and will help differentiate you from your CPA competitors.

Important Medicare Updates for 2001 and 2002

Prescription Drug Coverage Developments

One of the most glaring omissions in Medicare's benefits is the lack of prescription drug coverage. While over 98 percent of employer-sponsored health plans pay for prescription drugs, traditional Medicare does not cover the almost 400 drugs developed in the last decade to fight diseases such as cancer, heart disease, diabetes, and arthritis.

More specifically, the Original Medicare Plan does not cover prescription drugs except in a few cases. Medicare managed care plans cover prescription drugs, up to certain dollar limits, but sometimes at extra cost. Finally, some Medigap policies also cover prescription drugs, but not everyone is eligible.

Many seniors fall through the gaps in the aforementioned coverage. President Bush's announcement in July 2001 supports a new prescription drug benefit for seniors to help them live more enjoyable and healthy lives. Nine out of 10 Medicare beneficiaries will use at least one prescription drug this year and the proportion of older adults who incur very high drug spending continues to grow. The President stated that he intends to work with Congress in a bipartisan fashion to strengthen Medicare, including prescription drug coverage, based on his legislative framework. Even if enacted soon, all the proposals in Congress will take several years to provide meaningful prescription coverage to America's older adults. Almost all of the current proposals rely on the approaches used by private insurance plans to reduce the prices paid by Medicare beneficiaries and to help them use prescription drugs more effectively.

Currently, the President suggests that older Americans need assistance now and that steps must be taken toward providing a meaningful prescription benefit as soon as possible. Thus, the President announced the following initiatives:

Medicare will endorse and promote a number of qualified, privately administered prescription drug discount cards, to be made available either free of charge or at a nominal, one time enrollment charge, not to exceed $25. In addition:

- Medicare will require the approved card sponsors to publish the discounted prices for most prescription drugs purchased by older adults, to encourage price competition and simplify the prescription drug buying decisions of older Americans. The President suggests that well-informed seniors will drive the market to competitive pricing.
- Seniors will be provided with more information on drug prices and services, which will allow for more informed purchasing decisions, better patient-physician decisions and more appropriate pharmacy dispensing and use.
- Medicare launched a $35 million education campaign during the fall of 2001 to publicize and educate seniors about their Medicare choices, including the varied options among endorsed prescription cards.
- Card sponsors are encouraged to offer a combined retail/mail-order card. To ensure seniors access to retail-based discounts, a mail-order only option will not be available.
- Card sponsors can market additional services to cardholders but must allow seniors to decline to participate in additional services when they enroll.
- Card sponsors can adopt the quality-enhancement and cost-containment strategies common in private plans, including but not limited to formularies, preferred networks, patient and physician education programs, and disease management.

The selected card sponsors will be required to participate in and help finance a consortium to handle all enrollment and eligibility functions, as well as publicize comparative information on the different discounted drug prices and quality enhancements available from the various card sponsors. The administration expects

that the formulary, network, and education attributes of the program coupled with exclusive enrollment will provide the card sponsors with necessary market leverage to negotiate significant and competitive rebates from drug manufacturers. Medicare oversight will be limited to annual certification based on easily verifiable criteria and card sponsors must comply with HIPPA and all related privacy rules and regulations. The consortium is required to develop and implement a system to permit older adults to compare card programs using basic information on formulary content, networks, and discounts (required date October 1, 2001.) By October 1, 2002, the consortium will enhance the ability of older Americans to comparison shop by providing consumers with the actual discounted drug prices associated with various endorsed drug card programs, including information on generic and formulary alternatives consistent with the cards' programs.

Medicare Benefit Information Update for 2001 and 2002

Medicare began coverage of several new benefits to prevent and detect diseases at early stages, when they are more treatable. These include:

- *Mammograms.* Medicare coverage includes annual screening mammograms for all women age 40 and over. Beneficiaries pay the usual 20 percent copayment for mammograms, but Medicare will pay the other 80 percent, even if the beneficiary has not yet met her annual deductible.
- *Pap smears.* Medicare coverage allows for a screening pap smear to include both a pelvic exam and clinical breast exam every three years for most women. Exams are covered every year for women at high risk for cervical or vaginal cancer. Medicare pays the full claim for the pap smear and 80 percent of the claim for the pelvic and clinical exams, even if the beneficiary has not yet met her annual deductible.
- *Colorectal cancer.* Medicare covers colorectal cancer screening, including fecal-occult blood tests, flexible sigmoidoscopy, colonoscopy (for people at high risk for colorectal cancer), and in certain cases, barium enemas. Each test is covered under different circumstances, so patients should check with their physicians.
- *Glucose monitoring for diabetes.* All Medicare beneficiaries with diabetes, whether or not they use insulin, have coverage for blood glucose monitors and testing strips.
- *Diabetes education.* Medicare now covers a wider range of educational and training programs to help teach diabetics how to control their blood glucose levels. These training programs do not have to be based in hospitals; however, physicians must certify that a patient needs the service under a comprehensive plan of care.
- *Bone mass measurement.* Medicare covers bone density measurement for beneficiaries at risk for osteoporosis and other bone abnormalities.
- *Flu and pneumococcal vaccination program.* Medicare's existing flu and pneumococcal vaccine outreach programs will continue through the year 2002.

Some additional wellness activities available include:

- Peptic ulcer screening and education.
- ESRD education.

Medicare Deductible, Coinsurance, and Premium Amounts for 2001 and 2002

TABLE 7.1 HOSPITAL INSURANCE AND MEDICAL INSURANCE 2001–2002

Hospital Insurance (Part A)	2001	2002
Deductible per each benefit period	$792.00	$812.00
Coinsurance (daily rate for days 61–90, per benefit period)	$198.00	$203.00
Coinsurance (daily rate for days 91–150 per benefit period—also known as the 60 "nonrenewable, lifetime reserve days")	$396.00	$406.00
Skilled nursing facility coinsurance (daily rate for days 21–100, per benefit period)	$99.00	$101.50
Hospital insurance premium *	$300.00	$319.00
Reduced hospital insurance premium *	$165.00	$175.00
Medical Insurance (Part B)		
Deductible per year	$100.00	$100.00
Monthly premium	$50.00	$54.00

* Some people age 65 or older do not meet the Social Security Administration's requirements for premium free Hospital Insurance (Part A). People in this category can get Part A by paying a monthly premium. If the person has less than 30 quarters of Social Security coverage, the Part A premium will be $319 a month for 2002. If the person has 30 to 39 quarters of Social Security coverage, the Part A premium will be $175 a month for 2002.

Medicare Administration: The Health Care Financing Administration

Medicare is administered by the Health Care Financing Administration (HCFA), a federal agency in the Department of Health and Human Services (see Table 7.2 for a listing of HCFA regional offices). The Social Security Administration assists the HCFA by enrolling people in Medicare and by collecting Medicare premiums. Various commercial insurance companies are under contract with the HCFA to process and pay Medicare claims, and groups of doctors and other health care professionals have contracts to monitor the quality of care delivered to Medicare beneficiaries. The HCFA also forms partnerships with thousands of health care providers, including hospitals, nursing homes, home health agencies, and doctors, as well as medical equipment suppliers, clinical laboratories, and managed care plans. This network of providers and other organizations combine to provide and pay for health care services for Medicare's nearly 40 million beneficiaries.

TABLE 7.2 HEALTH CARE FINANCING ADMINISTRATION REGIONAL OFFICES

States Served	Regional Office	Customer Services
Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, Vermont	Boston	Phone (617) 565-3308 Fax (617) 565-1083
New York, New Jersey, Puerto Rico, Virgin Islands	New York	Phone (212) 264-1121 Fax (212) 264-6814

TABLE 7.2 (*CONTINUED*)

States Served	Regional Office	Customer Services
Delaware; Washington, D.C.; Maryland; Pennsylvania; Virginia; West Virginia	Philadelphia	Phone (215) 861-4248 Fax (215) 861-4280
Alabama, Florida, Georgia, Kentucky, Mississippi, North Carolina, South Carolina, Tennessee	Atlanta	Phone (404) 562-7438 Fax (404) 562-7477
Illinois, Indiana, Michigan, Minnesota, Ohio, Wisconsin	Chicago	Phone (312) 353-9635 Fax (312) 353-3419
Arkansas, Louisiana, New Mexico, Oklahoma, Texas	Dallas	Phone (214) 767-6321 Fax (214) 767-0322
Iowa, Kansas, Missouri, Nebraska	Kansas City	Phone (816) 426-3184 Fax (816) 426-6769
Colorado, Montana, North Dakota, South Dakota, Utah, Wyoming	Denver	Phone (303) 844-4722 Fax (303) 844-3753
Arizona, California, Hawaii, Nevada	San Francisco	Phone (415) 744-3696 Fax (415) 744-2692
Alaska, Idaho, Oregon, Washington	Seattle	Phone (206) 615-2313 Fax (206) 615-2088

The National Medicare Education Program (NMEP)

Practitioners providing CPA ElderCare services must engage in proactive research and continually update their knowledge about Medicare developments to help their older clients make informed, appropriate choices. Each client has individual medical needs, which must be taken into account during the health care decision process.

The traditional Medicare program is a complex maze of policies, regulations, and requirements, and new changes to the program that have been implemented are not likely to result in a less complex format. Beneficiaries and practitioners should approach the new plans cautiously and exercise vigilance to ensure that the Medicare program's basic goals are met. The HCFA has developed Web site resources at www.hcfa.gov and www.medicare.gov, which are helpful in this effort.

Additionally, the HCFA has developed the National Medicare Education Program (NMEP) which provides advocates and beneficiaries with information about Medicare program changes. The NMEP 's mission statement is "to empower beneficiaries, their families, and friends to make informed choices about their Medicare benefits and to change beneficiary behavior from passive receiver of information to active participant in Medicare choices." Beneficiaries receive information about the program changes through (1) a new Medicare Handbook and other Bulletin publications, (2) access to a toll-free number ((800) MEDICARE; TTY/TDD (877) 486-2048), (3) access to Internet resources (www.medicare.gov), (4) access to Medicare Compare (a plan comparison database available at www.medicare.gov), and (5) special health fairs. These efforts are the HCFA's attempt to ensure that beneficiaries can access information, understand the information needed to make sound choices, and view the NMEP as a trusted, credible

source of information. Beneficiaries are encouraged to understand that (1) there are more choices to receive health care, (2) the choice is up to the elderly person to make, (3) beneficiaries do not have to change their method of receiving services, (4) there is a trade-off between cost and choice, and (5) beneficiaries have the right to complain.

The NMEP uses a phased approach. That is, it encourages beneficiaries to move from awareness about the changes, to understanding the changes, to using new information to make informed choices. The five-year effort began in October 1998 with the Medicare Handbook, *Medicare and You* (the Handbook), mailed to beneficiaries in five states (Arizona, Florida, Ohio, Oregon, and Washington). The Handbook is now available at www. medicare.gov and is available in English, Spanish, and in an audiotape format. The Handbook also lists the Medicare + Choice options by area and will eventually include beneficiary satisfaction data and quality-of-care measures. The new toll-free Medicare number enables beneficiaries to receive assistance Monday through Friday, 8:00 a.m. to 4:30 p.m. (caller's local time).

Other Chapter Resources

- State Health Insurance Assistance Program phone numbers are listed in Table 7.5
- The Medicare carrier and other resources for each state is listed in Table 7.6
- A list of help references is located in Table 7.7
- A list of the State Agencies on Aging is located in Table 7.10.

Introduction to the Medicare Program

(Adapted from materials published by the Health Care Financing Administration and the U.S. Department of Health and Human Services)

Structure Summary

Pursuant to the Balanced Budget Act of 1997 (P.L. 105-33), substantive changes in the Medicare program have altered options available to beneficiaries. Elderly people face a potentially confusing array of new choices for receiving their health care services. The biggest change is the addition of Medicare + Choice, also known as Part C. Recipients are still assured of all of the basic Medicare benefits as well as new preventive care services to help them remain healthy, at no extra cost, and new health plan choices.

The following health plan choices are currently available:

- The Original Medicare Plan (known as Part A, hospital coverage, and Part B, fee for service coverage). Part A helps pay for care in a hospital and skilled nursing facility, and for home health and hospice care. Part B helps pay for doctors, outpatient hospital care, and various other medical services not covered in Part A.
- The Original Medicare Plan with a Supplemental Insurance Policy. A common supplemental policy is Medigap, and it covers the coinsurance amounts that exist with Parts A & B.
- Managed Care Plans that have contracts with Medicare (now known as Medicare + Choice, or in some circles, Part C). Dental costs, various levels of prescription coverage, vision coverage and routine physicals are offered with Medicare + Choice. However, choice of doctor is limited.

Recipients should be reminded that:

- If they are happy with the way they currently receive health care, they do not have to change to any other plan. The choice is theirs.
- No matter what choice they make, they are still in the Medicare program and will receive all the Medicare covered services.

The Decision Between Fee-for-Service (Original Plan) or Managed Care (Medicare + Choice). One important decision individuals may have to make is how they receive their Medicare hospital and medical benefits. Many areas of the country are now served by managed care plans, thus Medicare benefits may be received either through the traditional fee-for-service system or through a managed care plan (Medicare + Choice).

If the elderly person selects fee-for-service, he or she may choose from almost any doctor, hospital, or other health care provider. Generally, a fee is charged each time a service is used. Medicare pays its share of the bill, and the individual is responsible for paying the balance. In contrast, under managed care, the individual usually receives all care from the plan's doctors and health care providers, except in emergencies or when the person is out of the plan's service area and has an urgent medical need. Depending on the plan, individuals may have to pay a monthly premium and a copayment each time they use the services.

Managed care works differently than the traditional fee-for-service plan. The Medicare + Choice plans generally cover more services and have fewer out-of-pocket costs than fee-for-service plans. However, managed care plans also have different rules and generally maintain control over important health care decisions. They can also limit access to specialists and may intervene in other medical decisions.

Types of Medicare Managed Care Plans. Before enrolling in a managed care plan, the individual must understand whether the plan has a risk or cost contract with Medicare. There is an important difference.

Risk plans. These plans have "lock-in" requirements. That is, the individual must receive all covered care through the plan or through referrals from the plan. Services not authorized by the plan are not covered, nor will Medicare pay the costs. The only exceptions recognized by all Medicare contracting plans are for emergency services, which may be obtained anywhere in the United States, and for services urgently needed while the individual is temporarily out of the plan's service area. Another exception offered by some risk plans is called the point-of-service (POS) option, which permits the individual to receive certain services outside the plan's provider network for which the plan will pay a percentage of the charges.

Cost plans. These plans do not have lock-in requirements. If enrolled in a cost plan, the individual may select either affiliated providers or those outside the plan. If the individual elects to go outside the plan, the plan probably does not pay, but Medicare does. The individual is responsible for Medicare's coinsurance, deductibles, and other charges, just as if the individual received care under the fee-for-service system.

Who Is Eligible for Medicare?

Generally, individuals are eligible for Medicare if they have worked for at least 10 years in Medicare-covered employment, are 65 years old, and are a citizen or permanent resident

of the United States. Persons may also qualify for coverage if they are younger and disabled or have chronic kidney disease.

Part A (hospital fee for service) is available to persons aged 65 and over without having to pay for premiums if they fulfill one of the following criteria:

1. Are already receiving retirement benefits from Social Security or the Railroad Retirement Board
2. Are eligible to receive Social Security benefits or Railroad Retirement benefits but have not yet filed for them
3. Their spouse had Medicare-covered government employment

Individuals under 65 may get Part A without having to pay premiums if they fulfill one of the following:

1. Received Social Security or Railroad Retirement Board disability benefits for 24 months
2. Are a kidney dialysis or kidney transplant patient

Although persons do not have to pay a premium for Part A if they meet one of those conditions, they must pay for Part B if they want it. For 2001 and 2002, the Part B premium is $50 and $54 per month, respectively. It is deducted from Social Security, Railroad Retirement, or Civil Service Retirement checks.

Those not eligible for Medicare Part A without paying the premiums may pay for Part A (see the Medicare deductible, coinsurance, and premium amounts for 2001 and 2002 in Table 7.3 and Table 7.1, respectively.)

Managed care (Part C) is an option available only for those persons eligible for Parts A and B.

TABLE 7.3 MEDICARE HOSPITAL AND MEDICAL INSURANCE—2001
(SEE TABLE 7.1 FOR 2002 FIGURES)

Part A (Hospital)

Services	Benefit	Medicare Pays	Patient Pays
Hospitalization	First 60 days	All but $792	$792
Semiprivate room and board; general nursing and other hospitalization services and supplies (Medicare payments based on benefit periods)	61st to 90th day	All but $198 a day	$198 a day
	91st to 150th day*	All but $396 a day	$396 a day
	Beyond 150 days	Nothing	All costs
Skilled nursing facility care	First 20 days	100% of approved amount	Nothing
Semiprivate room and board; skilled nursing and rehabilitative services and other services and supplies**	Additional 80 days	All but $99 a day	Up to $99 a day
	Beyond 100 days	Nothing	All costs

TABLE 7.3 (CONTINUED)

Services	Benefit	Medicare Pays	Patient Pays
Home health care Part-time or intermittent skilled care; home health aide services; durable medical equipment and supplies; and other services	Unlimited as long as patient meets Medicare requirements for home health care benefits	100% of approved amount for services; 80% of approved amount for durable medical equipment	Nothing for services; 20% of approved amount for durable medical equipment
Hospice care Pain relief; symptom management and support services for the terminally ill	For as long as doctor certifies need	All but limited cost for outpatient drugs and inpatient respite care	Limited cost sharing for outpatient drugs and inpatient respite care
Blood When furnished by a hospital or skilled nursing facility during a covered stay	Unlimited during a benefit period if medically necessary	All but first 3 pints per calendar year	For first 3 pints***

* Sixty reserve days may be used only once.

** Neither Medicare nor Medigap insurance pays for most nursing home care.

*** To the extent that three pints of blood are paid for or replaced under one part of Medicare during the year, they do not have to be paid for or replaced under the other part.

Part B (Medical)

Services	Benefit	Medicare Pays	Patient Pays
Medical expenses Physician services; in/outpatient medical and surgical services and supplies; physical, occupational, and speech therapy; diagnostic tests; and durable medical equipment	Unlimited services if medically necessary, except for the services of independent physical and occupational therapists	80% of approved amount after $100 deductible; 50% of approved amount for most outpatient mental health services; up to $720 a year each for independent physical and occupational therapy	$100 deductible, 20% of approved amount after deductible, charges above approved amount; 50% for most outpatient mental health services; 20% of first $1,500 for each independent physical and occupational therapy and all charges thereafter each year
Clinical laboratory services Blood tests; urinalysis; and more	Unlimited, if medically necessary	Generally 100% of approved amount	Nothing for services

(continued)

TABLE 7.3 (CONTINUED)

Services	Benefit	Medicare Pays	Patient Pays
Home health care Part-time or intermittent skilled care; home health aide services; durable medical equipment and supplies; and other services	Unlimited, as long as patient meets Medicare conditions	100% of approved amount for services; 80% of approved amount for durable medical equipment	Nothing for services; 20% of amount Medicare approved for durable medical equipment
Outpatient hospital treatment Services for the diagnosis or treatment of an illness or injury	Unlimited, if medically necessary	Medicare payment to hospital based on hospital costs	No less than 20% of the Medicare payment amount
Blood	Unlimited, if medically necessary	80% of approved amount (after $100 deductible and starting with 4th pint)	First 3 pints plus 20% of approved amount for additional pints

Medicare Supplemental Insurance Policies

Although Medicare covers many health care costs, individuals still have to pay Medicare's coinsurance and deductibles. Also, Medicare does not cover many services. However, there are many types of private health insurance/coverage that one can buy to supplement, or fill in the gaps. Supplemental insurance will pay for some or all of the health care costs that are not covered by Medicare. Private supplemental health insurance/coverage includes employee or retiree coverage that may be provided from a person's employer or union, as well as Medicare supplemental insurance policies that are sold by private insurance companies. Medigap and Medicare Select are two such Medicare Policies.

Medigap Insurance

Medigap is private insurance designed to help pay for Medicare cost-sharing amounts. There are 10 standard Medigap policies, and each offers a different combination of benefits. (See Table 7.4 for a chart of the 10 standard Medigap plans.) The best time to buy a policy is during Medigap's open-enrollment period. For a period of six months from the date an individual is first enrolled in Medicare Part B and is 65 years of age or older, he or she has the right to purchase the Medigap policy of their choice. This is the open-enrollment period. During this time, the individual may not be turned down or charged higher premiums because of poor health. Once the Medigap open enrollment period ends, the individual may not be able to buy the policy of his or her choice and may have to accept whatever Medigap policy an insurance company is willing to sell him or her.

TABLE 7. 4 CHART OF THE 10 STANDARD MEDIGAP SUPPLEMENTAL PLANS

Medicare supplemental insurance, also known as Medigap, can be sold in only 10 standard plans. This chart shows the benefits included in every plan. Every company must make available Plan A. Some of the plans may not be available in every state. Premiums may vary greatly from one company to another. Insurance companies use three methods to calculate premiums: issue age, attained age, and age rating.

Basic benefits that are included in all plans include the following:

- Hospitalization: Part A deductible coinsurance plus coverage for 365 additional days after Medicare benefits end.
- Medical expenses: Part B coinsurance (generally 20 percent of Medicare-approved expenses).
- Blood: First three pints of blood each year.

Plan A	Plan B	Plan C	Plan D	Plan E	Plan F	Plan G	Plan H	Plan I	Plan J
Basic benefit	Basic benefit	Basic benefit	Basic benefit	Basic benefit	Basic benefit	Basic benefit	Basic benefit	Basic benefit	Basic benefit
		Skilled nursing coinsurance	Skilled nursing coinsurance	Skilled nursing coinsurance	Skilled nursing coinsurance	Skilled nursing coinsurance	Skilled nursing coinsurance	Skilled nursing coinsurance	Skilled nursing coinsurance
	Part A deductible	Part A deductible	Part A deductible	Part A deductible	Part A deductible	Part A deductible	Part A deductible	Part A deductible	Part A deductible
		Part B deductible			Part B deductible				Part B deductible
					Part B excess (100%)	Part B excess (100%)		Part B excess (100%)	Part B excess (100%)
		Foreign travel emergency	Foreign travel emergency	Foreign travel emergency	Foreign travel emergency	Foreign travel emergency	Foreign travel emergency	Foreign travel emergency	Foreign travel emergency
			At-home recovery			At-home recovery		At-home recovery	At-home recovery
							Basic drug benefit ($1,250 limit)	Basic drug benefit ($1,250 limit)	Basic drugv benefit ($1,250 limit)
				Preventive care					Preventive care

TABLE 7.5 CHART OF STATE HEALTH INSURANCE ASSISTANCE PROGRAM

Call the appropriate State Health Insurance Assistance Program (SHIP) numbers in this table if you need help with the following: the purchase of a Medigap policy, payment denials or appeals, Medicare rights and protections, complaints concerning care or treatment, choice of a Medicare health plan, or the administration of Medicare billings.

SHIP	Phone Number	SHIP	Phone Number
Alabama	(800) 243-5463	Arizona	(800) 432-4040
Alaska	(907) 269-3680	Arkansas	(800) 224-6330
American Samoa	(888) 875-9229	California	(800) 434-0222

(continued)

SHIP	Phone Number	SHIP	Phone Number
Colorado	(888) 696-7213	New Hampshire	(603) 225-9000
Connecticut	(860) 424-5245	New Jersey	(609) 588-3139
Connecticut (in state only)	(800) 994-9422	New Mexico	(505) 827-7640
Delaware	(302) 739-6266	New York	(800) 333-4114
District of Columbia	(202) 739-0668	North Carolina	(919) 733-0111
Florida	(800) 963-5337	North Dakota	(800) 247-0560
Georgia	(800) 669-8387	Northern Mariana Islands	(888) 875-9229
Guam	(888) 875-9229	Ohio	(800) 686-1578
Hawaii	(888) 875-9229	Oklahoma	(405) 521-6628
Idaho	(208) 334-4350	Oregon	(503) 947-7263
Illinois	(217) 785-9021	Pennsylvania	(800) 783-7067
Indiana	(317) 233-3475	Puerto Rico	(787) 721-8590
Iowa	(800) 351-4664	Rhode Island	(401) 222-2880
Kansas	(316) 337-7386	South Carolina	(803) 898-2850
Kentucky	(502) 564-2347	South Dakota	(605) 773-3656
Louisiana	(225) 342-5301	Tennessee	(800) 525-2816
Maine	(207) 623-1797	Texas	(800) 252-9240
Maryland	(410) 767-1100	Utah	(801) 538-3910
Massachusetts	(617) 727-7750	Vermont	(802) 748-5182
Michigan	(800) 803-7174	Virgin Islands	(340) 778-6311,
Minnesota	(800) 333-2433		ext. 2338
Mississippi	(800) 948-3090	Virginia	(800) 552-3402
Missouri	(800) 390-3330	Washington	(800) 397-4422
Montana	(406) 444-7781	West Virginia	(877) 987-4463
Nebraska	(800) 234-7119	Wisconsin	(800) 242-1060
Nevada	(800) 307-4444	Wyoming	(800) 856-4398

Medicare Select

Medicare Select is another form of Medicare supplemental health insurance sold by insurance companies and health maintenance organizations (HMOs) throughout most of the country. Medicare Select is the same as standard Medigap insurance in nearly all respects. The only difference is that each insurer has specific hospitals, and in some cases specific doctors, that the individual must use, except in an emergency, to be eligible for full benefits. Medicare Select policies generally have lower premiums than other Medigap policies because of this requirement.

Medicare + Choice: Information, Eligibility, Enrollment, and Timeline

Scope of Coverage

Medicare + Choice plans, except Medical Savings Accounts (MSAs) (described below), must provide coverage for the services currently available under Medicare Parts A and B.

These plans must also inform participants about the availability of hospice care. Medicare + Choice plans may offer supplemental benefits, for which an additional premium may be charged; however, the separate premium may not vary among individuals within the plan and must not exceed certain actuarial and community rating standards. The Balanced Budget Act of 1997 requires the secretary of the Department of Health and Human Services (DHHS) to establish standards, regulations, and rules for Medicare + Choice that are consistent with existing standards and regulations governing the Medicare program.

Eligibility

Beneficiaries must be eligible for *both* Parts A and B to enroll in a Medicare + Choice Plan. Individuals diagnosed with a terminal illness or ESRD are ineligible to participate. In general, individuals covered by federal employee health benefits plans or plans through the Veterans Administration or Department of Defense may not enroll in MSAs until policies are determined regarding these groups.

Medicare + Choice includes the following components:

1. *Traditional, fee-for-service Medicare.* This includes Parts A and B.
2. *Coordinated care plans.* These are managed care plans, which include health maintenance organizations (HMOs), preferred provider organizations (PPOs), and provider sponsored organizations (PSOs). The plans provide coverage for health care services, with or without a point-of-service option (the ability to use the plan or out-of-plan health care providers). Some plans limit the enrollee's choice of providers; some plans may offer such benefits as prescription drug coverage, in addition to those in the traditional program. Other plans may offer benefits, such as "supplemental coverage," for which an additional premium may be charged. Coverage details are complicated, and every plan must be considered carefully.
3. *Combination of medical savings accounts and Medicare + Choice high-deductible plans.* This complex and experimental project combines a health insurance plan carrying a high deductible ($6,000 in 1999) with a special savings account called a medical savings account (MSA). Every MSA participant is required to purchase a high-deductible health insurance plan. The plan pays either all medical expenses or all Medicare-covered services after the deductible is met. Medicare designates a sum of money for each MSA participant according to a statutory formula. Medicare takes some of this money to pay the premium for the high-deductible insurance plan. After the premium is paid, Medicare deposits any monies that remain into the participant's MSA account. These plans do not provide coverage until the participant has met the deductible. Money in the MSA may be used for any medical expenses, either before or after the deductible has been satisfied. The law does require that enough money be in the MSA to meet a portion of the deductible until it has been met each year. If there is extra money in the account, it may be used for nonmedical purposes; however, a tax penalty will be imposed on nonmedical withdrawals from an MSA. This program is limited to 390,000 participants nationwide. The pilot project extends from 1999 through 2002, unless Congress renews it. This option must be carefully considered, especially because participants must pay for $6,000 in medical expenses before the associated health insurance will reimburse for any medical expenses. Federal retirees and beneficiaries for whom the Medicare cost-sharing is paid by any form of Medicaid are excluded from this plan.

4. *Private fee-for-service contract plans.* This portion of the plan allows Medicare beneficiaries to enter into private contracts with a provider, a group of providers, or a network of providers. These contracts are totally outside the Medicare program, and no Medicare payment is made under these arrangements. The beneficiary must pay all costs in accordance with a contract made with the provider. In addition, the provider of services must agree in writing not to bill Medicare for any services for two years. Providers must disclose to the beneficiary that Medicare limits on balance billing will not apply and that Medicare supplemental policies may not pay benefits on such claims. Also, the contract must clearly state that beneficiaries may seek medical care from other providers who have not entered into private contracts and who are, therefore, permitted to bill Medicare for services.
5. *Religious and fraternal benefit plans.* Fraternal and religious organizations may offer Medicare + Choice plans. Enrollment in these plans is restricted to members of the organization. Plans must meet Medicare solvency standards, and Medicare may adjust payment amounts to meet the characteristics of the individuals enrolled.
6. *Department of Defense demonstration plans.* Medicare treats a military installation as a type of coordinated care plan. Demonstration projects take place on six sites.

Annual Enrollment Period

Beneficiaries receive information about Medicare + Choice annually in October of each year. The HCFA is required to mail all beneficiaries information about the Medicare + Choice plans in their area 15 days before the start of the election period.

In November of any given year, beneficiaries are required to make a choice about their health care coverage. Beneficiaries who fail to make an election will remain in the original Medicare program; individuals who are already covered in an HMO or other plan will also remain in that plan if they fail to make a different election.

Coverage for the following year becomes effective each January. Beneficiaries will be able to enroll or disenroll in plans through the end of 2001. During the first six months of 2002, beneficiaries will be entitled to one change during the year. After that time, beneficiaries will be permitted to change their option once a year and only during the first three months of the year. The only exceptions to the year-long "lock in" requirements will be if (1) the beneficiary moves from the plan's service area, (2) the plan no longer serves Medicare beneficiaries, or (3) the beneficiary can prove that the plan is not complying with its contract and that the beneficiary was injured by the noncompliance. Medicare + Choice plans may not deny enrollment to eligible individuals based on their health status or certain other factors. Individuals who elect an MSA must remain in that plan for at least one year. The following table shows the timeline.

Timeline

January 2001	MSA becomes effective
October 2001	Handbooks are sent to beneficiaries
November 2001	Annual enrollment period
January 2002	Effective date for all changes. Beneficiaries are "locked in" to choice for this year; disenrollment is permitted only during the first six months of 2002
January 2003	Beneficiaries are locked in to a choice for the year; disenrollment is permitted only during the first three months of 2003 and later years

Other Common Medicare Questions

Who Pays First?

Medicare is not always the primary payer of health care bills. Sometimes other insurers are required to pay before Medicare. Medicare will not make primary payment:

- If the individual has group health insurance based on his or her own, or the spouse's, current employment.
- For cases in which no-fault insurance or liability insurance is available as the primary payer.
- For services related to a worker's compensation claim or injury that can be made under a worker's compensation law.
- For services that are covered under the Federal Black Lung program.

If an individual can receive both Medicare and veterans' benefits, he or she may choose to receive treatment under either program.

What Is Assignment?

A patient should always ask the physicians and medical suppliers whether they accept assignment. If they do, they accept the amount Medicare approves for a particular service or supply and do not charge the individual more than the deductible and 20 percent coinsurance. This can mean significant savings for the elderly person.

Limiting Charge

Federal law prohibits a physician who does not accept assignment from charging more than 15 percent above Medicare's approved amount. Any overcharges must be refunded.

Other Charge Limits

Doctors who do not accept assignment for elective surgery are required to give the patient a written estimate of the costs before the surgery if the total charge will be $500 or more. If the patient is not provided a written estimate, he or she is entitled to a refund of any amount paid in excess of the Medicare-approved amount for the surgery performed.

Participating Doctors and Suppliers

To avoid excess charges, patients should consider doctors and medical suppliers who accept assignment. Some do on a case-by-case basis. Others, called participating doctors and suppliers, sign agreements to accept assignment of all Medicare claims. The names of these physicians and suppliers may be obtained by calling the Medicare carrier for each state. Table 7.6 is a listing of phone numbers of Medicare carriers and other resources.

TABLE 7.6 MEDICARE RESOURCE DIRECTORY

State	Medicare Carrier	End Stage Renal Disease Network	Insurance Information	Peer Review Organization	Durable Medical Equip. Carrier
Alabama	(800) 292-8855	(601) 936-9260	(800) 243-5463	(800) 760-3540	(800) 583-2236
Alaska	(800) 444-4606	(206) 923-0714	(800) 478-6065	(800) 445-6941	(800) 899-7095
Arizona	(800) 444-4606	(800) 783-8818	(800) 432-4040	(800) 359-9909	(800) 899-7095
Arkansas	(800) 428-5525	(800) 472-8664	(800) 224-6330	(800) 272-5528	(800) 583-2236
California	(800) 675-2266 (800) 952-8627	(800) 637-4767 (800) 232-3773	(800) 434-0222	(800) 841-1602	(800) 899-7095
Colorado	(800) 332-6681	(800) 783-8818	(888) 696-7213	(800) 727-7086	(800) 583-2236
Connecticut	(800) 982-6819	(860) 509-7400	(800) 994-9422	(800) 553-7590	(800) 842-2052
Delaware	(800) 444-4606	(800) 548-9205	(800) 336-9500	(800) 422-8804	(800) 842-2052
District of Columbia	(800) 444-4606	(804) 794-3757	(202) 739-0668	(800) 645-0011	(800) 270-2313
Florida	(800) 333-7586	(813) 251-8686	(800) 963-5337	(800) 844-0795	(800) 583-2236
Georgia	(800) 727-0827	(919) 788-8112	(800) 669-8387	(800) 979-7217	(800) 583-2236
Guam	(800) 444-4606	(415) 472-8590	(888) 875-9229	(800) 524-6550	(800) 899-7095
Hawaii	(800) 444-4606	(415) 472-8590	(888) 875-9229	(800) 524-6550	(800) 899-7095
Idaho	(800) 342-8900	(206) 923-0714	(800) 247-4422	(800) 445-6941	(800) 899-7095
Illinois	(800) 642-6930	(317) 257-8265	(800) 548-9034	(800) 647-8089	(800) 270-2313
Indiana	(800) 622-4792	(317) 257-8265	(800) 452-4800	(800) 288-1499	(800) 270-1313
Iowa	(800) 532-1285	(816) 880-9990	(800) 351-4664	(800) 752-7014	(800) 899-7095
Kansas	(800) 633-1113	(816) 880-9990	(800) 860-5260	(800) 432-0407	(800) 899-7095
Kentucky	(800) 999-7608	(317) 257-8265	(877) 293-7447	(800) 288-1499	(800) 583-2236
Louisiana	(800) 462-9666	(405) 843-8688	(800) 259-5301	(800) 433-4958	(800) 583-2236
Maine	(800) 882-1128	(203) 387-9332	(800) 750-5353	(800) 722-0151	(800) 842-2052
Maryland	(800) 444-4606	(804) 794-3757	(800) 243-3425	(800) 492-5811	(800) 270-2313
Massachusetts	(800) 882-1228	(203) 387-9332	(800) 882-2003	(800) 252-5533	(800) 842-2052
Michigan	(800) 482-4045	(651) 644-9877	(800) 803-7174	(800) 365-5899	(800) 270-2313
Minnesota	(800) 352-2762	(651) 644-9877	(800) 333-2433	(800) 444-3423	(800) 270-2313
Mississippi	(800) 682-5417	(601) 936-9260	(800) 948-3090	(800) 844-0600	(800) 583-2236
Missouri	(800) 392-3070	(816) 880-9990	(800) 390-3330	(800) 347-1016	(800) 899-7095
Montana	(800) 332-6146	(206) 923-0714	(800) 322-2272	(800) 497-8232	(800) 899-7095
Nebraska	(800) 633-1113	(816) 880-9990	(800) 234-7119	(800) 247-3004	(800) 899-7095

(continued)

TABLE 7.6 (*CONTINUED*)

State	Medicare Carrier	End Stage Renal Disease Network	Insurance Information	Peer Review Organization	Durable Medical Equip. Carrier
Nevada	(800) 444-4606	(303) 831-8818	(800) 307-4444	(800) 748-6773	(800) 899-7095
New Hampshire	(800) 882-1228	(203) 387-9332	(800) 852-3388	(800) 772-0151	(800) 842-2052
New Jersey	(800) 462-9306	(609) 490-0310	(800) 792-8820	(800) 624-4557	(800) 842-2052
New Mexico	(800) 423-2925	(303) 831-8818	(800) 432-2080	(800) 279-6824	(800) 583-2236
New York	(800) 442-8430 (800) 252-6550	(212) 289-4524	(800) 333-4114	(800) 331-7767	(800) 842-2052
North Carolina	(800) 672-3071	(919) 788-8112	(800) 443-9354	(800) 722-0468	(800) 583-2236
North Dakota	(800) 247-2267	(651) 644-9877	(800) 247-0560	(800) 472-2902	(800) 899-7095
Ohio	(800) 848-0106	(317) 257-8265	(800) 686-1578	(800) 589-7337	(800) 270-2313
Oklahoma	(800) 522-9079	(405) 843-8688	(800) 763-2828	(800) 522-3414	(800) 583-2236
Oregon	(800) 444-4606	(206) 923-0714	(800) 722-4134	(800) 344-4354	(800) 899-7095
Pennsylvania	(800) 382-1274	(412) 647-3428	(800) 783-7067	(800) 322-1914	(800) 842-2052
Puerto Rico	(800) 981-7015	(609) 490-0310	(877) 725-4300	(800) 981-5062	(800) 583-2236
Rhode Island	(800) 662-5170	(203) 387-9332	(800) 322-2880	(800) 662-5062	(800) 842-2052
South Carolina	(800) 868-2522	(919) 788-8112	(800) 868-9095	(800) 922-3089	(800) 583-2236
South Dakota	(800) 437-4762	(651) 644-9877	(800) 822-8804	(800) 658-2285	(800) 899-7095
Tennessee	(800) 342-8900	(601) 936-9260	(800) 525-2816	(800) 489-4633	(800) 583-2236
Texas	(800) 442-2620	(972) 503-3215	(800) 252-9240	(800) 725-8315	(800) 583-2236
Utah	(800) 426-3477	(303) 831-8818	(800) 541-7735	(800) 274-2290	(800) 899-7095
Vermont	(800) 882-1228	(203) 387-9332	(800) 642-5119	(800) 772-0151	(800) 842-2052
Virginia	(800) 444-4606	(804) 794-3757	(800) 552-3402	(800) 545-3814	(800) 270-2313
Virgin Islands	(800) 474-7448	(609) 490-0310	(340) 778-6311	(340) 712-2400	(800) 583-2236
Washington	(800) 444-4606	(206) 923-0714	(800) 397-4422	(800) 445-6941	(800) 899-7095
West Virginia	(800) 848-0106	(804) 794-3757	(877) 987-4463	(800) 642-8686	(800) 270-2313
Wisconsin	(800) 944-0051	(651) 644-9877	(800) 242-1060	(800) 362-2320	(800) 270-2313
Wyoming	(800) 442-2371	(303) 831-8818	(800) 856-4398	(800) 497-8232	(800) 899-7095

What Is Not Covered?

Many medical services and items are not covered by Medicare. They include, but are not limited to, routine physicals, most dental care, dentures, routine foot care, hearing aids, and most prescription drugs. Eyeglasses are covered only if corrective lenses are needed following a cataract operation. However, some Medicare + Choice

plans cover some of these services which motivates individuals to choose Medicare + Choice over the traditional fee-for-service option.

Second Opinions

Medicare pays the same way for a second opinion as it pays for other doctor services as long as the patient is seeking advice for the treatment of a medical condition covered by Medicare. Medicare also helps pay for a third opinion if the first two contradict each other.

Health Care Outside the United States

Generally, Medicare does not pay for health care obtained outside the United States and its territories, but it may pay for inpatient hospital services in Canada or Mexico with certain restrictions. When in doubt about whether Medicare pays for such services, contact the Medicare carrier.

Medicare and Other Health Care Providers

In addition to helping the elderly pay for care in a hospital or skilled nursing facility, Medicare covers a variety of services at special types of health care facilities, including:

- Ambulatory surgical centers
- Rural health clinics
- Comprehensive outpatient rehabilitation facilities
- Community mental health centers
- Federally qualified health centers
- Certified medical laboratories

Most physician services covered by Medicare must be provided by either a doctor or doctor of osteopathy. Medicare generally does not pay for routine services provided by optometrists, podiatrists, dentists, or chiropractors. However, in some cases, care from these professionals may be covered. Also, in some cases, Medicare covers services from nurse anesthetists, clinical nurse specialists, nurse practitioners, physical and occupational therapists, physicians' assistants, clinical social workers, and clinical psychologists (see Table 7.7).

Preventive Care Under Medicare

Medicare helps pay for a limited number of preventive services, including flu and pneumonia shots. Medicare also helps pay for the hepatitis B vaccine if an individual is at high risk for contracting the disease. Medicare provides coverage for mammograms, pap smears, colorectal screening, diabetic glucose monitoring and bone mass density screening.

Qualified Medicare Beneficiaries

The Qualified Medicare Beneficiaries program pays all Medicare's premiums, deductibles, and coinsurance amounts for certain elderly and disabled persons entitled to Medicare Part A whose annual income is at or below the national poverty level and whose savings and other resources are very limited.

Medicare Compare

Medicare Compare is an interactive database for Medicare managed care beneficiaries and people involved in their care. Medicare Compare provides easy access to information about Medicare-managed care plans, including costs, premiums, and types of services provided. The data in this database is provided by the Medicare managed care plans and verified by the HCFA. During the coming years, as more elderly people become enrolled in Medicare HMOs and other managed care plans, this data will be a resource for the CPA. CPAs will be able to use the data to help their clients make the best choices about their health care. This database can be accessed at www.medicare.gov.

Nursing Home Compare

Nursing Home Compare is another Internet tool to increase the quality of care in nursing homes. It is an interactive database designed for Medicare beneficiaries and other professionals to access comparison information about nursing homes. It contains information on every Medicare and Medicaid-certified nursing home in the country, including over 17,000 facilities nationwide. Nursing Home Compare provides contact information for long-term care ombudsmen, state survey agencies, and state health insurance programs. Summary information about facilities' performance and deficiencies during their most recent state inspection, as well as information related to nursing home and resident characteristics, is available. This database can be accessed at www.medicare.gov.

Medigap Compare

Medigap Compare enables users to search for private health insurance plans they can purchase to supplement Medicare. Visitors search by state or zip code to obtain current information about policies available in their area. This service can be accessed at www.medicare.gov.

Medicare Beneficiary Outreach Calendar

This calendar displays upcoming activities for beneficiaries, such as health fairs or presentations, on a variety of Medicare topics in their area. Information can be found at www.medicare.gov.

TABLE 7.7 WHERE TO GET HELP WITH MEDICARE QUESTIONS

The Medicare Bill

If you have a question about . . .	Then you should call . . .
Recognizing and reporting Medicare fraud and abuse	Office of the Inspector General, at (800) 447-8477
Your bill or Medicare coverage for doctors, outpatient care, or other medical services	State Medicare carrier (See state carrier listings in Table 7.6.)
How to understand medical bills	Insurance information, counseling and assistance programs (See state insurance listings in Table 7.6.)
A lost Medicare card	Social Security Administration (800) 772-1213

(continued)

TABLE 7.7 WHERE TO GET HELP WITH MEDICARE QUESTIONS (*CONTINUED*)

Managed Care Plans

If you have a question about . . .	Then you should call . . .
Choosing a managed care plan, deciding between fee-for-service Medicare and managed care, or understanding the new Medicare + Choice program	Insurance information, counseling and assistance programs (See state insurance listings in Table 7.6.)
Local seminars and health fairs on the new Medicare + Choice Program	Health Care Financing Administration (HCFA) regional office (See HCFA regional listings in Table 7.2.)
Whether you can continue to see your doctor if you join a managed care plan	Your doctor

Getting Medicare, Other Health Insurance, Other Benefits

If you have a question about . . .	Then you should call . . .
Social Security benefits, Supplemental Security Income, applying/enrolling in Medicare, or the Medicare amount deducted from Social Security check	Social Security administration, at (800) 772-1213
Eligibility for Medicare or a Medicare claim	State Medicare carrier (See state carrier listings in Table 7.6.)
How or whether to purchase additional health insurance (Medigap, LTC policy)	Insurance information, counseling, and assistance programs (See state insurance listings in Table 7.6.)
Medigap or Medicare Select policies available in your area	State insurance departments (See state insurance listings in Table 7.6.)

Complaints, Appeals, and Other Medicare Rights

If you have a question about . . .	Then you should call . . .
Understanding how to appeal payment denials, your Medicare rights and protections, or how to submit a complaint about medical care	Insurance information, counseling and assistance programs (See state insurance listings in Table 7.6.)
The quality of care from your doctor, hospital, nursing home, or managed care plan	Quality improvement organization (See state peer review listings in Table 7.6.)
The quality of care from a kidney dialysis facility	End Stage Renal Disease (ESRD) Network Organization (See state ESRD listings in Table 7.6.)
Any complaint you want to report directly to the HCFA	Your HCFA regional office (See HCFA regional listings in Table 7.2.)

Additionally, each state's insurance counseling office can answer questions about Medicare and other health insurance. Services are free. A state-by-state listing of counseling office telephone numbers is provided in Table 7.6.

Additional Tips for the ElderCare Practitioner

In order to facilitate the large amount of accounting paperwork that exists with Medicare administration, the following tips are useful.

- Your client has a right to file an appeal if you think Medicare should have paid for, or did not pay enough for, an item or services. See Table 7.6 for contact numbers. Additionally, appeal rights are located on the back of the Explanation of Medicare Benefits or Medicare Summary Notice that is mailed to the patient from a company that handles bills for Medicare. The notice will also tell why Medicare did not pay the bill, and will provide information on the appeal process.
- Do not make it a practice to send Medicare claim numbers over the Internet, and do not provide your client's Medicare claim number to anyone except Medicare health professionals.
- Protect your client's medical records from any unauthorized party.
- Make sure your client is not billed for health care services or medical supplies and equipment that was not provided by a medical practitioner.
- To obtain a new Medicare card for your client, call the Social Security Administration at (800) 772-1213. If your client receives benefits from the Railroad Retirement Board, call (800) 808-0772, or the local RRB office.
- You can call (800)-MEDICARE and request a copy of the following free booklets to facilitate your practice.
  - — *Medicare and Your Mental Health Benefits*
  - — *Medicare Coverage of Kidney Dialysis and Kidney Transplant Services*
  - — *Medicare Coverage of Skilled Nursing Facility Care*
  - — *Getting a Second Opinion Before Surgery*
  - — *Medicare Home Health Services*
  - — *Medicare Hospice Benefits*
  - — *Medicare Preventive Services*
  - — *Your Guide to Choosing a Nursing Home*
  - — *Choosing a Doctor (Hospital) (Treatments)*
  - — *Health Plan Comparison Information*
  - — *Understanding Your Medicare Choices*
  - — *2001 Guide to Health Insurance for People with Medicare*
  - — *Your Guide to Private Fee-for-Service Plans*
  - — *Your Guide to Medicare Medical Savings Accounts*
  - — *Worksheet for Comparing Medicare Health Plans*
  - — *Medicare Appeals and Grievances*
  - — *Medicare Fraud and Abuse*
  - — *Medicare Patient Rights*
  - — *Medigap Policies and Protections*
  - — *Do You Need Help to Pay Health Care Costs?*
  - — *Does Your Doctor or Supplier Accept Assignment?*

— *Medicare and Other Health Benefits: Your Guide to Who Pays First*

— *Your Guide to the Outpatient Prospective Payment System.*

Finally, the Handbook *Medicare and You*, located at www.medicare.gov, has a tremendous amount of additional information to further facilitate Medicare administration.

What Exactly Is www.medicare.gov?

The site www.medicare.gov is the official Internet site for Medicare consumer information. It is designed with the beneficiary in mind to offer a variety of useful and easy-to-read information about Medicare, health plans, nursing homes, and more. The site was designed especially for Medicare beneficiaries and the people involved in their care decisions; it provides credible, up-to-date, and easy to read information about Medicare. It includes search tools that allow users to customize information on various Medicare topics, including current health plans, nursing homes, health fairs, and Medigap plans. Also included are state-specific contact information and phone numbers for a variety of Medicare topics, including receiving Medicare, understanding the Medicare bill, Medicare rights, benefits, dealing with complaints and appeals, managed care, and Medicare fraud. The site provides information in English, Spanish, and Chinese.

MEDICAID

The Medicaid program was established to provide health insurance to low-income individuals. Currently, Medicaid provides services for more than 10 million elderly and disabled individuals and pays for approximately 50 percent of all nursing home care in America.

This program can be a significant resource to families who need assistance for their elderly relatives. Every state program is different and each has its own regulations. Understanding the basics of the Medicaid program in your state is an important task.

Overview of the Medicaid Program

(Adapted from materials published by the Health Care Financing Administration and the U.S. Department of Health and Human Services)

Who Does Medicaid Serve?

Recent statistics indicate that Medicaid serves more than 4.4 million elderly persons and 5.9 million blind and disabled individuals, as well as more than 18.7 million children and 7.6 million adults who care for these children.

What Services Does the Medicaid Program Purchase?

All states cover a minimum set of services, including hospital, physician, and nursing home services. States have the option of covering an additional 31 services, including prescription drugs, hospice care, community-based long-term care, and personal care services. Medicaid is the largest insurer of long-term care for all Americans, including the middle class. Medicaid covers 68 percent of nursing home residents and more than 50 percent of nursing home costs, as well as skilled nursing facility care, intermediate care facilities, and home and community-based services. Although most long-term care spending is for institutional care, Medicaid has made great strides in shifting the

delivery of services to home and community settings, which enable larger numbers of elderly people to live more independently in their homes for longer periods of time. For many of the elderly, such services help delay or avoid admission to nursing homes.

How Much Does Medicaid Cost?

Medicaid expenditures amount to over $150 billion per year. The states pay approximately 40 percent and the federal government pays approximately 60 percent. The federal government contributes between 50 percent and 80 percent of the payments made under the states' programs, depending on the average per capita income in each state.

Medicaid and Medicaid Planning

Many CPAs have limited experience with the rules, regulations, and penalties of the Medicaid program and Medicaid transfers. Some practitioners believe it unlikely that they will ever have a "Medicaid client." However, as the population ages and large numbers of older Americans seek assistance in paying for nursing home care and community-based long-term care services, possessing a knowledge of current Medicaid guidelines will be important to practitioners dealing with elderly clients and their families. The prudent approach for any practitioner is to maintain a high level of knowledge about the program, understand how Medicaid planning may affect other estate and tax planning efforts, and acknowledge the liability presented when the practitioner makes recommendations regarding Medicaid. An association with a knowledgeable and experienced elder law attorney can offer valuable assistance in this area of practice.

A major issue for CPAs, lawyers, financial planners, and individuals is the rule related to Medicaid eligibility concerning penalties for the transfer of assets. Part of the Kennedy-Kassenbaum Bill that guaranteed the portability of health insurance included a section now referred to as the "Granny goes to jail" law. This law became effective January 1, 1997, and provided for the criminal liability of elderly people who make transfers of assets for the purpose of achieving Medicaid eligibility.

Public Law 105-33 (H.R. 1025) of the Balanced Budget Act of 1997 (effective August 5, 1997) amended S. 217 of the previous law by removing the threat of criminal liability from seniors and placing it on anyone who, for a fee, counsels or assists a Medicaid applicant to make transfers of assets for the purpose of achieving Medicaid eligibility. Thus, the counseling or assisting is the crime, even though the transfers themselves may be legal.

The law reads as follows:

> Whoever . . .
>
> > (6) for a fee knowingly and willfully counsels or assists an individual to dispose of assets (including by any transfer in trust) in order for the individual to become eligible for medical assistance under a State plan under Title XIX, if disposing of the assets results in the imposition of a period of ineligibility for such assistance under Section 1917(c) shall . . . (ii) in the case of such a failure, conversion, or provision of counsel or assistance by any other person, be guilty of a misdemeanor and upon conviction thereof fined not more than $10,000 or imprisoned for not more than one year, or both.

In March 1998, the U.S. attorney general, in a letter to both houses of Congress, later explained that she declined to enforce the "Granny goes to jail" law. She noted that advice provided to elderly clients might be perfectly legal and that the person receiving the counsel might, in fact, have every right to follow the advice without fear of repercussions. The law, the attorney general wrote, would "prohibit attorneys and other professional advisers from counseling their clients to engage in an estate-planning strategy that itself is lawful." The attorney general further wrote that she was required to inform the Congress that the Department of Justice would not bring any criminal prosecutions under the current version of the section. In April 1998, a federal judge barred the government from enforcing the law.

This amendment is considered an effort to generally discourage and punish certain transfers of property that are seen as abusive manipulations of Medicaid eligibility regulations. Medicaid and Medicaid planning is a complicated issue, and practitioners are encouraged to obtain expert advice before advising clients in this area. Additional information and assistance may be obtained from the state Medicaid office or from the HCFA. (See Table 7.8 for state Medicaid office phone numbers.)

TABLE 7.8 MEDICAID ASSISTANCE BY STATE FOR NURSING HOME AND COMMUNITY-BASED LONG-TERM CARE PROGRAMS

State	General Information	Other
Alabama	(800) 362-1504	(800) 824-6584
Alaska	(800) 211-7470	(907) 465-3355
Arizona	(800) 654-8713	(800) 417-7100
Arkansas	(800) 482-8988	(800) 482-5431
California	(800) 952-5253	(888) 452-8609
Colorado	(800) 221-3943	(800) 688-7777
Connecticut	(800) 443-9946	(800) 994-9422
Delaware	(800) 372-2022	(800) 464-4357
District of Columbia	(202) 727-0735	(202) 783-2118
Florida	(888) 419-3456	Check county listings
Georgia	(800) 282-4536	(800) 246-2757
Hawaii	(800) 518-8887	None
Idaho	(800) 926-2588	(800) 685-3757
Illinois	(800) 252-8635	(217) 782-0963
Indiana	(800) 545-7763	(800) 433-0746
Iowa	(800) 338-9154	(800) 338-8366
Kansas	(800) 766-9012	(800) 933-6593
Kentucky	(800) 752-6200	(800) 372-2991
Louisiana	(225) 342-3891	(800) 327-3419

TABLE 7.8 (*CONTINUED*)

State	General Information	Other
Maine	(800) 321-5557	None
Maryland	(800) 332-6347	(800) 685-5861
Massachusetts	(800) 841-2900	(888) 665-9993
Michigan	(800) 642-3195	(800) 292-2550
Minnesota	(800) 657-3739	(800) 657-3672
Mississippi	(800) 421-2408	None
Missouri	(800) 392-2161	(800) 392-1261
Montana	(800) 332-2272	(800) 362-8312
Nebraska	(800) 358-8802	(800) 652-1999
Nevada	(800) 992-0900	None
New Hampshire	(800) 852-3345	(800) 351-1888
New Jersey	(800) 776-6334	(800) 356-1561
New Mexico	(800) 432-6217	(888) 997-2583
New York	(800) 206-8125	(800) 342-3009
North Carolina	(800) 662-7030	None
North Dakota	(800) 755-2604	None
Ohio	(800) 324-8680	(800) 686-6108
Oklahoma	(800) 522-0310	(800) 767-3949
Oregon	(800) 273-0557	(800) 336-6016
Pennsylvania	(800) 932-0939	(800) 692-7462
Rhode Island	(401) 462-5300	(401) 462-1300
South Carolina	(800) 834-1640	(800) 763-9087
South Dakota	(605) 773-6383	None
Tennessee	(800) 669-1851	None
Texas	(800) 834-7406	(800) 252-8263
Utah	(800) 662-9651	None
Vermont	(800) 250-8427	(800) 917-7787
Virginia	(800) 884-9730	(800) 552-8627
Washington	(800) 562-3022	(800) 562-6188
West Virginia	(800) 642-8589	(800) 688-5810
Wisconsin	(800) 362-3002	(800) 888-7989
Wyoming	(800) 996-8678	(800) 251-1269

Estate Recovery Provision

(Adapted from materials published by the Health Care Financing Administration and the U.S. Department of Health and Human Services)

Beneficiaries are notified of the Medicaid Estate Recovery Program during their initial application for Medicaid eligibility and annual predetermination process. Individuals in medical facilities who do not return home are sent a notice of action by their county department of social services informing them of any intent to place a lien or claim on their real property. The notice also informs them of their appeal rights. Estate recovery procedures are initiated after the beneficiary's death.

The Omnibus Budget Reconciliation Act (OBRA) of 1993 defines estates and requires every state to seek adjustment or recovery of amounts correctly paid by the state for certain Medicaid beneficiaries. The state must, at a minimum, seek recovery for services provided to a person of any age in a nursing facility, intermediate care facility, or other medical institution. The state may, at its option, recover amounts up to the total amount spent on the individual's behalf for medical assistance or other services under the state's plan. For individuals age 55 and older, states are required to seek recovery of payments from the individual's estate for nursing facility services, home and community-based services, and related hospital and prescription drug services. States have the option of recovering payments for all other Medicaid services provided to these individuals.

In addition, states that had state plans approved after May 1993 that disregarded assets or resources of persons with long-term care insurance policies must recover all Medicaid costs for nursing facility and other long-term care services from the estate of persons who had such policies. California, Connecticut, Indiana, Iowa, and New York are not required to seek adjustment or recovery from a person's estate who had a long-term care insurance policy. These states are exempt from seeking recovery from long-term care insurance policies. For all other individuals, these states are required to comply with the estate-recovery provisions as specified. States are also required to establish procedures, under standards specified by the secretary, for waiving estate recovery when recovery would cause an undue hardship.

Treatment of Trusts

(Adapted from materials published by the Health Care Financing Administration and the U.S. Department of Health and Human Services)

If an individual, a spouse, or anyone else acting on the individual's behalf establishes a trust using at least some of the individual's funds, that trust can be considered available to the individual for the purpose of determining eligibility for Medicaid. In determining whether the trust is available, no consideration is given to the purpose of the trust, the trustee's discretion in administering the trust, use restrictions in the trust, exculpatory clauses, or restrictions on distributions.

How a trust is treated depends, to some extent, on what type of trust it is—specifically, whether it is revocable or irrevocable, and what specific requirements and conditions the trust contains. In general, payments actually made to or for the benefit of an individual are treated as income to the person. Amounts that could be, but are not, paid to or for the benefit of the individual, are treated as available resources. Amounts that could be paid to or for the benefit of the individual, but are paid to someone else, are treated as

transfers of assets for less than fair-market value. Amounts that cannot, in any way, be paid to or for the benefit of the individual are also treated as transfers of assets for less than fair-market value.

Certain trusts are not counted as being available to the individual. These are:

1. Trusts established by a parent, grandparent, guardian, or court for the benefit of an individual who is disabled and under the age of 65, using the individual's own funds.
2. Trusts established by a disabled individual, parent, grandparent, guardian, or court for the disabled individual, using the individual's own funds, when the trust is made up of pooled funds and managed by a nonprofit organization for the sole benefit of every individual included in the trust.
3. Trusts composed only of pension, Social Security, and other income of the individual, in states that make individuals eligible for institutional care under a special income level, but do not cover institutional care for the medically needy.

In all these cases, the trust must provide that the state receives any funds, up to the amount of Medicaid benefits paid on behalf of the individual, remaining in the trust when the individual dies. A trust is not counted as a valuable when the state determines that counting the trust would cause an undue hardship. For additional information about how a specific state applies the rules on treatment of trusts, contact the state Medicaid office (see Table 7.8).

Spousal Impoverishment

(Adapted from materials published by the Health Care Financing Administration and the U.S. Department of Health and Human Services)

The expense of nursing home care—which may range from $3,000 to $4,000 per month or more—can rapidly deplete the lifetime savings of elderly couples. In 1988, Congress enacted provisions to prevent what has come to be called "spousal impoverishment," a situation in which the spouse who is still living at home in the community is left with little or no income or resources. These provisions help ensure that this situation will not occur and that spouses are able to live out their lives with independence and dignity in their community.

Resource Eligibility

The spousal impoverishment provisions apply when the member of the couple who is in a nursing facility or medical institution is expected to remain there for at least 30 days. When the couple applies for Medicaid, an assessment of their resources is conducted. The couple's resources are combined and exemptions for the home, household goods, an automobile, and burial funds are made. The result is the "spousal resource amount," which the state determines. The spousal resource amount is the state's minimum resource standard ($17,400 in 2001) or the spousal share, which is equal to one-half of the couple's combined resources not to exceed the maximum permitted by the state ($87,000 in 2001).

To determine whether the spouse residing in a medical facility is eligible for Medicaid, a determination of the couple's total countable resources must be made. All resources held by both spouses are considered to be available to the spouse in the medical facility, except for the "protected resource amount" (PRA). This PRA is the greatest of:

1. The spousal resource amount.
2. The state spousal resource standard, which is the amount that the state has determined will be protected for the community spouse.
3. An amount transferred to the community spouse for his or her support as directed by a court order.
4. An amount designated by a state hearing officer to raise the community spouse's protected resources up to the minimum monthly maintenance needs standard.

The remainder becomes attributable to the spouse that is residing in a medical institution as countable resources. If the amount of the resources is below the state's resource standard, the individual is eligible for Medicaid. Once resource eligibility is determined, resources of the community spouse are not attributed to the spouse in the medical facility.

Income Eligibility

The community spouse's income is not considered available to the spouse who is in the medical facility, and the two individuals are not considered a couple for these purposes. The state is to use the income eligibility standards for one person rather than two.

Posteligibility Treatment of Income

This process is followed after an individual in a nursing facility or medical institution is determined to be eligible for Medicaid. The posteligibility process is used to determine how much the spouse in the medical facility must contribute toward his or her cost of nursing facility or institutional care. This process also determines how much of the income of the spouse who is in the medical facility is actually protected for use by the community spouse. Deductions are made from the total income of the spouse who is residing in the medical facility in the following order:

1. A personal-needs allowance of at least $30 a month
2. The community spouse's monthly income allowance (between $1,406.25 and $2,175 for 2001), as long as the income is actually made available to him or her
3. A family monthly income allowance
4. An amount for medical expenses incurred by the spouse who is in the medical facility

The sum of these deductions, subtracted from the income of the individual who is in the medical facility, is the amount the individual must contribute to his or her cost of care. For additional information concerning federal rules on spousal impoverishment, contact the Medicaid Bureau's Office of Beneficiary Services at (410) 786-3417 or contact your state's Medicaid office directly (See Table 7.8 for Medicaid office phone numbers).

Nursing Facility Services for Individuals Age 21 and Older

(Adapted from materials published by the Health Care Financing Administration and the U.S. Department of Health and Human Services)

Nursing facility services for individuals age 21 and older is a mandatory Medicaid benefit. Nursing facilities are institutions that primarily provide skilled nursing care and related services to residents who require medical or nursing care or rehabilitative services.

A nursing facility that accepts or participates in Medicaid must provide the full range of services for residents who need them. Nursing facilities must meet a number of requirements related to provision of services, residents' rights, and administration. In general, to the extent needed to fulfill all plans of care, a nursing facility must provide, or arrange for the provision of, the following:

- Nursing and related services and specialized rehabilitative services
- Medically related social services
- Pharmaceutical services to meet the needs of each resident
- Dietary services that ensure that the meals meet the nutritional and dietary needs of every resident
- An ongoing program of activities
- Routine dental services
- Treatment and services required by mentally ill and mentally retarded residents

Residents' Rights

Each nursing facility resident has a defined right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility. A facility must protect the rights of each resident, and residents have the right to exercise their rights as both residents of the facility and as citizens of the United States.

Residents have the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising their rights. In the case of a resident adjudged incompetent by a court, the rights of the resident are exercised by a person appointed to act on the resident's behalf. In the case of a resident who has not been adjudged incompetent by a court, a legal-surrogate designated in accordance with state law may exercise the resident's rights to the extent provided by state law. The facility must inform the resident, both orally and in writing, of the resident's rights and all rules and regulations concerning resident conduct and responsibilities during his or her stay in the facility. The resident has the right to access all records pertaining to himself or herself, including current clinical records within 24 hours. The individual has a right to a copy of the records or any portion of the records. The resident has the right to be fully informed of his or her total health status. The resident has the right to refuse treatment, to refuse to participate in experimental research, and to formulate an advance directive.

The facility must inform each Medicaid resident in writing about the items and services that are included in the facility payment for which the resident may not be charged. The facility must disclose other items and services it offers for which the resident may be charged and the cost for those services. The resident must be informed when changes are made to the items, services, and costs.

During the course of a covered Medicaid (or Medicare) stay, facilities may not charge a resident for the following categories of items and services:

- Nursing services
- Dietary services
- An activities program

- Room and bed maintenance services
- Routine personal hygiene items and services
- Medically related social services

Items and Services That May Be Charged to the Resident's Funds

Following is a list of general categories and examples of items and services that the facility may charge to a resident's funds requested by a resident, provided that the facility informs the resident that there will be a charge and if payment is not made by Medicaid or Medicare:

- Telephone
- Personal comfort items
- Cosmetic and grooming items and services
- Personal reading materials
- Flowers and plants
- Noncovered special care services
- Television and radio
- Private room
- Personal clothing
- Gifts
- Social events and entertainment
- Specially prepared and alternative food

The facility may not charge a resident for any item or service not requested by the resident.

Medicaid Payments for Nursing Facility Services

(Adapted from materials published by the Health Care Financing Administration and the U.S. Department of Health and Human Services)

Before 1980, Medicaid and Medicare reimbursed nursing facilities on a retrospective, reasonable-cost basis. In 1980, the Boren amendment was passed, changing the reimbursement method for these services. Under the amendment, a state plan for medical assistance was required to provide for payment of nursing facility services through rates that were reasonable and adequate to meet the costs that must be incurred by efficiently and economically operated providers to provide care and services in conformity with applicable state and federal laws, regulations, and quality and safety standards. In addition, the regulations required states to publish a public notice if the changes made to the state plan amendments were significant.

In 1997, the Balanced Budget Act repealed the Boren requirements and replaced them with a requirement that states implement a public process when changes in payment rates or methodologies are proposed. The new public-process requirement applies to rates established on or after October 1, 1997. The HCFA is in the process of developing regulations regarding the implementation of this change. States have the flexibility to develop Medicaid reimbursement methodologies that conform to the federal laws and

regulations. Consequently, there is no requirement that states develop and use a single payment methodology for all facilities providing nursing services.

Nursing facilities' payments are generally made using one of three payment systems: cost based, per diem, and case mix. There is a greater use of prospective-payment systems (per diem or case mix) than cost-based systems for these services. It is important to note that although the payment systems can be categorized in general terms, the specific methodology varies from state to state. In addition, payment systems within a state may also vary between providers and provider types.

SOCIAL SECURITY

Social Security Update

(Adapted from materials published by the Social Security Administration and the U.S. Department of Health and Human Services)

Through the years, Congress has modified the original Social Security legislation to reflect the economic circumstances of the society it serves. Yearly updates show changes as annual increases in the cost of living or workers' average wages. Whether individuals are still working or are already a Social Security beneficiary, these changes are important. This section provides up-to-date information about the "built-in" changes that take place most years.

Information for People Who Are Working

Social Security and Medicare taxes are as follow:

	2002	*2001*	*2000*
Employee and employer (each)	7.65% up to $84,900	7.65% up to $80,400	7.65% up to $76,200
Self-employed	15.3% up to $84,900	15.3% up to $80,400	15.3% up to $76,200

Extra Medicare taxes may be required if an individual earns more than $84,900 in 2002, he or she continues to pay the Medicare portion of those taxes as indicated here:

	2002	*2001*	*2000*
Employee and employer (each)	1.45% above $84,900	1.45% above $80,400	1.45% above $76,200
Self-employed	2.9% above $84,900	2.9% above $80,400	2.9% above $76,200

Individuals need work credits to be eligible for Social Security benefits. The number of credits needed depends on the person's age and type of benefit claimed. Individuals can earn a maximum of four credits each year. Most people need forty credits to qualify for retirement benefits.

2002	*2001*	*2000*
$870 earns one credit	$830 earns one credit	$780 earns one credit

Information for Social Security Beneficiaries

Social Security beneficiaries under age seventy receive full benefits as long as their earnings are under the limits indicated here:

	2002	*2001*	*2000*
Age 70 or older	No limit on earnings	No limit on earnings	No limit on earnings
Age 65–69	$30,000 For every $3 over the limit, $1 is withheld from benefits.	$25,000 For every $3 over the limit, $1 is withheld from benefits.	$17,000 For every $3 over the limit, $1 is withheld from benefits.
Under age 65	$11,280 For every $2 over the limit, $1 is withheld from benefits.	$10,680 For every $2 over the limit, $1 is withheld from benefits.	$10,080 For every $2 over the limit, $1 is withheld from benefits.

For additional information, call Social Security at (800) 772-1213, 24 hours a day or visit their Web site at www.ssa.gov.

Social Security Basics

(Adapted from materials published by the Social Security Administration and the U.S. Department of Health and Human Services)

The Philosophy of Social Security

The Social Security system provides a minimum "floor of protection" for retired workers and for workers and their families who face a loss of income due to disability or the death of a family wage earner. Social Security payments are based on two underlying philosophies. First, the system clearly links how much a worker pays into the system and how much he or she receives in benefits. Basically, a high-wage earner gets more; lower-wage earners receive less. At the same time, the Social Security benefit formula is weighted in favor of low-wage earners, who have fewer resources to save or invest during their working years. Social Security retirement benefits replace approximately 60 percent of the preretirement earnings of a low-wage earner, 42 percent of the average-wage earner, and 26 percent of a high-wage earner.

Basically, the Social Security program is intended to provide a base of economic security in today's society. It is intended to help elderly and disabled Americans live independently and with dignity and to help relieve families of some of the financial burden they bear for elderly relatives living out their retirement years. Social Security provides a valuable package of disability and survivors insurance to workers over their working lifetimes.

Basic Facts About Social Security

Social Security is part of almost every American's life. Social Security protects more than 142 million workers and pays benefits to 43 million people. An average family may receive $322,000 in survivor's benefits, which are paid to a deceased worker's family. A

widow or widower age fifty or over who is disabled may receive benefits. Social Security also provides disability protection worth more than $200,000 to disabled individuals.

Almost every retiree receives Social Security benefits. More than nine out of 10 Americans who are age 65 or older receive these benefits. Full retirement benefits are now payable at age 65, with reduced benefits available as early as age 62. The age for full benefits will gradually rise in the next century, until it reaches age 67 in 2027 for people born in 1960 or later. Social Security has always been a part of a "three-legged stool" that could solidly support a comfortable retirement. The other two legs of the stool are pension income and savings and investments.

Social Security retirement benefit amounts, as of March 2001, for average wage earners are as follows:

Estimated Average Monthly Social Security Benefits

All Retired Workers	$ 845
Aged Couple, Both Receiving Benefits	$1,410
Widowed Mother and Two Children	$1,696
Aged Widow(er)	$ 811
Disabled Worker, Spouse and One or More Children	$1,310
All Disabled Workers	$ 786

Benefit amounts are based on steady lifetime earnings from age 22 through the year before retirement. Married workers can receive benefits based either on their own work record or that of their spouse, whichever is higher.

Social Security and Supplemental Security Income

When people discuss disability benefits, there is often confusion about Social Security and SSI (Supplemental Security Income). The confusion arises because the Social Security Administration administers both programs. Social Security disability insurance is a program that workers, employers, and the self-employed pay for with their Social Security taxes. Qualification for these benefits is based on work history and the amount for the benefit based on earnings. SSI is a program financed through general tax revenues—not through Social Security trust funds. SSI disability benefits are paid to people who have a disability, own few assets, and have a relatively low income.

Estimate of Social Security Benefits

Individuals can find out how much they can expect to receive from Social Security based on their own earnings record by requesting a Personal Earnings and Benefit Estimate Statement (PEBES) request form. To order the PEBES form, individuals may call (800)772-1213 or request the form on the Social Security Web site at www.ssa.gov.

Social Security Tax Dollars

Generally, out of every dollar paid in Social Security and Medicare taxes:

- Sixty-nine cents goes to a trust fund that pays retirement and survivors benefits.
- Nineteen cents goes to a trust fund that pays Medicare benefits.

- Eleven cents goes to a trust fund that pays disability benefits.
- One cent pays for administering Social Security.
- Reserve funds, estimated at $5 billion per month, are invested in U.S. Treasury bonds.

Veterans' Benefits and Information

(Adapted from materials published by the Veterans Administration)

Eligibility for most Veterans Administration (VA) benefits is based upon discharge from active military service under other than dishonorable conditions. Active service means full-time service as a member of the Army, Navy, Air Force, Marines, Coast Guard, or as a commissioned officer of the Public Health Service, the Environmental Services Administration, or the National Oceanic and Atmospheric Administration. Completion of at least six years of honorable services in the Selected Reserves provides home-loan benefits for those not otherwise eligible.

Honorable and general discharges qualify a veteran for most VA benefits. Dishonorable and bad-conduct discharges issued by general courts martial bar VA benefits. Veterans who are prisoners and parolees may be eligible for certain VA benefits; regional VA offices can clarify this eligibility. Certain VA benefits and medical care require wartime service. As specified by law, the VA recognizes these war periods:

- Mexican Border Period: May 9, 1916, through April 5, 1917
- World War I: April 6, 1917, through November 11, 1918
- World War II: December 7, 1941, through December 31, 1946
- Korean Conflict: June 27, 1950, through January 31, 1955
- Vietnam Era: August 5, 1964, through May 7, 1975
- Persian Gulf War: August 2, 1990, through a date to be set by law or presidential proclamation
- War on Terrorism: Covered under the Persian Gulf War recognition (still current)

A veteran's DD214 Form should be kept in a safe, convenient location accessible to the veteran or designated representative. The veteran's preference regarding burial in a national cemetery and use of a headstone provided by the VA should be documented and kept with this information. The following documents are needed for claims processing related to a veteran's death:

1. Marriage certificate
2. Death certificate
3. Children's birth certificates
4. Veteran's birth certificate for parents

Eligible veterans may receive significant health care and nursing care assistance. Pharmacy services can provide the veteran with substantial savings. For additional information, contact the Veterans Administration (see Table 7.9).

TABLE 7.9 TOLL-FEE VETERANS ADMINISTRATION NUMBERS FOR VETERANS AND DEPENDENTS

VA benefits	(800) 827-1000
Life insurance	(800) 669-8477
Debt-management center	(800) 827-0648
Mammography hotline	(888) 492-7844
Telecommunications device for the deaf	(800) 829-4833
Champva (health insurance)	(800) 733-8387
Headstones and markers	(800) 697-6947
Persian Gulf helpline	(800) PGW-VETS
Sexual trauma hotline	(800) 827-1000
Income verification center	(404) 235-1300 (800) 949-1008
Web site	www.va.gov
Alabama	(334) 213-3581
Alaska	(907) 257-4761
Arizona	(602) 640-4725
Arkansas	(501) 370-3780
California	(310) 235-7588
Colorado	(303) 914-5540
Connecticut	(860) 240-3396
Delaware	(302) 633-5412
District of Columbia	(202) 691-3120
Florida	(727) 319-7900
Georgia	(404) 347-1031
Hawaii	(808) 433-0560
Idaho	(801) 524-5450
Illinois	(312) 353-4005
Indiana	(317) 226-7047
Iowa	(515) 323-2669
Kansas	(316) 688-6842
Kentucky	(502) 582-5836
Louisiana	(504) 619-4360
Maine	(207) 623-8411

(continued)

TABLE 7.9 (*CONTINUED*)

Maryland	(410) 962-4678
Massachusetts	(617) 565-2630
Michigan	(313) 226-4308
Minnesota	(612) 970-5440
Mississippi	(601) 364-7028
Missouri	(314) 589-9881
Montana	(406) 447-7675
Nebraska	(402) 420-4011
Nevada	(775) 784-5650
New Hampshire	(603) 666-7475
New Jersey	(973) 645-2648
New Mexico	(505) 248-6705
New York	(212) 807-7229
North Carolina	(336) 631-5453
North Dakota	(701) 237-2628
Ohio	(216) 522-3534
Oklahoma	(918) 687-2143
Oregon	(503) 326-2622
Pennsylvania	(215) 381-3028
Rhode Island	(401) 528-4426
South Carolina	(803) 255-4242
South Dakota	(605) 333-6845
Tennessee	(615) 736-7136
Texas	(731) 383-3546
Utah	(801) 524-5330
Vermont	(802) 296-5151
Virginia	(540) 857-2424
Washington	(206) 220-6128
West Virginia	(304) 529-5743
Wisconsin	(414) 382-5181
Wyoming	(303) 914-5540

ADVANCE DIRECTIVES

(Adapted from materials published by the Health Care Financing Administration and the U.S. Department of Health and Human Services)

Patients' Rights

All adults in hospitals, skilled nursing facilities, and health care settings have certain rights. For example, individuals have a right to confidentiality of their personal and medical records and to know what treatment they will receive. Individuals also have the right to prepare a document called an "advance directive." In one type of advance directive, individuals state in advance what kind of treatment they want or do not want if they become mentally or physically unable to choose or communicate their wishes. In a second type, the individual authorizes another person to make those decisions if the individual becomes incapacitated.

Federal law requires hospitals, skilled nursing facilities, hospices, home health agencies, and HMOs serving persons covered by either Medicare or Medicaid to provide information about advance directives and explain the legal choices in making decisions about medical care. The law is intended to increase the individual's control over medical treatment decisions. However, state laws governing advance directives differ. The health care provider is required to give information about the laws on advance directives for the state in which the provider is located. If an individual resides in another state, he may wish to gather information about that state's laws from another source, such as the office of the state attorney general.

The Advance Directive

Generally, an advance directive is a written document that states how an individual wants medical decisions made if he or she loses the ability to make his or her own decisions. The two most commonly prepared advance directives are a living will and a durable power of attorney or health care power of attorney.

The value of an advance directive is that it allows a person to state choices for health care or to name someone to make those choices in the event of incapacitation. In other words, an advance directive ensures an individual's right to accept or refuse medical care.

The Living Will

A living will generally states the kind of medical care wanted (or not wanted) if an individual is unable to make his or her own decisions. It is called a living will because it takes effect while the person is still living. Most states have their own living will forms, each somewhat different. It may also be possible to complete and sign a preprinted living will form available in the community or prepare a statement of preferences for treatment. Individuals should consult with their attorney and physician to be certain that they have completed the living will in a way that their wishes will be understood and followed.

The Durable Power of Attorney for Health Care or Health Care Power of Attorney

In many states, a durable power of attorney for health care is a signed, dated, and witnessed paper naming another person, such as a spouse, child, friend, or other party, as the authorized spokesperson to make medical decisions for a person if that person becomes unable to make decisions for himself or herself. Instructions about any treatments

not wanted may also be included in the document. Some states have very specific laws allowing a health care power of attorney and provide printed forms to be used.

Which Is Better: A Living Will or Durable Power of Attorney for Health Care?

Very often, the existing laws in a particular state influence the decision to choose between a living will or a durable power of attorney for health care. It may also be possible to have both or to combine them into a single document that describes treatment choices in a variety of situations and names someone (called an agent or proxy) to make decisions if an individual is unable to make decisions. A physician should be consulted when considering these options.

The law on honoring an advance directive from one state to another is unclear. However, because an advance directive specifies an individual's wishes regarding medical care, it may be honored in any location, if the individual makes it known that he or she has an advance directive. If a great deal of time is spent in a state other than the home state, it may be preferable to have advance directives that meet the laws of both states.

Advance Directives: Not Required and Cancelable at Any Time

No one may be required to prepare an advance directive and, if one is prepared, individuals have the right to change or cancel it at any time. Any change or cancellation should be written, signed, and dated in accordance with state law, and copies should be provided to the physician or others to whom the individual may have given copies of the original. Anyone wishing to cancel an advance directive while in the hospital should notify the physician, family, or others who may need to know. Even without a change in writing, the person's wishes stated in person, directly to the physician, generally carry more weight than a living will or durable power of attorney, as long as the person can make decisions for himself or herself and is able to communicate his or her wishes.

It is important that an individual's attorney or family member knows about the existence of an advance directive and where it is located. The following may also be considered:

- A copy or original durable power of attorney should be given to an agent or proxy.
- The physician should make an advance directive part of the permanent medical record.
- Advance-directive documents should be stored in a safe place where they can be found easily, if needed.
- Individuals should carry a card stating that they have an advance directive, where it is located, and who is the agent or proxy, if one has been named.

Who Should Prepare an Advance Directive?

Individuals may want to consider preparing an advance directive if:

- They want their physician or other health care provider to know the kind of medical care they want or do not want if they become incapacitated.
- They want to relieve family and friends of the responsibility for making decisions regarding life-prolonging actions.

Additional Information

For additional assistance in preparing an advance directive, or for more information, contact a lawyer (an elder law attorney in particular has expertise in this area), a nearby hospital, hospice, long-term care facility, or the state's attorney general's office. See Chapter 10, "Associations, Organizations, Agencies, and Other Resources," for information on the National Academy of Elder Law Attorneys.

The National Family Caregiver Support Program

(Adapted from materials available from the United States Administration on Aging)

The enactment of the Older Americans Act Amendments of 2000 (Public Law 106-501) established an important new program, the National Family Caregiver Support Program (NFCSP). The program was developed by the Administration on Aging (AoA) of the U.S. Department of Health and Human Services (HHS). It was modeled in large part after successful LTC programs in such states as California, New Jersey, Wisconsin and Pennsylvania and after listening to the needs expressed by hundreds of family caregivers in discussions held across the country.

Funded at $125 million in fiscal year 2001, approximately $113 million has been allocated to states through a congressionally mandated formula that was based on a proportionate share of the 70+ population. The program called for all states, working in partnership with area agencies on aging and local community-service providers, to have five basic services for family caregivers, including:

- Information to caregivers about available services
- Assistance to caregivers in gaining access to supportive services
- Individual counseling, organization of support groups, and caregiver training to assist the caregivers in making decisions and solving problems relating to their caregiving roles
- Respite care to enable caregivers to be temporarily relieved from their caregiving responsibilities
- Supplemental services, on a limited basis, to complement the care provided by caregivers

In January 2001, AoA issued guidance to states on the implementation of the new program, and in February 2001, HHS Secretary Tommy G. Thompson announced the release of those funds to states. The conference highlighted innovative and successful state caregiver support initiatives that might warrant replication.

Eligible populations include the family caregivers of older adults as well as grandparents and relative caregivers of children not more than 18 years of age (including grandparents who are sole caregivers of grandchildren and those individuals who are affected by mental retardation or who have developmental disabilities).

The statute requires states to give priority consideration to (1) persons in greatest social and economic need (with particular attention to low-income, minority individuals) and (2) older individuals providing care and support to persons with mental retardation and related developmental disabilities.

The Older Americans Act Amendments of 2000 also established the Native American Caregiver Support Program, with $5 million of the $125 million designated to assist caregivers of Native American elders who are chronically ill or have disabilities. In addition, $6 million of the $125 million will fund competitive innovative grants, grants of national significance, conferences and training, to further develop comprehensive and effective systems of support in family caregiving.

Frequently Asked Questions

1. *Are most of the National Family Caregiver Support Program funds earmarked for respite services?* Funds under the National Family Caregiver Support Program (NFCSP) are not earmarked. Funds may be used to provide the five categories of services authorized: (1) information about services; (2) assistance with access to services; (3) individual counseling, organization of support groups, and caregiver training; (4) respite care; and (5) supplemental services, on a limited basis. States and area agencies have the flexibility to determine the funding allocated to these services. The category of supplemental services is designed to be on a limited basis. As a result, no more than 20 percent of the federal funding should be dedicated to this category. Five percent of the total program allocation is reserved at the national level for competitive innovation grants and activities of national significance, such as program evaluation, training, technical assistance, and research.
2. *Who is eligible to apply for the competitive innovative grants?* As with the discretionary authorization in Title IV, AoA will provide guidance regarding who is eligible to apply for the competitive innovative grants. Since the purpose of these grants is to assist in the development of multifaceted systems of caregiver support, states are likely to be one of the preferred grantees with incentives to include area agencies and others as partners.
3. *If a state already funds a caregiver support program, can funds from such a program be used to match the new federal program? If so, how does this affect the "maintenance of effort" requirements?* A state may use other funds currently used for related programs to match the federal NFCSP so long as such monies are not from other federal sources, such as Medicaid, and are not used to match other programs. The maintenance of effort requirements are met if the overall amount of state and local funding remains at or above what was previously allocated to existing caregiver programs.
4. *Are direct payments to family caregivers allowed with the new National Family Caregiver Support Program?* Direct payments to family caregivers are neither specifically included in, nor precluded by, the statute. As such, payments may be possible for certain services if so defined by the state.
5. *Do the grandchildren who are cared for by grandparents need to have a disability or chronic illness (including those with mental retardation and developmental disabilities) in order to receive services?* No, there is no requirement that the grandchildren have a disability. Under the NFCSP, states may design services for grandparents or older individuals who are relative caregivers. In these instances, the grandparent or relative caregiver must be an older individual (60+), who lives with the child, is the primary caregiver of the child, and has a legal relationship to the child or is raising the child informally. The child must be no more than 18 years old.

As a state determines how to target its services under the caregiver program, it shall give priority to older individuals in greatest social and economic need and older individuals caring for persons with mental retardation and developmental disabilities.

6. *Does the child with mental retardation/developmental disabilities have to be under the chronological age of 19?* Yes, the statute does not provide any distinctions other than the child must be no more than 18 years of age.
7. *Are states required to reserve 10 percent of the funding for services to grandparents?* No. States have the flexibility to determine the expenditures up to a maximum of 10 percent, to provide support services to grandparents and older individuals who are relative caregivers of children age 18 and under. States may design intrastate funding formula allocations that vary the proportion of funding among area agencies. It is conceivable that such a formula could be designed that would allocate the majority of funding to certain area agencies within the state.
8. *Can states reserve funds to conduct a caregiver demonstration in one geographic area of the state?* No. Funds under Title III-E must be allocated via an intrastate funding formula to area agencies on aging.
9. *Can the needs of other caregivers be addressed through the NFCSP?* The NFCSP was developed as an initial effort to meet the needs of a segment of the caregiver population. For fiscal year 2001, it was funded at $125 million and was designed to begin to address the needs of caregivers. As part of the program's original design, options were identified for expanding the population of caregivers to be covered. As the program matures, outcomes are generated, and—most important—as additional resources become available, consideration will be given to expanding the program to other groups of persons requiring and providing care.

Contact Information

The National Aging Network

Under the authority of the Older Americans Act, AoA works closely with the national network of aging organizations to plan, coordinate, and provide home and community-based services to meet the unique needs of older persons and their caregivers. AoA's aging network includes 56 state units on aging, 655 area agencies on aging (AAA), 225 tribal and native organizations representing 300 American Indian and Alaska Native tribal organizations and two organizations serving Native Hawaiians, plus thousands of service providers, adult care centers, caregivers, and volunteers.

The Local AAA

The local AAA is one of the first resources a caregiver should contact when help is needed. Almost every state has one or more AAA, which serves local communities, older residents, and their families. (In a few states, the state unit or office on aging serves as the AAA.) Local AAA's are generally listed in the city or county government sections of the telephone directory under "Aging" or "Social Services." For more information on the implementation of the NFCSP in a particular state, contact the State Unit on Aging. Contact information for State Unit on Aging staff is available at www.aoa.gov/aoa/pages/state.html (see Table 7.10).

TABLE 7.10 STATE AGENCIES ON AGING

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AMERICAN SAMOA

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Government of American Samoa
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GUAM

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Chicago Office: Phone: (312) 814-2630
Fax: (312) 814-2916
In-state toll-free senior helpline: (800) 252-8966
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Glossary of Medicare Terms

(Adapted from materials published by the Health Care Financing Administration and the U.S. Department of Health and Human Services)

This glossary explains terms in the Medicare program, but it is not a legal document. The official Medicare program provisions are found in the relevant laws, regulations, and rulings.

Abuse (Personal)

When another person knowingly does something that causes you mental or physical harm or pain.

Access, or Accessibility of Services

Your ability to get needed medical care and services when you need them.

Accreditation

A seal of approval by a private, independent group based on a type of evaluation rating.

Act, Law, or Statute

Legislation that has passed through Congress and has been signed by the President, or passed over the President's veto, and has become law.

Activities of Daily Living (ADLs)

Activities you usually do during a normal day. Although definitions differ, ADLs are usually considered to be everyday activities, such as walking, getting in and out of bed, dressing, bathing, eating, and using the bathroom.

Actual Charge

The amount of money a doctor or supplier charges for a certain medical service or supply, which is often more than the amount Medicare approves. (*See also* Approved Amount; Assignment.)

Adjusted Average Per Capita Cost (AAPCC)

An estimate of how much Medicare will spend in a year for an average beneficiary. (*See also* Risk Adjustment.)

Adjusted Community Rating (ACR)

A way that premium rates are decided based on community members' (and not individual) use of benefits.

Administrative Law Judge (ALJ)

A hearings officer who presides over appeal disagreements between providers of services for beneficiaries and Medicare contractors.

Admitting Physician

The doctor responsible for admitting you to a hospital or other inpatient health facility.

Advance Beneficiary Notice (ABN)

A notice that a doctor or supplier is required to give a Medicare beneficiary to sign in the following cases:

- Your doctor gives you a service that he or she knows or believes that Medicare does not consider medically necessary; and
- Your doctor gives you a service that he or she knows or believes that Medicare will not pay for.

If you do not get an ABN to sign before you get the service from your doctor, and Medicare does not pay for it, you are not responsible for paying for that service. If the doctor does give you an ABN, which you agree to sign before you get the service, and Medicare does not pay for it, you will have to pay your doctor for the service. ABN applies only if you are in the Original Medicare Plan. It does not apply if you are in a Medicare managed care plan. (*See also* Original Medicare Plan.)

Advance Directives

Your statement, which can be in the form of a living will, tells others how you would like to receive health care, including routine treatments and life-saving methods, if you are unable to say so yourself. You can also choose someone to act on your behalf to make medical decisions if you are unable to do so (durable, or health care power of attorney).

Advocate

A person who gives you support or protects your rights.

Affiliated Provider

A health care provider or facility that is paid by a health plan to give services to health plan members.

Ambulatory Care

All types of health services that do not require an overnight hospital stay.

Ambulatory Surgical Center

A free-standing facility or separate part of a hospital that does outpatient surgery.

Ancillary Services

Professional services in a hospital or other inpatient health program. These may include X-ray, drug, laboratory, or other services.

Annual Election Period

The annual election period for Medicare beneficiaries is the month of November each year. Medicare health plans enroll eligible beneficiaries into available health plans during the month of November each year. Starting in January 2002, this is the only time that most current Medicare beneficiaries will be able to switch to or join a new Medicare health plan. (*See also* Election Periods.)

Appeals Process

The process you use if you disagree with any decision about your health care services. If Medicare does not pay for an item or service you have been given, or if you are not given a service you think you should get, you can have the initial Medicare decision reviewed again. If you are in the Original Medicare Plan, your appeal rights are on the

back of the Explanation of Medicare Benefits (EOMB) or Medicare Summary Notice (MSN) that is mailed to you from a company that handles bills for Medicare. If you are in a Medicare managed care plan, you can file an appeal if your plan will not pay for, does not allow, or stops a service that you think should be covered or provided. The Medicare managed care plan must tell you in writing how to appeal. See your plan's membership materials or contact your plan for details about your Medicare appeal rights. (*See also* Organization Determination.)

Approved Amount

The fee Medicare sets as reasonable for a medical service covered under Medicare Part B (Medical Insurance). It may be less than the actual amount charged. Approved amount is sometimes also called "approved charge." (*See also* Actual Charge; Assignment.)

Area Agency on Aging (AAA)

State and local aging programs that help older people plan and care for their life-long needs, such as adult day health care, skilled nursing care or therapy, transportation, personal care, respite care, and meals.

Assessment

The rating or evaluation of your health and needs while you're in a nursing home.

Assignment

In the Original Medicare Plan, a process through which a doctor or supplier agrees to accept the amount of money Medicare approves for their fees as payment in full. You must pay any coinsurance amount. (*See also* Actual Charge; Approved Amount.)

Assisted Living Facility (ALF)

A homelike place with staff who look after and give 24-hour-per-day care to residents, including help with dressing, bathing, feeding, and housekeeping. Assisted Living Facilities usually give less care than you would get in skilled nursing facilities. Medicare does not cover care in an ALF.

Basic Benefits (Medigap)

The name given to the benefits in Medigap Plan A. They are also included in all other Medigap plans. (*See also* Medigap.)

Beneficiary

The name for a person who has health care insurance through the Medicare or Medicaid program.

Benefit Period

The way that Medicare measures your use of hospital and skilled nursing facility services. A benefit period begins the day you go to a hospital or skilled nursing facility. The benefit period ends when you have not received hospital or skilled nursing care for 60

days in a row. If you go into the hospital after one benefit period has ended, a new benefit period begins. You must pay the inpatient hospital deductible for each benefit period. There is no limit to the number of benefit periods you can have.

Benefits

The money or services offered to a beneficiary by an insurance policy. In Medicare or a health plan, benefits take the form of health care.

CAHPS (Consumer Assessment of Health Plans Study)

A yearly nationwide survey that reports information on Medicare beneficiaries' experiences and satisfaction with receiving care in managed care plans. The results are shared with Medicare beneficiaries and the public.

Capitation

The amount of money paid to a health plan or doctor that is used to cover the cost of a plan member's health care services for a certain length of time.

Care Plan

A plan written for your care when you are in a nursing home. The plan tells what services you will get to reach and keep your best possible physical, mental, and social well being.

Carrier

A private company that has a contract with Medicare to pay your Medicare Part B bills.

Case Management

A process used by a doctor, nurse, or chosen health professional to manage your health-related matters. Case management makes sure that needed services are given, and keeps track of the use of facilities and resources.

Case Manager

A nurse, doctor, or social worker who works with patients, doctors, nurses, and insurance companies to arrange all services that are necessary to provide proper health care to a patient or group of patients.

Catastrophic Illness

A very serious and costly condition that could be life threatening or cause life-long disability. The cost of medical services alone for this type of serious condition could cause you financial hardship.

Certified Registered Nurse Anesthetist

A nurse who is trained and licensed to give anesthesia, which is used during surgery and causes complete or partial loss of feeling.

Champus

The Civilian Health and Medical Program run by the Department of Defense to give medical care to the dependents of active duty members of the military and to retired members of the military (now called TriCare).

Claim

A claim is a request for payment for a provided service. *Claim* and *bill* are used for all Part A and Part B services billed through Fiscal Intermediaries; *claim* is used for Part B physician/supplier services billed through the carrier.

Cognitive Impairment

A loss or breakdown in a person's mental state that may affect a person's moods, fears, anxieties, and ability to think clearly.

Coinsurance

The percent of the Medicare-approved amount that you have to pay after you pay the deductible for Part A and/or Part B. In the Original Medicare Plan, the coinsurance payment is a percentage of the cost of the service (for example, 20 percent).

Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985

Among other things, this law requires an employer to allow you to remain covered under the employer's group health plan for a certain length of time after losing your job, after reducing your work hours, after the death of your spouse, or after getting a divorce. You may have to pay both your share and the employer's share of the premium.

Coordination of Benefits—Clause

A written statement that tells which plan or insurance policy will pay first if two health plans or insurance policies cover the same benefits. If one of the plans is a Medicare health plan, federal law may decide who pays first.

Copayment

In some Medicare health plans, this is the amount that you pay for each medical service you get, like a doctor visit. In the Medicare program, a copayment is usually a set amount you pay for a service, like $5 or $10 for a doctor visit.

Cost Sharing

The cost for medical care that you pay yourself, such as a copayment, coinsurance, or deductible.

Creditable Coverage

A way that prior health insurance coverage you may have had can be used to meet preexisting condition restrictions in a new insurance policy.
(*See also* Preexisting Conditions.)

Custodial Care

Personal care, such as bathing, cooking, and shopping, that is not covered by the Medicare program.

Deductible

The amount you must pay for health care, before Medicare begins to pay. There is a deductible for each benefit period for Part A, and each year for Part B. These amounts can change every year.

Deficiency (Nursing Home)

A way to show that a nursing home failed to meet one or more federal or state requirements.

Diagnosis Related Groups (DRGs)

A way to pay hospitals based on diagnosis, age, sex, and complications.

Discharge Planning

The process that social workers or other health professionals use to decide what a patient needs to make a smooth transition from one level of care to another, such as from a hospital to a nursing home or to home care. Discharge planning may also include the services of home health agencies to help with the patient's home care.

Disenroll

Leaving or ending your health care coverage with a health plan.

Dual Eligibles

Persons who are entitled to Medicare (Part A and/or Part B) who are also eligible for some form of Medicaid benefit.

Durable Medical Equipment (DME)

Medical equipment that is ordered by a doctor for use in the home. These items must be reusable, such as walkers, wheelchairs, or hospital beds. DME is paid for under Medicare Part B.

Elder Law

The group of laws that deal with rights and issues related to the health, finances, and well-being of the elderly.

Eldercare

Public and private programs, formal and informal support systems, government laws, and funding methods that help meet the needs of the elderly, including housing, home care, pensions, Social Security, long-term care, health insurance, and elder law.

Election

Your decision to enroll in or disenroll from the Original Medicare plan or a Medicare + Choice plan.

Election Periods

Time when an eligible person may elect the Original Medicare plan or a Medicare + Choice plan. There are four types of election periods in which you may enroll in and disenroll from Medicare health plans: Annual Election Period, Initial Coverage Election Period, Special Election Period, and Open Enrollment Period.

Annual Election Period: The Annual Election Period is the month of November each year. Medicare health plans enroll eligible beneficiaries to available health plans during the month of November each year. Starting in January 2002, this is the only time that most current Medicare beneficiaries will be able to switch to or join a new Medicare health plan.

Initial Coverage Election Period: The three months immediately before you are entitled to Medicare Part A and enrolled in Part B. If you choose a Medicare health plan during your Initial Coverage Election Period, the plan must accept you. The only time a plan can deny your enrollment during this period is when it has reached its limit of members, as approved by the Health Care Financing Administration. The Initial Coverage Election Period is different from the Initial Enrollment Period.

Special Election Period: You are given a Special Election Period to change Medicare+Choice plans or to return to Original Medicare in certain situations, which include: you make a permanent move outside the service area, the Medicare+Choice organization breaks its contract with you, or does not renew its contract with HCFA, or other exceptional conditions determined by HCFA. The Special Election Period is different from the Special Enrollment Period.

Open Enrollment Period: A set time that you may join or enroll in a Medicare health plan if the health plan is open and accepting new members. If a health plan chooses to be open, it must allow all eligible beneficiaries to join or enroll.

Eligibility/Medicare Part A

You are eligible for premium-free (no cost) Medicare Part A (Hospital Insurance) if (1) you are 65 or older and you are receiving, or are eligible for, retirement benefits from Social Security or the Railroad Retirement Board; (2) you are under 65 and you have received Social Security disability benefits for 24 months; (3) you are under 65 and you have received Railroad Retirement disability benefits for the prescribed time and you meet the Social Security Act disability requirements; (4) you or your spouse had Medicare-covered government employment; or (5) you are under 65 and have End-Stage Renal Disease.

Eligibility/Medicare Part B

You are automatically eligible for Part B if you are eligible for premium-free Part A. You are also eligible if you are age 65 or older, a resident of the United States, and a citizen or an alien lawfully admitted for permanent residence. In this case, you must have lived in the United States continuously during the five years immediately before the month during which you enroll in Part B.

Emergency Care

Care to treat severe pain, an injury, sudden illness, or suddenly worsening illness that you believe may cause serious danger to your health if you do not get immediate medical care. Medicare health plans must provide access to emergency care services 24 hours a day, seven days a week. Your plan must pay for your emergency care and cannot require prior approval for emergency care you receive from any provider. You can receive emergency care anywhere in the United States. Under the Original Medicare Plan, you can always go to any hospital of your choice, not only in an emergency.

Employer Group Health Plan (GHP)

A GHP is a health plan that provides health coverage to employees, former employees, and their families, and is supported by an employer or employee organization.

End-Stage Renal Disease (ESRD)

Permanent kidney failure that is treated with regular dialysis or a kidney transplant.

Enrollment, Medicare Part B

You must choose to keep Part B. There are three periods that you can make a choice about Part B: Initial Enrollment Period, General Enrollment Period, and Special Enrollment Period.

Initial Enrollment Period: This is the first chance you have to enroll in Part B. Your initial enrollment period starts three months before you first meet all the eligibility requirements for Medicare and continues for seven months.

General Enrollment Period: January 1 through March 31 of each year. Your Part B coverage is effective July 1 after the general enrollment period in which you enroll.

Special Enrollment Period: You can use this only if you have not taken Part B during the initial enrollment period, because you or your spouse currently work and have group health plan coverage through your current employer or union. You can sign up at any time you are covered under the group plan. If the employment or group health coverage ends, you have eight months to sign up. The eight-month special enrollment period starts the month after the employment ends or the group health coverage ends, whichever comes first.

The cost of Part B may go up 10 percent for each 12-month period that you could have had Part B but did not take it.

Episode of Care

Health care services given during a certain period of time, usually during a hospital stay.

Excess Charge

The difference between a doctor's or other health care provider's actual charge and the Medicare-approved payment amount, up to the limiting charge, which you are responsible for paying if the doctor or provider does not accept assignment.

Exclusions, Medicare

Items or services that Medicare does not cover, such as prescription drugs, long-term care, and custodial care in a nursing or private home.

Exclusions, Medigap

Items or services that Medigap generally does not cover, such as custodial care.

Exclusion Period

A period of time of up to six months when an insurance company can refuse to cover a preexisting condition. (*See also* Preexisting Condition.)

Explanation of Medicare Benefits (EOMB)

A notice that is sent to you after the doctor files a claim for Part B services under the Original Medicare Plan. This notice explains what the provider billed for, the approved amount, how much Medicare paid, and what you must pay. This is being replaced by the Medicare Summary Notice (MSN), which sums up all services over a certain period of time, generally monthly. (*See also* Medicare Summary Notice; Medicare Benefits Notice.)

Federally Qualified Health Center (FQHC)

Health centers that have been approved by the government for a program to provide low cost health care. Medicare pays for some health services in FQHCs that are not usually covered, such as preventive care. FQHCs include community health centers, tribal health clinics, migrant health services, and health centers for the homeless.

Fee Schedule

A complete listing of fees used by either a government or private health care plan to pay doctors and/or other providers on a fee-for-service basis.

Fiscal Intermediary

A private company that has a contract with Medicare to pay Part A (hospital) bills. (Also called "intermediary.")

Fiscal Year

For Medicare, a year-long period, which runs from October 1 through September 30 of the next year. The government and some insurance companies follow a budget that is planned for a fiscal year.

Formulary

A list of certain drugs and their proper dosages. In some Medicare health plans, doctors must order or use only drugs listed on the plan's formulary.

Fraud and Abuse

Fraud: To purposely bill for services that were never given or to bill for a service that has a higher reimbursement than the service provided.

Abuse: Sending in claims or bills for services that should not be paid by Medicare or Medicaid. This is not the same as fraud.

Free Look, Medigap

A period of time (usually 30 days) during which you can try out a Medigap policy. During this time, if you are not pleased with the policy or if you change your mind about wanting the coverage, the policy can be canceled and you will get your money back.

Freedom of Information Act (FOIA)

A special law that requires the U.S. government to give out certain information to the public when it receives a written request. FOIA applies only to records of the executive branch of the federal government, not to those of the Congress or federal courts, and does not apply to state governments, local governments, or private groups.

Gag Rule Laws

Special laws that require health plans to allow doctors to tell their patients complete health care information, including about treatments not covered by the health plan. The laws make it illegal to include "gag" clauses in doctor contracts. These gag clauses limit a doctor's ability to give information to their patients about all treatment choices for a health problem.

Gaps

Also called Medicare gaps, these are the costs or services that are not paid for under the Original Medicare Plan.

Gatekeeper

In a managed care plan, this is another name for the primary care doctor who gives you basic medical services and who coordinates proper medical care and referrals.

General Enrollment Period (GEP)

The GEP is January 1 through March 31 of each year. If you enroll in Part B during the GEP, your Part B coverage is effective on July 1. (*See also* Enrollment.)

Gerontology

The field of study and learning relating to older people and the process of aging.

Grievance

Complaints about the way your Medicare health plan is providing your care (other than complaints concerning your request for a service or payment), such as cleanliness of the health care facility, problems calling the plan by phone, staff behavior, or operating hours.

Group or Network HMO

A health plan that contracts with group practices of doctors to provide health care services in one or more places.

Guaranteed Renewable Policy

A Medigap policy that your insurance company must allow you to continue, unless you do not pay your premiums.

Health Care Financing Administration (HCFA)

The federal agency within the Department of Health and Human Services that runs the Medicare, Medicaid, Clinical Laboratories (under CLIA program), and Children's Health Insurance programs, and works to make sure that the beneficiaries in these programs are able to get high-quality health care.

Health Employer Data and Information Set (HEDIS)

A set of standard performance measures that can give you information about the quality of a health plan. You can get information on the effectiveness of care, access, cost, and other measures you can use to compare the quality of managed care plans. The National Committee for Quality Assurance (NCQA) collects HEDIS data. (*See also* National Committee for Quality Assurance.)

Health Insurance Portability and Accountability Act of 1996 (HIPAA)

The Health Insurance Portability and Accountability Act of 1996 includes important protections for employed persons and their families who have preexisting medical conditions, or possible discrimination in health coverage based on a person's past or present health. The law also does the following: limits the way group health plans and insurance companies can use preexisting medical conditions to keep you from getting health coverage; under most circumstances, gives you credit for prior health coverage; may give you special enrollment rights in group health coverage when you lose coverage or have a new dependent; and generally, guarantees your right to renew your health coverage. HIPAA does not replace the states' role as primary regulators of insurance.

Health Maintenance Organization (HMO)

A group of doctors, hospitals, and other health care providers who have agreed to provide care to Medicare beneficiaries in exchange for a fixed amount of money from Medicare every month. In an HMO, you usually must get all your care from the providers that are part of the plan.

Health Maintenance Organization (HMO) with a Point of Service Option (POS)

A type of managed care plan that allows you to use doctors and hospitals outside the plan for an additional cost.

Home Health Agency

An organization that provides home care services, including skilled nursing care, physical therapy, occupational therapy, speech therapy, and care by home health aides.

Home Health Care

Health care that is given at home, such as physical therapy or skilled nursing care. It is different from at-home recovery care, which is help with bathing, eating, and other daily living activities. (*See also* Activities of Daily Living.)

Hospice

A special way of caring for people with a terminal illness that provides medical, emotional, and social help in a comfortable and familiar place, usually the patient's own home. Hospice care is covered by Medicare whether you are in the Original Medicare Plan or another Medicare health plan.

Hospital Insurance (Part A)

The part of Medicare that covers hospice care, home health care, skilled nursing facilities, and inpatient hospital stays.

Information, Counseling, and Assistance Program

See State Health Insurance Assistance Program.

Initial Coverage Election Period

The three months immediately before you are entitled to Medicare Part A and enrolled in Part B. If you choose a Medicare health plan during your Initial Coverage Election Period, the plan must accept you unless it has reached its limit in number of members as approved by the Health Care Financing Administration. The Initial Coverage Election Period is different from the Initial Enrollment Period.

Initial Enrollment Period

The initial enrollment period (IEP) is the first chance a person has to enroll in Part B. Your IEP starts three months before you first meet all the eligibility requirements for Medicare and continues for seven months.

Insolvency

A legal decision that means a health plan no longer has the money or other means to stay open and give health care to patients.

Intermediary

A private company that contracts with Medicare to pay Medicare (Part A) bills. (Same as "fiscal intermediary.")

Instrumental Activities of Daily Living

More advanced than ADLs, instrumental activities of daily living include meal preparation, shopping, money management, telephone use, doing housework, and taking medications.

Lifetime Reserve Days, Medicare

Sixty days that Medicare will pay for when you are put in a hospital for more than 90 days. These sixty reserve days can be used only once during your lifetime. For each lifetime reserve day, Medicare pays all covered costs except for a daily coinsurance ($396 and $406 for 2001 and 2002, respectively).

Limiting Charge

The highest amount of money you can be charged by doctors and other health care providers who do not accept assignment for a covered service. The limit is 15 percent over Medicare's approved payment amount. The limiting charge only applies to certain services. (*See also* Approved Amount; Assignment.)

Long-Term Care

Custodial care provided at home or in a nursing home for people with chronic disabilities and prolonged illnesses. Long-term care is not covered by Medicare.

Long-Term Care Ombudsman

A supporter for nursing home patients who works to solve problems between patients and nursing homes. These are also called "ombudsman."

Malnutrition

A health problem caused by the lack (or too much) of needed nutrients.

Managed Care Plan

A group of doctors, hospitals, and other health care providers who have agreed to give health care to Medicare beneficiaries in exchange for a fixed amount of money from Medicare every month. Managed care plans include health maintenance organizations (HMO), HMOs with a point of service option (POS), provider sponsored organizations (PSO), and preferred provider organizations (PPO).

Mediate

To settle differences between two parties.

Medicaid

A joint Federal and State program that helps with medical costs for people with low incomes and limited resources. Medicaid programs vary from State to State, but most health care costs are covered if you qualify for both Medicare and Medicaid.

Medical Insurance (Part B)

The part of Medicare that covers doctors' services, outpatient hospital care, and other medical services that Part A does not cover, such as physical and occupational therapy.

Medical Underwriting

The process that a company uses to decide whether or not to take your application for insurance, and how much to charge you for that insurance.

Medically Necessary

Services or supplies that: are proper and needed for the diagnosis or treatment of your medical condition; are provided for the diagnosis, direct care, and treatment of your medical condition; meet the standards of good medical practice in the medical community of your local area; and are not mainly for the convenience of you or your doctor.

Medicare

The federal health insurance program for people age 65 or older, certain younger people with disabilities, and people with End-Stage Renal Disease (those with permanent kidney failure who need dialysis or a transplant, sometimes called ESRD).

Medicare Assistance Programs

Medicaid programs that help pay Medicare out-of-pocket expenses.

Medicare Benefits Notice

A notice you get after your doctor files a claim for Part A services under the Original Medicare Plan. This notice explains what the provider billed for, the approved amount, how much Medicare paid, and what you must pay. You might also get an Explanation of Medicare Benefits (EOMB) (for Part B services) or a Medicare Summary Notice (MSN). (*See also* Explanation of Medicare Benefits; Medicare Summary Notice.)

Medicare Carrier

A private company that contracts with Medicare to process Medicare Part B bills.

Medicare + Choice

A new Medicare program that allows for more choices among Medicare health plans. Everyone who has Medicare Parts A and B is eligible, except those who have End-Stage Renal Disease.

Medicare Coverage

Medicare coverage is made up of two parts: Hospital Insurance (Part A) and Medical Insurance (Part B).

Medicare Medical Savings Account Plan (MSA)

A Medicare health plan option made up of two parts. One part is a Medicare MSA Health Insurance Policy with a high deductible. The other part is a special savings account where Medicare deposits money to help you pay your medical bills.

Medicaid Only Dual Eligibles (Non-QMB, -SLMB, -QDWI, -QI-1, nor -QI-2)

Medicare beneficiaries who are entitled to Medicare Part A and/or Part B and qualify for full Medicaid benefits.

Medicare Part A (Hospital Insurance)

Medicare hospital insurance that pays for hospice care, home health care, care in a skilled nursing facility, and inpatient hospital stays. (*See also* Hospital Insurance.)

Medicare Part B (Medical Insurance)

Medicare medical insurance that helps pay for doctors' services, outpatient hospital care, and other medical services that are not covered by Part A. (*See also* Medical Insurance.)

Medicare Secondary Payer

Any situation where another health plan, such as a retiree group health plan, pays your medical bills before Medicare.

Medicare SELECT

A type of Medigap policy that must meet all of the requirements that apply to a standard Medigap policy. You may be required to use doctors and hospitals within its network in order to be eligible for full benefits.

Medicare Summary Notice (MSN)

A notice you receive after the doctor files a claim for Part A and Part B services under the Original Medicare Plan. This notice explains what the provider billed for, the approved amount, how much Medicare paid, and what you must pay. You might also get a notice called an Explanation of Medicare Benefits (EOMB) for Part B services. (*See also* Explanation of Medicare Benefits; Medicare Benefits Notice.)

Medigap

Medicare supplemental insurance policies that are sold by private insurance companies to Medicare beneficiaries to fill the "gaps" in Original Medicare Plan coverage. There are 10 standardized policies, labeled Plan A through Plan J. Your state decides which of the 10 policies can be sold in your state. Medigap policies only work with the Original Medicare Plan. (*See also* Gaps; Supplemental Insurance.)

National Committee for Quality Assurance (NCQA)

A nonprofit organization that accredits and measures the quality of care in Medicare health plans by using the Health Employer Data and Information Set (HEDIS) data reporting system. HEDIS uses the same measures for all Medicare health plans. (*See also* Health Employer Data and Information Set.)

Neglect

A term used for situations when caretakers do not give a person in their care the goods or services that are needed to avoid physical and mental harm, or illness.

Network

A group of doctors, hospitals, pharmacies, and other health care experts who work under a contract with a health plan to take care of its members.

Nonparticipating Physician

A doctor or supplier who does not accept assignment on Medicare claims.

Notice of Medicare Benefits

Statements that Medicare sends you to show what action was taken on a claim (*See also* Explanation of Medicare Benefits; Medicare Benefits Notice; Medicare Summary Notice.)

Nurse Practitioner (NP)

A state licensed registered nurse with training beyond basic nurse education, allowing the nurse to provide primary care services.

Nursing Facility

The general term for a place that provides nursing care, services to help with healing after an injury or hospital stay, or custodial care.

Occupational Therapy

Services given to help you return to usual activities (such as bathing, preparing meals, housekeeping) after an illness either on an in- or out-patient basis.

Ombudsman

A supporter for nursing home patients who works to solve problems between patients and nursing homes. Also called "Long-Term Care Ombudsman."

Open Enrollment Periods

A set time that you may join or enroll in a Medicare health plan if the health plan is open and accepting new members. If a health plan chooses to be open, it must allow all eligible beneficiaries to join or enroll. (*See also* Election Periods.)

Open Enrollment (Medigap)

A one-time only, six-month period after you enroll in Medicare Part B, and are 65 or older, when you can buy any Medigap policy you want. You cannot be denied coverage or be charged more because of your past or present health problems or claims history.

Organization Determination

A decision by a health plan on whether to pay all or part of a bill, or whether to give medical services. If the decision is not in your favor, the plan must give you a written notice—including a reason for the denial and a description of steps in the appeals process. (*See also* Appeals Process.)

Original Medicare Plan

The traditional pay-per-visit health plan that lets you go to any doctor, hospital, or other health care provider who accepts Medicare. You pay the deductible. Medicare pays its share of the Medicare-approved amount, and you pay your share (coinsurance). The Original Medicare Plan has two parts: Part A (Hospital Insurance) and Part B (Medical Insurance).

Out-of-Pocket Costs

Health care costs that you must pay on your own because they are not covered by insurance.

Outpatient Care

Medical or surgical care that does not include an overnight hospital stay.

Outpatient Hospital Services/Medicare

Outpatient hospital services that Medicare Part B helps pay for, including: blood transfusions; drugs; hospital billed laboratory tests; mental health care (a doctor must verify that without it you will have to receive in-patient treatment); medical supplies such as splints and casts; emergency room or outpatient clinic, including same day surgery; and X-rays and other radiation services.

Part A (Medicare)

Hospital insurance that covers hospice care, home health care, skilled nursing facilities, and inpatient hospital stays.

Part B (Medicare)

Medical insurance that helps pay for doctors' services, outpatient hospital care, durable medical equipment, and some medical services that are not covered by Part A.

Participating Physician or Supplier

A doctor or supplier who agrees to accept assignment on all Medicare claims. These doctors and suppliers may bill you only for Medicare deductible and/or coinsurance amounts.

Peer Review Organization (PRO)

Groups of practicing doctors and other health care experts paid by the federal government to monitor and improve the care given to Medicare patients. They must review your complaints about the quality of care provided by inpatient hospitals, hospital outpatient departments, hospital emergency rooms, skilled nursing facilities, home health agencies, Medicare managed care plans, and ambulatory surgical centers.

Physician Assistant (PA)

A health care worker who is trained and licensed to provide health care services under the direction of a doctor. The PA helps the doctor to find, treat, and prevent disease, and to keep you healthy.

Preexisting Condition/Medigap

Health problems that needed medical treatment within the six months before the date that a new health insurance policy goes into effect.

Preferred Provider Organization (PPO)

A type of managed care plan that works like other managed care plans in that you use doctors, hospitals, and providers that belong to the network. However, you have added flexibility in that you can use doctors, hospitals, and providers outside of the network for an additional cost.

Premium

Your monthly payment for health care coverage to Medicare, an insurance company, or a health care plan.

Preventive Care

Care to keep you healthy or to prevent illness, such as routine checkups and some tests like colorectal cancer screening, yearly mammograms, and flu shots.

Primary Care

A basic level of care usually given by doctors who work with general and family medicine, internal medicine (internists), pregnant women (obstetricians), and children (pediatricians). A nurse practitioner (NP), a state-licensed registered nurse with special training, can also provide this basic level of health care.

Primary Care Doctor

A health care professional who is trained to give you basic care. In many Medicare managed care plans, a primary care doctor coordinates and provides most or all of your health care. Many plans require you to see your primary care doctor for referral to a specialist. When you join a Medicare managed care plan, you may be asked to choose a primary care doctor from the doctors who belong to the plan.

Primary Payer

The insurance company that pays first on a claim for medical care. This could be Medicare or another insurance company.

Private Contract

A contract between you and a doctor or practitioner who has decided not to offer services through the Medicare program. This doctor cannot bill Medicare for any service or supplies given to you and all his or her other Medicare patients for at least two years. There are no limits on what you can be charged for services under a private contract. You must pay the full amount of the bill.

Private Fee-for-Service Plan

A private insurance plan that accepts Medicare beneficiaries. You may go to any doctor or hospital you want. The insurance plan, rather than the Medicare program, decides how much you pay for the services you receive. You may pay more for Medicare covered benefits. You may have extra benefits the Original Medicare Plan does not cover.

Program of All-Inclusive Care for the Elderly (PACE)

A special program that combines both outpatient and inpatient medical and long-term care services. To be eligible, you must be at least 55 years old, live in the service area of the PACE program, and be certified as eligible for nursing home care by the appropriate state agency. The goal of PACE is to keep you independent and living in your community as long as possible, and to provide quality care at low cost.

Protections and Guarantees (Medigap)

Your rights to Medigap coverage in certain cases.

Provider

A doctor, hospital, health care professional, or health care facility.

Provider Sponsored Organization (PSO)

A group of doctors, hospitals, and other health care providers who have agreed to provide care to Medicare beneficiaries in exchange for a fixed amount of money from Medicare every month. This type of managed care plan is run by the providers and doctors themselves, rather than by an insurance company.

Qualifying Individuals (1) (QI-1s)

Persons who have Medicare Part A, low monthly incomes, and limited resources, but who are not otherwise eligible for Medicaid. If you qualify, Medicaid pays your Medicare Part B premium only. Check your state, county, or local medical assistance office to see if you qualify under this year's income limits.

Qualifying Individuals (2) (QI-2s)

Persons who have Medicare Part A, low monthly incomes, and limited resources, but who are not otherwise eligible for Medicaid. If you qualify, Medicaid pays only a small portion of your Part B premium. Check your state, county, or local medical assistance office to see if you qualify under this year's income limits.

Qualified Medicare Beneficiary (QMB)

Persons who have Medicare Part A, low monthly incomes, and limited resources. Medicaid pays for your Medicare Part A premium (if you need it paid for), Part B premiums, and Medicare deductibles and coinsurance amounts for Medicare services provided by Medicare providers. Check your state, county, or local medical assistance office to see if you qualify under this year's income limits.

Quality Assurance

The process of looking at how well a medical service is provided. The process may include formally reviewing health care given to a person, or group of persons, locating the problem, correcting the problem, and evaluating actions taken.

Referral

Your primary care doctor's written permission for you to see a certain specialist or to receive certain services. Some Medicare health plans may require referrals. Important: if you either see a different doctor from the one on the referral, or if you see a doctor without a referral and the service is not for an emergency or urgently needed care, you may have to pay the entire bill.

Regional Home Health Intermediaries

A private company that contracts with Medicare to process claims and perform checks of home health care.

Religious Fraternal Benefit Society Plans

Health plans offered by a Religious Fraternal Benefit Society for its members. Only members of the society may enroll. The society must meet Internal Revenue Service (IRS) and Medicare requirements for this type of organization.

Risk Adjustment

The way that payments to health plans are changed to take into account a person's health status.

Respite Care

Short term care given to a hospice patient by another caregiver, so that the usual caregiver can rest.

Restraint

Any physical or chemical way to prevent a patient's freedom of movement or normal access to one's own body. These restraints are used to prevent patient injury and are not used for treating medical symptoms.

Secondary Payer

The insurer that pays second on a claim for medical care. This could be the group health plan, Medicare, or Medicaid, depending on the circumstances.

Service Area

The geographic area where a health plan accepts enrollees. For plans that require you to use their doctors and hospitals, it is also the area where services are provided. The plan may disenroll you if you move out of the plan's service area.

Skilled Nursing Care

A level of care that must be given or supervised by licensed nurses and is under the general direction of a doctor. All of your needs are taken care of with this type of service, including giving direct services. Examples of Skilled Nursing Care are getting intravenous injections, tube feeding, oxygen to help you breathe, and changing sterile dressings on a wound. Any service that could be safely performed by an average nonmedical person (or one's self) without the direct supervision of a licensed nurse is not covered.

Skilled Nursing Facility (SNF)

A facility that provides skilled nursing or rehabilitation services to help with recovery after a hospital stay.

Social Health Maintenance Organization (SHMO)

A special type of health plan that provides the full range of Medicare benefits offered by standard Medicare HMOs, plus other services that include the following: prescription drug and chronic care benefits, respite care, and short-term nursing home care; and homemaker, personal care services, and medical transportation. Other services provided are eyeglasses, hearing aids, and dental benefits.

Special Election Period

A set time that a beneficiary is given to change health plans or to return to the Original Medicare Plan in certain situations, which include a permanent move outside the service area by the beneficiary, the Medicare+Choice organization violates its contract with the beneficiary, the organization does not renew its contract with HCFA, or other exceptional conditions determined by HCFA. The Special Election Period is different from the Special Enrollment Period (SEP). (*See also* Election Periods; Enrollment; Special Enrollment Period.)

Special Enrollment Period (SEP)

A set time that you can sign up for Medicare Part B only if you have not taken Medicare Part B during the Initial Enrollment Period, because you or your spouse currently work and have group health plan coverage through your current employer or union. You can sign up at any time you are covered under the group plan. If the employment or group health coverage ends, you have eight months to sign up. The eight-month SEP starts the month after the employment ends or the group health coverage ends, whichever comes first. The Special Enrollment Period is different from the Special Election Period. (*See also* Enrollment; Election Periods; Special Election Period.)

Specialist

A doctor who gives health care services for a specific disease or part of the body. Examples include oncologists (care for cancer patients), cardiologists (care for the heart), and orthopedists (care for bones).

Specified Low-Income Medicare Beneficiaries (SLMB)

Persons entitled to Medicare Part A, who have low monthly incomes and limited resources. If you qualify, Medicare pays your Part B premium only. Check your state, county, or local medical assistance office to see if you qualify under this year's income limits.

State Health Insurance Assistance Program (SHIP)

A State organization that receives money from the Federal Government to give free health insurance counseling and assistance to Medicare beneficiaries. See Table 7.5 for state contact numbers.

Supplemental Insurance

There are many types of private health insurance/coverage that you can buy to supplement, or fill the gaps in, your Medicare coverage. This supplemental insurance will pay for some or all of your health care costs that are not covered by Medicare. These types of private health insurance/coverage include employee coverage (from your employer or union), retiree coverage (from your employer or union) and Medigap Insurance (from a private company or group).

People often refer to all of these types of private health insurance/coverage as "supplemental insurance." However, "Medicare Supplemental" or "Medigap" insurance is a specific type of private insurance that is subject to federal and state laws. (*See also* Gaps; Medigap.)

Supplier

Generally, any company, person, or agency that provides a medical item or service, for example, durable medical equipment.

Unforeseen Out-of-Area Urgently Needed Care

Services you get for a sudden illness or injury that needs urgent medical care while you are out of your health plan's service area for a short time, and cannot wait until you return home.

Urgently Needed Care

An unexpected illness or injury that needs medical care right away, but is not life threatening. Your primary care doctor generally provides urgently needed care if you are in a Medicare health plan other than the Original Medicare Plan. If you are out of your plan's service area for a short time and cannot wait until you return home, the health plan must pay for urgently needed care.

Waiting Period

The time between when you sign up with a Medigap insurance company or Medicare health plan and when the coverage starts.

CHAPTER 8:

Hearth and Home Alternatives

CHAPTER 8:

Hearth and Home Alternatives

Housing Options

It is estimated that the majority of older adults will live the remainder of their lives in the place they celebrate their 65th birthday. Notwithstanding, older adults have many reasons why they may want or need to move, including the following:

- Current home does not meet needs.
- Neighborhood is changing.
- They need to be near children or other support.
- They need to avoid stairs.
- They need to scale down.
- They need to produce cash.
- They need to be near public transportation.
- They need to increase social interaction.
- They need to avoid severe weather.
- They need to seek a new lifestyle.

Older adults have tended, over the past 30 years, to move to smaller communities with warmer climates and more recreational and cultural activities. Older adults seem to find greater satisfaction after a long-distance move if they have shared interests with other neighbors and have a strong support system in place.

Older adults have many housing options, including the following.

Active Senior Communities

A senior community can be like any other neighborhood or community except it is restricted to people usually 55 or over, or 62 or over. Differences in minimum age are usually established when the original community entitlement and funding is obtained. Those with a 55+ restriction require one resident of the household to be 55 or over. Other residents must be over 18 but are permitted to be younger than 55. In a 62+ community, all residents must meet the age requirement. Department of Housing and Urban Development (HUD) regulations used to require amenities, activities, and services that cater to seniors to be provided or available. Although no longer required by law, to be competitive and attractive to a retirement lifestyle, age-restricted communities are continuing to offer amenities, activities, and services that cater to residents.

Active senior communities are oriented toward an active lifestyle, or "younger thinking" seniors. They might offer golf, tennis, swimming pool and spa facilities, exercise rooms, and a variety of clubs and interest groups.

Subsidized Senior Housing

Federal and state programs exist that subsidize housing for elderly adults with low to moderate incomes. Some of these facilities offer assistance to residents who need help with certain tasks, such as shopping and laundry, but residents generally live independently within the senior housing complex. Subsidized senior housing serves as a lower-cost alternative to assisted living, although assisted-living communities are frequently newer, more luxurious, and offer extensive services for residents.

"Seniors Only" Apartments

Some older seniors sell their homes of many years and move to an apartment. This frees up equity that can then supplement income, through interest or dividends earned or by spending the capital. The move also frees seniors from home maintenance.

Mobile Home Communities

Mobile home communities have full-time and part-time residents. Part-time residents may be "snowbirds," who stay for three months or a bit longer. The lots and the mobile units—which are not very mobile—may be leased to, or owned by, the residents.

Elder Cottage Housing Opportunity

Elder Cottage Housing Opportunity (ECHO), Accessory Units, or Granny Flats refer to a housing opportunity where seniors occupy a second family living unit or apartment with a separate entrance, on a single family lot, with another family. Generally property owners are permitted by the jurisdiction to foster affordable housing, or aid families with elderly parents unable to live completely alone. The owner of the home and lot may be a senior, or the "renting" party may be seniors.

Shared Housing

Seniors can share their home or share the home of another. The roommate need not also be a senior. Professional organizations that specialize in these arrangements match the two parties based on needs on one side with abilities to provide on the other side. Professionals screen before matching and follow up afterward to help the match work out. Most organizations that organize shared housing are nonprofit and supported from sources other than those seeking their help.

Seniors who share their home should understand the planning involved to do it successfully.

Congregate Housing

Congregate communities offer independent living in private, separate apartments, and the opportunity to share activities of daily living with other residents as one chooses. They may offer rental or ownership units.

Board and Care Homes

Board and care homes are group living arrangements (sometimes called group or domiciliary homes) that are designed to meet the needs of people who cannot live

independently but do not require nursing home services. These homes may or may not offer a wider range of services than do independent living options. Most provide some assistance with the activities of daily living, including eating, walking, bathing, and toileting. In some cases, private long-term care insurance or medical assistance programs help pay for this type of care. These facilities may or may not be regulated by the state. Regulations, where available, may be significantly less rigorous than for other facilities.

Senior Short-Term Housing

Senior short-term vacation housing offers the chance to "try before you buy." It allows one to take advantage of a senior community in a distant location. People too frail for the rigors of hotels and restaurants for multiple days can vacation at a slower pace with needed care available to them.

Assisted Living Facilities

Currently, approximately 800,000 people are living in assisted living facilities (ALFs). Some elderly individuals require assistance with only a small number of tasks, such as cooking and laundry. Some may need only to be reminded to take their medications. For these people, assisted-living facilities may be considered. Instead of nursing home shared rooms, seniors live in private homes with their own bedroom, or in apartments which have kitchenettes and bathrooms. The facility has staff available for assistance with eating, bathing, and dressing. Housekeeping, laundry, and transportation are also available. ALFs do not provide medical care; however, the staff will often supervise medications. One quarter of ALFs have special wings for people with Alzheimer's disease and other forms of dementia.

In most cases, residents pay a regular monthly rent and then pay additional fees for the services they require. The cost of ALF facilities vary by geographic area and luxury; however, a studio apartment costs about $27,000 a year, less than two-thirds the cost of a nursing home. Ninety percent of residents pay out of pocket. However, some long-term care insurance policies can help pay for assisted living.

The advantages of ALFs include social interaction, exercise classes, and trips to museums and malls. Additionally, residents get to remain independent for as long as possible. Additionally, some facilities are expanding to home care and may provide the services of assisted living, but in the home.

Currently, this form of care is unregulated. Hidden fees may exist for items such as laundry or meals. Ensure that contracts are read carefully prior to acceptance and consult legal counsel. Furthermore, facilities in many states can evict residents with little notice. The rent can rise annually and as the need for care increases, one may still need to hire a helper.

Finally, you need to consider how the facility will meet the future changing needs of your client. This is an important consideration since approximately 75 percent of assisted living residents eventually leave because they need a higher level of care.

Continuing Care Retirement Communities

Continuing Care Retirement Communities (CCRCs) are housing communities that offer and provide different levels of care based on the needs of the residents, from independent

living homes and apartments to skilled nursing in an affiliated nursing home. Residents move from one setting to another based on their needs but continue to remain a part of their CCRC. CCRCs are designed to offer active seniors an independent lifestyle and a private home from which to enjoy it, regardless of future medical needs. Many CCRCs require a large payment (called a buy-in) before admission. They may require monthly payments covering services, amenities, and needed medical attention. The buy-in may be refundable in part or not at all. Many CCRCs are too expensive for elderly persons with modest incomes. Ninety-four percent of CCRCs are run by nonprofit groups.

The average entry fee is $110,000 for a two-bedroom apartment, and more than that at more luxurious communities. Unfortunately, the elder does not obtain equity in an apartment, and one must pay monthly fees.

The main advantage of CCRCs is peace of mind. All forms of care are guaranteed and are nearby, which can be especially appealing for couples at different stages of health. One may want to move in when young and healthy in order to take full advantage of the activities and pay a lower entry fee. You should inquire of the procedures used if the on-site nursing home is full at the time of participant need. As with some ALFs, some CCRCs are now providing services in a person's home. Members sign up while healthy and are guaranteed future care such as nursing and meals delivered to the home.

Ensure that facilities recommended to your client are accredited by the Continuing Care Accreditation Commission, (202) 783-7286. This organization checks consumer protection and quality of care as well as the organization's financial health. Ask the facility for its latest audit report or obtain the information from the state insurance commission.

Skilled Nursing Facilities and Nursing Homes

Skilled nursing homes may be freestanding or be part of a seniors community offering any or all of the following: congregate housing, assisted living, or a continuum of care. The nursing home may specialize in short-term or acute nursing care, intermediate care, or long-term skilled nursing care. The nursing home is a residence that provides room, meals, recreational activities, help with the activities of daily living, and protective supervision to residents. Generally, nursing home residents have physical or mental impairments that keep them from living independently. Nursing homes are certified to provide different levels of care, from custodial to skilled nursing services that can be administered only by a trained professional.

When looking for facilities to age in place, make sure the older adult clients are looking to the future and not just where they live today. For example, if the client is considering moving to a senior community, the practitioner should ask whether the home can handle a broken hip or provide other forms of assistance if needed.

Staying at Home

Most elderly people prefer to remain in their own homes as long as possible. To do so, they need a support network, which may be made up of both family members and professional caregivers. The geriatric care manager (GCM) or other health care professional can assess whether remaining at home is both feasible and appropriate for a client.

A person who is ill or disabled and needs assistance may be able to obtain a variety of home services that make moving into a nursing facility unnecessary. Home services include meals-on-wheels, visiting and companion programs, shopper services, and adult day care. In addition, a variety of programs help care for people in their own homes. Some nursing homes offer short-term respite care to caregivers of ill or disabled homebound patients. Depending on the case, Medicare, private insurance, and Medicaid may pay some home care costs.

The GCM, or other professional, working with the client and family members, needs to identify who will have the responsibility of being the primary caregiver. A primary caregiver may be a family member or a professional caregiver. If a family member has volunteered to be the primary caregiver, the family member's health, location, time constraints, and need for assistance and respite must be considered. If the client is capable of self-care with reminders and occasional assistance, a sole caregiver may be able to provide the assistance needed. When more assistance is needed, outside medical or custodial help is required.

Another element of the care network the professional considers is whether adequate home and community-based services are available. Many communities have private, governmental, social, and religious organizations that provide such services as meals, housekeeping, and transportation for the elderly. The availability of some programs is based on financial need; others are not. Other locales have very limited options available. The GCM or other health care professional assesses what programs are available to meet the client's needs.

For the well-being of the elderly person, there should be a connection to family and friends as health and mobility decline. Being involved in meaningful activity also aids well-being. For example, the GCM or other health care professional should inquire about volunteer opportunities or hobbies that would interest the care recipient. Being involved in church, synagogue, or community activities can keep the older adult mentally fit. There may be transportation issues that have to be resolved. Having a pet can help provide companionship. Telephones, faxes, and computers can also be used to increase contact with the outside world. A day care program might be considered to provide socialization and companionship to the client.

Part of the assessment should include an assessment of the safety and security of the client's home. The Home Evaluation Checklist in Chapter 11 can aid you in this process. The assessment addresses the home's accessibility to someone with disabilities. A professional home inspection may need to be conducted to determine the cost and practicability of required modifications.

A nutritionist or health care professional may need to develop a nutrition plan to address any special needs of the client. A balanced diet must be planned because many elderly people do not pay attention to proper diet and food preparation. Many CPA ElderCare clients have trouble preparing meals, doing the shopping, and getting transportation to the grocery store. If local Meals-on-Wheels programs or other meal programs are available, this can provide a significant benefit to the client.

Can the CPA ElderCare client take his or her own medications? If not, alternative arrangements have to be made. Ensuring that medications are taken properly and on time may require, at least, constant reminders and perhaps professional administration.

Even keeping multiple medications organized can be a challenge. The primary physician needs to be made aware of all medications being taken (prescription and nonprescription) by the client. All medications should be checked for drug or food interactions. All medication instructions should be written in a place that is easily accessible. Be aware that most jurisdictions have strict legislation governing who may administer medications, other than the immediate family members. Transportation to the pharmacy and physician to adjust or refill medications must also be addressed.

Another area of assessment is the elderly person's transportation needs. If the client cannot drive safely, alternative arrangements must be made. Arrangements for either a hired driver, taxi service, other transportation provider, or a friend or family member volunteer, should be investigated. If the client owns a vehicle and employs a driver, an insurance professional should be consulted to make certain that the client is not exposed to unanticipated liability. Failure to address this issue could expose the client to enormous uninsured risks in the event the employed driver gets into an accident and causes damage to property and injury to people.

The client's unique concerns regarding assistance need to be addressed. Mitigating these concerns is essential to both the mental and physical well-being of the client.

Chapter 11, "Sample Documents and Checklists," contains a questionnaire that can be used when assessing an ElderCare client's ability to remain at home.

Home Health Care Agencies

Home care describes a wide range of health and social services delivered in the home environment of elderly people who need nursing, medical, social, housekeeping, and other therapeutic skills to provide assistance with activities of daily living (ADLs) or instrumental activities of daily living (IADLs).

Activities of Daily Living (ADLs)

ADLs vary slightly, depending on the organization defining them, but generally they include the following activities:

- Eating
- Bathing
- Dressing
- Toileting
- Transferring (that is, moving from bed to wheelchair, or wheelchair to bathtub)
- Mobility

Instrumental Activities of Daily Living (IADLs)

IADLs include:

- Using the phone
- Handling money
- Shopping
- Getting around
- Preparing meals

- Ability to do light housework
- Ability to do heavy housework
- Transport ability
- Taking medicine

Home care is appropriate when the older adult who prefers to live at home is unable to perform an ADL or some IADL, which would prevent him from living without assistance. Given the current trend to "age in place," home care is an important component of remaining in one's own home. Home care organizations include a variety of disciplines and include a wide array of services. Home care organizations may be affiliated with a national chain, an exempt organization, a large corporation, or an individual provider. Many home care services are available 24 hours a day and 7 days a week (known as "24/7"). Depending on the needs of the older adult, the services can be provided hourly, daily, or weekly, by individuals or by a team of professionals.

Home Care Providers

The following are some types of home care providers:

- Home health agencies
- Hospices
- Homemaker and home care aid agencies
- Staffing and private duty agencies
- Registries
- Geriatric care managers
- Pharmaceutical and infusion therapy companies
- Durable and medical equipment and supply dealers
- Independent providers

After securing the names of home care providers, the practitioner needs to obtain more information about the services offered; sources could be other clients, patients, physicians, professionals, and agencies on aging and accrediting bodies. Personal meetings with care providers and company management are essential. It is also important to determine the level of independence that references have from the potential provider by asking questions such as these:

1. Do you frequently refer clients to this provider?
2. Do you have a contractual relationship with the provider? If so, is a standard of quality required and was it met?
3. What feedback have you received from clients receiving care from this provider?
4. Do you know any clients using these providers' services with a situation similar to the one being considered? May those clients be contacted?

In gathering information about home care services, it is important to understand how they are paid and to ascertain the client's ability to pay for services not covered by Medicare, other government, or private insurance. Medicare or government insurance may pay for certain medical services provided by a Medicare-certified home health agency. In general, this would include periodic visits by a nurse to a patient recuperating

from a hospital stay or other intermittent nursing care. Medicare does not fund the cost of a 24-hour-a-day nurse in a patient's home, a service that has to be paid for from private funds. (Some long-term care insurance policies may cover 24-hour-a-day nursing, or restrict coverage to people who need significant assistance with at least three ADLs, as defined by the policy. It is important to check the policy to determine what is covered.) Medicare often pays for the cost of medical equipment such as hospital beds or wheelchairs, if a doctor certifies they are medically necessary. See Chapter 7, "Federal and State Programs for the Elderly," for further information.

In general, housekeeping services, companions, and other nonmedical services are not paid for by Medicare or private health insurance but may be covered under some long-term care insurance policies. If not covered by insurance, they must be paid for privately. These nonmedical services are not always available from a single source, and the practitioner may need to arrange for services from a number of different entities and agencies, including Meals-on-Wheels, housekeeping services, and private companions.

Many times, the individuals who provide these services qualify as employees of the elderly person, necessitating payroll tax collection and reporting responsibilities with which the practitioner may provide assistance. An insurance provider should be consulted to determine if workers' compensation insurance is required.

Since these people are alone in the home of a frail, and vulnerable older person, they need to be supervised. One should ensure that all companies recommended perform criminal background checks on workers and provide worker references. In addition, procedures for providing coverage when they are ill or fail to show up must be established.

Chapter 11, "Sample Documents and Checklists," contains a checklist of questions that can be used when considering home care providers.

Skilled Nursing Facilities and Medicare

Medicare should not be considered as a long-term financing method for nursing home care. Unfortunately, many elderly people and families mistakenly assume that the hospital benefits offered in their plan cover skilled nursing care over the long term. This can be a costly assumption when skilled services are needed. The CPA can help clients understand their financial responsibilities by acquiring a sound working knowledge of this area of the Medicare program.

Medicare Part A helps provide up to 100 days of skilled nursing care per benefit period in a "certified skilled nursing facility," a place that provides elderly and disabled persons with daily skilled nursing care or skilled rehabilitative care, plus other medical services. Also, a certified skilled nursing facility must be certified under the Medicare Act to have met high standards for care. The goals of a certified nursing facility include high-quality care, 24 hours a day, in a comfortable, safe environment with recreational programs to fit needs.

If the elderly adult is eligible for Medicare, both Part A and Part B insurance can help pay for skilled nursing care if (1) a medical professional certifies that the individual needs skilled care or rehabilitation on a daily basis, and (2) all the following apply:

1. The care can be provided only in a skilled nursing facility.
2. The individual has been in a hospital for at least three days, not including the day of discharge.

3. The individual is admitted to the skilled nursing facility within 30 days after a hospital stay.
4. The care in the facility is for a condition that was treated in the hospital.
5. The Medicare intermediary does not disapprove the stay.

For the first twenty days, Part A insurance pays all covered costs. For the next 80 days, Part A insurance pays all covered costs beyond $99 per day in 2001. Covered services include:

- Room and board in a semiprivate room (two to four beds per room)
- Physical, occupational, and speech therapies
- Medical social services
- Drugs, supplies, appliances, and blood transfusions

As an ElderCare practitioner, the CPA can help clients conserve their assets in times of confusion and uncertainty. For instance, simply understanding what is covered and what is the client's financial responsibility for the first 100 days of needed nursing home care can help alleviate some of the stress that accompanies such situations. The knowledgeable ElderCare CPA can provide valuable assistance to clients and their families through prior planning for some of the emergencies that arise in the lives of elderly persons.

Choosing a Nursing Home

(Adapted from materials published by the Health Care Financing Administration and the U.S. Department of Health and Human Services)

Notice to the Reader

The Health Care Financing Administration (HCFA), the federal agency that oversees Medicare and Medicaid, wants consumers to be aware of issues involving nursing homes. First, nursing homes cannot require prepayment from residents who are relying on Medicare or Medicaid to pay for their nursing services. Second, nursing homes may not use physical or chemical restraints on residents, except when medically necessary.

Prepayment

It is unlawful for a facility to require patients to pay a cash deposit when they apply for admission as a Medicare or Medicaid patient. Federal law prohibits nursing facilities from requiring a prepayment as a condition of admission for care covered by either pay source. The facility may, however, request that a Medicare beneficiary pay coinsurance amounts and other charges for which the beneficiary is liable. Payment for charges should be made as they come due, not before. A facility may also require a cash deposit before admission if the patient's care will not be covered by either Medicare or Medicaid.

Restraints

CPAs should be aware that federal law prohibits nursing homes from using physical or chemical restraints on residents for discipline or convenience of nursing home staff. Restraints increase the chances that residents will develop incontinence, impaired circulation, and swelling. Restrained residents also tend to suffer decreased functional

ability; lower self-esteem; and feelings of depression, anger, and stress. Restrained residents are not safer than they would be if left unrestrained. Restrained individuals are more likely to incur serious injuries when they fall.

Restraints may be used only when necessary to treat medical symptoms or to ensure the safety of other nursing home residents. Except in emergencies, physical and chemical restraints may be used only under the written orders of physicians. Physical restraints include articles, such as belts or vests, that secure a resident's limbs or bind a resident to a bed, chair, or other stationary item. In addition, common nursing home items, such as lap trays and bed rails, when employed solely to keep a resident from moving about, are considered restraints. Chemical restraints are drugs that are administered to keep a resident subdued. If the practitioner knows of a nursing facility that is improperly demanding prepayments or restraining residents, one should immediately contact the state's survey agency. (See Table 8.1 for a listing of agency phone numbers.)

TABLE 8.1 STATE RESOURCES: PHONE NUMBERS

State	Long-Term Care Ombudsman*	State Survey Agency*	Insurance Counseling and Assistance
Alabama	(334) 242-5743	(334) 240-3503	(800) 243-5463
Alaska	(907) 563-6393	(907) 561-8081	(800) 478-6065
Arizona	(602) 542-4446	(602) 674-4340	(800) 432-4040
Arkansas	(501) 682-2441	(501) 682-8430	(800) 852-5494
California	(916) 323-6681	(916) 445-3054	(800) 434-0222
Colorado	(303) 722-0300	(303) 692-2835	(800) 544-9181
Connecticut	(203) 424-5200	(203) 566-1073	(800) 994-9422
Delaware	(302) 453-3820	(302) 577-6666	(800) 336-9500
District of Columbia	(202) 662-4933	(202) 727-7190	(202) 676-3900
Florida	(850) 422-6190	(850) 487-2527	(800) 963-5337
Georgia	(404) 657-5319	(404) 657-5850	(800) 669-8387
Hawaii	(808) 526-0100	(808) 586-4080	(808) 586-0100
Idaho	(208) 334-2220	(208) 334-6626	(800) 247-4422
Illinois	(217) 785-3143	(317) 383-6262	(800) 452-4800
Indiana	(317) 232-7134	(515) 281-4115	(800) 351-4664
Iowa	(515) 281-5187	(217) 782-2913	(800) 548-9034
Kansas	(913) 296-6539	(913) 296-1240	(800) 432-3535
Kentucky	(502) 564-6930	(502) 564-2800	(800) 372-2973
Louisiana	(504) 925-1700	(334) 240-3517	(800) 259-5301
Maine	(207) 621-1079	(207) 287-2606	(800) 750-5353
Maryland	(410)-225-1074	(410) 764-2750	(800) 243-3425

TABLE 8.1 (*CONTINUED*)

State	Long-Term Care Ombudsman*	State Survey Agency*	Insurance Counseling and Assistance
Massachusetts	(617) 727-7750	(617) 727-5860	(800) 882-2003
Michigan	(517) 336-6753	(517) 335-8649	(800) 803-7174
Minnesota	(612) 296-0382	(612) 643-2171	(800) 882-6262
Mississippi	(601) 359-4970	(601) 354-7300	(800) 948-3090
Missouri	(573) 751-3082	(573) 751-6302	(800) 390-3330
Montana	(406) 444-5900	(406) 444-2037	(800) 332-2272
Nebraska	(402) 471-2306	(402) 471-4961	(402) 471-2201
Nevada	(702) 486-3545	(702) 687-4475	(800) 307-4444
New Hampshire	(603) 271-4375	(603) 271-4592	(800) 852-3388
New Jersey	(609) 588-3614	(609) 292-9874	(800) 792-8820
New Mexico	(505) 827-7663	(505) 827-4200	(800) 432-2080
New York	(518) 474-0108	(518) 473-3517	(800) 333-4114
North Carolina	(919) 733-3983	(919) 733-7461	(800) 443-9354
North Dakota	(701) 224-2577	(701) 224-2352	(800) 247-0560
Ohio	(614) 644-7922	(614) 466-7857	(800) 686-1578
Oklahoma	(405) 521-6734	(405) 271-4200	(800) 763-2828
Oregon	(503) 378-6533	(503) 945-6456	(800) 722-4134
Pennsylvania	(717) 783-7247	(717) 787-8015	(800) 783-7067
Puerto Rico	(809) 721-8225	(809) 721-4050	(809) 721-8590
Rhode Island	(401) 222-2858	(401) 222-2566	(800) 322-2880
South Carolina	(803) 737-7500	(803) 737-7205	(800) 868-9095
South Dakota	(605) 773-3656	(605) 773-3356	(800) 822-8804
Tennessee	(615) 741-2056	(615) 367-6316	(800) 525-2816
Texas	(512) 438-2633	(512) 438-2633	(800) 252-3439
Utah	(801) 538-3984	(801) 538-6559	(800) 439-3805
Vermont	(802) 748-8721	(802) 277-2345	(802) 828-3302
Virginia	(804) 644-2923	(804) 367-2100	(800) 552-3402
Washington	(253) 838-6810	(253) 838-6810	(800) 397-4422
West Virginia	(304) 558-3317	(304) 558-0050	(800) 642-9004
Wisconsin	(608) 266-8944	(603) 267-7185	(800) 242-1060
Wyoming	(307) 322-5553	(307) 777-7123	(800) 856-4398

* Numbers may be for regional offices.

Introduction to Choosing a Nursing Home

Selecting a nursing home is one of the most important and difficult decisions that elderly individuals and families may be asked to make. Though difficult to admit, several years may be spent in a nursing home, so it is important to make the best decision possible and base the decision on the most complete and timely information available. This section provides a step-by-step process suggested by the HCFA that assists in the decision. It provides some key resources that help elderly individuals and families conduct a wise search for the nursing home or long-term care facility that best suits the person's needs.

Step 1: Building a Network and Planning

When searching for a nursing home, it may be helpful to put together a network of knowledgeable people who can help make an appropriate choice. This team should consist of family and friends (who are important to the individual) and may also include the physicians and other health care professionals who understand the person's needs. In addition, hospital social workers, geriatric care managers, and clergy are valuable network members.

When assisting in the selection of a nursing home, make every effort to involve the elderly individual in the selection process. If the client is alert, oriented, and competent to make the decision, it is essential that his or her decision be respected. People who are involved in the selection process are better prepared and may adapt more quickly when the time comes to move into a nursing facility.

Identifying a nursing home that provides the appropriate services in a pleasant, comfortable environment requires research. Ideally, individuals should plan ahead, examine several facilities, and make the appropriate financial plans. By planning ahead, the elderly individual and family have more control over the selection process, more time to gather accurate information, and more time to make certain that everyone in the network or team is comfortable with the ultimate choice. Planning ahead is the best way to ease the stress that accompanies choosing a nursing home and helps ensure that clients and families make the best choices.

Unfortunately, a great many people must select a nursing home with little notice—frequently during a family crisis or right after a serious illness or operation. A client in this situation may not be able to follow all the suggested steps, but information about nursing homes, the people who may be able to help, and what individuals and families should look for in a nursing home is helpful.

Step 2: Long-Term Care Options

Until recently, few alternatives to nursing homes existed for people who could no longer take care of themselves. Even today, some people are placed in nursing homes simply because neither they nor their family know about the alternatives to nursing homes. Today, people who cannot live completely independently may choose from a variety of living arrangements that offer different levels of care. For many individuals and families, these alternatives are preferable to nursing homes. See the section at the beginning of this chapter titled "Housing Options" for a description of various living arrangements.

Choosing an Option

Before decisions are made on which care setting is most appropriate, discussions with physicians and social workers can provide a realistic assessment of the elderly individual's care needs. If considering home care, you should understand all the work that comes with caring for a chronically ill person. If considering independent living, consider the risks associated with an unsupervised environment. Be sure to discuss long-term care options with family members who will be the main home caregivers. It is important to recognize that caring for someone who is very sick or has numerous needs requires much work. Nursing homes are designed to meet the needs of acutely or chronically ill individuals. The options previously discussed may work for persons who require less than skilled care or who require skilled care for only brief periods of time. Many individuals with long-term skilled care needs require a level and amount of care that cannot easily be handled outside of a nursing home.

Step 3: Gathering Information

Once you and your client decide that a nursing home is the appropriate choice, you start to gather information about the nursing homes in the area. Find out exactly how many nursing homes are located in a particular area. Check the yellow page listings of nursing homes and facilities. In addition, state and local offices on aging have a list of nursing homes in the area and will be able to make referrals to the local long-term care ombudsman.

Information about nursing homes in the area may come from a variety of sources:

- Word of mouth can be one good source of information. Friends and neighbors may know individuals who have stayed in local nursing homes.
- The local long-term care ombudsman is one of the best sources of information. Ombudsmen visit nursing homes on a regular basis. Their job is to investigate complaints, advocate for residents, and mediate disputes. Ombudsmen often have very good knowledge about the quality of life and care inside every nursing home in their area. Although they are not allowed to recommend one facility over another, they can provide information about specific nursing homes on these subjects:
  - — Results of the latest survey
  - — Number of outstanding complaints
  - — Number and nature of complaints lodged in the last year
  - — Results and conclusions of recent complaint investigations

(See Table 8.1 for a listing of the long-term care ombudsman phone numbers, and Chapter 9, "Long-Term Care Insurance," for comprehensive ombudsman contact information.)

Other Community Resources

Many other resources that elderly individuals and families can consult before selecting a nursing home include the following:

- Hospital discharge planners and social workers
- Physicians who service the elderly
- Clergy and religious organizations

- Volunteer groups that work with the elderly and chronically ill
- Nursing home professional associations

Consider some of these factors to help narrow the list of potential nursing facilities:

- Religious and cultural preferences
- Medicare and Medicaid participation (Be certain that if the patient will be using Medicare or Medicaid, the facility will accept these pay sources. Often, only a portion of the home is certified for Medicare or Medicaid.)
- HMO contracts (If the individual belongs to a managed care plan that contracts with a particular nursing home in the area, it is important that homes being considered have contracts with the individual's managed care company.)
- Availability (Make certain that the preferred nursing homes will have space available at the time the person might need to be admitted.)
- Special care needs (If the individual requires care for special medical conditions or dementia, be sure the preferred nursing homes are capable of meeting those special circumstances.)
- Location (If there are a large number of nursing facilities in the area, it is usually a good idea to consider nursing homes that family and friends can easily visit. In most cases, it is a mistake to select a nursing home that is difficult to visit on a regular basis. Frequent visits are the best way to make sure the patient does well in the nursing home.)

Paying for Nursing Home Care

Nursing home care is very expensive (approximately $200 a day in many parts of the country). For most people, finding ways to finance nursing home care is a major concern. There are several ways that nursing home care is financed.

- *Personal resources.* About half of all nursing home residents pay nursing home costs out of their personal resources, usually their personal savings. As personal resources are spent, many people who remain in nursing homes for long periods of time eventually become eligible for Medicaid.
- *Long-term care (LTC) insurance.* LTC insurance is private insurance designed to cover long-term care costs. Plans vary widely, and research is important before purchasing any policy. Generally, only relatively healthy people may purchase LTC insurance. For further information, review "Shopper's Guide to Long-Term Care Insurance," in Chapter 9.
- *Medicaid.* Medicaid is a state and federal program that pays most nursing home costs for people with limited income and assets. Eligibility varies by state, and it is important to check into a state's eligibility requirements before assuming that an individual is either eligible or ineligible for the program. Medicaid pays only for nursing home care provided in Medicaid-certified facilities.
- *Medicare.* Under certain limited conditions, Medicare pays some nursing home costs for Medicare beneficiaries who require skilled nursing or rehabilitative services. To be covered, an individual must (after a qualifying hospital stay) receive the services from a Medicare-certified skilled nursing home. In addition to information contained in the Medicare section in Chapter 7, "Federal and State Programs for the Elderly," you can obtain a free copy of Your Medicare Handbook from the HCFA at (800) 638-6833 or on the Internet at www.medicare.gov.

- *Medicare Supplemental Insurance.* Also known as Medigap, this private insurance pays Medicare's deductibles and coinsurances and may cover services not covered by Medicare. Most Medigap plans help pay for skilled nursing care, but only when that care is covered by Medicare.

Additional questions about paying for nursing home care, what coverage is already available, or whether there are any government programs that help with nursing home expenses may be directed to your state's insurance counseling and assistance program. Telephone numbers for those programs are available in Table 8.1.

Step 4: Visiting Nursing Homes

The nursing home visit is probably the most important step in the selection of an appropriate facility. A visit, often in the form of a formal tour, provides the elderly client and family members with an opportunity to meet with the staff and, more importantly, the people who live and receive care at the nursing home. Although a useful introduction to the home, the tour should not be the only factor individuals consider. When the tour is completed, they should return to some of the places where staff are caring for residents and ask them about their jobs and how they feel about caring for people with so many different needs. The checklist provided in Chapter 11, "Sample Documents and Checklists," provides additional ideas for questions to ask.

Clients should spend some time examining the nursing home's most recent survey report. By law, this report must be posted in the nursing home in an area that is accessible to visitors and residents. Surveyors compile a survey report that lists areas in which the nursing home is cited for deficient practices. Clients should keep these deficiencies in mind as they visit the facility and determine whether the home has corrected the deficient practices listed on the survey report.

Over the past decade, laws and regulations have been enacted to raise the standards of nursing home care, particularly with respect to quality of life. The law now requires that residents receive necessary care and services that enable them to reach and maintain their highest practical level of physical, mental, and social well-being.

What Is a Survey?

All nursing homes that are certified to participate in the Medicare or Medicaid programs are visited by a team of trained state surveyors approximately once a year. Surveyors, like inspectors, examine the home over several days and inspect the performance of the nursing home in numerous areas, including quality of life and quality of care. At the conclusion of the survey, the team reports its findings. Nursing homes with deficiencies are subject to fines and other penalties if they are not corrected.

Quality of Life

When visiting a nursing facility, it is important to pay special attention to quality-of-life issues. People who are admitted into nursing homes do not leave their personalities at the door, nor do they lose their basic human needs for respect, encouragement, and friendliness. All individuals need to retain as much control over the events in their daily lives as possible.

Nursing home residents should have the freedom and privacy to attend to their personal needs—from managing their finances (if they are able) to decorating their rooms with

favorite personal items. They should also be able to participate in their care planning and retain the right to examine their medical records. Most important, staff must always respect the dignity of each individual resident. To assess the facility's respect of individuals better, try to answer these questions:

- Are staff members courteous to residents and is the home's management responsive to concerns raised by residents?
- Does the home offer a variety of activities and allow residents to choose the activities they want to attend?
- Does the nursing home provide menu choices or prepare special meals at the request of the residents? Sample the food if possible.
- Are family members encouraged to visit and are they allowed to visit in privacy when requested?

Quality of Care

Without a medical or social work background, it might be difficult to assess how well the nursing home provides high-quality health care to its residents. However, individuals may take a number of actions to evaluate whether the home is providing high-quality health care.

- Check the survey report and determine if the home was cited for deficient practice in any quality-of-care areas.
- Inquire about the home's staffing and ask residents if staff are available when needed.
- Inquire about the number of residents assigned to each nurse and nurse aide. Be aware that there might be fewer staff at night or on the weekends.
- If the individual has any special care needs, such as dementia or ventilator dependency, make sure that the home has experience in working with people who have had the same condition.
- Inquire about the nursing home's staff physician and the frequency of physician visits to the home. Because the home's doctor may be called in case of emergencies, residents and families should be confident the home's doctor can take care of the residents' needs.

By law, nursing homes must complete a comprehensive assessment for every new resident within two weeks of admission. The home must also complete a care plan that is designed to help each resident reach or maintain his or her highest level of well-being. Inquire about the home's care-planning process and be sure the individual agrees with the home's philosophy. Remember, residents who have meaningful activities and are as independent as possible are generally better able to maintain their health.

Step 5: Follow-Up Analysis

Once the individual or family has narrowed the list of nursing homes, it is time to revisit some of the earlier steps. Contact the people from the network established in step 1 and make sure they are comfortable with potential choices.

Follow-Up Visits

Nursing homes on the list should be visited at least one more time or as many times as necessary. It is valuable to see the home at least once in the evening, on a weekend, or both, because staffing is frequently different at these times. These visits should be conducted at

different times of the day than the first visit. At least one of the visits should be during the late morning or midday to observe residents when they are out of bed, eating, and attending activities. Also, the follow-up visit should include attending a meeting of the nursing home's resident council and family council. These meetings provide a unique look at the concerns of residents and families. If the nursing home does not have resident or family councils, that might be telling about the philosophy of the home's management.

After the follow-up visits, it may still be difficult to select one nursing home from the short list of facilities. A final call to the ombudsman and the other people who provided information in the past may help. The facility should be contacted to respond to any remaining questions or concerns. Following this process, the individual should now be ready to select the nursing home that is best able to meet his or her needs. With enough information, individuals and families feel more confident that they are making the wisest possible choice.

Step 6: After Admission

Even when individuals make well-reasoned choices in selecting a nursing home, it is still possible that they may not be entirely satisfied with their choice. New residents may go through a difficult adjustment period, even if the nursing home is doing all that it can. Be aware that the law gives individuals and relatives specific rights in the nursing home. Nursing homes should be held accountable if they are not honoring the rights of residents and family members. A summary of those rights is detailed in the following sections.

Resident Rights in a Nursing Home

Some people think that nursing home residents surrender the right to make medical decisions, manage funds, and control their activities when they enter a nursing home. That is not true. As a nursing home resident, individuals have the same rights as anyone else, as well as certain special protections under the law. The nursing home must post and provide new residents with a statement that details each resident's rights. New residents also have these specific rights:

1. *Respect.* Individuals have the right to be treated with dignity and respect and the right to make their own schedule (including bedtime) and select the activities they would like to attend (as long as it fits the plan of care). A nursing home is prohibited from using physical or chemical restraints except when necessary to treat medical symptoms.
2. *Services and fees.* The nursing home must inform residents, in writing, about its services and fees before admission to the home. Most facilities charge a basic rate that covers room, meals, housekeeping, linen, general nursing care, recreation, and some personal care services. Extra charges may be incurred for personal services, such as haircuts and telephone.
3. *Managing money.* Individuals have the right to manage their own money or to designate someone else to do so. If the nursing home is allowed to manage personal funds, individuals must sign a written statement that authorizes the nursing home to manage finances, and the nursing home must allow them access to their own funds. Federal law requires that the home protect these funds from any loss by having a bond or similar arrangement.

4. *Privacy, property, and living arrangements.* Individuals have the right to privacy. In addition, residents have the right to keep and use their own personal property, as long as it does not interfere with the rights, health, or safety of others. Mail may never be opened by the home's staff unless the resident allows it. The nursing home must have a system in place to keep residents safe from neglect and abuse and to protect personal property from theft. If an individual and a spouse live in the same home, they are entitled to share a room (if they both agree to do so).
5. *Guardianship and advanced directives.* Nursing home residents are responsible for making their own decisions (unless they are unable to do so). Residents may designate someone else to make health care decisions for them and residents may also prepare advance directives. A durable power of attorney will become the resident's legal guardian if he or she becomes incapable of decision making. End-of-life decisions may also be stated in a living will. Depending on the state's laws, individuals may need a lawyer to prepare these documents.
6. *Visitors.* Individuals have the right to spend private time with the visitors of their choice at any reasonable hour. Residents have the right to make and receive telephone calls in privacy. The nursing home must permit families to visit the resident at any time. Any person who provides the resident with health or legal services may also visit at any reasonable time. A resident does not have to see anyone he or she does not wish to see.
7. *Medical care.* Residents have the right to be informed about their medical condition and medications and to participate in their plan of care. They have the right to refuse medications and treatments and to see their own doctor.
8. *Social services.* The nursing home must provide each resident with social services, including counseling, mediation of disputes with other residents, assistance in contacting legal and financial professionals, and discharge planning.
9. *Moving out.* Living in a nursing home is voluntary. Individuals are free to move to another facility or return to their home. However, nursing home admission policies usually require that residents give proper notice that they are leaving. Residents whose nursing home services are covered by Medicare and Medicaid do not have to give the nursing home proper notice before moving out.
10. *Discharge.* The nursing facility may not discharge or transfer residents unless:
    - — It is necessary for the welfare, health, or safety of others.
    - — The resident's health has declined to a point that the nursing home cannot meet his or her care needs.
    - — The resident's health has improved to the extent that nursing home care is no longer necessary.
    - — The nursing home has not received payment for services delivered.
    - — The nursing home ceases operation.

Relatives' Rights

Relatives and friends of nursing home residents have rights, too. Family members and legal guardians have the right to privacy when visiting the nursing home (but only when requested by the resident). They also have the right to meet with the families of other residents. If the nursing home has a family council, relatives have the right to join or address the group.

By law, nursing homes must develop a plan of care for every resident. Family members are permitted to assist in preparing the development of this care plan, with the resident's permission. In addition, relatives who have legal guardianship of nursing home residents have the right to examine all medical records concerning their loved one. Federal law gives guardians the right to make important decisions on behalf of their relatives.

It is important to remember that relatives play a major role in making sure that nursing home residents are receiving good care. This can be achieved by visiting often, expressing concerns whenever they arise, and being active in the nursing home's family council (or helping to start a family council if the home does not have one). Finally, if concerns are not being addressed by the nursing home or if individuals and family members have complaints, there are people and agencies to provide help and assistance.

Nursing Home Checklist

The Nursing Home Checklist in Chapter 11, "Sample Documents and Checklists," is designed to assist in the evaluation and comparison of nursing homes. Make several copies of the checklist so that one can be completed for each home visited. After completing checklists on all nursing homes visited, compare the lists. Comparisons are helpful in selecting the most appropriate facility for a particular individual's needs. The checklist may be used in part to compare and evaluate assisted living facilities also.

Long-Term Care Resources

Long-Term Care Ombudsmen

These individuals investigate nursing home complaints, act as advocates for nursing home residents, and mediate disputes between nursing homes and residents or their families. Ombudsmen can assist with nursing home information in your state or if you have a complaint about a nursing home. See Chapter 9, "Long-Term Care Insurance," for comprehensive contact information.

State Survey Agencies

These agencies conduct annual surveys or inspections of every Medicare- or Medicaid-certified nursing home in your state, and cite homes for deficient practices. Survey agencies enforce federal guidelines on nursing homes and have the power to sanction homes. If you have a complaint about the quality of life or quality of care inside a nursing home, contact your state survey agency.

Insurance Counseling and Assistance

Programs provide free help with questions on long-term care costs. If you are confused about Medicare coverage of nursing home services, Medicaid eligibility requirements, private long-term care insurance, or if you have health insurance questions, contact the state's insurance counseling and assistance center for help.

Table 8.1 lists the phone numbers, by state, of these services.

FUNDING THE COST OF AGING

Once it is clear what types and costs of services will be needed, you can assist the client by preparing a cash flow projection to help plan for the payment of these services. When providing a cash flow projection to a client the following issues should be considered:

- Resources the CPA should explore:
  - — Identify and document all sources of income.
  - — Identify and document all expenses.
  - — Review effect of spouse's death on future income and expenses.
  - — Consider equity and insurance conversions to supplement income if needed.
  - — Consider other options for supplementing income, such as liquidating assets or purchasing annuities.
  - — Investigate availability of trust assets and determine whether access to funds is available to cover housing and care costs.
  - — Explore availability of free or low-cost services.
- Service opportunities the CPA should explore:
  - — Consider setting up automatic deposits for income sources.
  - — Consider setting up automatic bill payment.
  - — Identify who will approve and pay bills, make deposits, reconcile bank accounts, and organize records.
  - — Identify who will calculate and pay employment taxes.
  - — Identify who will prepare income taxes returns.
  - — Identify who will manage investments, real estate, and other assets.
  - — Identify who will make applications for Social Security, Medicare, Medicaid, or other government and community programs.
  - — Review restrictions, financial and psychological, of Medicaid participation. Also consider impact of long-term care insurance and effect on insurance and financial planning needs.
  - — Identify who will coordinate billing of insurance and Medicaid providers.
  - — Evaluate potential tax deductibility for costs of housing and care.

Finally, protection the CPA should provide often relates to scams from telemarketers, direct mail solicitations, television infomercials, the Internet, and other similar sources. The CPA can help determine the amount of loss, decide (with legal counsel) whether recovery is possible, and contact police and other authorities such as the U.S. Attorney's Office, the Federal Bureau of Investigation, the Federal Trade Commission, the Better Business Bureau, the Chamber of Commerce and the District Attorney's Office.

CHAPTER 9:

Long-Term Care Insurance

CHAPTER 9:

Long-Term Care Insurance

Long-Term Care Insurance Facts

It has been suggested that one in five individuals will require assistance in a nursing home at some time in their lives. Many individuals will live in a nursing home more than two years. How does the risk of needing long-term care insurance compare with other risks we usually insure?

- The risk of house fire is 1 in 1,200.
- The risk of being involved in a serious auto accident is 1 in 120.
- The risk of requiring long-term care assistance is 1 in 5.

Because it is a product that is unfamiliar to many practitioners, elderly persons, and families, long-term care insurance is a complex consideration. The following section helps ElderCare CPAs become knowledgeable about current products and issues. First, complete the 10 questions in Table 9.1 and test your knowledge about long-term care insurance.

Table 9.1 Long-Term Care Insurance Quiz

Source: National Council on Aging and John Hancock Mutual Life Insurance Co., Inc.

1. About what percentage of people currently receiving long-term care services are between the ages of 18 and 64?
   a. Less than 25%
   b. Between 25% and 34%
   c. Between 35% and 44%
   d. Between 45% and 60%
   e. Greater than 60%
2. On average, a one-year stay in a nursing home today costs about $40,000.
   True
   False
3. What do you think is the approximate chance that someone aged sixty-five will ever be admitted to a nursing home?
   a. Less than 25%
   b. Between 25% and 34%
   c. Between 35% and 44%
   d. Between 45% and 60%
   e. Greater than 60%
4. People have to spend all or almost all of their assets before they can get Medicaid benefits.
   True
   False

(continued)

TABLE 9.1 (*CONTINUED*)

5. What do you think is the likelihood that a woman, aged 65, will spend one year or more in a nursing home at some time in her life?
   a. Less than 25%
   b. Between 25% and 34%
   c. Between 35% and 44%
   d. Between 45% and 60%
   e. Greater than 60%
6. Medicare benefits pay for nearly all the costs associated with an extended stay in a nursing home.
   True
   False
7. What do you think is the likelihood than a man, aged 65, will spend one year or more in a nursing home at some time in his life?
   a. Less than 25%
   b. Between 25% and 34%
   c. Between 35% and 44%
   d. Between 45% and 60%
   e. Greater than 60%
8. About 15 percent of all full-time employees in the United States provide some care for elderly relatives or friends.
   True
   False
9. About what percentage of elderly people receiving long-term care get that care in their homes?
   a. Less than 25%
   b. Between 25% and 34%
   c. Between 35% and 44%
   d. Between 45% and 60%
   e. Greater than 60%
10. What do you think is the approximate average cost of a home visit by a visiting home health nurse?
    a. $25 per visit
    b. $50 per visit
    c. $75 per visit
    d. $100 per visit
    e. More than $100 per visit

Answers and Rationalization

1. (*C*) The U.S. Government Accounting Office estimates that approximately 39.6 percent of Americans receiving long-term care either in an institution, a home, or community-based setting are between the ages of 18 and 64. Americans of all ages receive long-term care.

TABLE 9.1 (*CONTINUED*)

2. (*True*) The Health Association of America reported that the national average cost for private nursing home is about $40,000 per year. This cost may be significantly higher in metropolitan areas.
3. (*C*) A 1991 *New England Journal of Medicine* article found that at age 65, the average American has a 43 percent lifetime chance of being admitted to a nursing home.
4. (*True*) Medicaid is the federal-state health program for people with low incomes and few assets. In most states, a single individual cannot have more than $2,000 in assets to qualify.
5. (*B*) At age 65, a woman has a 31 percent lifetime chance of spending one year or more in a nursing home.
6. (*False*) Medicare coverage of skilled nursing facilities is limited to people who require 24-hour, skilled nursing care immediately following a hospital stay. Nursing home coverage is limited to short-term stays, and on average, Medicare pays for 27 days of skilled nursing facility costs. Medicare will not pay for the cost of personal or custodial care services.
7. (*A*) At age 65 a man has a 14 percent lifetime chance of spending a year or more in a nursing home.
8. (*True*) It is estimated that 15 percent of full-time workers in the United States have some elder care responsibilities.
9. (*E*) Almost 80 percent of elderly people who require assistance with the activities of daily living and instrumental activities of daily living receive that assistance in their own homes or other community-based setting.
10. (*D*) The average cost for a home visit by a home health nurse is about $94.

A SHOPPER'S GUIDE TO LONG-TERM CARE INSURANCE

The guide presented on the following pages is reprinted with the permission of the National Association of Insurance Commissioners. The information contained in the guide will help you better understand long-term care services and the various insurance options that exist to help pay for those services. In the following guide, you will find helpful answers to questions such as—

- Is long-term care insurance necessary?
- What kind of insurance policies are available?
- How does one's health affect one's ability to buy insurance?

So, take the time to understand the different issues involved in the purchase of long-term care insurance, by reading this guide.

A Shopper's Guide to

LONG-TERM CARE INSURANCE

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NAIC

National Association of Insurance Commissioners

Directory of State Long-Term Care Ombudsman Programs

Long-term care ombudsmen are advocates for residents of nursing homes, board and care homes, assisted living facilities and similar adult care facilities. Since the Long-Term Care Ombudsman Program began 25 years ago, thousands of paid and volunteer ombudsmen working in every state have made a dramatic difference in the lives of long-term care residents (see Table 9.2 for contact information). Long-term care ombudsmen advocate on behalf of individuals and groups of residents as well as work to effect system changes on a local, state, and national level. They provide an on-going presence in long-term care facilities, monitoring care and conditions and providing a voice for those who are unable to speak for themselves.

Table 9.2 Contact Information

Alabama
Marie Tomlin, State LTC Ombudsman
Alabama Dept. of Senior Services
770 Washington Avenue
RSA Plaza, Suite 470
Montgomery, AL 36130
Phone (334) 242-5743, Fax (334) 242-5594

Alaska
John Richard, State LTC Ombudsman
Office of the State Ombudsman
Alaska Mental Health Trust Authority
550 West 7th Avenue, Suite 1830
Anchorage, AK 99501
Phone (907) 334-4480, Fax (907) 334-4486

Arizona
Robert Nixon, State Ombudsman
Arizona Aging & Adult Administration
1789 West Jefferson 2SW 950A
Phoenix, AZ 85007
Phone (602) 542-6454, Fax (602) 542-6575

Arkansas
Alice Ahart, State LTC Ombudsman
Arkansas Division of Aging & Adult Services
PO Box 1437, Slot 1412
Little Rock, AR 72201-1437
Phone (501) 682-2441, Fax (501) 682-8155

California
Beth Mann, State LTC Ombudsman
California Dept. on Aging
1600 K Street
Sacramento, CA 95814
Phone (916) 324-3968, Fax (916) 323-7299

TABLE 9.2 (*CONTINUED*)

Colorado
Pat Tunnell, State LTC Ombudsman
The Legal Center
455 Sherman Street, Suite 130
Denver, CO 80203-4403
Phone (800) 288-1376, Fax (303) 722-0720

Connecticut
Teresa Cusano, State LTC Ombudsman
Connecticut Dept. of Social Services
25 Sigourney Street, 10th floor
Hartford, CT 06106-5033
Phone (860) 424-5200, Fax (860) 424-4966

Delaware
Tim Hoyle, State LTC Ombudsman
Division of Services for Aging & Adults
1901 North Dupont Highway, Main Admin. Bldg. Annex
New Castle, DE 19720
Phone (302) 577-4791, Fax (302) 577-4793

District of Columbia
Jerry Kasunic, State LTC Ombudsman
AARP Foundation, Legal Counsel for the Elderly
601 E Street, NW, A4-330
Washington, DC 20049
Phone (202) 434-2140, Fax (202) 434-6595

Florida
Steve Rachin, State LTC Ombudsman
Florida State LTC Ombudsman Council
600 South Calhoun Street, Suite 270
Tallahassee, FL 32301
Phone (888) 831-0404, Fax (850) 488-5657

Georgia
Becky Kurtz, State LTC Ombudsman
Georgia Division of Aging Services
2 Peachtree Street, NW, 9th Floor
Atlanta, GA 30303-3142
Phone (888) 454-5826, Fax (404) 463-8384
Web site: www.state.ga.us/departments/dhr/aging.html

Hawaii
John McDermott, State LTC Ombudsman
Executive Office on Aging
250 South Hotel Street, Suite 109
Honolulu, HI 96865
Phone (808) 586-0100, Fax (808) 586-0185

(continued)

TABLE 9.2 (*CONTINUED*)

Idaho
Cathy Hart, State LTC Ombudsman
Idaho Commission on Aging
PO Box 83720
3380 American Terrace, Suite 120
Boise, ID 83720-0007
Phone (877) 471-2777, Fax (208) 334-3033

Illinois
Beverly Rowley, State LTC Ombudsman
Illinois Department on Aging
421 East Capitol Avenue, Suite 100
Springfield, IL 62701-1789
Phone (217) 785-3143, Fax (217) 524-9644

Indiana
Arlene Franklin, State LTC Ombudsman
Indiana Division Disabilities/Rehab Services
402 West Washington St., Room W 454
PO Box 7083
Indianapolis, IN 46207-7083
Phone (800) 545-7763, Fax (317) 232-7867

Iowa
Debi Meyers, State LTC Ombudsman
Iowa Department of Elder Affairs
Clemens Building, 200 10th Street
Des Moines, IA 50309-3609
Phone (515) 242-3327, Fax (515) 242-3300

Kansas
Matthew Hickam, State LTC Ombudsman
Kansas Office of the State LTC Ombudsman
610 SW 10th Street, 2nd Floor
Topeka, KS 66612-1616
Phone (785) 296-3017, Fax (785) 296-3916

Kentucky
Acting State Ombudsman
State LTC Ombudsman
Office of Aging Services
275 East Main Street, 5W-A
Fankfort, KY 40621
Phone (800) 372-2991, Fax (502) 564-4595

Louisiana
Linda Sadden, State LTC Ombudsman
Louisiana State LTC Program
412 N. 4th Street, 3rd Floor
PO Box 80374
Baton Rouge, LA 70802
Phone (225) 342-7100, Fax (225) 342-7144

TABLE 9.2 (*CONTINUED*)

Maine
Brenda Gallant, State LTC Ombudsman
Maine State LTC Ombudsman Program
1 Weston Court, PO Box 128
Augusta, ME 04332
Phone (207) 621-1079, Fax (207) 621-0509

Maryland
Patricia Bayliss
Maryland Dept. of Aging
301 West Preston Street, Room 1007
Baltimore, MD 21201
Phone (410) 767-1100, Fax (410) 333-7943

Massachusetts
Mary McKenna, State LTC Ombudsman
Massachusetts Executive Office of Elder Affairs
1 Ashburton Place, 5th Floor
Boston, MA 02108-1518
Phone (617) 727-7750, Fax (617) 727-9368

Michigan
State Ombudsman
Citizens for Better Care
4750 Woodward Avenue, Suite 410
Detroit, MI 48201-1308
Phone (313) 832-6387, Fax (313) 832-7407

Minnesota
Sharon Zoesch, State LTC Ombudsman
Office of Ombudsman for Older Minnesotans
121 East Seventh Place, Suite 410
St. Paul, MN 55101
Phone (800) 657-3591, Fax (651) 297-5654

Mississippi
Anniecde McLemore, State LTC Ombudsman
Mississippi Dept. of Human Services
750 North State Street
Jackson, MS 39202
Phone (601) 359-4927, Fax (601) 359-9664

Missouri
Carol Scott, State LTC Ombudsman
Missouri Division on Aging
PO Box 1337
Jefferson City, MO 65102
Phone (800) 309-3282, Fax (573) 751-8687
Web site: www.dss.state.mo.us/da/ombud.htm

(continued)

TABLE 9.2 (*CONTINUED*)

Montana
Robin Homan, State LTC Ombudsman
Senior & LTC Division
Montana Dept. of Health & Human Services
PO Box 4210
111 Sanders
Helena, MT 59604-4210
Phone (800) 551-3191, Fax (406) 444-7743

Nebraska
Cindy Kadavy, State LTC Ombudsman
Division of Aging Services
PO Box 95044
Lincoln, NE 68509-5044
Phone (402) 471-2307, Fax (402) 471-4619
Web site: www.hhs.state.ne

Nevada
Gilda Johnstone, State LTC Ombudsman
Nevada Division for Aging
445 Apple Street, #104
Reno, NV 89502
Phone (775) 688-2964, Fax (775) 688-2969

New Hampshire
Ronald Adcock, Acting State LTC Ombudsman
Office of Ombudsman
NH LTC Ombudsman Program
129 Pleasant Street
Concord, NH 03301
Phone (603) 271-4375, Fax (603) 271-4771

New Jersey
William Isele, State LTC Ombudsman
Office of Ombudsman
PO Box 807
Trenton, NJ 08625-0807
Phone (609) 943-4026, Fax (609) 943-3479

New Mexico
Agapito Silva, State LTC Ombudsman
New Mexico State Agency
228 East Palace Avenue
Sante Fe, NM 87501
Phone (505) 827-7663, Fax (505) 827-7649

New York
Faith Fish, State LTC Ombudsman
New York State Office
2 Empire State Plaza, Agency Building #2
Albany, NY 12223-0001
Phone (518) 474-7329, Fax (518) 474-7761

TABLE 9.2 (*CONTINUED*)

North Carolina
Sharon Wilder, State LTC Ombudsman
North Carolina Division
2101 Mail Service Center, Room 634
Raleigh, NC 27699
Phone (919) 733-8395, Fax (919) 733-0443

North Dakota
Helen Funk, State LTC Ombudsman
LTC Ombudsman Program
Aging Services Division
600 South 2nd Street
Bismarck, ND 58504
Phone (800) 451-8693, Fax (701) 328-8989

Ohio
Beverly Laubert, State LTC Ombudsman
Ohio Department of Aging
50 West Broad Street, 9th Floor
Columbus, OH 43215
Phone (614) 644-7922, Fax (614) 644-5201

Oklahoma
Esther Houser, State LTC Ombudsman
Aging Services Division
312 NE 28th Street
Oklahoma City, OK 73103
Phone (405) 521-6734, Fax (405) 521-2086

Oregon
Meredith Cote, State LTC Ombudsman
Oregon Office of the LTC Ombudsman
3855 Wolverine NE, Suite 6
Salem, OR 97305-1251
Phone (503) 378-6533, Fax (503) 373-0852

Pennsylvania
Cynthia Boyne, State LTC Ombudsman
555 Walnut Street, 5th floor
PO Box 1089
Harrisburg, PA 17111
Phone (717) 783-7247, Fax (717) 772-3382

Puerto Rico
Norma Venegas, State LTC Ombudsman
Puerto Rico Governor's Office
Call Box 50063, Old San Juan Station
San Juan, PR 00902
Phone (787) 725-1515, Fax (787) 721-6510

(continued)

TABLE 9.2 (*CONTINUED*)

Rhode Island
Roberta Hawkins
State LTC Ombudsman
Alliance for Better Long Term Care
422 Post Road, Suite 204
Warwick, RI 02888
Phone (401) 785-3340, Fax (401) 785-3391

South Carolina
Jon Cook
State LTC Ombudsman
SC Dept. of Health and Human Services
PO Box 8206
Columbia, SC 29202-8206
Phone (800) 868-9095, Fax (803) 898-4513

South Dakota
Jeff Askew
State LTC Ombudsman
Department of Social Services
South Dakota Office of Aging
700 Governors Drive
Pierre, SD 57501-2291
Phone (605) 773-3656, Fax (605) 773-6834

Tennessee
Adrian Wheeler
State LTC Ombudsman
Tennessee Commission on Aging and Disability
Andrew Jackson Building
500 Deaderick Street, 9th Floor
Nashville, TN 37243
Phone (615) 741-2056, Fax (615) 741-3309

Texas
John Willis
State LTC Ombudsman
Texas Department on Aging
4900 N. Lamar Blvd, 4th Floor, PO Box 12786
Austin, TX 78711
Phone (800) 252-2412, Fax (512) 424 6890
Web site: www.tdoa.state.tx.us

Utah
Chad McNiven
State LTC Ombudsman
Department of Human Services
Utah Division of Aging
120 North 200 West
Salt Lake City, UT 84101
Phone (801) 538-3924, Fax (801) 538-4395

TABLE 9.2 (*CONTINUED*)

Vermont
Jacqueline Majoros
Vermont Legal Aid, Inc.
264 North Winooski
PO Box 1367
Burlington, VT 05402
Phone (802) 863-5620, Fax (802) 863-7152

Virginia
Joani Latimer
State LTC Ombudsman
Virginia Association
530 East Main Street, Suite 428
Richmond, VA 23219
Phone (804) 644-2923, Fax (804) 644-5640
Web site: www.vaa.gov

Washington
Kary Hyre
State LTC Ombudsman
1200 South 336th Street, PO Box 23699
Federal Way, WA 98093
Phone (253) 838-6810, Fax (253) 815-8173

West Virginia
Larry Medley
State LTC Ombudsman
West Virginia Bureau
1900 Kanawha Blvd. E.
Charleston, WV 25302
Phone (304) 558-3317, Fax (304) 558-0004

Wisconsin
George Potaracke
State LTC Ombudsman
Wisconsin Board on Aging
214 North Hamilton Street
Madison, WI 53703
Phone (608) 266-8945, Fax (608) 261-6570

Wyoming
Deborah Alden
State LTC Ombudsman
Wyoming Senior Citizens
756 Gilchrist, PO Box 94
Wheatland, WY 82201
Phone (307) 322-5553, Fax (307) 322-3283

CHAPTER 10:

Associations, Organizations, Agencies, and Other Resources

CHAPTER 10:

Associations, Organizations, Agencies, and Other Resources

Associations and Organizations

(Source: Leadership Council of Aging Organizations)

This section presents a list of associations and organizations that can provide valuable help and information for your ElderCare practice. As your practice develops, you may be confronted with numerous and varied issues, situations, and questions that you will need assistance with in resolving. The associations and organizations listed here are excellent resources for finding that assistance.

AARP: The American Association of Retired Persons

601 E Street NW
Washington, DC 20049
Phone: (800) 424-3410; fax: (202) 434-2320
Web site: www.aarp.org

An organization with various goals, one of which is helping elderly Americans achieve lives of independence, dignity, and purpose

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Access America for Seniors

Web site: www.seniors.gov

A site that allows seniors to request government documents online and provides resource information about programs for seniors and links to other senior sites

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AFSCME Retiree Program

1625 L Street NW
Washington, DC 20036
Phone: (202) 429-1000; fax: (202) 429-1293
Web site: www.afscme.org

A public employee and health care workers' union

Alliance for Aging Research

2021 K Street NW, Suite 305
Washington, DC 20006
Phone: (202) 293-2856; fax: (202) 785-8574
Web site: www.agingresearch.org

A nonprofit organization dedicated to promoting research on human aging and the independence of elderly Americans

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Alzheimer's Association

1319 F Street NW, Suite 710
Washington, DC 20004
Phone: (800) 272-3900; fax: (202) 393-2109
Web site: www.alz.org

National voluntary health agency dedicated to researching the prevention, cures, and treatments of Alzheimer's disease and related disorders

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American Association for International Aging

1900 L Street NW, Suite 512
Washington, DC 20036
Phone: (202) 833-8893; fax: (202) 833-8762
Website: www.unm.edu

A governmental organization that undertakes applied research and information exchange on global aging

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American Association of Homes and Services for the Aging

2519 Connecticut Avenue NW
Washington, DC 20008-1520
Phone: (202) 783-2242; fax: (202) 783-2255
Web site: www.aahsa.org

Represents not-for-profit organizations dedicated to providing high-quality health care, housing and services to the nation's elderly

---

American Foundation for the Blind

11 Penn Plaza, Suite 300
New York, NY 10001
Phone: (800) AFB-LINE
Web site: www.afb.org

A national resource for people who are blind or visually impaired, the organizations that serve them, and the general public

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American Geriatrics Society

350 Fifth Avenue
New York, NY 10118
Phone: (212) 308-1414; fax: (212) 832-8646
Web site: www.americangeriatrics.org

Professional organization of health care providers dedicated to improving the health and well-being of all elderly people

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American Institute of CPAs

1211 Avenue of the Americas
New York, NY 10036-8775
Phone and fax: See section "AICPA ElderCare Services Task Force Members" (page 304)
Web site: www.aicpa.org; www.cpa2biz.com

Extensive discussion of assurance services and recent activity of related committees and task forces

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American Society on Aging

833 Market Street, Suite 511
San Francisco, CA 94103-1824
Phone: (415) 974-9600; fax: (415) 974-0300
Web site: www.asaging.org

Provider of professional information in the field of aging through meetings, seminars, and conferences held throughout the country

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Association Nacional por Personas Mayores

234 East Colorado Blvd., Suite 300
Pasadena, CA 91101
Phone: (626) 564-1988; fax: (626) 564-2559
www.lcao.org/members/association_nacional_por-personals.htm

Formed to inform policy makers and the public regarding the status, needs, and capabilities of elderly Hispanics

---

Association for Gerontology and Human Development in Historically Black Colleges and Universities

PO Box 311495
Atlanta, GA 21131
Phone: (404) 752-1612; fax: (404) 762-1159

Provides education, training, and research programs in gerontology for two- and four-year colleges

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Association for Gerontology in Higher Education

1030 15th Street NW, Suite 240
Washington, DC 20005-1503
Phone: (202) 289-9806; fax: (202) 289-9824
Web site: www.aghe.org

Established to advance gerontology as a field of study in institutions of higher learning

---

Association of Jewish Aging Services

316 Pennsylvania Avenue SE, Suite 402
Washington, DC 20003-1175
Phone: (202) 543-7500; fax: (202) 543-4090
Web site: www.ajas.org

Serves as an information clearinghouse, advocacy, and educational organization for its services

---

B'nai Brith Center for Senior Housing and Services

1640 Rhode Island Avenue NW
Washington, DC 20036
Phone: (202) 857-6535; fax: (202) 857-0980
Web site: www.bnaibrith.org

A Jewish service organization that engages in community service, education, programs for youth, and public affairs advocacy

---

Eldercare America, Inc.

1141 Loxford Terrace
Silver Spring, MD 20901
Phone and fax: (301) 593-1621

Represents the interests and speaks on behalf of family members who care for older relatives and promotes more responsive public policies and programs to strengthen caregivers

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Elderweb Online

1305 Chadwick Drive
Normal, IL 61761
Phone and fax: (309) 451-3319
Web site: www.elderweb.com

Site has numerous links to Web resources for ElderCare professionals and consumers

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Families USA

1334 G Street NW
Washington, DC 20005
Phone: (202) 737-6340; fax: (202) 347-2417
Web site: www.familiesusa.org

A national advocacy organization working for fundamental change in America's health and long-term care systems

---

Gerontological Society of America

1030 15th Street NW, Suite 250
Washington, DC 20005-4006
Phone: (202) 842-1275; fax: (202) 842-1150
Web site: www.geron.org

A national organization in aging dedicated to advancing knowledge, generating new ideas, and translating research findings into practice

---

Green Thumb, Inc.

2000 North Fourteenth Street, Suite 800
Arlington, VA 22201
Phone: (703) 522-7272; fax: (703) 522-0141
Web site: www.greenthumb.org

National nonprofit organization whose mission is to make a positive difference in local communities by empowering mature individuals to use their talents and abilities

---

Health Insurance Association of America

1201 F Street NW
Washington, DC 20001-1204
Phone: (202) 824-1600
Web site: www.hiaa.org

Information on Medigap policies and long-term care insurance

Insure.com

76 LaSalle Road
West Hartford, CT 06107
Phone: (860) 233-2800; fax: (860) 231-7357 (Address all insurance questions to editor@insure.com.)
Web site: www.insure.com

Health, life, auto, and other insurance advice; annuity advice, including portfolio performance

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Law for All

950 Parker Street
Berkeley CA 94710-2524
Phone: (800) 728-3555; fax: (800) 645-0895
Web site: www.nolo.com

National Asian Pacific Center on Aging

1511 Third Street
Melbourne Tower, Suite 914
Seattle, WA 98101-1626
Phone: (206) 624-1221; fax: (206) 624-1023

National organization committed to the well-being of elderly Asians and Pacific Islanders

---

National Association of Area Agencies on Aging

927 15th Street NW, Sixth Floor
Washington, DC 20005
Phone: (202) 296-8130; fax: (202) 296-8134
Web site: www.N4A.org

Represents the interests of a network of local agencies dedicated to helping all elderly Americans remain healthy and independent

---

National Association of Foster Grandparent Program Directors, Inc.

7400 Laurel Hill Oaks Circle
Orlando, FL 32818
Phone: (407) 298-4180; fax: (407) 298-2725

Provides advocacy and visibility for the Foster Grandparent Program, program sponsors, and other community groups

---

National Association of Home Care

228 Seventh Street SE
Washington, DC 20003
Phone: (202) 547-7424; fax: (202) 547-9559
Web site: www.nahc.org

A nonprofit organization representing the nation's home care providers and the individuals they serve

---

National Association of Meal Programs

1414 Prince Street, Suite 202
Alexandria, VA 22314
Phone: (703) 548-5558; fax: (703) 548-8024
Web site: www.mealsonwheelsassn.org

The oldest organization in the United States representing those who provide meal services to people in need

---

National Association of Nutrition and Aging Services Programs

PO Box 9007
Grand Rapids, MI 49509
Phone: (616) 531-9909; fax: (616) 531-3101

A professional membership organization representing nutrition and other home and community based providers serving the elderly and disabled

---

National Association of Retired Federal Employees

606 N. Washington Street
Alexandria, VA 22314-1914
Phone: (703) 838-7760; fax: (703) 838-7785
Web site: www.narfe.org

Offers counseling, information, and assistance to members who need help dealing with government agencies

---

National Association of Retired Senior Volunteer Program (RSVP) Directors

PO Box 852
Athens, AL 35612
Phone: (256) 232-7207; fax: (256) 232-8842

Provides visibility and advocacy for RSVP and elderly Americans to the legislative and executive branches of the federal government, and other appropriate governmental and national units

---

National Association of Senior Companion Project Directors

2195 Ironwood Court
Coeur D'Aline, ID 83814
Phone: (208) 664-8544; fax: (208) 664-6623

Provides a national focus for Senior Companion Directors

National Association of State Units on Aging

1225 I Street NW, Suite 725
Washington, DC 20005
Phone: (202) 898-2578; fax: (202) 898-2583
Web site: www.nasua.org

A national public interest organization that provides information, technical assistance, and professional development support to its members; works to promote social policy at the federal and state level

---

National Caucus and Center on Black Aged

1220 L Street
Washington, DC 20005
Phone: (202) 637-8400; fax (202) 347-0895
Web site: www.ncba-blackaged.org

A nonprofit organization that works to improve the quality of life for elderly black Americans

---

National Committee to Preserve Social Security and Medicare

10 G Street NE, Ste. 600
Washington, DC 20002
Phone: (202) 216-0420; fax: (202) 216-0446
Web site: www.spry.org

An advocacy and education program dedicated to protecting and enhancing federal programs vital to seniors' health and economic well-being

---

National Council of Senior Citizens

8403 Colesville Road, Ste. 1200
Silver Spring, MD 20910-3314
Phone: (301) 578-8800; fax (301) 578-8999
Web site: www.ncscinc.org

An advocacy organization of senior activists in affiliated local clubs and area and state councils; works for state and federal legislation to benefit elderly people

---

National Council on the Aging

409 Third Street SW, Suite 200
Washington, DC 20024
Phone: (202) 479-1200; fax: (202) 479-0735
Web site: www.ncoa.org

A private, nonprofit organization that serves as a resource for information, training, technical assistance, advocacy, and leadership in all aspects of aging

---

National Hispanic Council on Aging

2713 Ontario Road NW, Suite 200
Washington, DC 20009
Phone: (202) 745-2521; fax: (202) 745-2522
Web site: www.nhcoa.org

A private, nonprofit organization that works to promote the well-being of elderly Hispanics

---

National Osteoporosis Foundation

1232 22nd Street NW
Washington, DC 20037-1292
Phone: (202) 223-2226; fax: (202) 223-2237
Web site: www. nof.org

A volunteer health agency dedicated to reducing the widespread incidence of osteoporosis

---

National Senior Citizens Law Center

1101 Fourteenth Street NW, Ste. 400
Washington, DC 20005
Phone: (202) 289-6976; fax: (202) 289-7224
Web site: www.nsclc.org

A public interest law firm that specializes in the legal problems of elderly individuals

---

National Senior Service Corps Directors Association Retired Senior Volunteer Program

4958 Butteworth Place NW
Washington, DC 20016
Phone: (202) 244-2244; fax (202) 244-2322

Association of project directors from RSVP, Foster Grandparents, and Senior Companions

---

Older Women's League

666 Eleventh Street NW, Suite 700
Washington, DC 20001
Phone: (202) 783-6686; fax: (202) 638-2356
Web site: www.owl-national.org

A national organization addressing the special concerns and needs of women as they age to enable its members to achieve economic and social equity and to improve the image and status of middle-aged and elderly women

---

UAW, International Union Retired and Older Workers Department

8731 East Jefferson Avenue
Detroit, MI 48214
Phone: (313) 926-5231; fax: (313) 926-5666

Develops programs and provides services to UAW retirees

Federal Agencies

Following is a list of federal agencies that can provide valuable help and information for your ElderCare practice. Many of the Web sites of these agencies contain useful news and resources, essential to maintaining an ElderCare practice that is up-to-date with the latest federal programs and regulations.

Administration on Aging

Cohen Building
330 Independence Avenue SW
Washington, DC 20201
Phone: (202) 619-7501; fax: (202) 260-1012
Web site: www.aoa.dhhs.gov

Federal focal point and advocacy agency for elderly persons, responsible for carrying out the Older Americans Act

---

Department of Health and Human Services, Health Care Financing Administration (HCFA)

P.O. Box 340
Columbia, MD 21945
Phone: (410) 786-3000
Web sites: www.hcfa.gov; www.medicare.gov

Agency responsible for Medicare and Medicaid; offers excellent consumer information

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Medicare Toll-Free Hotline

Phone: (800) 633-4227
Web site: www.medicare.gov

Recorded information 24 hours a day, weekends and holidays included

---

National Aging Information Center

330 Independence Avenue SW, Room 4656
Washington, DC 20201
Phone: (202) 619-7501; fax: (202) 401-7620
Web site: www.aoa.dhhs.gov/naic

Central source of many program- and policy-related materials and statistical data

---

National Center on Elder Abuse

1225 I Street NW, Suite 225
Washington, DC 20005
Phone: (202) 898-2586; fax: (202) 898-2583
Web site: www.elderabusecenter.org

Operates the Clearinghouse on Abuse and Neglect of the Elderly, provides technical assistance, and disseminates information

---

National ElderCare Locator

Phone: (800) 677-1116 (Monday-Friday, 9 a.m.–8 p.m. EST)
Web site: www.aoa.dhhs.gov

A nationwide directory assistance program to assist individuals in locating local aging support centers

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National Institute of Mental Health

NIMH Public Inquiries
6001 Executive Blvd., RM 8184, MSC 9663
Bethesda, MD 20892-9663
Phone: (301) 443-4513; fax (301) 443-4279
Web site: www.nimh.nih.gov

Conducts and supports mental health research

Social Security Administration

Phone: (800) 772-1213; hearing impaired: tty # (800) 325-0778
Web site: www.ssa.gov

State Offices on Aging

Following is a list of state offices on aging. These offices coordinate services for elderly Americans. They provide information on services, programs, and opportunities for consumers and professionals.

State	Phone Number	Fax and Other Phone Number
Alabama	(334) 242-5743	Fax: (334) 242-5594
Alaska	(907) 465-3250	Fax: (907) 465-4716
Arizona	(602) 542-4446	Fax: (602) 542-6575
Arkansas	(501) 682-2441	Fax: (501) 682-8155
California	(916) 322-5290	(916) 324-1903
Colorado	(303) 866-2800	(303) 866-2696
Connecticut	(860) 424-5298	(860) 424-4966
Delaware	(302) 577-4791	(302) 577-4793
District of Columbia	(202) 724-5622	(202) 724-4979
Florida	(850) 414-2000	(850) 414-2004
Georgia	(404) 657-5258	(404) 657-5285
Hawaii	(808) 586-0100	(808) 586-0185
Idaho	(208) 334-3833	(208) 334-3033
Illinois	(217) 785-3356	(217) 785-4477
Indiana	(317) 232-7020	(317) 232-7867
Iowa	(515) 242-3333	(515) 242-3300
Kansas	(785) 296-4986	(785) 296-0256
Kentucky	(502) 564-6930	(502) 564-4595
Louisiana	(225) 342-7100	(225) 342-7133
Maine	(207) 624-5335	(207) 624-5361
Maryland	(410) 767-1100	(410) 333-7943
Massachusetts	(617) 727-7750	(617) 727-9368
Michigan	(517) 373-8230	(517) 373-4092
Minnesota	(651) 296-2770	(651) 297-7855
Mississippi	(601) 359-4925	(601) 359-4370
Missouri	(573) 751-3082	(573) 751-8687
Montana	(406) 444-4077	(406) 444-7743
Nebraska	(402) 471-2307	(402) 471-4619

(continued)

State	Phone Number	Fax and Other Phone Number
Nevada	(775) 687-4210	(775) 687-4264
New Hampshire	(603) 271-4680	(603) 271-4643
New Jersey	(609) 943-3436	(609) 588-3317
New Mexico	(505) 827-7640	(505) 827-7649
New York	(518) 474-5731	(518) 474-0608
North Carolina	(919) 733-3983	(919) 733-0443
North Dakota	(701) 328-8910	(701) 328-8989
Ohio	(614) 466-5500	(614) 466-5741
Oklahoma	(405) 521-2281	(405) 521-2086
Oregon	(503) 945-5811	(503) 373-7823
Pennsylvania	(717) 783-1550	(717) 772-3382
Puerto Rico	(787) 721-5710	(787) 721-6510
Rhode Island	(401) 222-2858	(401) 222-2130
South Carolina	(803) 898-2501	(803) 898-4515
South Dakota	(605) 773-3656	(605) 773-6834
Tennessee	(615) 741-2056	(615) 741-3309
Texas	(512) 424-6840	(512) 424-6890
Utah	(801) 538-3910	(801) 538-4395
Vermont	(802) 241-2400	(802) 241-2325
Virgin Islands	(340) 774-0930	(340) 774-3466
Virginia	(804) 662-9333	(804) 662-9354
Washington	(360) 725-2310	(360) 438-8633
West Virginia	(304) 558-3317	(304) 558-5699
Wisconsin	(608) 266-2536	(608) 267-3203
Wyoming	(307) 777-7986	(307) 777-5340

State Vocational and Rehabilitation Offices

Presented in this section is a list of state vocational and rehabilitation offices. State vocational and rehabilitation agencies coordinate and provide services for disabled persons. These services include counseling, evaluation, training, and job placement. There are also services for the blind, deaf, and those with lesser sight and hearing impairments. These agencies may be able to provide information and resources on assistive devices and technology.

State	Phone Number
Alabama	(800) 441-7607
Alaska	(800) 478-5389
American Samoa	011-684-633-2696
Arizona	(602) 789-9129
Arkansas	(501) 296-1600
California	(916) 263-8981
Colorado	(303) 620-4153
Connecticut	(860) 723-1111
Delaware	(302) 351-1441
District of Columbia	(202) 645-5807
Florida	(850) 488-6210
Georgia	(404) 657-2238
Guam	Not available
Hawaii	(808) 587-1060
Idaho	(208) 334-2411
Illinois	(800) 843-6154
Indiana	(800) 545-7763
Iowa	(515) 281-4311
Kansas	(785) 296-3959
Kentucky	(800) 372-7172
Louisiana	(225) 295-8900
Maine	(207) 287-3707
Maryland	(410) 554-9388
Massachusetts	(617) 727-2183
Michigan	(800) 605-6722
Minnesota	(800) 328-9095
Mississippi	(601) 351-1441
Montana	(406) 444-2590
Nebraska	(402) 471-3644
Nevada	(702) 486-5230
New Hampshire	(603) 271-4515
New Jersey	(609) 292-5987

(continued)

State	Phone Number
New Mexico	(505) 954-8500
New York	(212) 630-2300
North Carolina	(919) 733-3364
North Dakota	(701) 328-8800
Ohio	(614) 466-7730
Oklahoma	(405) 951-3400
Oregon	(503) 325-7335
Pennsylvania	(800) 922-9536
Rhode Island	(800) 752-0888
South Carolina	(803) 896-6500
South Dakota	(800) 265-9679
Tennessee	(615) 313-4700
Texas	(800) 687-2676
Utah	(301) 443-2216
Vermont	(802) 244-8103
Virginia	(800) 552-5019
Washington	(800) 552-7103
West Virginia	(540) 963-6005
Wisconsin	(414) 438-4860
Wyoming	(307) 777-7389

Better Business Bureaus

Better business bureaus (BBBs) are nonprofit organizations supported primarily by local business memberships. BBBs strive to promote an ethical marketplace by providing alternative dispute resolution. BBBs offer a variety of consumer services, such as providing educational materials, answering consumer questions, and providing information about a company, particularly whether there are unanswered or unsettled complaints or other problems. Consumer requests should be submitted in writing, and the BBB will then take up complaints with companies. BBBs may offer an alternative dispute settlement process, such as arbitration or mediation. BBBs do not judge or rate individual products or trends, handle complaints concerning the price of goods or services, handle employee/employer wage disputes, or give legal advice.

Presented below is a list of state BBBs. The Council of Better Business Bureaus is the umbrella organization for the BBBs and also provides programs and publications for consumers. Its phone number is (703) 276-0100.

State	Phone Number
Alabama	(205) 558-2222
Alaska	(907) 562-0704
Arizona	(602) 264-1721
Arkansas	(501) 664-7274
California	(858) 496-2131
Colorado	(719) 636-1155
Connecticut	(203) 269-2700
Delaware	(302) 594-9200
District of Columbia	(202) 393-8000
Florida	(904) 721-2288
Georgia	(404) 766-0875
Hawaii	(808) 536-6956
Idaho	(208) 342-4649
Illinois	(312) 832-0500
Indiana	(513) 421-3015
Iowa	(515) 243-8137
Kansas	(316) 263-3146
Kentucky	(502) 583-6546
Louisiana	(504) 581-6222
Maine	(207) 878-2715
Maryland	(410) 347-3990
Massachusetts	(508) 652-4800
Michigan	(616) 774-8236
Minnesota	(651) 699-1111
Mississippi	(601) 987-8282
Missouri	(314) 645-3300
Montana	No bureau
Nebraska	(402) 391-7612
Nevada	(702) 322-0657
New Hampshire	(603) 224-1991
New Jersey	(609) 588-0808
New Mexico	(505) 346-0110
New York	(212) 533-7500

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State	Phone Number
North Carolina	(704) 527-0012
North Dakota	(651) 699-1111
Ohio	(513) 421-3015
Oklahoma	(918) 492-1266
Oregon	(503) 226-3981
Pennsylvania	(412) 456-2700
Rhode Island	(401) 785-1212
South Carolina	(803) 254-2525
South Dakota	(712) 252-4501
Tennessee	(423) 266-6144
Texas	(214) 220-2000
Utah	(801) 892-6009
Vermont	(617) 426-9000
Virginia	(804) 648-0016
Washington	(509) 455-4200
West Virginia	(330) 454-9401
Wisconsin	(414) 847-6000
Wyoming	(970) 484-1348

PUBLICATIONS

Presented in this section are directories, continuing professional education (CPE) courses, and other publications that can provide valuable information on aging and other matters of interest to those CPAs performing ElderCare services.

AICPA Training Courses

The AICPA ElderCare Services Task Force has worked with the AICPA's Professional Development Team to develop a series of training courses designed to fulfill the multidisciplinary needs of the CPA ElderCare Services practitioner. Five seminar courses (also available in self-study) are currently available to meet your training needs.

- *Developing an ElderCare Practice* (product number 730070). This course provides you with an overview of the service, and introduces you to the various disciplines with which you need to be familiar in order to competently provide CPA ElderCare Services. Available as video course (product number 181640).
- *ElderCare: The Medical and Psychosocial Effects of Aging* (product number 731403). This course gives you a working knowledge of the most common physical and psychosocial

effects of aging, as well as showing you how to improve your communications with the elderly client. Available as video course (product number 181750).

- *ElderCare Practice Management and Practice Development Issues in CPA ElderCare Services* (product number 731402). This course addresses the practice issues unique to CPA ElderCare Services. The course topics range from engagement letters to quality control for the practitioner, with practice aids and checklists designed by the AICPA ElderCare Task Force specifically for this service. Available as video course (product number 181740).
- *ElderCare: The Financial Issues of Aging* (product number 731400). This course addresses the planning needs and financial concerns of aging, including planning for the costs of long-term care.
- *ElderCare: The Legal Issues of Aging* (product number 731406). This course covers powers of attorney, living wills, and other legal issues related to the elderly. It also discusses how some of these legal issues affect the CPA ElderCare practitioner. Available as video course (product number 181760).

In addition, you can gain valuable training from the following highly recommended courses:

- *Professional Ethics for CPAs* (product number 731593). This product is a CPE course that reviews the AICPA's Code of Professional Conduct and its application in practice. It explains the reasoning and application of the Code and explains the fundamentals, definitions, implementation, and authoritative bases of the Code.
- *Meeting the Older Client's Needs: Tax, Health Care and Asset Protection Planning* (product number 732070). This is a CPE course that provides ideal training for the practitioner who has or expects to have elderly clients. This practical course shows you how to leverage basic tax and financial information into a wide range of custom value-added services. It provides you with ready-to-use analytical tools and prepares you to meet your client's unique needs.

Call the AICPA at (888) 777-7077 to order these valuable training courses.

CPA ElderCare Marketing Toolkit

The AICPA contracted with the advertising firm of Hill, Holiday, Connors & Cosmopoulos to develop an ElderCare Marketing Toolkit for practitioners offering CPA ElderCare Services or for those who wish to develop a practice in this area. The AICPA ElderCare Services Task Force oversaw the development of this kit. The advertising kit contains two direct mail letters, four brochures, and sixteen advertisements suitable for your local market. Letters are targeted directly to the elderly and also targeted directly toward their children.

All letters and forms come in electronic form and are customizable for each individual firm, by taking the CD-ROM to a print shop, or by using Quark Xpress or Adobe Photoshop, if your firm has those programs. These advertisements are professionally produced by our advertising firm for use by you. To order, call (888) 777-7077 and ask for product number 022508.

Assurance Services Alert: CPA ElderCare Services—2001 (product number 022248)

Serving as both an update on new developments as well as an introduction to those unfamiliar with CPA ElderCare services, this Alert contains an abundant amount of

information, a list of helpful Web sites and a listing of ElderCare Task Force members to contact for further information.

AICPA LifeCare Professional Subscription

This online service offers a library, pertinent news items, and an "Ask the Experts" function in addition to providing you with around-the-clock access to a list of providers of adult care services nationwide. This service, usually available only to covered employees of major corporations and government agencies, is now available to AICPA members through a special agreement with LifeCare.com. This site is of enormous value to CPAs offering CPA ElderCare Services since it saves considerable time in researching issues related to older adults and provides information about licensed service providers. And at $119 for an annual subscription, it costs less than $10 per month. Call (888) 777-7077 to subscribe.

Directory of Members—National Association of Geriatric Care Managers

This publication helps CPAs locate a geriatric care manager in specific areas. To obtain this directory, call (520) 881-8008, or send $35.00, your name, and address to the following address:

National Association of Professional Geriatric Care Managers
1604 North Country Club Road
Tucson, AZ 85716-3102

How to Protect Your Life Savings from Catastrophic Illness

This book was written by Harley Gordon, attorney at law, and can be obtained by calling (800) 582-2889, or sending $19.95 plus $3.00 shipping and handling, your name, and address to the following address:

Financial Strategies Press
15 Broad Street, Suite 700
Boston, MA 02109

National Academy of Elder Law Attorneys Registry

The National Academy of Elder Law Attorneys (NAELA) is a professional association of attorneys concerned with improving the availability of legal services to elderly people. This NAELA registry lists over 375 attorneys in 43 states who practice elder law. To obtain the registry, send $25.00, your name, address, and telephone number to the following address, or call (520) 881-4005.

National Academy of Elder Law Attorneys
1604 North Country Club Road
Tucson, AZ 85716

Resource Directory for Older People

This directory includes federal resource centers, professional societies, private groups, and volunteer programs. More than 200 national organizations and agencies concerned with resources for elderly Americans are included. The directory contains names, addresses, phone numbers, fax numbers, and e-mail information.

To obtain the directory, send $11.00 to the following address and request publication number 0106200145-6. For credit card orders, call (202) 512-1800.

Superintendent of Documents
P.O. Box 371954
Pittsburgh, PA 15250-7954

Other Books About Aging

Following is a list of some books on aging, caregiving, family relationships, financial issues, and health. Many public libraries and bookstores can provide a wide variety of information related to aging, old age, and elderly people.

- *The 36 Hour Day: A Family Guide to Caring for Persons with Alzheimer's Disease,* by N. L. Mace and P. V. Pabins (Baltimore, Md.: Johns Hopkins Press, 1991)
- *Adult Development and Aging,* by M. Perlmutter and E. Hall (New York: John Wiley and Sons, 1992)
- *Aging and Mental Health,* by R. N. Butler, M. I. Lewis, and T. Sunderland (New York: Allyn and Bacon, 1998)
- *Caring for the Elderly Client,* by M. A. Anderson and J. V. Braun (Philadelphia, Penn.: F. A. Davis and Co., 1995)
- *Caring for Your Aging Parents,* by C. Eisdorfer (New York: Putnam Publishing, 1995)
- *The Fountain of Age,* by B. Freidan (New York: Simon and Schuster, 1993)
- *Hiring Home Caregivers,* by H. O. Susik (Impact Books, 1995)
- *How and Why We Age,* by L. Hayflick and R. N. Butler (New York: Ballentine Books, 1996)
- *How Did I Become My Parent's Parent?* by H. S. Schiff (New York: Viking, 1996)
- *Successful Aging,* by R. L. Kahn, Ph.D., and J. W. Rowe, M.D. (New York: Pantheon Books, 1998)
- *The Validation Breakthrough: Simple Techniques for Communicating with People with Alzheimer's Type Dementia,* by N. Feil (Baltimore, Md.: Health Professions Press, 1993)

Telecommunications Services for Deaf and Speech-Impaired People

(Source: U.S. Office of Telecommunications & Information Applications)

Telecommunications relay services are a way to link telephone conversations between hearing individuals, using a standard (voice) telephone, and deaf and speech-impaired individuals, using a telecommunications device for the deaf (TDD). Relay services allow hearing individuals to call TDD numbers and allow deaf and speech-impaired individuals to call standard (voice) telephone numbers. Deaf or speech-impaired individuals who use a TDD can get assistance for calls to a TDD number by calling (800) 855-1155. If you need assistance and have TDD equipment, this phone number puts you in touch with a TDD operator, who can help you with matters such as directory assistance, collect calls, and calling card calls.

A number of states operate local relay services to link deaf, hearing-impaired, and speech-impaired individuals in their local areas. Consult the local telephone directory for information on the use, services provided, and dialing instructions for the local relay.

The Federal Relay Service (FRS) provides telecommunications service accessibility for individuals who are deaf, hearing-impaired, and speech-impaired to conduct official business nationwide with and in the federal government. FRS serves as an intermediary for conversations between hearing individuals, deaf, hearing-impaired, and speech-impaired individuals using TDD. The FRS toll-free TDD voice number is (800) 877-8339.

For more information on relay telecommunications or to obtain a FRS brochure on how to use the FRS service, call (800) 877-0996.

Where to Learn More About Aging

Presented in this section is a list of institutions that can provide additional information and courses in gerontology and aging studies. The source of this information is the Association for Gerontology in Higher Education (AGHE), 1030 15th Street NW, Suite 240, Washington, DC 20005-1503; phone: (202) 289-9806; fax: (202) 289-9824; Web site: www.aghe.org. Established in 1974 to advance gerontology as a field of study in institutions of higher learning, the AGHE is the only national membership organization devoted to gerontological and geriatrics education.

Alabama

Shelton State Community College, Tuscaloosa

University of Alabama, Birmingham

University of Alabama, Tuscaloosa

University of North Alabama, Florence

University of South Alabama, Mobile

Arizona

Arizona State University, Tempe

Arizona State University–West, Phoenix

Northern Arizona University, Flagstaff

Phoenix College, Phoenix

University of Arizona, Tucson

Yavapai College, Prescott

Arkansas

University of Arkansas, Fayetteville

University of Arkansas, Little Rock

University of Central Arkansas, Conway

California

American River College, Sacramento

California College for Health Sciences, National City

California State University; Fullerton

California State University; Sacramento

Chaffey College, Rancho Cucamonga

Charles R. Drew University, Los Angeles

Loma Linda University, Loma Linda
Los Angeles Pierce College, Woodland Hills
San Diego State University, San Diego
San Francisco State University, San Francisco
San Joaquin Delta College, Stockton
San Jose State University, San Jose
Stanford University, Stanford
University of California–Los Angeles
University of California–San Diego
University of California–San Francisco
University of LaVerne, LaVerne
University of Southern California, Los Angeles

Colorado

Community College of Denver, Denver
Metropolitan State College of Denver, Denver
Naropa University, Boulder
University of Colorado Health Sciences Center, Denver
University of Colorado–Colorado Springs
University of Denver, Denver
University of Northern Colorado, Greeley

Connecticut

Central Connecticut State University, New Britain
Quinnipiac College, Hamden
Southern Connecticut State University, New Haven
St. Joseph College, West Hartford
University of Connecticut, Storrs

Delaware

University of Delaware, Newark

Florida

Bethune Cookman College, Daytona Beach
Broward Community College, Ft. Lauderdale
Florida Atlantic University, Boca Raton
Florida Gulf Coast University, Fort Meyers
Florida International University, North Miami
Florida State University, Tallahassee
Lynn University, Boca Raton
Nova Southeastern University, Ft. Lauderdale
University of Central Florida, Orlando
University of Florida, Gainesville

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University of Miami, Miami
University of South Florida, Tampa

Georgia

Columbus State University, Columbus
Floyd College, Rome
Ft. Valley State College, Ft. Valley
Georgia State University, Atlanta
Kennesaw State College, Kennesaw
Southern Regional Education Board, Atlanta
State University at West Georgia, Carrollton
University of Georgia, Athens
Valdosta State University, Valdosta

Hawaii

University of Hawaii, Honolulu

Idaho

Boise State University, Boise
College of Southern Idaho, Twin Falls
Idaho State University, Pocatello

Illinois

Bradley University, Peoria
College of DuPage, Glen Ellyn
Concordia University, River Forest
Eastern Illinois University, Charleston
Garrett Evangelical Theological Seminary, Evanston
Illinois State University, Normal
John Logan College, Cartersville
National College of Chiropractic, Lombard
National Louis University, Evanston
Northeastern Illinois University, Chicago
Rosary College, River Forest
Southern Illinois University, Edwardsville
University of Illinois at Springfield, Springfield
Western Illinois University, Macomb
Wilbur Wright College, Chicago

Indiana

Ball State University, Muncie
Indiana University, Bloomington
Ivy Tech State College, Muncie
Manchester College, North Manchester
Purdue University, Ft. Wayne

Purdue University, West Lafayette
St. Mary of the Woods College, St. Mary of the Woods
University of Evansville, Evansville

Iowa

Drake University, Des Moines
Iowa State University, Ames
University of Iowa, Iowa City

Kansas

Ft. Hays State University, Hays
Kansas State University, Manhattan
University of Kansas, Lawrence
Wichita State University, Wichita

Kentucky

Eastern Kentucky University, Richmond
Kentucky State University, Frankfort
University of Kentucky, Lexington
University of Louisville, Louisville
Western Kentucky University, Bowling Green

Louisiana

Grambling State University, Grambling
New Orleans Baptist Theological Seminary, New Orleans
Northeast Louisiana University, Monroe
Tulane University, New Orleans
University of Louisiana, Monroe
University of New Orleans, New Orleans

Maine

University of New England, Biddeford
University of Southern Maine, Gorham

Maryland

Maryland Consortium for Gerontology in Higher Education (eight affiliates), Baltimore
Montgomery College, Rockville
University of Maryland, Baltimore
University of Maryland, College Park
University of Maryland, Eastern Shore

Massachusetts

American International College, Springfield
Assumption College, Worcester
Boston University, Boston

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Brandeis University, Waltham
Harvard University, Boston
Lasell College, Newton
North Shore Community College, Beverly
Salem State College, Salem
Springfield College, Springfield
Tufts University, Boston
University of Massachusetts, Boston
University of Massachusetts, Lowell
University of Massachusetts, North Dartmouth
Worcester State College, Worcester

Michigan

Central Michigan University, Mt. Pleasant
Eastern Michigan University, Ypsilanti
Grand Rapids Community College, Grand Rapids
Lansing Community College, Lansing
Michigan State University, East Lansing
Northern Michigan University, Marquette
University of Michigan, Ann Arbor
Wayne State University, Detroit
Western Michigan University, Kalamazoo

Minnesota

College of St. Scholastica, Duluth
Luther Theological Seminary, St. Paul
Mankato State University, Mankato
Minnesota State University, Mankato
St. Cloud State University, St. Cloud

Mississippi

Mississippi Geriatric Education Center, Jackson
William Carey College, Hattiesburg

Missouri

Avila College, Kansas City
Central Missouri State University, Warrensburg
Kalamazoo Valley Community College, Kalamazoo
Madonna University, Livonia
University of Missouri and Lincoln University Consortium, Columbia
Missouri Southern State College, Joplin
Missouri Western State College, St. Joseph
Southeast Missouri State University, Cape Girardeau
Southwest Missouri State University, Springfield

St. Louis University, St. Louis
St. Paul School of Theology, Kansas City
University of Missouri, Columbia, Kansas City, Rolla, St. Louis
Washington University, St. Louis
Webster University, St. Louis

Montana

University of Montana, Missoula

Nebraska

University of Nebraska, Omaha

Nevada

Peru State College, Peru
University of Nevada, Las Vegas
University of Nevada, Reno

New Hampshire

St. Anselm College, Manchester
University of New Hampshire, Durham

New Jersey

Caldwell College, Caldwell
Felician College, Lodi
Hudson County Community College, Jersey City
Kean College, Union
Monmouth College, West Long Branch
Montclair State University, Upper Montclair
Ocean County College, Toms River
Richard Stockton College of New Jersey, Pomona
Rutgers University, New Brunswick
Union County College, Cranford
William Paterson College, Wayne

New Mexico

University of New Mexico, Albuquerque

New York

Alfred University, Alfred
Canisius College, Buffalo
College of New Rochelle, New Rochelle
Columbia University, New York City
Columbia–Greene Community College, Hudson
Cornell University, Ithaca
Dominican College of Blauvelt, Orangeburg

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Hofstra University, Hempstead
Hostos Community College, Bronx
Hunter College, New York City
Ithaca College, Ithaca
Le Moyne College, Syracuse
Long Island University, South Hampton
Maria College, Albany
Molloy College, Rockville Centre
Mount Sinai Medical Center, New York City
New York Medical College, Valhalla
New York University, New York City
Oswego State University, Oswego
Rockland Community College, Suffern
Siena College, Loudonville
St. John Fisher College, Rochester
State University of New York Health Science Center, Brooklyn
State University of New York, Albany, Buffalo, Cortland
Syracuse University, Syracuse
Touro College, Dix Hills
Utica College of Syracuse University, Utica
Westchester Community College, Valhalla
Yeshiva University, New York City

North Carolina

Appalachian State University, Boone
Bowman Gray School of Medicine, Winston–Salem
Duke University, Durham
East Carolina University, Greenville
North Carolina State University, Raleigh
University of North Carolina–Chapel Hill, Chapel Hill
University of North Carolina–Charlotte, Charlotte
University of North Carolina–Greensboro, Greensboro
University of North Carolina–Wilmington, Wilmington
Wake Forest University, Winston–Salem
Winston–Salem State University, Winston–Salem

North Dakota

University of North Dakota, Grand Forks

Ohio

Baldwin–Wallace College, Berea
Bowling Green State University, Bowling Green
Case Western Reserve University, Cleveland

Central State University, Wilberforce
Cleveland State University, Cleveland
College of Mount St. Joseph, Cincinnati
Columbus State Community College, Columbus
Cuyahoga Community College, Cleveland
Jefferson Community College, Steubenville
John Carroll University, University Heights
Kent State University, Kent
Lourdes College, Sylvania
Medical College of Ohio, Toledo
Miami University, Oxford
Northeastern Ohio Universities College of Medicine, Rootstown
Ohio Dominican College, Columbus
Ohio State University, Columbus
Ohio University, Athens
Sinclair Community College, Dayton
University of Akron
University of Findlay, Findlay
Wright State University, Dayton
Youngstown State University, Youngstown

Oklahoma

Langston University, Langston
Oklahoma City Community College, Oklahoma City
Oklahoma State University, Stillwater
Southeast Oklahoma State University, Durant
University of Central Oklahoma, Edmond
University of Oklahoma Health Sciences Center, Oklahoma City
University of Oklahoma, Norman

Oregon

Marylhurst College, Marylhurst
Oregon Health Sciences University, Portland
Oregon State University, Corvallis

Pennsylvania

California University of Pennsylvania–California
Carlow College, Pittsburgh
Cedar Crest College, Allentown
Clarion University of Pennsylvania, Clarion
Drexel University, Philadelphia
East Stroudsburg University, East Stroudsburg

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Gwynedd Mercy College, Gwynedd Valley
Immaculata College, Immaculata
Indiana University of Pennsylvania, Indiana
King's College, Wilkes Barre
Lehigh Carbon Community College, Schnecksville
Marywood University, Scranton
Pennsylvania State University, University Park
Shippensburg University, Shippensburg
Slippery Rock University, Slippery Rock
Temple University, Philadelphia
Theil College, Greenville
University of Pittsburgh, Pittsburgh
University of Scranton, Scranton

Rhode Island

Rhode Island College, Providence
University of Rhode Island, Kingston

South Carolina

Clemson University, Clemson
Coastal Carolina University, Conway
Medical University of South Carolina, Charleston
University of South Carolina, Columbia

South Dakota

Augustana College, Sioux Falls
South Dakota State University, Brookings

Tennessee

Austin Peay State University, Clarkville
East Tennessee State University, Johnson City
Life Care Centers of America, Cleveland
Middle Tennessee State University, Murfreesboro
University of Tennessee, Knoxville

Texas

Abilene Christian Academy, Abilene
Baylor University, Waco
Del Mar College, Corpus Christi
Laredo Community College, Laredo
Southwestern Baptist Theological Seminary, Ft. Worth
St. Edward's University, Austin
Texas A&M, Kingsville
Texas Christian University, Fort Worth
Texas Tech University Health Sciences Center, Lubbock

University of Houston, Houston
University of North Texas Health Science Center, Ft. Worth
University of North Texas, Denton
University of Texas Health Science Center, Houston
University of Texas Medical Branch, Galveston
University of Texas Southwestern Medical Center, Dallas
University of Texas–Austin, Austin
University of the Incarnate Word, San Antonio

Utah

Brigham Young University, Provo
Utah State University, Logan

Vermont

Trinity College, Burlington
University of Vermont, Burlington

Virginia

George Mason University, Fairfax
James Madison University, Harrisonburg
Presbyterian School of Christian Education, Richmond
Radford University, Radford
Virginia Commonwealth University, Richmond
Virginia Polytechnic Institute and State University, Blacksburg

Washington, DC

Howard University

Washington State

Eastern Washington University, Cheney
Spokane Falls Community College, Spokane
University of Washington, Seattle

West Virginia

Southern West Virginia Community and Technical College, Mount Gay
West Virginia State College, Institute
West Virginia University, Morgantown

Wisconsin

Concordia University of Wisconsin, Mequon
Mount Mary College, Milwaukee
North Central Technical College, Wausau
University of Wisconsin, LaCrosse; Madison; Menomonie, Milwaukee
Wisconsin School of Professional Psychology, Milwaukee

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Puerto Rico

University of Puerto Rico, San Juan

Alberta, Canada

Long–Term Care Inservice Resource Centre, Calgary
Mount Royal College, Calgary

British Columbia, Canada

University of Victoria, Victoria

Manitoba, Canada

University of Manitoba, Winnipeg

Ontario, Canada

Lakehead University, Thunder Bay
McMaster University, Hamilton
Ryerson Polytechnic University, Toronto

AICPA ElderCare Services Task Force Members

The ElderCare Services task force welcomes your comments and questions about the emerging practice area of CPA ElderCare services. The following table provides contact information.

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CHAPTER 11:

Sample Documents and Checklists

CHAPTER 11:

Sample Documents and Checklists

This chapter contains sample documents and checklists to assist you in engaging in ElderCare services. You should use your judgment when preparing documents, such as engagement letters, brochures, and assessment forms, and tailor these sample documents and checklists to fit the circumstances of every engagement. See the following pages for the sample forms.

Sample Marketing Brochure

Presented on the following page is a sample marketing brochure. A brochure is a helpful instrument in explaining and promoting your ElderCare services. Personalize this sample brochure with your name, address, and phone numbers. In addition, tailor the wording of the brochure as necessary to reflect the circumstances of your firm and your services.

The sample marketing brochure is intended to be in the form of a common folded brochure that can fit into a standard business envelope. When you create your firm's brochure from this sample (or if you have an outside printing firm prepare it), be sure to use larger typefaces and a matte finish to accommodate the needs of elderly people.

Sarah Snyder

Certified Public Accountant

Announces

CPA ElderCare Services

A Multidisiplinary Approach to the Needs of Elderly People and Their Families

6 Spice Street
Remy, New Jersey 00000
(555) 555-5555

About Our Professionals

Sarah Snyder, CPA, has over twenty years of public accounting experience. She holds a BA in Accounting and MACC in Taxation from the University of New Jersey and is a member of the *American Institute of Certified Public Accountants* (AICPA), the *New Jersey Association of CPAs*, the *New Jersey Society of CPAs*, and the *Remy Estate Planning Council*. Sarah is also assistant chairman of the Eastern Conference on Geriatric Issues.

Joshua Snyder, MSW, LMSW, is licensed for professional practice by the New Jersey Board of Social Work Examiners, Joshua is a graduate of Avalon College and received his Masters from the University of New Jersey. In addition, he received a Graduate Certificate in Gerontology at UBD. As a *Professional Member* of the *National Association of Professional Geriatric Care Managers*, Joshua is also a member of the *Gerontological Society, National Association of Social Workers, National Council on Aging*, and *Sigma Phi Omega* (national honorary gerontology society).

Overview of Our Services

The population of the U.S. is aging—and in record numbers. We're living longer and are usually healthier than previous generations. The longer life span, however, demands that individuals plan earlier and smarter for the years of old age. More services and agencies are serving the needs of elderly persons than ever before. Accessing that maze of resources and services can be frustrating for elderly people and their families.

Our services are designed to provide both assessment and planning assistance to assure a more secure life for elderly persons, as well as offer assurance services to family members, attorneys, guardians, trust officers, and other responsible parties, that the needs of their elderly loved ones or clients are being met. *We can serve as* ***"family members"*** *when members of the family or other responsible parties cannot be present to supervise care for their loved ones.* Also, we provide assistance, consultation, advocacy, and educational services for individuals, families, organizations, and businesses.

Financial Services

- **Assess and evaluate** the desires and goals of the client and family to facilitate decision making.
- **Record** receipts, deposits, and account for income, providing assurance that expected revenues are received.
- **Review and pay** bills, and assess transactions for reasonableness.
- **Monitor** investments and accounting for the client's assets.
- **Review logs and diaries** to determine if paid caregivers are meeting the agreed-upon criteria.
- **Provide information** for handling unusual or unexpected situations.
- **Prepare payroll and tax** filings for household employees and independent contractors.
- **Report** to client and family as to the monthly activities, including complete accounting for all financial transactions.
- **Provide** appropriate long-term care, Medicare/Medigap, and life insurance recommendations for the preservation of assets.

Geriatric Social Services

- **Assess** the client's personal situation and goals through client and family interviews.
- **Design** a plan of service to achieve client goals, taking into consideration changing client circumstances.
- **Coordinate** services and assistance with application for benefits and entitlements.
- **Facilitate** client selection of appropriate community resources.
- **Monitor** service provision on a regular or as-needed basis.
- **Assess** alternative living arrangement options considering the client's desire to age in place.
- **Recommend** devices and modifications for environmental safety.
- **Provide referrals** to local services and agencies (for example health, legal, financial, and homecare).

In Summary

- **Initial interviews** will help determine what services and assistance are desired and needed by the client and family. During this process, we will assist in identifying those services that are critical to the client's physical and financial well-being, and how those services will be administered.
- **We will assist the client and family** in developing and implementing a care program that will meet assistance needs, with emphasis on **aging in place** and **client's need for self-determination.** In addition, we will provide the client and family with alternative resources available in the community, which can provide for the client's continued care, as well as costs for the services. Once arrangements have been made with the care providers, we will assist in monitoring service provision.
- **We are available to consult with employers** to help their employees deal with stressful caregiving responsibilities at home so job performance does not suffer.
- **Our professional fees** are based on the amount of time spent on the engagement. We can provide short- or long-term care management and monitoring.

SAMPLE RESPONSE LETTER FOR CPA ELDERCARE SERVICES INQUIRY

To promote your ElderCare services to the public, you may prepare and distribute marketing brochures, speak at various engagements, and inform accountants, lawyers, doctors, and other people in association with elderly people of your practice. Inquiries will be sent to you, requesting further information about the kind of service you and your firm provides. You should promptly and properly respond to inquiries about your ElderCare practice. Use the sample response letter presented below to respond to those inquiries. Tailor this letter as necessary to fit your circumstances.

[*Firm Letterhead*]

[*Date*]

[*Client Name*]

[*Address*]

[*City, State, Zip Code*]

Dear [*Client*],

Thank you for your recent inquiry about [*firm's*] CPA Eldercare services. Our firm, in association with a multidisciplinary team of professionals, can assist our elderly clients, their families, and other responsible parties assess the needs and appropriate level of service required by our elderly clients. Also, we assist individuals and families locate and employ qualified caregivers and care providers in the community and then monitor the services. We then report to the client, family, or responsible party on a regular basis. We are available to monitor income and disbursements, monitor investments, account for the estate, pay bills as authorized, and accumulate and provide information on appropriate resources as circumstances change. Our multidisciplinary team, a group of degreed, licensed professionals from social work, legal, and insurance specialties, will provide comprehensive geriatric care management services, including needs assessment, care planning, referral, coordination of services, and advocacy and educational services to individuals, families, organizations, and business and industry.

These services are a natural extension of the work our firm has been doing for clients in the areas of tax-return preparation, personal financial planning, compilation and review services, and estate planning. We recognize that many of our elderly clients, with appropriate assistance, can remain in their own homes. However, when the demands of independent living become difficult for the client and family, CPA ElderCare services offers the correct mix of assistance and oversight protection to help the years of old age be more secure and enjoyable. We work with individuals and families on simple or complicated issues that must be addressed, including asset preservation and long-term care planning.

The enclosed information further details CPA ElderCare services. Be assured that we can customize our services to suit your special needs. Thank you for your interest in the services offered by [*firm name*]. If we can be of further assistance, please contact us.

Sincerely,

[*CPA Name, CPA ElderCare Services*]

SAMPLE PRESS RELEASE

The following sample press release should be tailored to the circumstances of your firm and your services. Press releases can be used in mailings, newsletters, and bulletins to clients, senior service agencies and other professionals. Additionally, they can be used to announce your new ElderCare Services by sending them to different media outlets, including newspapers and editors of business and financial publications.

[*Name of CPA Firm*] Announces New Service

[*Name of CPA firm*] announced today that the firm is now offering CPA Eldercare Services. CPA ElderCare is a service wherein the staff of [*name of CPA firm*] will act as the eyes and ears of absent family members to ensure that elderly persons can remain living independently, with dignity, and assured of receiving the care and services for which they are paying.

[*Name of CPA firm*] recognizes that as America ages, many elderly persons in the community no longer have family members nearby to assist them with independent living. Family members living in other communities are concerned that their elderly family members receive proper care and services and that they are not taken advantage of by unscrupulous parties who prey on the elderly. Therefore, this service is being offered to assist the elderly in meeting their needs and to inform their family members of the needs of their elderly relatives and the degree to which those needs are being met by the proper caregivers.

[*Name of CPA firm*] can assist the elderly person, or their family members, in assessing the assistance required for independent living, help them locate and employ the appropriate caregivers in the community, and monitor the caregivers to make sure the proper level of care agreed upon is being received. The staff of [*name of CPA firm*] will work with other professionals (home health services, lawyers, repairmen, and others) to actually give the needed care and services. The firm's CPAs will monitor the services provided by others and report to the client and family members on a periodic basis. The firm will also be available to monitor income and investments, account for the estate, pay bills authorized by the elderly person or appropriate family members, and accumulate and provide information to the proper persons in the event of unusual or unforeseen circumstances. One CPA will be assigned as the primary party in each engagement, so the CPA assigned to the engagement will become familiar with the elderly person and be able to report to family members if additional or different assistance appears to be needed.

[*Name of partner*] of [*name of CPA firm*] stated that ElderCare is a natural extension of the work they have been doing for their clients for many years in the areas of tax return preparation, personal financial planning, audit services, and estate planning. "Although long-term institutional care may be the only answer for some elderly persons," he said, "we recognize that many of our elderly clients can, with the proper assistance, live out their lives in the comfort of their own homes. Nevertheless, we realize that for many of these persons, taking care of the daily demands of independent living may become too burdensome. We feel that CPA ElderCare Services offer the right mix of protection and assistance to help the golden years truly be happy ones."

SAMPLE ENGAGEMENT LETTERS

For additional guidance on composing ElderCare engagement letters see the following areas of this guide:

Chapter 5, "Quality Control, Best Practices, and Risk Management"

Chapter 13, "Frequently Asked Questions"

Elderly Person Contracting With the CPA Directly[1]

June 6, 2000

Mrs. Rena Flint
31 Dogwood Road
Front Royal, Virginia

Dear Mrs. Flint,

Further to our discussion and in accordance with the terms of your late husband's will, we are pleased that you have selected our firm to provide you with CPA Eldercare services. This letter summarizes our discussions about the services you feel that you require at this time.

It is our understanding that you have given a Power of Attorney to your niece, Mrs. Jan Lester, and that she should be contacted immediately in the event that you become unable to make decisions.

a) Personal Finances

We have prepared a budget of your personal living expenses and determined them to be approximately $8,000 per month inclusive of our fees. You have instructed your bank to make a monthly transfer to the Mutual Bank, account number 555-1212, which is a Trust account in your name. We have signing authority on this account. All household bills will be directed to us for payment. We will not pay any bill that is not budgeted for unless you or Mrs. Lester approve the expense.

We will review all transactions in your account monthly to ensure all expected receipts are properly deposited to your account.

We will reconcile all accounts monthly and recommend transfers to or from your investment account from time to time as necessary.

b) Investments

We will monitor your investment account at Spatz & Co. monthly and review recommendations made by your investment advisor, Wedge Donovan, for adherence to criteria you have established. We will arrange an annual meeting on or about November 15 to assist in preparing a budget of your income and cash needs for the following year and reviewing your overall investment strategy.

[1] For correspondence directly with the older adult, use fourteen point font.

c) Contracts

We will handle all communications with tenants, lawyers, public utilities, municipalities, and agents concerning your apartment buildings at 2200–2500 Devon Drive, Front Royal, Virginia.

We will also assist in any other agreements to which you are a party, provided we are made aware of them and have a copy we can refer to. You have agreed to provide us with a list of those contracts.

d) Sitters

We understand that you have hired Home Services, Inc., to provide specific day care and meal preparation services. We will monitor your satisfaction with these arrangements through monthly visits and telephone contact. We will also obtain periodic reports from Home Services, Inc. verifying that the sitter was present and that tasks were completed as assigned. We will pay the account and act on your behalf to resolve problems with Home Services, Inc.

e) Medical

We understand that you have given a personal care Power of Attorney to Mrs. Lester. In the event that we become aware of changes in your medical condition, we will follow the guidelines of the Advanced Directive that you have executed, a copy of which is in our files. It is imperative that we be notified immediately if this Directive is amended or altered in any fashion.

f) Taxes

We will prepare and send to you for review and signing the following tax returns:

Form 1040 Individual tax return and related schedules

Virginia Form 140 state tax return and related schedules

W-2s/W-3s and 1099s

We will calculate, prepare and remit quarterly installments to the Internal Revenue Service and the state of Virginia as necessary.

g) Household Maintenance

We will visit your home monthly to review normal maintenance of your home and grounds including providing instructions to your handyman, Mr. Haney. We will notify Mr. Haney when minor repairs are required. We will contract out services that he is unable to perform. We will obtain three competitive bids, when practical, for all repairs or household expenditures costing more than $500.

h) Insurance

We will monitor your insurance coverage to provide reasonable assurance that premiums are paid when due. We will prepare all claims under your policies and review coverage with you at our annual meeting.

i) Consent

Professional standards prevent us from disclosing client information without your express consent. We understand that we do have your permission to disclose information to Mrs. Jan Lester in general and to third parties as necessary in arranging for your care. Such disclosures, if any, will be limited to information necessary for the care provider to determine appropriate measures.

j) Restrictions on Gifts, Loans, etc.

It is our policy that no partner, shareholder, employee or agent of our firm will directly or indirectly benefit from any gift, loan, inheritance or bequest from you or your estate.

k) Reporting

We will report quarterly, detailing all cash receipts and disbursements through your accounts.[2] A copy of this report will be forwarded to Mrs. Jan Lester.

l) Fees

We estimate our fees for the services outlined above will range between $500 to $650 per month. We will draw a monthly retainer in the amount of $500 from your Trust account. An annual statement will be prepared and billed reflecting actual hours devoted to your care.

m) Emergency Situations

In the event of a medical emergency, we understand that Home Services, Inc., has authorization to contact Millennium Ambulance Services to transport you to the nearest available hospital facility. Upon notification by the hospital or Home Services, we will contact Mrs. Jan Lester, who, as noted above, has all necessary authority to act on your behalf.

Should your home, for whatever reason, become temporarily uninhabitable, we understand that you have made arrangements to be moved to the Shady Acres Retirement Lodge.

n) Termination of Agreement

You may terminate this engagement at any time upon written notice. We may terminate if we feel that serious matters that have come to our attention and about which you have been notified are not being taken care of. Termination will not be done, however, until four weeks after notification of you and Mrs. Jan Lester by registered mail.

If this letter correctly expresses your understanding, please sign the enclosed copy where indicated and return it to us.

Sincerely,

Yamamoto Accountants

_____

By

_____

Date

Accepted and agreed to:

_____

Name Date

Witnessed:

_____

[2] Include the appropriate standards under which this report will be issued.

Attorney in Fact for Elderly Person Contracting With the CPA

Dear Mr. Farragut:

Thank you for choosing Audit, Accounting & Associates to provide services to your mother, Mrs. Farragut. It is our understanding that you are the agent for your mother, acting under a durable power of attorney, dated January 1, 2000.

Your mother, Mrs. Farragut, is currently living at her home on 123 E. Tanneytown Road, Anywhere, New York, and needs some assistance in maintaining her independence. Due to a recent stroke, her mobility is limited, but she still expects to lead an active life as much as possible. You have hired Home Health Agency, Inc., to provide sitter services and assistance with medication, exercise, bathing, and other personal needs.

We will provide the following services for your mother:

- We have prepared a monthly disbursement budget for your review, estimating your mother's total monthly expenditures at $7,000 per month. This budget, a copy of which is enclosed, will be used to validate the normal monthly recurring bills approved in advance for payment. We will prepare disbursements on your mother's checking account from bills received, and submit them to you for signature. Any expense submitted not included in the attached budget will be first submitted to you via fax for approval. You may verify approval of payment either via fax or e-mail. We will also include prepared envelopes for mailing the payments to vendors.
- Our assigned staff member, Bernadette Galland, will visit your mother on a weekly visit. During that visit, Bernadette will retrieve any bills that need to be paid and review any other correspondence of a financial nature that your mother may have received.
- During the weekly visit, Miss Galland will discuss with your mother any other services she may need. She will also, through conversations with your mother, question the services provided to your mother by Home Health Agency, Inc. If at any time we feel that service is not being rendered as expected, we will notify you immediately.
- We will arrange for home cleaning services on a weekly basis. We will only use a company that employs bonded employees, and will perform reference checks on these companies before engaging their services. We understand that the monthly fee cannot exceed $225. We will also be sure that your mother is in agreement with our choice, and that the service continues to meet her expectations.
- We will arrange for weekly trips to the shopping center for your mother. We will use the service Shopping 'R You to transport your mother. The employee of Home Health Agency, Inc., will accompany your mother on these trips.
- We will manage your mother's rental property at 116 N. Seminary Place, North Anywhere, New York. This property is currently under a one-year lease, which expires March 31, 2003. We will collect rents, and pay all insurance, taxes, etc., as prescribed in the approved budget. Any additional repair and maintenance expenses in excess of $500 will be forwarded to you via fax for your approval. If approved, you will fund the disbursement account accordingly, and verify approval of payment either via fax or email.

- We will reconcile your mother's investment account on a monthly basis, and will prepare an analysis for your review. The analysis will include a summary of holdings and a listing of any sales or purchases. It is our understanding that your mother's investment adviser, Mr. Audie Winchester, has the authority to trade as he deems fit. Annually, we will prepare a yearly summary of holdings, activity in the account and the rate of return.
- We will reconcile the disbursement account. You will receive the monthly bank statement, including cancelled checks, directly and we will receive a copy of that statement from the bank.
- At the end of each month, we will send to you a listing of all checks disbursed during the month, and all monies received.
- We will prepare your mother's individual federal and state income tax returns and quarterly estimates.[3] These will be sent to you for signature.
- We understand that in the event of a medical emergency, the sitter on duty shall:
  - — Call Reliable Ambulance Company to transport your mother to St. Barnabas Hospital.
  - — Call Dr. Suchezski, your mother's primary care physician.
  - — Call you at (XXX) XXX-XXXX. In the event, you cannot be reached, the sitter will call Bernadette Galland, our assigned staff member, at (XXX) XXX-XXXX (daytime) or (YYY) YYY-YYYY (evenings/weekends).
- In the event of other emergencies, the sitter shall immediately call the applicable governmental agency (fire, police, etc.) and, as soon as possible, notify Bernadette Galland at the above listed numbers.

If a conflict arises about care issues that cannot be satisfactorily resolved, you have the authority to make the final decision, or if you are incapacitated, your niece has the final authority. If a conflict is resolved in a manner that we believe to be damaging to your mother, we reserve the right to withdraw from the engagement.

This engagement letter will be reviewed and updated annually or when there is a change in the engagement's nature or scope. Additional services requested by you will require us to send you an addendum to this engagement letter, describing the additional services requested and the additional fees for these services. You will be responsible for reading, signing and returning a copy of any and all addenda to us on a timely basis.

It is our responsibility to retain engagement records for X years. These records consist of our working papers, copies of correspondence and copies of records that you have provided to us. We will return your original records to you on no less often than a quarterly basis.

This engagement may be terminated by you at any time, upon written notice. In addition, this engagement may be terminated by us if we feel that serious matters which have come to our attention and about which you have been notified are not being handled. Termination will not be done, however, until four weeks after notification to you and Mrs. Farragut's attorney by registered mail as to our intentions to withdraw from the engagement.

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[3] Specifically list all the tax returns you would contemplate preparing for the client. Avoid statements such as "all tax returns" or "all necessary returns."

Our fees will be charged at our standard hourly rates and will be dependent on the time required to perform the services. We estimate our fees for the services outlined above will range between $500 and $600 per month. Please note: *As mandated by our firm's policy, no member of our firm may be the recipient of any gift, inheritance, or other bequest as a result of their association with your mother.*

Fees for our services are to be paid upon receipt of a billing from us. Failure to do so may result in a termination of this engagement.

If this letter correctly expresses your understanding, please sign the enclosed copy where indicated and return it to us.

Sincerely,

Audit, Accounting & Assoc.

Sample Engagement Letter With Agency Agreement

June 6, 2002

Mr. Paul Bellarmine

as Attorney in Fact for Mrs. Bellarmine

Dear Mr. Bellarmine:

We are pleased that you have selected our firm to provide ElderCare services for your mother. This agreement contains the general terms of the nature of the services that are described in the following paragraphs. We understand that you have been granted a Durable and Unlimited Power of Attorney for your mother.

Personal Finances:

We will handle all of your mother's personal finances. This will include preparing checks for payment of all personal and household bills. We will prepare and sign checks and mail the payments to the appropriate parties. To have a complete understanding of your, our, and the bank's responsibilities in the signing of these checks, refer to the Agency Agreement for Receipts and Disbursements attached hereto and made a part of this engagement letter. We will deposit all monies mailed to your mother directly into her checking account. Mail will be picked up from her home periodically, but not less than weekly. We will reconcile her bank account monthly and request transfers of cash from her investment account when necessary.

Investments:

We will monitor your mother's investment account at Pennypacker Investments in Spokane, Washington, and will review any changes recommended by her investment advisor, Catherine Donderewicz. We will assist Mrs. Donderewicz in planning your mother's income and cash needs. Any recommendations concerning the investment of your mother's account will be forwarded to you for your decision acting under your Power of Attorney.

Contracts:

We will handle all communications with attorneys, lessors, and agents concerning oil leases, rents, timber sales, and any other agreements to which your mother is a party. We will send all contracts to you and you will sign as Power of Attorney and you will make any decisions related to use of your mother's property.

Taxes:

We will prepare and send to you for your signature the following tax returns: federal and state income tax returns, quarterly payroll reports, W-2s, and other year-end payroll tax reports. We will also assist you in tax planning and will prepare and file quarterly estimates when required.

Household and Auto Maintenance:

We will oversee the normal maintenance of your mother's home, auto, and yard including supervision of Luigi Marconi. We will notify you when minor repairs are needed and will contract out services that Mr. Marconi is unable to perform. We will obtain bids for major repairs of more than $500 that will be referred to you for your decision. We will also contact you before replacing any equipment.

Insurance:

We will monitor all of your mother's insurance coverage including homeowners', auto, medical, and liability policies to prevent a lapse in coverage. We will prepare all claims under her policies, and will consult you about any recommended changes in her coverage.

Reporting:

We will compile a statement of cash receipts and disbursements each month detailing all receipts and expenditures of the household maintenance account. Copies of these reports will also be mailed to your sister, Miss Lincoln, but it is our understanding that such reports to Miss Lincoln are for informational purposes only and that all decisions concerning your mother's care will be made by you.

Other Matters:

From time to time during the course of the engagement, differences of opinion may arise between you and Miss Lincoln concerning matters discussed in this agreement. If such disagreements arise and a compromise cannot be reached between you and Miss Lincoln, we understand that you, acting under your Unlimited Power of Attorney, will make the final decision as to the matter involved in the disagreement.

In addition to Francis Almeida, who is the partner in charge of this engagement, Janet Osmena, and Margaret O'Higgins will be working on this engagement and may from time to time have contact. Perry Olsen will also be handling some of the administrative duties related to this engagement. Perry will not have direct contact with your mother, but may need to contact you from time to time about certain administrative matters. If there is a change in the staffing of your mother's engagement, you will be notified in writing about the change.

These services are being undertaken on a fee basis. Gifts or loans to any member of our staff will not be allowed. Any attempts by Mrs. Bellarmine to include any member of the engagement team in her will as a recipient of a portion of the residual estate will not be acceptable. As a part of this agreement, you will furnish us with a copy of a letter to Mrs. Bellarmine's attorney indicating they will not comply with any request on the part of Mrs. Bellarmine to do so and will immediately notify us, and you, of any such attempts.

This engagement letter will be updated no less than annually and more often if the scope or nature of our engagement changes. If additional services are requested, you will be asked to acknowledge these services by signing and returning an addendum to this letter, which we will prepare.

Our firm policy is to retain engagement records for X years. Our records consist of copies of original client documents, copies of correspondence and our working papers. We will return the originals of your mother's documents to you on a monthly basis.

Termination of Engagement:

Fees for our services are to be paid upon receipt of a billing from us. Failure to do so may result in a termination of this engagement. In addition, this engagement may also be terminated by you at any time, upon written notice, and by us if we feel that serious matters that have come to our attention and about which you have been notified are not being handled. Termination will not be done, however, until four weeks after notification to you and Mrs. Bellarmine's attorney by registered mail as to our intentions to withdraw from the engagement.

Our fees will be charged at our hourly rates and will be dependent on the time required to perform the services. When possible, certain services, such as clerical and bookkeeping services, will be assigned to a staff member with a lower hourly rate. We estimate that our fees will range between $500 and $600 per month.

If this letter correctly expresses your understanding, please sign the enclosed copy where indicated and return it to us.

Sincerely,

By Audit, Accounting & Associates

PP:wds

Enclosure

The services described in the foregoing letter are consistent with our requirements, are acceptable to us, and are hereby agreed to.

_____ _____

Signature of Mr. Paul Bellarmine as Attorney in Fact for Mrs. Bellarmine — Date

Agency Agreement for Receipts and Disbursements

PRINCIPAL: Mr. Paul Bellarmine, as attorney in fact for Mrs. Bellarmine

AGENT: Audit, Accounting & Associates and Henry Mclintok, CPA

In consideration of the covenants contained in this Agreement, Mr. Paul Bellarmine as attorney in fact for Mrs. Bellarmine, whose address is Spokane, Washington (called Principal); and Audit, Accounting & Associates by and exclusively through Henry Mclintok, CPA (called Agent) agree as follows:

1. *Background*: Principal has retained regularly the services of Henry Mclintok, CPA (Mclintok), of Audit, Accounting & Associates to perform for Principal various accounting functions and services. Principal wishes to retain Mclintok for the purposes of overseeing and satisfying the obligations of Principal as they become due and are evidenced by billings and/or written statements submitted and/or provided to Mclintok for payment and approval. To facilitate this service, it is the intent of the parties that the Principal shall establish and maintain bank accounts into which he shall regularly make deposits sufficient to cover his obligations in the United States, and shall authorize Mclintok to make deposits to such accounts as well as draw checks and remit payments on behalf of Principal.
2. *Employment*: The Principal employs Agent to oversee and monitor deposits into any and all bank accounts maintained by Principal at US Bank, with the understanding that Principal shall make deposits to such accounts from time to time to cover and pay the obligations of Principal incurred in and around the State of Washington. Principal employs Agent to specifically receive, receipt, and approve any and all bills incurred by the Principal and upon approval of same by Agent to pay them from proceeds deposited into accounts maintained at US Bank. Agent further shall receive and receipt for any and all payments due Principal and payable in Spokane, Washington, under any contracts entered into by Principal. Principal further shall make deposits in sufficient amounts to cover any and all of his obligations with such frequency as may be recommended and in such amounts as may be recommended by Agent.
3. *Duration of Agency*: This Agreement shall remain in effect until terminated in accordance with the provisions hereof.
4. *Indemnification of Agent*: Principal agrees to indemnify and hold Agent harmless from and to pay Agent promptly on demand any and all losses arising from the Agent's conduct in accordance with the terms of this Agreement.
5. *Termination*: Either party may terminate this Agreement by giving the other party written notice thirty days' before the effective date of the notice. The Agent shall perform its obligations hereunder up to and including the final date of termination.
6. *Authorized Signatories*: Principal maintains a savings and checking account at US Bank and may, from time to time, open additional accounts. Principal shall execute such authorizations as may be required of such banking institutions to provide Agent with the authorization to draft and draw checks on any and all such accounts and make deposits. All receipts collected by Agent that are payable to Principal shall be deposited promptly by Agent in the banking accounts referred to herein. Principal authorizes the Agent to endorse any and all checks drawn to the order of Principal for deposit in such accounts, and Principal shall furnish such depository bank with a statement authorizing Agent to make such endorsements. Agent shall have authority

to draw checks against all or any part of the funds now or subsequently deposited in the above referenced accounts.

7. *Accounting Obligation*: No less frequently than quarterly, Agent shall provide to Principal a complete accounting of any and all receipts and disbursements collected or made by Agent on behalf of Principal.
8. *Compensation*: Principal shall compensate Agent for the services provided hereunder such amounts as may be established from time to time as Agent's regular rate for accounting and other services provided Principal by Agent.

Dated this _____ day of _____, 20_____.

Audit, Accounting & Associates

_____

Mr. Paul Bellarmine

PRINCIPAL _____

CPA

Henry Mclintok AGENT

SAMPLE PRIVACY NOTICE

As discussed in Chapter 6, "Engagement Services, Professional Standards, and Reporting," under the Gramm-Leach-Bliley Act requirements, it is now necessary to provide annual privacy notices to all nonbusiness individual clients for whom you provide financial products and services. The notice must be clear, conspicuous, accurate, and in writing (or supplied electronically, with advance client approval). If the notice is to be combined with other information—for example, engagement letters or tax return information organizers—the notice must have "distinctive type size, style, and graphic devices, such as shading or sidebars."

The notice must contain the following information:

- The kinds of nonpublic personal information you collect regarding the client
- The kinds of nonpublic personal information you disclose about the client
- The parties to whom you disclose this information, other than under an exception to the prohibition on nondisclosure
- The client's right to "opt out" of the disclosure (generally not applicable to CPA clients because CPAs normally do not disclose client information)
- Your policies with respect to sharing information on a person who is no longer a client
- Your practices for protecting the confidentiality and security of your clients' nonpublic personal information.

It is especially important for an ElderCare practitioner that clients understand their legal rights to privacy. All planned exceptions to privacy procedures required by law must be specified in, and agreed upon by your client in the engagement letter. Obtaining client permission to release medical and/or financial information to family members during times of duress while at the same time avoiding liability is key to a successful ElderCare practice.

[*Firm Name*] PRIVACY POLICY

CPAs, like all providers of personal financial services, are now required by law to inform their clients of their policies regarding privacy of client information. CPAs have been and continue to be bound by professional standards of confidentiality that are even more stringent than those required by law. Therefore, we have always protected your right to privacy.

Types of Nonpublic Personal Information We Collect

We collect nonpublic personal information about you that is provided to us by you or obtained by us with your authorization.

Parties to Whom We Disclose Information

For current and former clients, we do not disclose any nonpublic personal information obtained in the course of our practice except as required or permitted by law. Permitted disclosures include, for instance, providing information to our employees, and in limited situations, to unrelated third parties who need to know that information to assist us in providing services to you. In all such situations, we stress the confidential nature of information being shared.

Protecting the Confidentiality and Security of Current and Former Client Information

We retain records relating to professional services that we provide so that we are better able to assist you with your professional needs and, in some cases, to comply with professional guidelines. In order to guard your nonpublic personal information, we maintain physical, electronic, and procedural safeguards that comply with our professional standards.

****

Please call if you have any questions, because your privacy, our professional ethics, and the ability to provide you with quality financial services are very important to us.

CONSIDERATION OF POTENTIAL LIABILITIES CHECKLIST

Firm Issues

- Does staff have sufficient training or experience to handle the engagement?
- Does the firm have sufficient and appropriate staffing to handle the increased workload?
- Can we refer some of the work to another professional?
- Is this engagement going to be handled by a team approach?
- Do we understand the responsibilities of each staff member involved on the engagement?
- Are appropriate internal controls in place?
- Will staff receive proper supervision?
- Has a lawyer been consulted about firm policies on suspicion of elder abuse and the reporting requirements for elder abuse in our state, province or jurisdiction?
- Has a lawyer been consulted about firm policies on termination of ElderCare engagements?
- Has a lawyer been consulted on our policies of disclosing confidential client information in conjunction with the performance of an ElderCare engagement?
- Has the firm's underwriter been contacted to make sure that our existing policy covers ElderCare services?

Client Issues

- Do we know who the client is? Have we made that clear to all parties to the engagement?[4]
- Is the elderly person competent? If the elderly person is not competent, are we aware of whom the attorney in fact, guardian, and other third parties are?
- Does the client understand the nature of the engagement?
- Does the client understand the scope of the engagement?
- Does the client understand his responsibilities in the engagement?
- Is the client on good terms with his or her family members? Is the client estranged from any family members?
- If the client was referred to us, did we communicate with the referring party about the client and the type of services that were requested of us?
- If this is a team engagement, does the client clearly understand the responsibilities of each individual professional on the team?
- Were most of the client's documents found during the inventory of documents?
- If requested to obtain certain documents, did the client do so?
- Does there appear to be any signs of elder abuse?

[4] The AICPA ElderCare Task Force has recommended that the client should always be considered to be the elderly person. Please see the course, *Developing an ElderCare Practice,* for more information on this topic.

Engagement Issues

- Are we issuing reports as part of this engagement? Will the reports be restricted? Do we know all the parties who will be receiving these reports?
- Have we issued an engagement letter for the engagement? Does the engagement letter clearly define the scope and nature of the services to be performed and the client's responsibilities as part of the engagement? Has the client signed the engagement letter?
- Will we be reporting on performance criteria? Did we have a role in the development of the criteria? Are the criteria worded as objectively as possible?
- Are the criteria, as developed, measurable or suitable?
- Is sufficient, verifiable information available with which to measure adherence to criteria?

SAMPLE CLIENT INTAKE FORM

This brief information form may be used by the CPA during an initial phone contact or referral related to ElderCare services.

Date: _____

Time of contact: _____

Referral source: _____

Relationship to elderly person: _____

Address: _____

Phone number: _____

Best time to call: _____

Caller's immediate concerns or needs: _____

Client Information

Name: _____

Address: _____

Current address: _____

Phone number: _____

Living arrangements:

Alone _____ w/Spouse _____ w/Other _____ Full-time caregivers _____

Age: _____ Spouse's age: _____

Type of residence:

House _____ Apartment _____ Condo _____

Senior facility _____ Assisted living _____ Nursing home _____

Other _____

How long there? _____

Level of Capacity

_____ Independent

_____ Needs assistance with some daily routines

_____ Needs extensive assistance

_____ Homebound

_____ Bedridden

Level of education: College _____ High school _____ Elementary _____

SAMPLE CLIENT INTAKE FORM (*CONTINUED*)

Work history: _____

Current health status: _____

_____

_____

_____

Health problems or concerns: _____

_____

_____

_____

Number of medications per day: _____

_____

Local physicians: _____

_____

Recent hospitalizations: _____

_____

Is the person a driver: Yes_____ No_____

Religious affiliation: _____

Financial status: _____

_____ Monthly income
_____ Monthly Social Security
_____ Monthly pensions
_____ Savings or investments
_____ Medicare A B Supplement
_____ Medicaid
_____ Long-term care insurance

Advance Directives

_____ Durable power of attorney
_____ Health care power of attorney
_____ Living will
_____ Resuscitation orders
_____ Guardian or responsible parties: _____

(continued)

SAMPLE CLIENT INTAKE FORM (*CONTINUED*)

Primary caregiver: _____

Address: _____

Phone number: _____

Have client and caller conferred about needs? _____

Type of assistance requested: _____

_____

_____

Send materials requested: _____ Date: _____

Sample Client Information Form

The CPA should fill out this form for every client, as a means of accumulating detailed information on the client. This information is essential to developing a proper plan of care for the client and for subsequent services.

Personal Information

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Date of birth: _____ Phone number: _____

Place of birth: _____

Location of birth certificate: _____

Social Security number: _____

Marital Status

Married _____ Single _____ Widowed _____ Divorced _____

Spouse name: _____

Spouse Social Security number: _____

Location of license, decrees: _____

Location of spouse's death certificate, if applicable: _____

Citizenship: USA _____ Other _____

Health insurance

Company: _____

Policy number: _____

Medicare number: _____

Medicaid number: _____

Supplemental insurance or Medigap policy: _____

Long-term care policy: _____

Location of policy: _____

Organ donation requests: _____

Pets

Name: _____

Vet: _____

(continued)

SAMPLE CLIENT INFORMATION FORM (*CONTINUED*)

Address: _____

Phone number: _____

Kennel: _____

Children

	Living?		Maintain contact?	
Name	Yes	No	Yes	No
_____				
_____				
_____				
_____				
_____				
_____				

Siblings

	Living?		Maintain contact?	
Name	Yes	No	Yes	No
_____				
_____				
_____				
_____				
_____				
_____				

Religious affiliation: _____

Church, synagogue, other: _____

Address: _____

Phone number: _____

Clergy: _____

Attorney name: _____

Address: _____

Phone number: _____

Durable power of attorney: _____

Individual named: _____

SAMPLE CLIENT INFORMATION FORM (*CONTINUED*)

Address: _____

Phone number: _____

Will: _____

Executor names: _____ Trustee named: _____

Address: _____ Address: _____

Phone number: _____ Phone number: _____

Trust Documents

Name of trust: _____

Attorney: _____

Location of documents: _____

Advance Directives

Living will: _____

Health care power of attorney: _____

Do not resuscitate order: _____

Location of documents: _____

Funeral Plans

Cemetery lot owned: _____

City: _____

Location of deed: _____

Instructions for funeral provided to: _____

Funeral director selected: _____

Organizations to be contacted or included: _____

Clergy selected: _____

Military Service

Branch of service: _____

Date and kind of discharge: _____

Military or veteran's claim number: _____

Location of discharge papers: _____

Location of information for pensions, retirement benefits: _____

(continued)

SAMPLE CLIENT INFORMATION FORM (*CONTINUED*)

Retirement Assets

Employee benefit plans: _____

Profit sharing: _____

401(k): _____

Pension plan: _____

Name of administrator or personnel director: _____

Phone number: _____

Real Property

Primary residence: _____

Owned: _____ Rented: _____

Mortgage held by: _____

Address: _____

Phone number: _____

Other Properties Owned

Address: _____

Address: _____

Properties Owned With Others

Partner's name: _____

Address: _____

Phone number: _____

Other mortgages: _____

Location of mortgage, titles, surveys, and deeds: _____

Insured by: _____

Agent: _____ Phone number: _____

Property Leased to Others

Location: _____

Tenant name: _____

Location of lease documents: _____

SAMPLE CLIENT INFORMATION FORM (*CONTINUED*)

Insurance

Agent: _____

Health: _____

Home: _____

Long-term care: _____

Stocks, Bonds, Securities

List all securities and certificate numbers. Attach information.

_____

_____

_____

_____

_____

Name of Broker or Firm

Address: _____ Phone number: _____

Location of records: _____

Checking and Savings Accounts

Checking Accounts

Bank: _____

Address: _____

Contact: _____

Location of bank statements: _____

Savings Accounts

Bank: _____

Address: _____

Contact: _____

Location of passbooks: _____

Person Authorized to Sign Checks

Name: _____

Address: _____

Phone number: _____

(continued)

SAMPLE CLIENT INFORMATION FORM (*CONTINUED*)

Safe Deposit Box

Location: _____

Address: _____

Phone number: _____

Location of keys: _____

Persons with access: _____

Personal Property

Items of Personal Property

Car: _____

Model: _____ Year: _____

Car: _____

Model: _____ Year: _____

Boat: _____

Model: _____ Year: _____

Household furnishings: _____

_____

_____

_____

_____

_____

Jewelry: _____

_____

_____

_____

Coin collection: _____

Art collection: _____

_____

Location of inventories: _____

Proof of ownership documents: _____

SAMPLE CLIENT INFORMATION FORM (*CONTINUED*)

Credit Cards

Name: _____ Name: _____

Account number: _____ Account number: _____

Phone number: _____ Phone number: _____

Name: _____ Name: _____

Account number: _____ Account number: _____

Phone number: _____ Phone number: _____

Tax Records

Location of documents: _____

Preparer: _____

Professionals Familiar With Individual (Name, Address, Phone Number)

Primary care physician: _____

_____

Specialty physicians: _____

_____

_____

_____

Attorney: _____

_____

Accountants: _____

_____

Trust officer: _____

_____

Executor: _____

_____

Employment

Place of employment: _____

Dates: _____

Supervisor: _____

SAMPLE CLIENT ASSESSMENT FORM

This form could be used by the CPA in conjunction with a case manager, social worker, nurse, or others. as a comprehensive health, psychosocial, and environmental status assessment tool in gathering information from the client and other professionals.

Date: _____ Assessment by: _____

Record updates: _____ Updated by: _____

Place of assessment: Home: _____ Hospital: _____ Other: _____

Primary caregiver: _____

Primary physician: _____

Personal attorney: _____

Client's name: _____

Address: _____

Directions to residence: _____

_____

_____

_____

Date of birth: _____

Male: _____ Female: _____

Marital status:

Married ____ Widowed ____ Divorced ____ Separated ____ Single ____

Type of residence:

House ____ Condo ____ Apartment ____ Room ____ Hotel/house ____

Mobile home ____ Senior complex ____ Assisted living/residential care facility ____

Retirement community ____ Intermediate/skilled nursing facility ____

Foster care ____ Other ____

Living arrangement:

Alone ____ With spouse only ____ With spouse and relatives ____

With children only ____ With other relatives ____ With nonrelatives ____

Group home ____ ICF/SNF ____ Other ____

Ethnicity:

White ____ Hispanic ____ Black ____ Asian ____ Am. Indian ____ Other ____

Primary language: English _____ Spanish _____ Other _____

Interpreter needed: Yes _____ No _____

SAMPLE CLIENT ASSESSMENT FORM (*CONTINUED*)

Interpreter's Name: _____

Phone number: _____

Occupation or former occupation: _____

Daytime emergency contact: _____

Phone number: _____

Relationship: _____

Nighttime emergency contact: _____

Phone number: _____

Relationship: _____

Legal guardian:

Yes _____ No _____ Name: _____ Phone number: _____

Power of attorney:

Yes _____ No _____ Name: _____ Phone number: _____

Advance directives: Yes _____ No _____

Health insurance

Medicare A B

Medigap: Policy name and number: _____

Medicaid: Yes _____ No _____ Medicaid number: _____

Comments: _____

_____

_____

_____

Medical Condition

[*Interviewer says, "I am going to ask you several questions about your health, how you are feeling, and how you are managing at home."*]

At the present time, what health problems are you experiencing? Do you have any past medical conditions that you see a physician for a review or check-up?

Condition: _____

_____

_____

_____

(continued)

SAMPLE CLIENT ASSESSMENT FORM (*CONTINUED*)

Comments: _____

_____

_____

_____

_____

In general, compared with other people your age, would you say your health is:

Excellent ____ Very good ____ Good ____ Fair ____ Poor ____

Compared with one year ago, how would you rate your health in general now?

Much better ____ Somewhat better ____ About the same ____

Somewhat worse ____ Worse ____

During the past four weeks, have you been bothered by any of the following problems?

a. Trouble hearing
b. Trouble seeing
c. Trouble sleeping
d. Trouble with teeth or dentures
e. Foot problems
f. Pain
g. Fatigue
h. Falling, losing balance

Comments:

_____

_____

_____

_____

_____

Health Maintenance

[*Interviewer says, "I am going to read a list of routine health care examinations and tests. I would like to know the date of your last test or exam."*]

Mammogram _____

Pap smear _____

Prostrate exam _____

Dental exam _____

SAMPLE CLIENT ASSESSMENT FORM (*CONTINUED*)

Eye exam _____

Hearing exam _____

Flu vaccine _____

Pneumococcal vaccine _____

Blood pressure _____

Tetanus _____

Weight _____

Height _____

Do you exercise on a regular basis? Yes _____ No _____

Comments: _____

_____

_____

_____

Medications

Are you currently taking any prescribed medication? Yes _____ No _____

What prescriptions are you currently taking and what is the dosage? _____

_____

_____

_____

_____

Note discrepancies between prescribed dosage frequency and actual dosage frequency:

_____

Total number of prescription medications: _____

_____

Are you taking any over-the-counter medications? Yes _____ No _____

What over-the-counter medications are you currently taking? _____

_____

_____

_____

Total number of over-the-counter medications: _____

(continued)

SAMPLE CLIENT ASSESSMENT FORM (*CONTINUED*)

Are you having any difficulty taking any of your medications?

Yes _____ No _____

Have you had any problems with side effects from your medications?

Yes _____ No _____

Do you have any problems storing your medications? Yes _____ No _____

Comments: _____

_____

_____

_____

Functional Ability

By yourself, and without using aids, how much difficulty do you have doing the following activities? Would you say that you can do the activity with no difficulty, with a lot of difficulty, or that you are unable to do the activity at all?

	No difficulty	Some difficulty	Unable to do
a. Walking 1/4 mile			
b. Walking up 10 steps			
c. Stooping, kneeling, or crouching			
d. Using your fingers to grasp or handle objects			
e. Lifting or carrying something that weighs 10 pounds			

Did you spend all or most of the time in bed last month? Yes _____ No _____

If yes, how long has this been the case?

Less than one month _____ One to three months _____ More than three months _____

Instrumental Activities of Daily Living

[*Interviewer says, "Now I am going to ask about some everyday activities and whether you have any difficulty doing them by yourself."*]

Because of a health or physical problem, do you have any difficulty—

	Yes	No	Does not do it
Shopping for personal items?			
Using the telephone?			
Doing light housework?			
Preparing meals?			
Using public transportation or riding in automobile?			
Taking medications?			

SAMPLE CLIENT ASSESSMENT FORM (*CONTINUED*)

Activities of Daily Living

[*Interviewer says, "Now I am going to ask about some other everyday activities. I would like to know if you have any difficulty doing each one by yourself."*]

Do you have any difficulty—

	Yes	No	Does not do it
Taking a bath or shower?			
Dressing?			
Using the toilet?			
Getting in or out of bed or chairs?			
Eating?			
Walking?			

You mentioned that you receive help with daily living activities. Who provides the help?

_____

Who gives you the most help? _____

_____

Comments: _____

_____

_____

_____

Adaptive Equipment

Do you use any of the following equipment or devices? (Please circle appropriate items.)

Cane

Walker

Wheelchair

Braces

Hearing aid

Dentures

Glasses

Other low vision devices

Raised toilet seat

Commode chair

Bath bench or shower chair

(continued)

SAMPLE CLIENT ASSESSMENT FORM (*CONTINUED*)

Grab bars

Oxygen

Emergency alert system

Ramp

Other: _____

Comments: _____

_____

_____

_____

Continence

[*Interviewer says, "Now I would like to ask you about a health problem that is more common than people think."*]

How often do you have accidents with urine?

Never

Occasionally

Frequently

Multiple daily occurrences or no control over bladder

How often do you have accidents with your bowels?

Never

Occasionally

Frequently

Multiple daily occurrence or no control over bowels

Do you use incontinence supplies (pads)?

Comments: _____

_____

_____

_____

Nutrition and Diet

Without wanting to, have you gained or lost 10 pounds in the past six months?

Yes _____ No _____

SAMPLE CLIENT ASSESSMENT FORM (*CONTINUED*)

Do you have any of the following problems? (Please circle appropriate items.)

Chewing problems

Swallowing problems

Mouth pain

Other problems that hinder your eating

Comments: _____

_____

_____

_____

Alcohol and Smoking

In the past month, have you had more than three alcoholic drinks in any day, including beer and wine? Yes _____ No _____

Have you increased drinking alcoholic beverages lately? Yes _____ No _____

How may cigarettes do you smoke in an average day?

None

Less than one-half pack

One-half pack

About one pack a day

Between one and two packs per day

More than two packs per day

Do you smoke in bed? Yes _____ No _____

Cognitive Functioning

In the past year have you become more forgetful and confused?

Yes _____ No _____

During the past month, how often have you gotten lost or not known where you were?

Never

Once

Two to three times

More than three times

(continued)

SAMPLE CLIENT ASSESSMENT FORM (*CONTINUED*)

During the past month, how much difficulty have you had remembering things?

None

A little

Some

A lot

Psychosocial Functioning

How much, during the last month have you felt downhearted and blue?

None of the time

A little of the time

Some of the time

A good bit of the time

Most of the time

All of the time

During the past month, how much have you been bothered by such emotional problems as feeling unhappy, anxious, depressed or irritable?

Not at all

Slightly

Moderately

Quite a bit

Extremely

[*If downhearted or blue "quite a bit" or if bothered by emotional problems "quite a bit," refer the client for professional evaluation.*]

Major Life Changes

Have any of the following things happened and do they still upset you?

Death of a spouse

Death of a close family member

Death of a close friend

Divorce

Separation

Major illness or injury

Illness of spouse or relative

SAMPLE CLIENT ASSESSMENT FORM (*CONTINUED*)

Family discord or trouble

Friends moving away

Retirement

Change in living arrangements

Death of a pet

Other: _____

Comments: _____

_____

_____

_____

_____

_____

Social Relationships

In a usual month, how often do you see family members or friends?

Every day

At least once a week

At least once a month

Usually not at all

In a usual month, how often do you speak to family members or friends on the phone?

Every day

At least once a week

At least once a month

Usually not at all

Taken together, are you satisfied with the amount you see and talk to friends and family members?

Satisfied

Not enough

Too much

Can a relative, friend, or neighbor take care of you for a few days, if necessary?

Yes _____ No _____

If yes, name: _____ Relationship: _____ Phone: _____

(continued)

SAMPLE CLIENT ASSESSMENT FORM (*CONTINUED*)

On average, how often do you leave your home in a month (not counting going into a hallway, going on the porch or going in the yard)?

Every day

At least once a week

At least once a month

Usually not at all

Is there anyone you can confide in or who confides in you? Yes _____ No _____

Have there been any disagreements about your care or planning for your care?

Yes _____ No _____

If yes, briefly describe: _____

_____

Comments: _____

_____

_____

_____

Service Utilization

In the previous 12 months, have you stayed overnight in a nursing home?

Yes _____ No _____

For each different physician that you see, I need to know the physician's name and kind of physician or specialty.

Physician's name Type of physician or specialty

_____

_____

_____

_____

During the past three months, have you used any of the following services?

Podiatrist	_____	Physical or occupational therapy	_____
Chiropractor	_____	Home health aid or homemaker	_____
Mental health worker	_____	Social worker	_____
Psychologist or counselor	_____	Senior center or day program	_____
Nurse	_____	Home-delivered meals	_____
Other	_____		

SAMPLE CLIENT ASSESSMENT FORM (*CONTINUED*)

Comments: _____

_____

_____

_____

Transportation

Do you drive a car? Yes _____ No _____

If yes, do you have any difficulty driving your car or worry about your ability to drive?

Explain: _____

_____

Have you had an accident in the last three years? Yes _____ No _____

Do you always wear a seat belt? Yes _____ No _____

Do you have trouble traveling to and from places you want to go?

Yes _____ No _____

Financial and Legal

Are you currently receiving:

Medicaid

Supplemental Security Income

Social Security disability income

Food stamps

Energy assistance

Subsidized housing

Other assistance (pensions)

Thinking about you and your money situation, would you say that you:

Are comfortable?

Have just enough to get by?

Cannot make ends meet

Which of the categories best describes your income, before taxes, for the last calendar year, including wages, salaries, Social Security, pensions, IRAs, rental income, and other sources?

$10,000 or less
$10,000–$20,000
$20,000–$30,000
$30,000 or more

(continued)

SAMPLE CLIENT ASSESSMENT FORM (*CONTINUED*)

Vulnerability

Does the care coordinator or manager suspect any type of abuse?

Yes _____ No _____

Type of suspected abuse or exploitation (Please circle appropriate items.)

Multiple bruises

Broken bones

Food withheld

Disappearance

Overuse of medications

Sexual abuse

Malnutrition

Body lice

Inadequate clothing

Left alone unsafely

Other: _____

Are any life threatening? Yes ____ No ____

What is the source of the neglect? Self ____ Others ____ Self and others ____

Objective observation: _____

_____

_____

_____

_____

_____

_____

Environmental Assessment

Environmental problems:

Space _____ Utilities _____ Safety _____ Cleanliness _____ Pets _____ Pests ____

Home easily accessible	Yes	No
Telephone available	Yes	No
Stairs	Inside	Outside

SAMPLE CLIENT ASSESSMENT FORM (*CONTINUED*)

Throw rugs secured or removed	Yes	No
Furniture arranged for easy ambulation	Yes	No
Adequate assistive devices for toilet, bathing	Yes	No
Home has adequate ventilation	Yes	No
Heating and cooling systems adequate for client	Yes	No
Smoke detectors and fire extinguishers present	Yes	No
Adequate electrical outlets	Yes	No
Clean, secure storage area for medical supplies	Yes	No
Clean, secure refrigerated place for medications	Yes	No
Adequate running water	Yes	No
Instructed in the use of 911	Yes	No
Grab bars installed	Yes	No

Comments: _____

_____

_____

_____

_____

Who Provided Assessment Information

_____ Client alone completed

_____ Client and primary caregiver completed

_____ Primary caregiver was the proxy respondent

_____ Other caregiver was the proxy respondent

_____ Other respondent

Name: _____ Relationship: _____ Phone number: _____

Sample Care Plan Form

CPAs should use this form to resolve specific issues or problems their client may have. By using this form to document an issue and the steps involved to resolve that issue, the CPA will be able to address the needs of each client in an orderly, methodical, and effective manner. The CPA will most likely need to work with other professionals in completing this form and developing the care plan.

Care plan for: _____

Prepared by: _____

Date: _____

Client name: _____

Address: _____

Phone number: _____

Emergency contact: _____

Phone number: _____

Issue: ***Physical health status***

Problem: _____

_____

_____

Goal: _____

_____

_____

Intervention: _____

_____

_____

Time frame: _____

Date: _____

Outcome: _____

_____

_____

Goal attained: _____

Unmet need: _____

Reason: _____

_____

_____

SAMPLE CARE PLAN FORM (*CONTINUED*)

Issue: ***Nutrition***

Problem: _____

_____

_____

Goal: _____

_____

_____

Intervention: _____

_____

_____

Time frame: _____

Date: _____

Outcome: _____

_____

_____

Goal attained: _____

Unmet need: _____

Reason: _____

_____

_____

Issue: ***Psychosocial***

Problem: _____

_____

_____

Goal: _____

_____

_____

Intervention: _____

_____

_____

(continued)

SAMPLE CARE PLAN FORM (*CONTINUED*)

Time frame: _____

Date: _____

Outcome: _____

_____

_____

Goal attained: _____

Unmet need: _____

Reason: _____

_____

_____

Issue: ***Environmental***

Problem: _____

_____

_____

Goal: _____

_____

_____

Intervention: _____

_____

_____

Time frame: _____

Date: _____

Outcome: _____

_____

_____

Goal attained: _____

Unmet need: _____

Reason: _____

_____

_____

SAMPLE CARE PLAN FORM (*CONTINUED*)

Issue: *Financial*

Problem: _____

_____

_____

Goal: _____

_____

_____

Intervention: _____

_____

_____

Time frame: _____

Date: _____

Outcome: _____

_____

_____

Goal attained: _____

Unmet need: _____

Reason: _____

_____

_____

Issue: *Legal*

Problem: _____

_____

_____

Goal: _____

_____

_____

Intervention: _____

_____

_____

(continued)

SAMPLE CARE PLAN FORM (*CONTINUED*)

Time frame: _____

Date: _____

Outcome: _____

_____

_____

Goal attained: _____

Unmet need: _____

Reason: _____

_____

_____

Issue:

Problem: _____

_____

_____

Goal: _____

_____

_____

Intervention: _____

_____

_____

Time frame: _____

Date: _____

Outcome: _____

_____

_____

Goal attained: _____

Unmet need: _____

Reason: _____

_____

_____

SAMPLE CARE PLAN FORM (*CONTINUED*)

Issue:

Problem: _____

_____

_____

Goal: _____

_____

_____

Intervention: _____

_____

_____

Time frame: _____

Date: _____

Outcome: _____

_____

_____

Goal attained: _____

Unmet need: _____

Reason: _____

_____

_____

Issue:

Problem: _____

_____

_____

Goal: _____

_____

_____

Intervention: _____

_____

_____

(continued)

SAMPLE CARE PLAN FORM (*CONTINUED*)

Time frame: _____

Date: _____

Goal attained: _____

Unmet need: _____

Reason: _____

_____

_____

Example

Issue: *Physical Health Status*

Problem: Client cannot identify reason for decline in memory function.

Goal: Within six months, the client will receive accurate, timely diagnosis of the etiology related to recent memory loss.

Intervention: Client will receive comprehensive geriatric assessment by board-certified geriatric physicians group.

Time frame: Six months

Date: June 30, _____

Goal attained: Physician identified drug interaction as cause of memory loss. Medications stopped.

Unmet need: None

Monthly Price Comparison Worksheet

This worksheet can be used as a planning tool and a marketing tool, when potential clients are convinced that it is too expensive for them to provide ElderCare for their parent or to pay for it themselves. Complete a sample worksheet based on average costs in your area, and if the difference is negligible, do include a sample comparison as one of your marketing tools.

Nursing Home or Long-Term Care Facility

All-inclusive cost for 31 days	$_____
CPA ElderCare provider	$_____
Other	$_____
Total costs	$_____
Less insurance and Medicare recovery	$_____
Net out-of-pocket cost	$_____

Retirement Community or Senior Living Facility

Monthly rent	$_____
Utilities	$_____
Cable TV and telephone	$_____
Doctor bills	$_____
Medicine	$_____
Transportation	$_____
Food	$_____
CPA ElderCare provider	$_____
Other	$_____
Total costs	$_____
Less insurance and Medicare recovery	$_____
Net out-of-pocket cost	$_____

In-Home Care

Monthly rent or mortgage	$_____
Utilities	$_____
Cable TV and telephone	$_____
Property taxes	$_____
Property insurance	$_____

(continued)

MONTHLY PRICE COMPARISON WORKSHEET (*CONTINUED*)

Repairs and maintenance	$_____
Doctor bills	$_____
Medicine	$_____
Transportation	$_____
Groceries or meal delivery	$_____
Homemaker	$_____
Health care aide	$_____
Gardener	$_____
Transportation	$_____
CPA ElderCare provider	$_____
Other	$_____
Total costs	$_____
Less insurance and Medicare recovery	$_____
Net out-of-pocket cost	$_____

DOCUMENT INVENTORY CHECKLIST

Personal and Family

- Birth certificates
- Marriage certificates
- Citizenship papers
- Divorce or separation papers
- Adoption papers
- Social Security numbers and cards
- Passports (numbers and expiration dates)
- Military records
- Testamentary will
- Powers of Attorney

Medical

- Healthcare professionals (names, addresses, telephone numbers) including:
  - — Physicians
  - — Dentists
  - — Pharmacists
  - — Other professionals
- Healthcare proxies/living wills
- Medications (dosages, name of prescribing physicians, pharmacy, address, telephone)
- Hospitals of choice (address, telephone)
- Medicare numbers
- Medicaid numbers (caseworker numbers, address, telephone)
- Social worker or caseworker names (address, telephone)

Financial

- Income sources (retirement benefits, disability benefits, and Social Security)
- Financial assets
- Cash and checking accounts (institution names, account numbers, address, telephone, form of ownership, current value)
- Money market funds (institution names, account numbers, address, telephone, form of ownership, current value)
- Savings accounts (institution names, account numbers, address, telephone, form of ownership, current value)
- Certificates of deposit (institution names, account numbers, address, telephone, interest rate, rollover and maturity date)

(continued)

DOCUMENT INVENTORY CHECKLIST (*CONTINUED*)

- Retirement and pension plans (institution names, account numbers, address, telephone, form of ownership, current value)
- Stocks (institution names, account numbers, address, telephone, form of ownership, current value)
- IRAs/RRSPs (institution names, account numbers, address, telephone, form of ownership, current value)
- Bonds (institution names, type of bond, account numbers if applicable, address, telephone, current value, yield, maturity date, call date)
- Annuities (institution names, account numbers, address, telephone, form of ownership, current value)
- Mutual funds (institution names, account numbers, address, telephone, form of ownership, current value)
- Life insurance (institution names, account numbers, address telephone, form of ownership, current value)
- Real estate (property addresses, location of deeds, form of ownership, current value)
- Primary home
- Investment properties
- Vacation home
- Other assets (location of items, titles, documents, form of ownership, current value)
- Automobiles
- Collectibles
- Boats
- Household items
- Inheritances
- Hidden valuables, items in storage
- Jewelry
- Loans to family members, friends
- Liabilities (creditor institutions, address, telephone, approximate debt, maturities)
- Mortgages
- Notes
- Personal loans
- Credit cards
- Other

Insurance

For each policy, list company name, policy number, location and beneficiary.

- Life Insurance
- Health

DOCUMENT INVENTORY CHECKLIST (*CONTINUED*)

- Medigap
- Long-term care
- Dental
- Disability
- Homeowners, renters
- Liability
- Automobile

Legal

- Wills (dates of documents, executor names, address/telephone)
- Powers of Attorney (type, names, including back-up, address/telephone)
- Advance medical directives
- Durable medical powers of attorney
- Health care proxies
- Living wills
- Guardianship (names, address, telephone)
- Trust agreements

Contact Information

- Family members (name, address, telephone, relationship to the elderly person, signatory authority or powers which they hold, access to client's premises)
- Attorneys (name, firm, address, telephone)
- Insurance agents (names, firm, address, telephone)
- Financial advisers (names, firm, address, telephone)
- Stockbrokers (names, firm, address, telephone)
- Bankers (names, institutions, address, telephone)
- Religion (name, affiliation, place of worship, address, telephone)
- Other CPAs (name, firm, address, telephone)
- Past employers (company name, address, telephone, date of retirement or separation, contact person, employee identification number)
- Neighbors (name, address, telephone, access to keys or access to client's home)
- Friends (name, address, telephone, access to keys or client's home)
- Service providers (names, addresses, telephone numbers, services provided, frequency of services, access to keys or client's home)
- Club memberships, volunteer activities, senior center (names, address, telephone numbers)
- Landlord (name, address, telephone, access to keys or client's home)

(continued)

DOCUMENT INVENTORY CHECKLIST (*CONTINUED*)

Other Relevant Information

- Inventory of family historical records (documents, photos, keepsakes)
- Burial instructions
- Funeral home location
- Name of director
- Prepaid arrangement
- Cemetery name and location
- Deeds to cemetery plots and location of plots
- Safe deposit boxes (institution names, address, telephone, location of keys and list of contents, other names on safe deposit box records)
- Tax records

Document Inventory Control

Document	Last Updated	Document Location	Comments, Named Parties, etc.
Will:	_____	_____	_____
Power of attorney for property:	_____	_____	_____
Health care power of attorney:	_____	_____	_____
Guardianship:	_____	_____	_____
Living will:	_____	_____	_____
Do not resuscitate (DNR):	_____	_____	_____
Organ donation agreements:	_____	_____	_____
Funeral arrangements and desires:	_____	_____	_____
Prepaid funeral contracts:	_____	_____	_____
Other prepaid expenses:	_____	_____	_____
Trust documents:	_____	_____	_____
Deeds, mortgages:	_____	_____	_____
Care and housing contracts:	_____	_____	_____
Health care provider preferences:	_____	_____	_____
Insurance policies:	_____	_____	_____
Investment certificates:	_____	_____	_____

MONTHLY ENGAGEMENT CHECKLIST

Client _____ For month of _____

✓ Client was visited ___ times this month by _____.

During the visits inquiries were made about :

_____

_____

Did Mrs. Allen have any comments or complaints about the care or the sitters from Home Health Agency?

_____

_____

Did the shopping service arrive to pick up Mrs. Allen and her sitter for their regular Tuesday afternoon shopping trips?

_____

_____

Did the cleaning service come every Wednesday morning?

_____

_____

Any concerns Mrs. Allen had?

_____

_____

✓ ___ Checks were prepared for signature, starting with check number____ and ending with check number ____.

✓ Copy of monthly bank statement was received on _____.

✓ Disbursement account was reconciled on _____.

✓ List of disbursements and receipts were prepared on _____.

✓ Date by which all rents were received on _____.

✓ Copy of investment account statement was received on _____.

✓ Analysis of account was completed on _____.

✓ Were additional services performed this month?

Will there be additional services needed in future months?

_____

Does the engagement letter need updating as a result of these services?

_____

SNOWBIRD CHECKLIST

(Snowbirds are people who spend the winter in warmer climates.)

1. Review and list sources of income insuring that during your client's absence, funds will be deposited directly into your client's bank account or alternative arrangements are made in advance for the funds.
2. Arrange to have bank statements, investment information, and other financial statements forwarded to your office, with copies sent to client's snowbird address.
3. Review investments and record maturity dates of interest-bearing investments so renewal arrangements can be made.
4. Make sure client's snowbird address and telephone number are given to client's investment adviser, attorney, family members, and neighbors.
5. Preview in advance what bills have to be paid during your client's absence and make sure appropriate arrangements have been made for handling them.
6. Determine cash needs of stay at snowbird address and ensure bank account balances, credit card lines, traveler's checks, and other necessary funds are available to pay for snowbird disbursements.
7. Make sure client takes his or her private telephone directory list, including toll-free and reduced direct telephone company long-distance connection numbers.
8. Cancel newspapers and make arrangements for handling or forwarding mail.
9. Make sure client understands custom duties, import restrictions, and related exemptions.
10. Remind client to take birth certificates and, as required, passports and driver's licenses.
11. Make sure client has purchased an extended traveler's medical plan.
12. Ensure your client's will is up-to-date and a copy is accessible.
13. Remind client to carry his or her emergency phone number on his or her person while out of the country. Client should also be reminded to carry his or her public health card.
14. Photocopy important papers and place a copy with your client's will and another copy to travel with your client.
15. Make sure your client has an "emergency medical kit" with him or her, including any personal medications and prescription medications to cover the length of stay out of the country.
16. Review security precautions for your client's residence and consider storing valuables off site. Arrange for periodic visits to the residence and pick up mail and newspapers that could not be stopped or were delivered in error. Arrange for snow removal.
17. Make sure that at least two individuals at your firm have your client's snowbird address and telephone number in case of emergency.
18. If your client's absence from his or her home state is over December 31, ensure that all tax planning for the calendar year has been arranged and in place before departure.

HOME CARE AGENCY CHECKLIST

- ❑ 1. Who owns the care-providing organization?
- ❑ 2. How long has this provider been serving the community?
- ❑ 3. Does a national accreditation organization accredit the agency?
- ❑ 4. Are nurses and other professionals required to evaluate the patient's home care needs? If so, what does the evaluation entail? Do they consult with the older adult's physician and family members?
- ❑ 5. Does the provider include the older adult and family in its development of a care plan? Are they involved in making changes to the plan? How often is the care plan evaluated and revised?
- ❑ 6. Is the older adult's course of treatment documented in writing? Are the specific tasks to be performed by each professional caregiver detailed? Who receives a copy of this plan? Are updates to the plan provided in writing?
- ❑ 7. Does the care provider inform the family members of the care being administered to the older adult?
- ❑ 8. Will the care provider train family members to provide care?
- ❑ 9. Is the agency certified to receive Medicare? Medicaid?
- ❑ 10. How is agency staff selected and trained?
- ❑ 11. Does the individual or agency maintain adequate malpractice insurance?
- ❑ 12. Does the agency have a mission statement or organizational goals, which are known by their employees?
- ❑ 13. Do employees seem happy and content in their work?
- ❑ 14. Are agency employees screened and monitored? Who oversees the quality of care the patients receive? How often are supervisory visits made to the older adult's home to assess the quality of care provided?
- ❑ 15. Does the care provider supply literature explaining fees and funding resources?
- ❑ 16. Is a Patient's Bill of Rights provided to each patient?
- ❑ 17. Will the agency send the same care provider to the client s home on each visit or is a team approach used? Are personalities, gender, and cultural issues taken into consideration on staffing assignments?
- ❑ 18. How many employees (in each discipline) does the agency maintain on its rolls? Are they full- or part-time staff?
- ❑ 19. Are professionals licensed and bonded?
- ❑ 20. Does the agency require a contract for administering services? If so, are rates and frequency of visits detailed for the patient and family? What payment or financing plans are available?
- ❑ 21. What is the agency's contingency plan to provide services in the event of such emergencies as natural disasters, power failures, and bad weather?
- ❑ 22. How are weekend, evening, or holiday hours covered?
- ❑ 23. How is patient confidentiality assured?

HOME CARE AGENCY CHECKLIST (*CONTINUED*)

- ❑ 24. What is the procedure for making a complaint? Is a specific person assigned to patient satisfaction issues?
- ❑ 25. What is the organizational structure of the care-providing agency?
- ❑ 26. What is the financial strength of the care-providing agency? Are annual reports and other evidence of financial security provided to each client?
- ❑ 27. Can the agency provide references including doctors, discharge planners, older adults and their families, geriatric care managers, and others that are familiar with the care provider s quality of service?

HELPING CLIENTS STAY AT HOME QUESTIONNAIRE

A **Caregivers**

- Who will be the primary caregiver?
- What services will each of the caregivers provide?
- How frequently can they be available?
- How quickly can they respond?
- Will health concerns, geographic distance, or time constraints affect their ability to help?
- What assistance needs to be added for the caregiver?
- Has respite for the caregiver been provided for?
- What home and community services are available?
- Which services are appropriate?
- What are the eligibility conditions?
- Have performance expectations been developed?

B **Monitoring**

- Who will oversee each of the care providers?
- Are personal response systems appropriate?

C **Medical concerns**

- What support and medical services will be needed, and how frequently are they required?
- Is the client capable of caring for himself or herself with reminders and occasional assistance?
- Can the client take his or her own medications properly and on time?
- Has the primary physician been made aware of all medications being taken (prescription and nonprescription)?
- Have all medications been checked for drug or food interactions?
- Are all medical instructions written down in a place that is easily accessible to the client or a caregiver?
- Are all medications stored in their original containers and are they clearly marked?
- Are there problems getting to the pharmacy or physician to adjust or refill medications?

D **Personal**

D-1 **Social**

- How will the client stay connected to family and friends as his or her health and mobility decline?
- How will he or she stay involved in meaningful activity?
- Are there volunteer opportunities or hobbies that would interest the client?

HELPING CLIENTS STAY AT HOME QUESTIONNAIRE (*CONTINUED*)

- Can he or she stay actively involved in church or synagogue?
- Are there any activities that could be done from home?
- Would a pet help provide companionship?
- Can telephones, faxes, or computers be used to increase contact with the outside world?
- Would a day-care program be beneficial?
- How else can isolation be alleviated?

D-2 **Home Environment (Also see "Home Evaluation Checklist," next)**

- Is the home safe and secure?
- Is it accessible to someone with handicaps or mobility problems?
- Have all lamp, extension, telephone, and other cords been checked to make sure that they are out of the flow of traffic and in good condition?
- Are small rugs and runners slip resistant?
- Are emergency numbers posted on or near the telephone?
- Is there a telephone accessible in case of a fall or other emergency that prevents reaching a wall phone?
- Are smoke detectors working and properly located?
- Is there a carbon monoxide detector?
- Do all outlets and switches have cover plates and are there any ones which are unusually hot to the touch?
- Are space heaters being used properly?
- Is there an emergency exit plan and an alternate exit plan in case of fire?
- Are towels and curtains kept away from the stovetop?
- Are hallways and other high traffic areas well lit?
- Are bathtubs and showers properly equipped to prevent falls?
- Is the water temperature set at 120 degrees or lower?
- Is a light switch located at the entrance to each room?
- Are small electrical appliances unplugged when not in use?
- Are ashtrays, smoking materials, or other fire sources located away from beds or bedding?
- Are containers of volatile liquids, gasoline, paints, solvents tightly capped and stored away from ignition sources?
- Are stairs well lit?
- Are handrails on stairways well fastened?
- Do the steps allow secure footing?

(continued)

HELPING CLIENTS STAY AT HOME QUESTIONNAIRE (*CONTINUED*)

D-3 **Meals and Transportation**

- Does the client have special nutritional needs?
- Does the client eat a balanced diet?
- Does the client have trouble preparing meals, doing the shopping?
- Are Meals-on-Wheels or other meal programs available?
- Are these programs acceptable to the client?
- Is transportation a problem?
- Can the client drive safely?
- Is there anyone else available to transport him?
- Are other transportation services available, how are they arranged and what do they cost?

D-4 **Overview**

- Have the client's concerns been addressed?
- How can those concerns be mitigated?

HOME EVALUATION CHECKLIST

(Adopted from materials from the National Resource Center for Supportive Housing and Home Modification, 2001)

Client: _____

Completed by: _____ Date: _____

Utilize this checklist to consider primary home safety issues for your older client when considering initiating an in-home care plan. Answer the following questions for each room or area of the home; list any problems noted and ideas for improvement.

	Yes	No
Windows/Doors		
Are windows/doors easy to open/close?	_____	_____
Are locks sturdy/easy to operate?	_____	_____
Are doors wide enough for walker/wheelchair?	_____	_____
Are door thresholds too high?	_____	_____
Is space adequate to maneuver while opening/closing doors?	_____	_____
Does the front door have a view panel?	_____	_____
If so, is it at an appropriate height for the resident?	_____	_____
Floor Surfaces		
Is the surface non-skid/slip and safe?	_____	_____
Does the client have scatter rugs or mats that contribute to the risk of falling?	_____	_____
If so, are they secured to the floor or marked in some way?	_____	_____
Steps/Stairways/Walkways		
Are these in good repair with safe surfaces?	_____	_____
Are handrails available on both sides of stairways?	_____	_____
Is grasping space available for fingers on railings?	_____	_____
Are the stair treads deep enough for the whole length of the foot?	_____	_____
Are there any hazardous open risers on the stairs?	_____	_____
Is an appropriate area available for a ramp if it becomes necessary?	_____	_____

(continued)

HOME EVALUATION CHECKLIST (*CONTINUED*)

	Yes	No
Appliances/Kitchen/Bath		
Is room arrangement convenient and safe?	_____	_____
Can oven/refrigerator/other appliances be opened easily?	_____	_____
Are stove/oven controls well marked and easy to use?	_____	_____
Is counter height adequate for client?	_____	_____
Can the client sit while working if necessary?	_____	_____
Are cabinet pulls secure and easy to use?	_____	_____
Are faucets in good repair and easy to use?	_____	_____
Does the sink contain a working garbage disposal?	_____	_____
Is a trash compactor available?	_____	_____
Is a hand-held shower head available in the bathroom?	_____	_____
Can the client enter/exit tub/shower easily/safely?	_____	_____
Does the client own a shower seat/stool/tub transfer bench?	_____	_____
Are grab bars installed and adequate	_____	_____
Is the hot water heater regulated to avoid scalding/burning?	_____	_____
Storage		
Is storage adequate and conveniently located?	_____	_____
Are closet shelves accessible?	_____	_____
Are storage areas enhanced with innovative products?	_____	_____
Electrical outlets/switches/alarms		
Are outlets/switches operable and easy to turn off/on?	_____	_____
Are outlets properly grounded to prevent accidental shocks?	_____	_____
Are electrical cords in good condition?	_____	_____
Are extension cords used?	_____	_____
Are working smoke detectors in all living areas?	_____	_____
Does client have a monitored alarm system?	_____	_____
Does client utilize a Personal Emergency Response System?	_____	_____
Is the telephone accessible and convenient for emergencies?	_____	_____
Is the telephone equipped with hearing/visual enhancement features?	_____	_____
Can the doorbells be heard throughout the home?	_____	_____

HOME EVALUATION CHECKLIST (*CONTINUED*)

	Yes	No
Lighting/Ventilation		
Is lighting adequate/appropriate for the area/tasks?	_____	_____
Is lighting bright enough for safety?	_____	_____
Are nightlights used in residence?	_____	_____
Is the area well ventilated?	_____	_____
Are operable flashlights easily accessible?	_____	_____
Driveway/Garage		
Is covered parking space available?	_____	_____
Is it convenient to entry of residence?	_____	_____
Are bushes/shrubs trimmed back to discourage prowlers?	_____	_____

Other improvements to enhance client comfort, safety, and independence include:

Lever door and faucet handles

Adjustable closet rods

Nightlights

Removal of all interior scatter rugs and mats

Handrails added to both sides of stairways

Enhanced stairway lighting

Installation of large light switches

Elevation of electrical outlets

Addition of peepholes/view panels at all entrances

Installation of walk-in-shower with grab bars and adjustable shower seat

Addition of non-skid materials to tub/shower/bathroom floor

Installation of grab bars near toilet

Installation or use of portable telephone in all areas of home in case of falls

Rounded edged counter tops

Sliding shelves/lazy susans in cabinets

First floor bedroom/bath to allow living entirely on one level, if necessary.

NURSING HOME CHECKLIST

FIRST IMPRESSIONS

A-1 First Impressions—Building

- ❑ 1. Do you like the location and outward appearance of the residence?
- ❑ 2. As you enter the lobby and tour the residence, is the décor attractive and homelike?
- ❑ 3. Does the building seem to be clean and odor-free?

A-2 First Impressions—Resident Care

- ❑ 1. Do residents appear to be clean, groomed and odor-free? Do residents seem happy and engaged? Do residents socialize with each other and appear happy and comfortable? Does the atmosphere seem pleasant?
- ❑ 2. Do the residents seem to be appropriate housemates for the potential resident?
- ❑ 3. Were you able to talk with residents about how they like the residence and staff? Did you have lunch with residents? Did a resident guide your tour?
- ❑ 4. Does the residence have plenty of plants and pets? Are children and young adults actively involved in programs and activities? Are family members and people from the community actively involved in programs and activities?
- ❑ 5. Were you given a tour of the whole facility? Did you have free access to anything you wanted to see, without violating the privacy of current residents?

A-3 First Impressions—Staff

- ❑ 1. Are the staff members that you pass during your tour friendly to you? Do you receive a warm greeting from staff welcoming you to the residence? Do the staff members treat each other in a professional manner? Do the administrator and staff call residents by name and interact warmly with them as you tour the residence? Do staff members speak directly to the potential resident as well as to family members? Do you feel comfortable talking with the staff? Does there seem to be enough staff available?

PHYSICAL FEATURES

B-1 General

- ❑ 1. Are the living spaces and common areas attractive, comfortable, clean, and free of odors? Are kitchen and other utility areas clean and of adequate size? Is food handling separated from dishwashing and garbage areas? Are spills cleaned up quickly? Are the grounds and building well maintained? Does the facility have good natural and artificial lighting?

B-2 Location

- ❑ 1. Is the facility conveniently located for visiting family and friends?
- ❑ 2. Is the facility located near to physician and health care services?
- ❑ 3. Is the facility near shopping and entertainment?

NURSING HOME CHECKLIST (*CONTINUED*)

B-3 Design

- ❑ 1. Are private units available? Are different sizes and types of units available? Are room or unit sizes adequate for the needs of the resident?
- ❑ 2. Is the facility designed so spouses with different care needs can be accommodated?
- ❑ 3. Do all units have windows to the outside? Do shared rooms have curtains or dividers to provide privacy to each resident? Do residents have their own lockable doors?
- ❑ 4. Are private bathrooms included in each unit? Do unit bathrooms have showers or tubs? How many residents share community showers and tubs?
- ❑ 5. Are there outdoor courtyards, patios, and porches for residents and visitors? Is sufficient outdoor furniture available? Is there space for gardening and other resident projects? Are there private areas other than the bedroom for visits? Is a private exam room available for use when doctors and nurses visit?
- ❑ 6. Does the facility allow residents to use their own furniture? Is there adequate space for personal belongings for each resident? Is extra bulk storage space available?
- ❑ 7. Do units have telephone and TV hookups? Is there an extra charge for these? Is each unit provided with a refrigerator, sink and cooking equipment? Do units have individually controlled heating and cooling? Do faucets, call buttons, telephones, and televisions work?

B-4 Safety & Security

- ❑ 1. Are the entries and parking area well lit? Does the residence provide ample security? Is building staffed 24 hours a day? Is staff awake at night?
- ❑ 2. Is a 24-hour emergency response or nurse call system accessible from each unit?
- ❑ 3. Does the facility have smoke detectors and alarms? Does the facility have a sprinkler system? Does the facility have portable fire extinguishers? Does the facility have emergency generators and emergency lighting?
- ❑ 4. Is the facility in compliance with all state and local fire safety and building codes? Are they in compliance with ADA and FHA codes? Have they provided documentation of their compliance?
- ❑ 5. Are monthly fire drills held? Does the residence have a written emergency evacuation plan? Is it prominently posted? Are exits clearly marked, unobstructed, and unlocked from within?

B-5 Accessibility

- ❑ 1. Are walkers, wheelchairs, and scooters permitted? Are doorways, hallways, and rooms accommodating to wheelchairs and walkers?
- ❑ 2. Does the floor plan allow for easy mobility? Are all areas of the facility accessible to wheelchairs, including entry and parking areas? Are handrails available to aid in walking? Are elevators available for those unable to use stairways? Are floors of a nonskid material and carpets firm to ease walking?
- ❑ 3. Are bathrooms accessible to residents using wheelchairs and walkers? Is bathroom safety equipment installed (grab bars, raised toilet seat)?

(continued)

NURSING HOME CHECKLIST (*CONTINUED*)

- ❑ 4. Are cupboards and shelves easy to reach? Are all appliances, equipment, and controls in easy reach of residents in wheelchairs?

B-6 Services

- ❑ 1. Are housekeeping or maid services provided?
- ❑ 2. Are laundry services available? Are there additional charges for bed linens and towels, if provided by the residence? Is personal laundry provided? Is it an additional expense? Are washers and dryers available for the use of the resident?

B-7 Food

- ❑ 1. Is the food tasty and appealing?
- ❑ 2. Does the residence provide three nutritionally balanced meals a day, seven days a week? Do menus vary from day to day and meal to meal? Are cultural or ethnic preferences considered? Are extra helpings and substitutions available? Are specialized diets available? May a resident request special foods? Does a dietitian plan or approve menus?
- ❑ 3. Does the facility provide assistance with eating?
- ❑ 4. May residents keep food in their units? May residents eat meals in their units?
- ❑ 5. Are common dining areas available? Is there a private dining room for special events and occasions, if desired? May residents have guests for meals in the dining room?
- ❑ 6. Are residents involved in menu planning? Can residents help with meal preparation and have access to the kitchen?
- ❑ 7. May meals be provided at a time a resident would like or are there set times for meals? Are snacks and beverages readily available between meals?

B-8 Transportation

- ❑ 1. Does the residence provide transportation to doctors offices, the hairdresser, shopping and other activities desired by residents? How are everyday transportation needs handled? Can residents arrange for transportation on fairly short notice?
- ❑ 2. Does the facility provide assistance with shopping?
- ❑ 3. May the resident s car remain in the parking lot? Are there any fees for parking?

ACTIVITIES & PROGRAMS

C-1 Activities

- ❑ 1. Are religious services held on the premises or does the residence assist in making arrangements for attending nearby services?
- ❑ 2. Does the facility provide designated space, supplies, and equipment for:
  - — Exercise and fitness programs
  - — Library

NURSING HOME CHECKLIST (*CONTINUED*)

— Woodworking shop and crafts areas
— Gardening
— Barber and beauty shop
— Games and cards
— Coffee or snack bars, gift shops, shops with convenience items
— Web surfing and email
— Fax and copy machines
— Lecture programs, guest speakers, or distance learning

❑ 3. Is somebody designated to conduct activities? Is there a written schedule of activities? Is there evidence of an organized activities program, such as a posted daily schedule, events in progress, reading materials, and visitors? Are the resident activity programs appropriate for the prospective resident? Did you observe residents actively participating in the activities and using the facilities?

❑ 4. Do residents participate in activities outside of the residence in the neighboring community? Do community volunteers, including family members, come into the residence to help with or conduct programs?

❑ 5. Does the residence encourage residents to participate in certain activities or perform simple chores for the group as a whole?

❑ 6. Does the facility take residents on frequent outings? Are all residents able to participate?

C-2 Medical Programs

❑ 1. Are pharmacy, physical therapy, dental, or other medical services offered onsite? Is there a staff person to coordinate home care visits from a nurse, physical therapist, or occupational therapist if needed?

❑ 2. Does the residence have programs for people with Alzheimer's or other dementias and disabilities? Is staff available to assist residents who experience memory, orientation, or judgment losses? Does the facility provide counseling and mental health services for residents? Does the residence have programs in other specialized areas?

❑ 3. Does the facility provide assistance with transfers (for example, from wheelchair to bed)? Does the facility provide assistance with bathing? How many times per week is bathing provided? Does the facility provide assistance with dressing? Does the facility provide assistance with incontinence? Does this include assistance with both bowel and bladder?

❑ 4. Does the facility have formal programs for improving residents' ability to care for themselves, such as incontinence programs, medication management programs, and occupational therapy?

❑ 5. Does the residence use a pharmacy that provides delivery, consultation, and review of medicines? Does the residence have specific policies regarding storage of medication, assistance with medications, training and supervision of staff, and recordkeeping? How

(continued)

NURSING HOME CHECKLIST (*CONTINUED*)

do staff members supervise and assist a resident in taking medicine? Is self-administration of medication allowed? What is the residence policy regarding storage of medication, assistance with medications, training, supervision of staff, and recordkeeping?

- ❑ 6. Does a physician or nurse visit the resident regularly to provide medical checkups? Does facility inform family and physician when an unusual event occurs? How are medical emergencies handled?
- ❑ 7. Is there a family support group? Is family counseling available? How are communications with family members handled? How regularly is communication scheduled?
- ❑ 8. Does the residence have a process for assessing a potential resident's need for services, developing a care plan, and reviewing it periodically? Does this process include the resident, family, facility, and personal physician? Are care planning meetings scheduled at times when family members would be able to attend?

CONTRACTUAL ISSUES

D-1 Rights and Responsibilities

- ❑ 1. Is a written statement of resident rights and responsibilities available? Are there house rules? Do they seem reasonable?
- ❑ 2. Are the terms of the financial and provider agreement reasonable? Can agreements or contracts be modified? Does the contract require the responsible party's signature, and does that signature improperly make the responsible party liable for contractual payments? Has an attorney reviewed the contract for compliance with state and national standards for resident rights?
- ❑ 3. Are residents' pets allowed in the residence? Who is responsible for their care? Are residents able to bring their own furnishings for their unit and what may they bring? Is telephone use accessible and conducive to privacy? May residents smoke in their units? In public spaces?
- ❑ 4. For what reasons may a resident be discharged or involuntarily transferred from one room or section of the facility to another? If hospital or nursing home care is needed, will the room be held? Will there be a fee? Can a resident be discharged for refusing to comply with a care plan? Is there a written policy for transfer decisions? What happens if no bed is available when a transfer is needed or requested? Who makes transfer decisions? What notice will be given for involuntary transfers?
- ❑ 5. Is there a resident council? A family council? Do they have a voice in setting facility policies, procedures, programs, activities, and charges? Is there a reasonable grievance procedure?
- ❑ 6. Must the resident share his or her room with another person? Does the resident have the right to refuse a specific roommate or ask for him or her to be moved?
- ❑ 7. Can a family member or guest spend the night in the resident's room or elsewhere in the facility?

NURSING HOME CHECKLIST (*CONTINUED*)

- ❑ 8. Does the resident have a choice in the selection of medical or health care providers if additional services are needed?
- ❑ 9. Does the resident have a choice about when to rise and go to bed? About when to get dressed? About what to wear? About where, when and what to eat? About what activity programs to participate in?
- ❑ 10. May a resident handle his or her own finances? Is the facility able to manage resident financial affairs? Does the facility provide resident banking ?
- ❑ 11. Is a safe available for resident property? Does the facility have procedures to protect personal property of the resident? Does the facility have a process to inventory the resident's property, equipment, and furniture and ensure it is returned at discharge? Is it clear who is responsible for property damage or losses?

D-2 Costs

- ❑ 1. Are the specific services offered clearly identified in the agreement? What is included in the basic fee? What is extra? Are there different costs for various levels or categories of services? Are any other services included in the fees, such as a specific number of days of skilled nursing care? How are additional services charged for, such as nursing care when needed on a temporary basis? Is there a charge for the room while the resident is away on home or family visits or other temporary absences?
- ❑ 2. How often can fees be increased and for what reasons? Are there any caps on increases? How much have fees increased in the last few years?
- ❑ 3. Are there any government, private, or corporate programs available to help cover the cost of services to the resident?
- ❑ 4. Are billing, payment, and credit policies clearly stated? Do they seem fair and reasonable?
- ❑ 5. Is a room deposit or entrance fee required? Are there any other pre-move-in payments? Is the deposit returned when the resident moves out? Are refundable deposits and entrance fees kept in escrow? Is the unused portion of the rent refunded upon transfer or discharge?
- ❑ 6. What happens if funds are depleted and full payments can no longer be made?
- ❑ 7. Are residents responsible for utility expenses? External maintenance or capital improvements? Are residents required to purchase renters insurance for personal property in their units?

D-3 Provider Qualifications

- ❑ 1. If the state requires the administrator to be licensed or certified, does he or she have a current license or certification?
- ❑ 2. If the state requires the residence to be licensed or certified, does it have a current license or certification? Is it displayed? Is the facility subject to state surveys? Has the facility provided copies of any survey results?
- ❑ 3. Is the facility a member of a trade or professional association?

(continued)

NURSING HOME CHECKLIST (*CONTINUED*)

- ❑ 4. Is the facility Medicaid certified? Medicare certified?
- ❑ 5. Is the facility accredited by any accreditation organization, such as the Joint Commission on Healthcare Organizations (JCAHO) or the Continuing Care Retirement Community Commission? Are they in good standing?
- ❑ 6. Does the facility have a formal quality assurance program? Does the facility conduct resident satisfaction surveys on a regular basis? Will it provide the results of those surveys?
- ❑ 7. Is there a formal staff training program? Does staff receive training to work with special needs or behaviors, such as dementia? What is the operator/or administrator's training?
- ❑ 8. Is staff turnover fairly low? How long has staff been with this organization? What is the ratio of staff to resident? How are nights and weekends staffed compared with days?
- ❑ 9. Has the facility provided references? What religious or fraternal organizations is the facility affiliated with?
- ❑ 10. Which hospitals and nursing homes does the facility have transfer agreements with? Are those facilities acceptable to the resident?
- ❑ 11. Have the local Area on Aging, Better Business Bureau, and health care providers been checked for negative reports?
- ❑ 12. Has an audit report or other financial disclosure been provided to verify the financial stability of the organization? Are cash reserves adequate? Are deposits and entrance fees held in escrow? Are they protected from creditors or purchasers in the event of bankruptcy or sale?

Receipts and Expenditures Worksheet

Receipts	**Husband**	**Wife**	**Total**
Pension income			
Social Security payments			
Interest income			
Dividend income			
Net cash flow from businesses			
Net cash flow from rental property			
Trust distributions			
Asset sales			
Other			
Other			
Total receipts			
Expenditures—Housing			
Mortgage payment			
Rent			
Utilities			
Maintenance			
Property insurance			
Property taxes			
Home furnishings			
Other			
Subtotal			
Expenditures—Food			
Groceries			
Household supplies			
Subtotal			
Expenditures—Clothing			
Clothing purchases			
Cleaning and alteration			

(continued)

RECEIPTS AND EXPENDITURES WORKSHEET (*CONTINUED*)

	Husband	Wife	Total
Subtotal			
Expenditures—Transportation			
Automobile payments			
Automobile insurance			
Fuel			
Repairs			
Taxies and public transportation			
Other			
Subtotal			
Expenditures—Insurance Premiums			
Disability			
Liability			
Life			
Medicare Part A and B			
Medigap			
Employer group health			
Long-term care insurance			
Other			
Subtotal			
Expenditures—Healthcare Not Covered by Insurance			
Daycare			
Nursing home, assisted living fees			
Over-the-counter drugs			
Prescription drugs			
Medical equipment			
Physicians, nurses, and therapists			
Lab, X-ray, other tests			

RECEIPTS AND EXPENDITURES WORKSHEET (*CONTINUED*)

	Husband	Wife	Total
Caregivers and domestic help			
Other			
Subtotal			
Expenditures—Personal			
Entertainment			
Vacation and travel			
Clubs and recreation			
Gifts			
Other			
Subtotal			
Total expenditures			
Net receipts (expenditures)			

REVIEW CHECKLIST FOR WILLS

There are a number of essentials that make a will valid. The will must be written, it must be signed by the testator (the person making the will) and must be signed by at least two (or in a few states, three) competent witnesses. Additionally, the testator must be of sound mind and body; not insane, senile, mentally disabled, and not acting under the duress or under the control of another. In an ElderCare practice, senility and duress are areas that may often come into question. Additionally, your clients may also want to change their wills due to birth or death of beneficiaries, the death of a designated executor or guardian, or changes in property owned. You should periodically inquire of clients whether these variables have changed. The following list of topics will help you review both new and continuing client wills. This list is not meant to be all-inclusive and you should consult with an ElderCare attorney during the formation and review of wills. Since the CPA may have more ongoing knowledge of a client's environment than the attorney, you can act as a second pair of eyes for legal counsel and ensure that necessary client issues are addressed in the document

The executor: The will must designate an executor. If the executor named is an employee in your practice, client continuity is imperative and provisions must be made for changes in employee status or else your practice may lose the business if the employee leaves your firm. The will must provide alternate or successor executors as well. Additionally, the executor must be independent of the court. One should also note if the executor is a beneficiary. If so, dual executors can increase independence. If the estate needs to continue for an indefinite period of time to finalize affairs, provisions for administrative costs must be included in the will. Finally, if the will gives the executor the power to allocate capital gains between income and principal, one may be able to minimize taxes for the estate and the heirs.

A bond: One should note the designation of a bond requirement. Many states require executors and trustees to post a bond, usually paid out of estate funds, to ensure that they complete the job properly. The testator can save them this expense by stating that no bond is needed.

The testator: The will needs to include the legal name of the testator, including all potential names that have been used by the client. Additionally, the will needs to express the testator's reason for drawing up the document. The will should revoke all previous wills and/or any codicils (amendments). There must be separate places for the signatures of the testator and the correct number of witnesses. In addition, there must be a self-proving affidavit (with its own separate signature line). Finally, the will must have an attestation clause.

The spouse: The CPA should note if the spouse is included in the will. If not, the CPA should inquire as to the reason in order to try to anticipate any future challenges to the will. A spouse may also be given marital bequest such as the right to direct the sale of non-income producing assets. The CPA should note if the marital bequest is given to the spouse directly or if it is in trust. Provisions for these issues need to be included in the will.

The children: The CPA should inquire as to the number of natural and adopted children, and ensure all are named if that is the testator's intent. If it is not, secure the testator's intention. Also ensure that the document addresses inheritances for any current or potential future adopted or stepchildren in the line of descent. The birthdates

REVIEW CHECKLIST FOR WILLS (*CONTINUED*)

of all children should be included in the will. Finally, unborn children need to be included if that is the testator's intent. Provisions for the death of unborn children should also be included.

Liabilities and expenses: Estates have expenses that must be paid prior to beneficiary bequests. Therefore, a clause must be included that directs the payments of the testator's liabilities and expenses. Additionally the nature of the taxable estate and the disposal of assets determine how debts are paid out. For example, if there are only taxes to pay, payment is determined by federal and state tax apportionment provisions. However, if there are other debts to be paid as well, payments may be made from the residuary estate alone or be apportioned among the bequests and the residuary bequest. The will can also provide the right to pay administrative expenses and liabilities from income earned on assets.

Residuary bequest: A will must have a statement naming a residuary legatee for the estate residue, which is the portion left after bequests of specific items. (The residuary estate is often the largest portion, and the person or persons who get it are those the deceased intended to get the most.) All property must be disposed of, and the will must provide for the disposal of remaining assets if the residuary beneficiary dies before the testator.

Specific bequest best practices: One should itemize specifically who will get which personal items. (A memorandum can be filed with the will with instructions on how these kinds of assets should be distributed. The will should reference the memorandum, if the list exists outside the will.) All specific bequests need to include a description of the asset and the specific identification of the respective beneficiary. The will must also direct who gets the item if the beneficiary predeceases the testator. If there is potential for strife however, have the executor determine the distribution and do not name a child as the executor. When possessions are equally divided among children, it reduces will contests. The will can also specify that the children are to choose items in sequence and direct them to draw lots to decide who chooses first, second, and so on. Finally, have the testator leave extra cash to the person getting items of lesser value if there is a significant difference in value. Finally, the CPA needs to inquire about the existence of such items as life insurance owned on the life of another, or the ownership of a personal residence and insure disposition requirements for such assets.

Trusts: Trusts can be created to act as beneficiaries, instead of leaving assets directly to people. There are many advantages to trusts. Probate can be reduced or bypassed and estate taxes can be reduced. Certain trusts can shield assets, others can manage assets for the beneficiaries of two separate marriages. Some things to look for regarding trusts include the following. First, every trust needs to have a trustee designated. There should also be provisions to limit a trustee's liability so the trustee will be willing to carry out the duties. In addition, good compensation should be provided for the trustee so that the trustee is enthusiastic about the job. One should note if designated distribution of income to a surviving spouse is mandatory or discretionary. If it is discretionary, the surviving spouse should not act as trustee. Note how broad the trustee's powers are; if the will grants the trustee broad discretion over investments, the will should have clauses to protect the beneficiaries from wrongdoing by the trustee. Also note whether the trustee has the right to retain assets transferred to the trust.

SAMPLE NONTRADITIONAL REPORT

(Note: Use 14 point type or larger if this report is addressed to the older adult.)

April 18, 2002

Mrs. Sarah Snyder
31 Dogwood Road
Front Royal, Virginia

In accordance with the engagement letter between our firm and you dated May 26, 2001, the following report details our activities for the quarter ended March 31, 2002.

Personal Finances

A statement of cash receipts and disbursements in your account at the Mutual Bank (account number 555-1212) is attached to this report. All payments were in accordance with budgeted amounts except for—

1. A payment to Red Stick Appliances in the amount of $855.43 for the purchase of a new refrigerator.
2. A payment of $1,786.00 for the removal of a tree damaged in the winter storm occurring on February 12, 2002.

We received specific authorization from you before paying either of these invoices.

We also noted that the regular quarterly dividend from Crockett Financial Corporation, which is normally approximately $15,000 per quarter, was not received during the quarter. We have contacted Crockett Financial to determine the status of this expected payment. Initial information from the company indicates that the dividend check was issued, but it has been neither cashed nor returned. We will continue to pursue this matter until the check has been located. If the check cannot be located within the next three weeks, we will request Crockett Financial to place a stop payment on the check and reissue another dividend check to you.

Investments

Copies of the monthly statements on your investment account at Spaatz & Co. are attached for your review. We noted no unusual transactions during the period, and Wedge Donovan, your financial adviser, has made no recommendations during the quarter concerning changes in the portfolio.

Contracts

Communications concerning your apartment buildings at 2200–2500 Devon Drive, Front Royal, Virginia, have all concerned tenant vacancies and new leases, in accordance with rental rates and terms previously approved by you, except for a letter to your attorney (a copy of which was forwarded to you) requesting that she commence eviction proceedings on the tenant of Suite 2400 at 2200 Devon Drive. The tenant is presently four months delinquent in payment of rent and has not been attempting to cooperate in working out arrangements for bringing the rental payments current.

SAMPLE NONTRADITIONAL REPORT (*CONTINUED*)

Sitters

We have visited your home on three occasions over the last quarter to observe the work being performed by Home Services, Inc. It appeared that the premises were being maintained in an orderly manner, and you indicated that you were pleased with the service being rendered, except that the person preparing your meals was unable or unwilling to prepare foods that you preferred and in a manner to which you were accustomed.

Acting on your behalf, we contacted Home Services, Inc., on February 1, 2002, and requested that a different person be assigned to you for meal preparation services. Based on subsequent visits and discussions with you, it is our understanding that the meals are now satisfactory.

Medical

Nothing to report.

Taxes

We have prepared and mailed to you for your review and signature the following tax returns pertaining to the year ended December 31, 2001:

Form 1040 Individual tax return and related schedules

Virginia Form 140 state tax return and related schedules

W-2s/W-3s and 1099s

We have also made the first quarterly installment payment in the amount of $45,000 to the Internal Revenue Service and the State of Virginia for taxes anticipated to be owed for the year 2002.

Household Maintenance

On each of our visits to your home, we toured the property with Mr. Haney and noted no items that appeared to require repairs. As previously noted, however, a tree was damaged during a winter storm on February 12. Mr. Haney contacted us concerning the matter because the tree was too large for him to remove. We received competitive bids from three tree services and selected Arbor Cuts, Ltd., as the lowest, most responsible bidder. Arbor removed the tree under Mr. Haney's supervision, and we paid its invoice in the amount of $1,786.00. Mr. Haney is concerned that there may be hidden damage to other vegetation as a result of the storm. However, we have agreed that nothing will be done about that possibility until spring.

Insurance

We filed a claim with your homeowner insurance carrier concerning the tree noted in the preceding paragraph. However, the carrier denied coverage because the storm fell under the "act of God" clause.

(continued)

SAMPLE NONTRADITIONAL REPORT (*CONTINUED*)

Although we feel that the policy does cover such losses, an appeal or, ultimately, litigation would be costly. Because you have a $1,500 deductible for each occurrence and the total possible collection on the claim would be only $286, we have not pursued an appeal of that denial.

If you have any questions concerning the matters discussed in this report or concerning any other matters for which we are responsible, please let us know.

Sincerely,

Yamamoto Accountants

[Date]

Attachments:

Statement of Cash Receipts and Disbursements
Copies of Investment Statements for January, February, and March

cc: Mrs. Jan Lester

Oral Report Memo to the File

TO: Files

FROM: Bernadette Galland

SUBJECT: Mrs. Farragut

DATE: April 18, 2002

In accordance with the terms of our engagement agreement, I telephoned Mr. John Farragut, attorney-in-fact and guardian for Mrs. Farragut, at 3 p.m. on April 17 to report on our activities and observations for the month of March.

In that conversation, I reported on the two visits we had made to Mrs. Farragut's home, the conditions we found at the times of our visits, and other personal observations concerning the engagement. In particular, I reported that on the visit made on March 30 at 5 p.m., Mrs. Farragut had not yet been dressed for the day, although she was sitting in her wheel chair. The sitter explained that she had so much to do that day to clean the house and prepare food that she had just failed to dress Mrs. Farragut, particularly because they were not planning on leaving the house. Mr. Farragut said he would talk to the sitter to make sure she understood the importance of dressing Mrs. Farragut carefully each day.

I also noted that the grass is beginning to grow and that he needs to contact the lawn service company so they can commence maintaining the grounds as spring commences. Mr. Farragut asked me to contact the same service used last year and to ask them to send him a contract for signature. I telephoned Christopher Pike at Quality Lawn Care this morning, and he will send a contract to Mr. Farragut today so that they can commence work on the property.

Mr. Farragut also asked me to call Septimus Home Maintenance to perform an inspection on the home to make sure that no problems had cropped up during the winter months that would require attention and repair. I called Israel Gitstein at Septimus, and he will send an inspector out tomorrow. When I receive his report, I will forward it on to Mr. Farragut for his decision and direction.

AGREED-UPON PROCEDURES REPORT

[Date]

Mrs. Regina Crater
105 Union Road
Franklin, Tennessee

Dear Mrs. Crater:

Attached hereto is a copy of the report furnished to your aunt, Mrs. Lucy Martine, for the quarter ended March 31, 2002.

During the quarter, Burdette Home Care Agency representatives have visited Mrs. Martine on a weekly basis to check on her physical condition. They indicated to us that her condition is basically unchanged since they last reported to you.

In addition, Mrs. Mary Pitcher, a licensed social worker employed by your aunt, has visited twice to observe your aunt's condition. She has made no recommendations concerning additional or changed care routines.

If you have any questions concerning this correspondence or the attached reports, please do not hesitate to call.

Sincerely,

Bunker Hill Accountants

Attachments, as noted

(continued)

AGREED-UPON PROCEDURES REPORT (*CONTINUED*)

Independent Accountant's Report
on Applying Agreed-Upon Procedures

Mrs. Regina Crater
105 Union Road
Franklin, Tennessee

We have performed the procedures enumerated below, which were agreed to by you, solely to assist you in evaluating Burdette Home Care Agency's compliance with the terms and conditions of the agreement dated December 30, 1999, between you and Burdette Home Care Agency for the ongoing care of your aunt, Mrs. Lucy Martine, for the three-month period ended March 31, 2002. Burdette Home Care Agency is responsible for complying with the terms and conditions of the December 30, 1999, agreement. This agreed-upon procedures engagement was performed in accordance with standards established by the American Institute of Certified Public Accountants. The sufficiency of these procedures is solely the responsibility of the specified user of the report.

Consequently, we make no representation regarding the sufficiency of the procedures described below either for the purpose for which this report has been requested or for any other purpose.

1. Inspect meal menus from January 1, 2002, through March 31, 2002, to determine whether there is a notation that at least one meal each day contains a leafy vegetable, specifically, a salad, kale, cabbage, turnip greens, or cole slaw.

   We inspected meal menus from January 1, 2002, through March 31, 2002, and determined that one of the vegetables listed in the procedure above was listed on the meal menus each day, except for the days of February 10, February 22, and March 15.

2. Inspect time logs for sitters from January 1, 2002, through March 31, 2002, to determine whether hours logged indicate that Mrs. Martine was not left unattended.

   We inspected time logs maintained by the sitters (sign-in/sign-out logs) from January 1, 2002, through March 31, 2002, and noted no instance in which the time a departing sitter signed out was earlier than the time at which the arriving sitter signed in.

3. Inspect prescription bottles for _____, _____, and _____ to determine date last filled and number of refills remaining.

Our inspection of prescription bottles on March 31, 2002, indicated the following information:

Prescription	*Last Filled*	*Remaining Refills*
	November 22, 2001	None
	December 12, 2001	Three
	December 12, 2001	Two

(continued)

AGREED-UPON PROCEDURES REPORT (*CONTINUED*)

We were not engaged to, and did not, perform an examination, the objective of which would be the expression of an opinion on compliance. Accordingly, we do not express such an opinion. Had we performed additional procedures, other matters might have come to our attention that would have been reported to you.[5] This report is intended solely for your use and is not intended to be and should not be used by anyone other than you.

[*Signature of Firm*]

Fayette, Missouri USA

April 16, 2002

[5] In connection with the application of the agreed-upon procedures, if matters come to the practitioner's attention by other means that significantly contradict the assertion referred to in the practitioner's report, the practitioner should include this matter in his or her report.

LONG-TERM CARE INSURANCE POLICY CHECKLIST

(See additional Long Term Care Insurance Checklists in Chapter 9, "Long-Term Care Insurance.")

		Yes	*No*
1.	Does the policy pay full benefits for:		
	Skilled nursing care?	_____	_____
	Intermediate care?	_____	_____
	Custodial care?	_____	_____
	Home health care?	_____	_____
	Adult Day Health Care?	_____	_____
	Alternative care?	_____	_____
2.	What are typical nursing home fees in the area?	_____ per day	
3.	When do benefits begin for care in a facility?	_____ no. of days	
	For home care?	_____ no. of days	
4.	How will the policyholder become eligible for benefits?	_____	
	What level of needs must be demonstrated?	_____	
	Who/how will they be judged before benefits can be received?	_____	
5.	How long do benefits last?	_____	
6.	What is the elimination period? (period of time before the policy takes effect during which the owner pays all expenses)	_____	
7.	Is prior hospitalization required before the policy pays for facility or home health care services?	_____	_____
8.	Does the policy offer non-forfeiture benefits?	_____	_____
9.	Does the policy offer only one deductible for the life of the policy?	_____	_____
10.	Does the policy offer a waiver of premium	_____	_____
	How soon after NH admission?	_____	
11.	Is the policy guaranteed renewal for life?	_____	_____
12.	Can the policyholder upgrade or downgrade the coverage if payment becomes a problem?	_____	_____
13.	Will premiums increase yearly or more often?	_____	_____
14.	Does the policy provide an automatic compounded inflation rider with a lifetime benefit?	_____	_____
15.	What are the waiting periods for pre-existing conditions?	_____	

(continued)

LONG-TERM CARE INSURANCE POLICY CHECKLIST (*CONTINUED*)

	Yes	*No*
16. Is coverage provided for Alzheimer's and other dementia-related diagnoses?	_____	_____
17. Does the policy provide restoration of benefits?	_____	_____
18. Is the policy underwritten before being issued?	_____	_____
19. Does the policy cover or pay for assisted living/residential care facilities?	_____	_____
20. What is the Carrier's A.M. Best rating?	_____	

Rating Agencies

A.M. Best	(908) 439-2200, ext. 5742	www.ambest.com
Fitch	(800) 853-4824	www.fitchratings.com
Moody's	(212) 553-0377	www.moodys.com
Standard & Poors	(212) 438-2400	www.standardandpoors.com
Weiss Research	(800) 289-9222	www.weissratings.com

CHAPTER 12:

PowerPoint Presentation for Clients

CHAPTER 12:

PowerPoint Presentation for Clients

PRESENTATION AND SPEAKER'S NOTES

The PowerPoint presentation included with this Practice Aid titled *CPA ElderCare Services and the Client* is to be used to present and explain CPA ElderCare services to potential clients. Presented on the following pages are copies of those presentation slides and speaker's explanation notes.

Personalizing Your Presentation

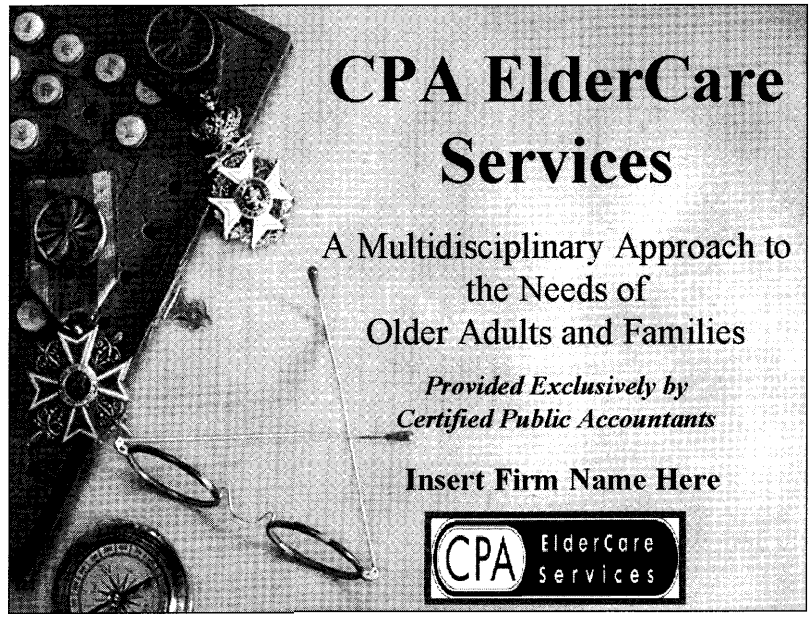
Follow these steps to personalize the ElderCare presentation with your firm name:

1. Open Microsoft PowerPoint and insert the CD-ROM into your computer's CD-ROM drive.
2. Go to the FILE menu and select OPEN.
3. Select the "CPA ElderCare Services and the Client" file from your CD-ROM drive.
4. Click OPEN.
5. On the first slide, move the cursor to "Insert Firm Name Here" and double click.
6. Delete the row of letters and type in your name and your firm's name.
7. Click outside the box when finished.
8. Advance to the last slide.
9. Complete steps 5 through 8 to enter your name, address, phone number, fax number, and e-mail address.
10. When complete, click on FILE.
11. Click on SAVE AS.
12. Select the desired location on your hard drive.
13. Click on SAVE.

Slide 1

The first slide introduces your client to CPA ElderCare services, a service provided exclusively by the certified public accounting professional.

So your name and your firm name appear on this slide (as well as the final slide), be sure to follow the customizing instructions located at the beginning of this chapter before you start the presentation to your client or audience. Also, review the section titled "Creating an Inviting Environment for Your Elderly Clients," in Chapter 1 , "Understanding With the Client, Engagement Letters, and Planning."

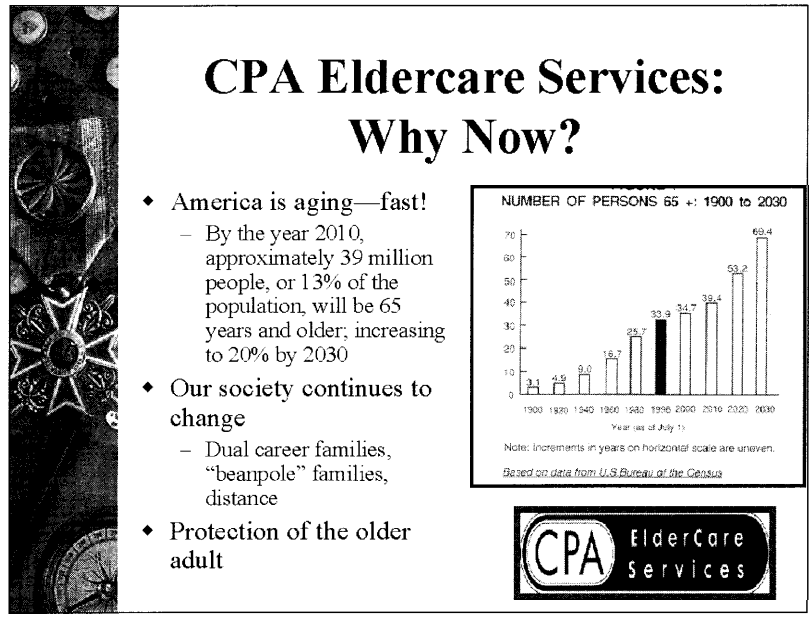


Slide 2

This slide provides important background information about our changing population and culture.

Point out the significant growth in the number of elderly people since 1900. The increased number of these individuals during the coming years demands planning for the latter years of life.

"Beanpole" families represent an elongated configuration of the family structure. Families today are more likely to include several generations but have fewer younger members to care for the growing number of older relatives.



Slide 3

This slide assists the client in recognizing the need to consider CPA ElderCare services.

Direct the client's attention to the emphasis on the multidisciplinary team approach, a unique and important component of sound financial and care planning.

Slide 4

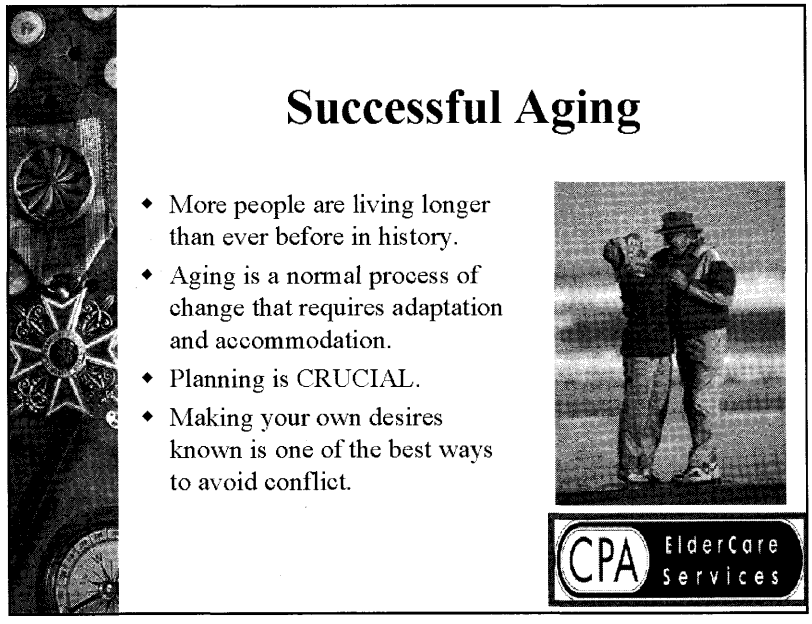
This slide describes a variety of the elderly person's needs addressed by CPA ElderCare services.

This service is grounded in providing appropriate services at an appropriate level that can help the elderly client age happily by addressing important needs.

Slide 5

This slide describes some of the important components for successful aging.

Note: Like other stages of life, the later years require consideration of needs, direct communication, and appropriate planning.



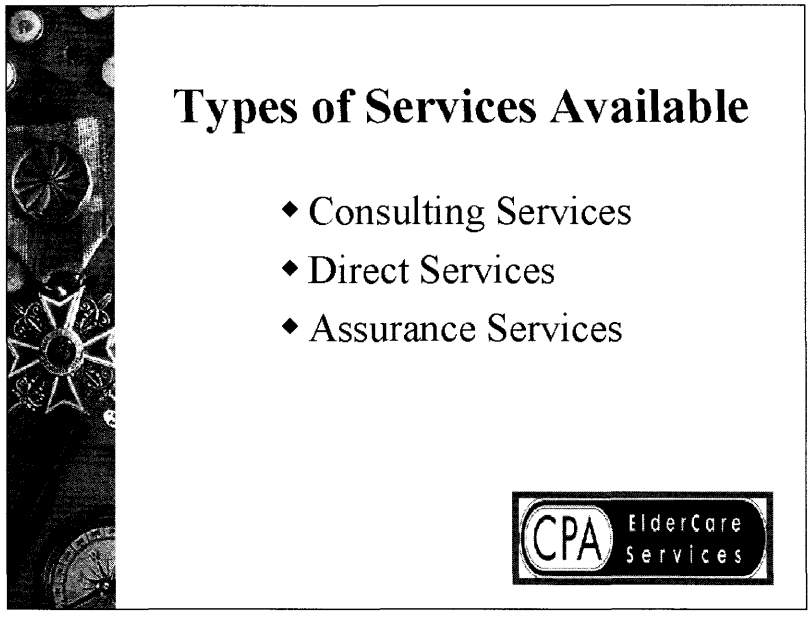
Slide 6

This slide describes the components of the multidisciplinary approach to care planning.

Note: Point out the advantages of the client dealing with licensed, degreed professionals for these tasks. The value of working with a professional team is that the client gets assurance that his or her needs are being addressed by competent, responsible individuals.

Slide 7

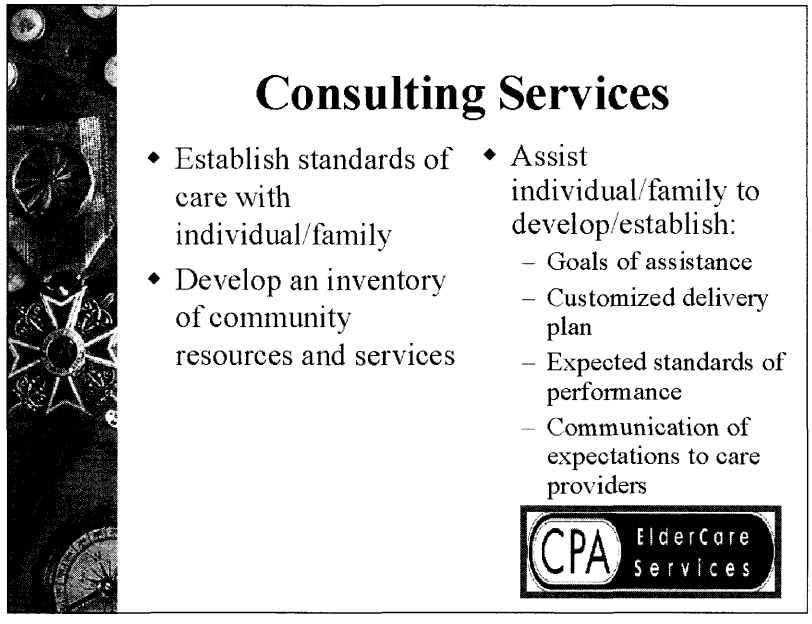
This slide depicts the types of services offered by CPA ElderCare services.



Slide 8

This slide depicts the wide range of consulting services offered by CPA ElderCare services.

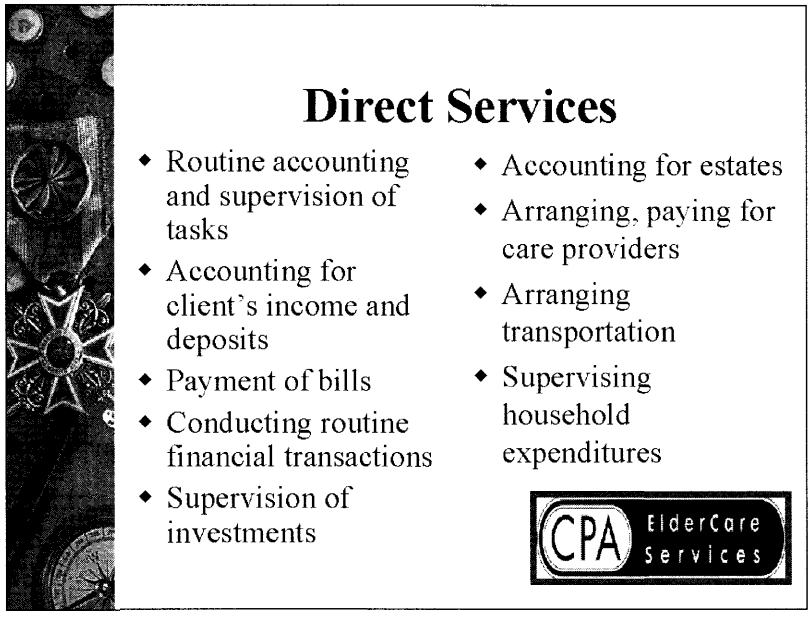
Note: ElderCare services expand the range and variety of services offered by the CPA. In addition, the CPA brings a high degree of integrity, competency, and professionalism to the provision of such services.



Slide 9

This slide shows the client the wide range of direct services available with CPA ElderCare services.

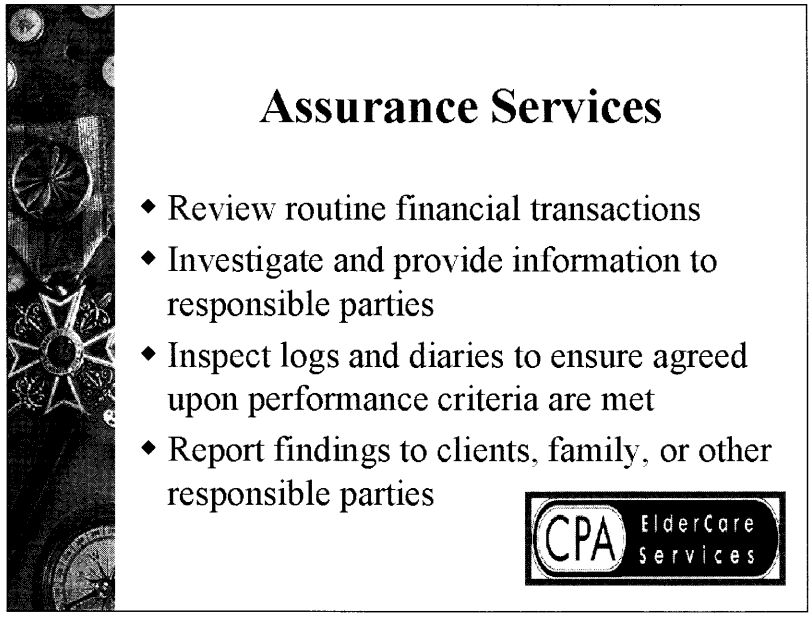
Note: CPAs already perform many of these tasks for their clients; however, assurance services add additional nontraditional services specifically designed to assist the elderly person and family.



Slide 10

This slide describes the content of assurance services.

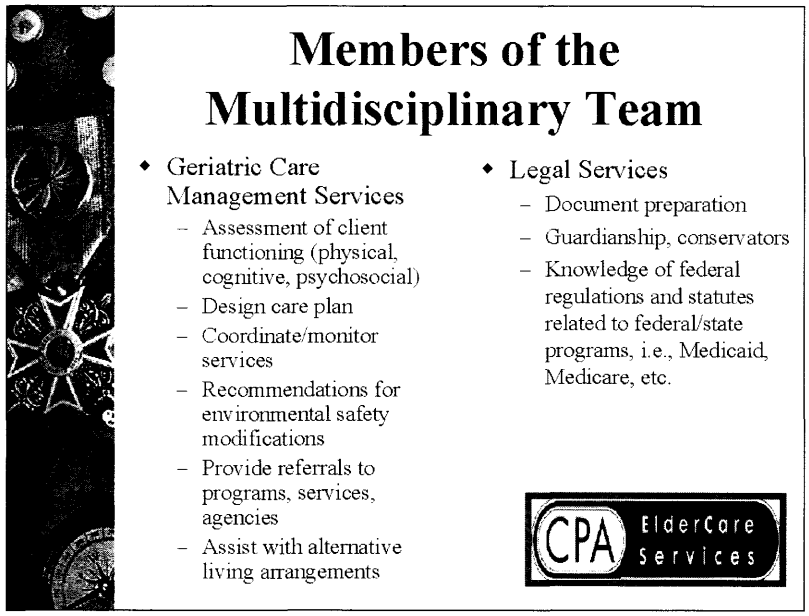
This service reports the results of agreed-upon criteria to the responsible parties. This service more closely relates to services already performed by CPAs, except that the reporting may be for both financial and nonfinancial matters.



Slide 11

This slide further describes the multidisciplinary team, an important and exciting component of CPA ElderCare services.

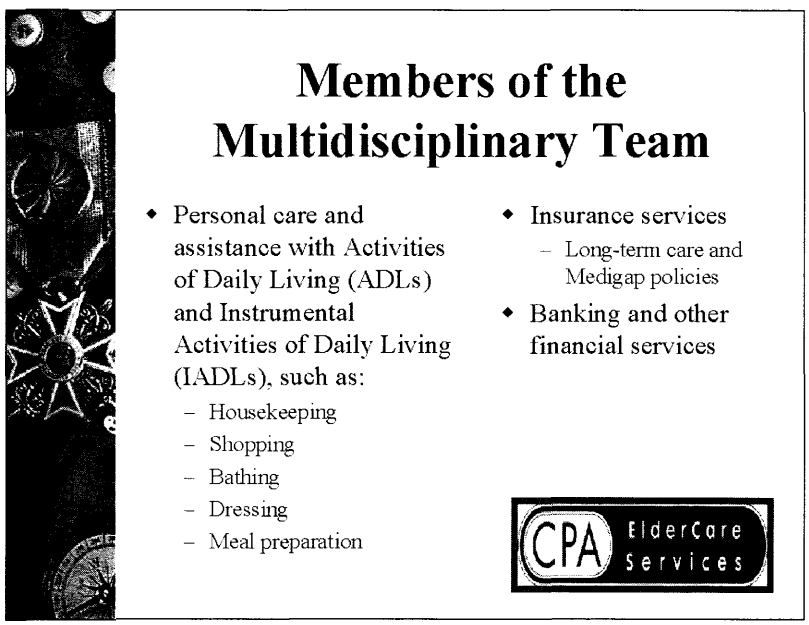
Note: The inclusion of professionals from the social services, legal, and other financial professions assists the elderly person and family to better prepare for the changing circumstances associated with old age.



Slide 12

This slide completes the discussion of the outside professionals who will be a part of the planning team and their role in these activities.

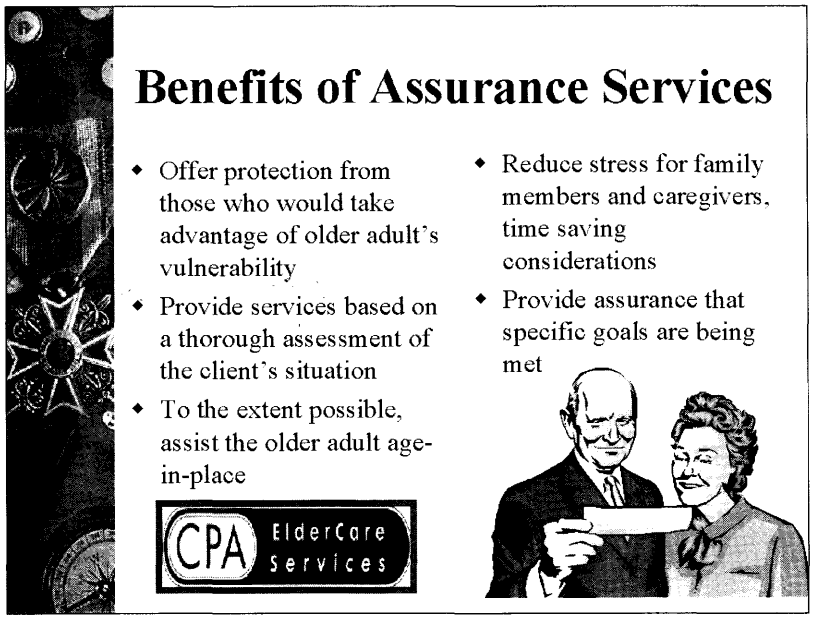
Note: Point out that CPAs already communicate with most of these professionals and that working as a team offers the greatest chance for the client's goals to be achieved.



Slide 13

This slide summarizes the services and advantages of using CPA ElderCare services.

The services are designed to assist the elderly individual and family by following a comprehensive assessment of client needs and resources. The use of ElderCare services encourages client self-determination and may assist the elderly person to remain independent for a longer period of time. In addition, ElderCare services can assist family members to provide a higher quality of care for their loved ones, as well as reduce the level of stress often experienced with care-giving activities.



Slide 14

The final slide in the series should also be personalized with your firm name.

This slide remains on the screen as you close your presentation and answer questions. Be sure you have read Chapter 4 for tips on improved communication with elderly people. If the client seems to be confused about some portion of the presentation, encourage him or her to ask additional questions but do not make him or her feel "put on the spot." Finally, offer any brochures or additional materials you have prepared and thank the client for his or her interest. Set a time that you will contact him or her for a follow up.

CHAPTER 13:

Frequently Asked Questions

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Frequently Asked Questions

These questions and answers have not been acted upon by senior technical committees of the AICPA and do not represent an official position of the Institute.

GENERAL

Why would a potential client hire a CPA to perform ElderCare services?

Although many other service providers are available, the CPA can bring another level of assurance or comfort to the elderly person (and family members). CPA ElderCare services use the CPA's reputation for independence, objectivity, and integrity to provide a service that is in the public interest.

The CPA's ability to apply attitudes of independence and objectivity to problems allows decisions and recommendations to be made that are in the client's best interests. The CPA is at the hub of a wheel of providers, conducting ongoing, continuous, and objective review of the performance of each of the service providers. Those providers not meeting goals, objectives, and criteria for performance are quickly weeded out; other providers will strive to improve their level of service delivery.

Do I need to have any specific experience already?

You are not expected to have many years of experience, because CPA ElderCare services are a relatively new market for CPAs. Many services are outside the normal arena of CPA duties. As these services develop, the AICPA is updating the education and skill requirements. You should have some knowledge of geriatric health issues and terminology, even though the CPA relies on other health care professionals in the direct provision of these services. The CPA should also have general financial planning and management skills. Communication skills, particularly with the elderly, as well as mediation techniques and facilitation skills, are more important in this arena than perhaps in other client services.

COMPETENCIES

Am I taking on something I am not qualified to do when I get involved with the range of services needed by an elderly person?

The practitioner should not attempt to render services he or she is not qualified to provide, for instance, skilled nursing care. Rather, the role of the practitioner is that of oversight. The whole concept of the practitioner acting as the eyes and ears of the absent family members in an ElderCare engagement involves reliance on qualified specialists, employed by the client or the responsible family member, to provide services outside the scope of the CPA's expertise. The practitioner's role is then that of observer and reporter

of how those service providers are meeting the client's needs and the criteria for care established by the family members.

The ElderCare Service Development Task Force envisions the service as a coordination and evaluation service combined with traditional financial services. Typically, strategic partnerships and alliances are developed when the practitioner needs assistance in performing certain tasks and assessments. For instance, a practitioner might develop a strategic partnership with a social worker to perform assessments or for inspection and reporting on care criteria that are outside of the practitioner's area of expertise.

How are CPA ElderCare services engagements staffed?

Tasks, such as visits to the home and accumulation of information regarding choices available to family members, are assigned to the person with prime responsibility for the ElderCare engagement. In such person-to-person contacts, continuity of the staff person or partner making the contact is extremely important.

Other tasks should be assigned commensurate with the abilities of the individual asked to perform those tasks. Some tasks, such as payment of bills, receipt and deposit of income, and accounting for financial transactions, might be handled by a paraprofessional. Estate planning, tax planning, and personal financial planning require more experienced professionals.

Typically, the practitioner relies on other professionals, such as elder law attorneys, geriatric care managers, social workers, insurance agents or medical personnel, to provide services for which the practitioner or the practitioner's staff was not trained.

How much training do support staff require to work on this type of engagement?

If any staff are to be involved directly with the client, they need the same type of training as the engagement partner. Support staff generally are involved in the financial aspects of the engagement and may not require any specific ElderCare training. Most of their work is at the direction of the engagement partner, performing such tasks as preparing financial statements or, in some cases, paying bills and making deposits. If the staff, however, were involved in other aspects of the ElderCare engagement, such as preparation of insurance claims, they would require additional training.

What material is now available that I can use to develop the ElderCare skills I need and to commence developing an ElderCare practice?

The AICPA ElderCare Service Development Task Force has worked with the AICPA's Professional Development Team to develop a series of training courses designed to fulfill the multidisciplinary needs of the CPA eldercare services practitioner. The following five seminar courses offered through state societies and also available in self-study text and video formats are currently available to meet your training needs.

- *Developing an ElderCare Practice* (Product Number 730072BE, text; 181641BE, video). This course provides an overview of the service and outlines the steps the CPA will need to take to get started in the eldercare practice. The course also introduces practitioners to the various disciplines with which they need to be familiar in order to competently provide CPA eldercare services.

- *ElderCare: The Medical and Psychosocial Issues of Aging* (Product Number 731404BE, text; 181751BE, video). This course gives the eldercare practitioner a working knowledge of the most common physical and psychosocial effects of aging. Emphasis is placed on understanding how aging affects the need for financial and social services. It provides a structured approach to coordinating care from government, private, or managed care programs.
- *ElderCare Practice Management and Practice Development* (Product Number 731414BE, text; 181741BE, video). This course addresses practice issues and marketing needs unique to CPA eldercare services. Everything from engagement letters, checklists, and quality control for the eldercare practitioner can be found here.
- *ElderCare: The Financial Issues of Aging* (Product Number 731411BE, text; 181771BE, video). This course helps practitioners serve the planning needs of their elderly clients and addresses the most pressing issue for all elderly Americans today, selecting the kind of care that is best for them and being able to afford it. Emphasis is placed on the financial aspects; including the role of long-term care insurance and vehicles for asset protection
- *ElderCare: The Legal Issues of Aging* (Product Number 731408BE, text; 181761BE, video). This course covers powers of attorney, living wills, and other legal issues related to the elderly. It also discusses how a number of these legal issues affect the CPA eldercare practitioner.

In addition, you can gain valuable training from the following highly recommended continuing professional education (CPE) courses:

- *Professional Ethics for CPAs* (Product Number 731596BE). This CPE course reviews the AICPA's Code of Professional Conduct and its application in practice. It explains the reasoning and application of the Code and explains the fundamentals, definitions, implementation, and authoritative bases of the Code.
- *ElderCare; Tax, Health Care, and Asset Protection* (Product Number 732074BE). This practical course shows you how to leverage basic tax and financial information into a wide range of custom value-added services, provides you with ready-to-use analytical tools, and prepares you to meet your client's unique needs. Topics include resolving the conflict between "traditional" and medical estate planning, capitalizing on entitlement and other financial resources, ensuring adequate medical coverage, nursing home considerations, disability legal documentation, and more.
- *Today's Hottest Device in Estate Planning: The Family Limited Partnership* (Product Number 735263BE). This course shows when and how to make the best use of a family limited partnership to protect client assets and reduce the estate tax burden by 35 percent or more.

The AICPA also publishes an annual Alert, Assurance Services Alert: CPA ElderCare Services, which highlights trends, current events, and critical issues that are crucial to the success of an ElderCare practice.

You can call the AICPA at (888) 777-7077 to order these valuable products.

Should you have health care specialists or geriatric care specialists on your staff?

The task force recommends that the practitioner develop a multidisciplinary team to serve the elderly client. Some team members may be employees; other members may be independent professionals used only on an as-needed basis.

Will Medicare be involved in any way, and if so, how will it be handled?

The practitioner will probably have to deal with Medicare home health benefits and services, long-term care benefits, and other Medicare services. Therefore, the practitioner will need to have a thorough understanding of the Medicare program and all services and benefits available. Medicaid benefits may also be involved in some ElderCare engagements and would require the practitioner to have knowledge of that program as well. A great deal of information on these programs is available in this resource guide in Chapter 7, "Federal and State Programs for the Elderly."

Engagement Issues

Who will the practitioner's client be?

Generally, the client should be considered to be the elderly person. At all times, the best interests of the elderly person should be considered in the course of an ElderCare engagement. The client can also be the responsible family member, or some third party, such as a guardian or an attorney, who holds a power of attorney for the elderly person. This varies by engagement. It is extremely important to have an understanding at the beginning of the engagement about who will have the final word over issues that involve individual preferences.

What are some of my potential liabilities?

The practice of ElderCare often requires the CPA to assume roles with which he has not traditionally been associated. In some cases the CPA will be acting in a fiduciary capacity. These activities can result in additional liabilities that the practitioner must address and be sure are covered.

The practitioner should clearly state that he will not be giving an opinion on the health of the elderly person. Also, the practitioner should not give his opinion on highly subjective assertions. Just as a CPA would never write a report that states, "This company is in great shape!" the CPA should refrain from reporting that "Everything was okay," "Your Mom looked good," "Your Dad's as healthy as an ox," or other subjective comments which would leave the CPA open to potential litigation.

Fully document all ElderCare activities in writing. If oral reports are requested, prepare written notes before the oral communication and make written notes on the recipient's comments on the report.

The CPA firm should use a checklist or other device to provide reasonable assurance that its staff is properly evaluating the risks involved in accepting an ElderCare engagement. A checklist is located in Chapter 11, "Sample Documents and Checklists" and additional liability information is located in Chapter 5, "Quality Control, Best Practices, and Risk Management."

Will my professional liability insurance cover this type of engagement?

A firm that is adding CPA ElderCare services to its practice should make sure that the individual services that it plans to offer or is now offering are covered by its professional liability insurance. To do this, the firm should inform the agent or broker of its plans and request a written interpretation or coverage analysis from the carrier addressing the protection provided under the professional liability policy for the ElderCare services being considered. Such action may initiate additional underwriting by the carrier, and possibly, the assessment of additional premium. The increase in premium may be preferable to having insufficient coverage.

The AICPA's Professional Liability Insurance Carrier offers a toll-free hotline, the CNA Alert Hotline, which can be used (by those members covered under the AICPA insurance program) to check coverage for nontraditional services, receive referrals to attorneys who have liability expertise, and receive assistance on risk management. More information is located in Chapter 5, "Quality Control, Best Practices, and ElderCare Risk Management."

The team approach to providing services may increase risk on engagements, due to the increase in opportunities for miscommunication. Therefore, the CPA should confirm the coverage of any professional who is part of the ElderCare engagement team. The CPA should request a copy of the professional's current declarations page or policy as a routine part of asking them to form an alliance. The same is true if it is another professional who is asking the CPA to provide their client with a particular service.

Is insurance bonding necessary on an ElderCare engagement?

Bonding is vital for those who work with cash or in another fiduciary capacity on CPA ElderCare engagements.

There are four standardized forms of fidelity bonds:

- *Commercial blanket bonds.* The commercial blanket bond is taken by an employer and covers all employees up to a total policy amount. For example, an owner of a store may take out a commercial blanket bond for $50,000. If employee theft occurs, the store is covered up to a maximum of $50,000.
- *Blanket position bond.* The blanket position bond is taken by an employer and insures each employee for a specific amount. For example, a bank may take out a blanket position bond for each of its employees to a maximum amount of $10,000. If any employees embezzle funds, the bank is covered up to a maximum of $10,000.
- *Individual fidelity bond:* The individual fidelity bond is taken by an individual who insures himself or herself to protect those whose money, merchandise, and securities he or she handles.
- *Scheduled fidelity bond:* A scheduled fidelity bond is taken by an employer. It covers named employees who perform tasks relating to specific positions that are described in the bonds themselves. For example, the manager is responsible for checking daily cash receipts and making daily deposits. To insure against theft by that employee, the employer may take out a scheduled fidelity bond for $2,000.

The firm's insurance broker or agent can often arrange any bonding that the firm will require as part of providing CPA ElderCare services.

May I use "canned" engagement letters?

It would be unusual in this type of highly individualized service to have a canned engagement letter. Certainly, various aspects of the engagement letter can be common to most engagement letters, but every engagement will have unique characteristics and services. See Chapter 11, "Sample Documents and Checklists," for sample engagement letters and Chapter 5, "Quality Control, Best Practices, and ElderCare Risk Management" —Professional Liability Exposure section, for additional information on engagement letter content and liability risk.

How should I bill for ElderCare services?

The methods used for billing clients vary from practitioner to practitioner. Practitioners generally bill engagements on an hourly basis, though some use fixed fees. Billing on an hourly basis seems to be advisable because it represents the time spent on the ElderCare engagement. Some clients need little involvement from the practitioner, whereas others require considerable attention. Attempts to estimate in advance the time demanded for each engagement would be difficult and would not allow for consideration of changes in needs and attention required during the term of the engagement. Clients may become unsure of themselves and rely more on the practitioner, and some clients may simply call the practitioner regularly because they are lonely. Hence, charging on an hourly fee basis, depending upon the skill level of the employee involved, seems more equitable to both the practitioner and the client.

It may be important, however, in some cases to consider a monthly retainer or fee that will approximate the annual fee and then make adjustments at year end. This is particularly important for elderly people who perceive themselves as living on a fixed income.

Why do I need an inventory of services available within the community, and how can I develop such an inventory?

Information concerning the services available within the community is of great value to the potential ElderCare client. Such information assists the elderly client or the responsible family member in making choices concerning the type of care he can expect and information about where he can go to contact various care providers.

To develop such an inventory of services, review the relevant chapters in this resource guide.

Who is responsible for making final decisions regarding the level of care or conflicts that arise during the ElderCare engagement?

In any ElderCare engagement, there should be clear understanding of who has the final word in any conflicts or decisions regarding level of care. If the person holding this authority is a third party (a responsible family member or another third party), it is recommended that he also hold an appropriate (depending on individual state laws) power of attorney from the elderly person. Then it is clear to the practitioner that the third party has the ability to make such decisions.

What if the elderly person involved in the ElderCare engagement decides he no longer wants assistance?

The practitioner's response would depend on the terms and conditions of the engagement and on the party contracting for the services. If the elderly person is the party making the arrangements for the service and decides he no longer needs the assistance, that person would presumably be able to cancel the engagement in accordance with the terms thereof. If, however, a legally responsible third party is the contracting party, he should be made aware of the situation, and the third party's instructions should be followed by the practitioner. If the responsible third party agrees that the services should be terminated, this should be handled in accordance with the written arrangements pertaining to termination of the engagement. For instance, the interval between notice of termination and the cessation of services should allow sufficient time for other care alternatives to be implemented.

If I am paying bills and handling the finances for an ElderCare client, should I maintain a separate bank account for each client or could I commingle them in a single bank account?

Separate accounts should be maintained for each client. Maintenance of separate accounts for each client allows certain checks and balances on the account, such as bank statements being mailed to the responsible family member, that would not be available in a commingled account.

If I have responsibility for paying my client's bills, how can the responsible party know this is being handled properly?

Various safeguards, such as having bank statements sent directly to the responsible party, can be integrated into the engagement. In addition, the practitioner should implement appropriate internal controls within the firm to ensure that funds are handled properly.

Is the purpose of ElderCare to minimize expenses being incurred by the elderly person or on behalf of the elderly person?

The object of ElderCare is to allow the elderly person to live comfortably at a standard of living to which they are accustomed. Although the ElderCare practitioner should discourage extravagant or profligate expenses, he or she should not try to be a "penny pincher." Any unusual or suspicious spending should be reported to the responsible family member, but ordinary, routine expenditures (that might not be what the practitioner would spend funds on) should be left to the discretion of the elderly person. The ElderCare engagement letter should carefully spell out the practitioner's responsibility in this area.

How can I, as a CPA, know if home health agencies or other caregivers are rendering the care they are supposed to be giving?

One way is to have the users clearly enumerate certain criteria they wish to be followed. If the criteria are objective enough, the practitioner should be able to determine independently whether they are being met. In certain cases, however, the criteria may involve specialties that are outside of the practitioner's area of expertise. In such cases, a

strategic alliance with an individual or firm skilled in that particular area can be developed whereby the practitioner engages that firm or individual on an as-needed basis to perform the necessary evaluations.

What do you do when a caregiver does not perform according to the contract?

This may not be an uncommon situation, and the practitioner should have a plan in place to deal with the situation.

The arrangement between the elderly person or responsible family member and the caregiver should be evaluated at the beginning of the engagement. Responsibilities of the caregiver should be clearly defined, and the actions to be taken in a default of responsibility should be stated. The responsible family members should be made aware of the potential risks due to failure of a caregiver to perform.

The practitioner's engagement letter should specify the actions, if any, the practitioner should take if a caregiver fails to meet performance criteria. This may involve only notification of the responsible family member. However, in unusual or emergency situations, the practitioner may need to arrange for other care providers on a temporary basis until the responsible family member can make permanent arrangements.

How should I handle an emergency situation involving the elderly client?

Emergencies do happen. Therefore, the practitioner's engagement letter should clearly specify the chain of responsibility and what actions, if any, the practitioner should take in an emergency situation.

In an ideal situation, the responsible family member should be contacted by telephone, advised of the situation and any information the practitioner can provide, given a choice of options, and asked to make a decision as to actions to be taken. If the responsible family member cannot be contacted, the practitioner, upon advice and after consultation from appropriate medical personnel or other professionals involved in the immediate emergency, should make such decisions as are necessary to protect the elderly person's health or security.

What kind of financial reporting is provided to the client if I am hired to oversee the client's financial matters and with what frequency are these reports made?

The form and frequency of reporting should be specified in the engagement letter. For instance, a statement of cash receipts and disbursements might be prepared monthly. A summary written or oral report on the client's care and status might be prepared by the CPA ElderCare provider.

What is my responsibility to the elderly person if for any reason I need to terminate or withdraw from an ElderCare engagement?

Conditions under which the engagement may be terminated by either party should be listed in the practitioner's engagement letter. Typically, these would include such things as nonpayment of fees, unresolvable conflicts between the practitioner and the elderly client or responsible family member, or situations in which the practitioner feels that the interests of the elderly person are not being properly addressed.

Although professionally the practitioner has to abide only by the conditions pertaining to engagement termination, the practitioner cannot morally abandon engagements of this type when a person's well-being is at stake without properly alerting the responsible parties to make other arrangements. Therefore, sufficient time should be allowed for the elderly person or responsible family member to make other arrangements.

Professional Considerations

Will CPA ElderCare services be subject to peer review?

Those ElderCare services that need to comply with the Statements on Standards for Attestation Engagements, Statements on Standards for Accounting and Review Services, and Statements on Auditing Standards are subject to peer review. ElderCare services that are outside of these professional standards (for example, consulting services) are not subject to peer review.

Should I recommend a particular caregiver or agency to individuals or families needing assistance?

Ideally, the practitioner should be able to offer a listing of several providers for each type of service needed by the elderly person, and the responsible family member or members should make the final decision on the caregiver to employ. Such listings should be as objective and factual as possible.

May I release information concerning the elderly client to family members other than the responsible family member?

One of the basic premises of the CPA profession is that a client's financial information is confidential. Normally, this requirement presents no problem, and the practitioner is accustomed to maintaining the confidentiality of such information.

In the CPA ElderCare engagement, however, the client (that is, the elderly person), may not be able to authorize when and how to release confidential financial information. For instance, many assisted-living facilities require extensive financial information before admitting a client.

The CPA ElderCare engagement letter should specify, as completely as possible, all situations in which the practitioner is authorized to release personal financial information on the ElderCare client. The engagement letter should also specify to whom financial information can be disclosed and prescribed reports should be issued. If a situation arises in which personal financial information is required that is not authorized in the engagement letter, a separate authorization for release of the information should be obtained from the client (either the elderly person or the responsible family member). A CPA will have to be vigilant and remind staff to refer to the engagement letter before disclosing financial information to third parties, even if they are family members involved in the engagement.

Even more problematic to a practitioner in a CPA ElderCare engagement is nonfinancial information that may be required by family members or other interested parties. Many jurisdictions have very strict confidentiality requirements concerning the release of medical information. Whenever possible, the practitioner should rely on professional

medical personnel to relay the necessary information to responsible family members. However, the practitioner's responsibility concerning such information should be specified in the engagement letter.

Of more concern is information the practitioner develops during the ElderCare engagement that would indicate that the elderly client is the subject of either physical or financial abuse. In some cases, this abuse is perpetrated by family members, some of whom may have the legal authority to act on behalf of the elderly person, including an unlimited power of attorney. For potential warning signs, see Chapter 2, "Overview of Aging."

Should the CPA ever get involved with the investment of the client's funds?

This is difficult to answer and would depend on the terms of the individual engagement and, in some cases, applicable state laws. As a professional, the CPA can be involved in personal financial planning or estate planning, which involve the development of various investment strategies.

In other cases, the client may wish for the practitioner to be more actively involved in the daily investment decisions. The practitioner should always carefully examine every situation to make sure that there is no actual or perceived conflict of interest that could impair the practitioner's objectivity and ethical standards.

Practitioners should also be aware that actual investment of the client's funds by the practitioner may be such that, depending on individual state laws, a separate license may be required to perform such services. Although investment of clients' funds in such instruments as bank certificates of deposit would not normally trigger such a licensing requirement, transactions in stocks and similar investment securities are typically much more regulated and may require separate licensing. For further information, refer to the PFP Library publication *Guide to Registering as an Investment Adviser*, published by the AICPA.

May I be a trustee of a trust or an executor of an estate and also provide ElderCare services to a beneficiary?

The practitioner should be cautious when acting as a trustee or an executor and also rendering ElderCare services. The practitioner should carefully examine every situation to make sure that his objectivity and ethical standards are maintained at all times.

If I refer an ElderCare client to another practitioner in the area where the elderly person resides, can I ask for a commission from the other practitioner?

The task force recommends that commissions not be sought for referrals (and such commissions may be illegal in some states). The main goal is to find another practitioner to provide quality ElderCare services to an elderly person.

Should I allow myself or staff to receive loans, gifts, or bequests from my ElderCare clients?

What professionals have to offer is independence, integrity, and trust, and it is in their best interest to ensure, in writing, that they will not accept loans, gifts, or bequests.

Should I accept commissions or overrides on invested funds?

Even where state boards would allow this, it is not felt to be in the best interest to accept commissions and jeopardize the independence, integrity, and trust that we maintain.

MARKETING

Who is my market?

The elderly population of the United States is the fastest growing segment of the population today. The AICPA Special Committee on Assurance Services estimates that these ElderCare services have the potential, when fully developed, of a $2 billion to $7.5 billion annual market.

Specifically, your market is twofold: First, your direct market is the elderly population. Elders typically want to maintain their independence by living at home but need some of the financial services that we can provide. Your indirect market is the family members of the elderly, typically living in another area, that want the reassurance of knowing that there is an ethical, capable professional overseeing different activities of their elders.

ElderCare services are not for everybody. The most appropriate clients are elders who have significant assets or incomes that need to be protected or whose families have the financial ability to hire a professional to assist them in caring for their family members.

Should I try to develop a practice in ElderCare even though I do not live in a retirement area?

ElderCare services may add to the profitability of any practice. Although there may be some economy of scale in handling a large number of ElderCare clients, it is possible to develop a profitable ElderCare practice in areas where there are very few ElderCare clients. Demographic trends indicate that the number of elderly persons will continue to grow.

How can I best reach the market for persons who are interested in and able to afford ElderCare services?

There are basically two markets for ElderCare services: elderly clients of the practitioner who have the financial resources to avail themselves of the services, and the children of elderly persons (client or nonclient) who have the resources and interest to see that their loved ones are cared for.

Tax-preparation time is an opportunity to reach both of these markets. Let the elderly client be aware of the services the practitioner can offer in ElderCare. This can be done orally, through a firm brochure, or through a mailing to those clients who meet certain criteria that the practitioner feels would make them potential ElderCare clients.

Similar information about the availability of ElderCare services could also be made available to the children of elderly clients. Interviews during tax preparation or estate planning engagements are opportunities to obtain the names and addresses of the elderly client's children to mail them information on the practitioner's ElderCare services.

Networking with other professionals serving elderly clients, such as investment advisers, physicians, estate planning attorneys, elder law attorneys, bankers, and clergy, is also a way of getting referrals of clients in need of ElderCare services.

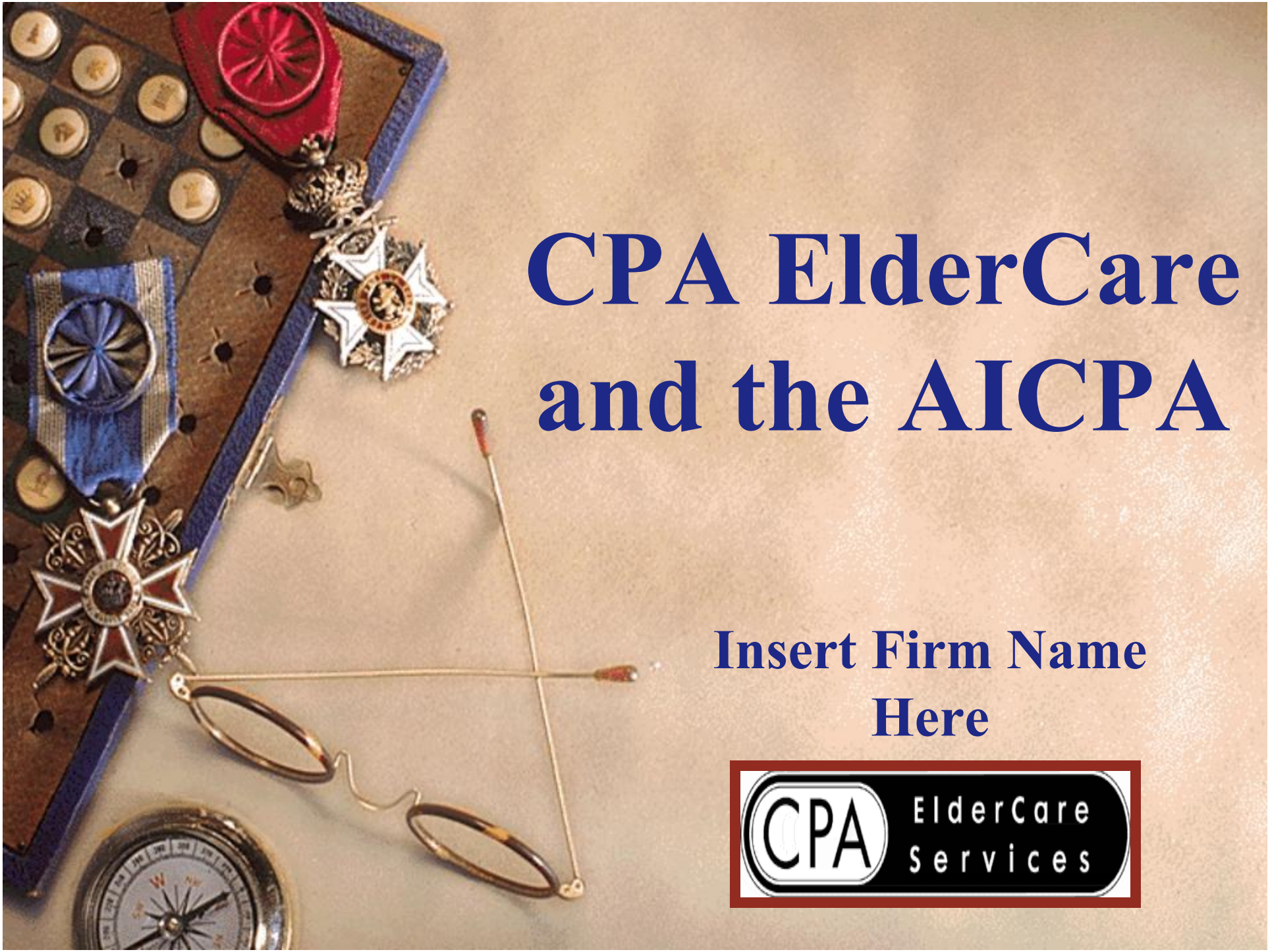
Some organizations are already claiming to provide the services we propose. Will ElderCare cause conflict with those agencies?

Properly handled, many of the organizations referred to in this question can become strategic partners of the practitioner in an ElderCare engagement. Practitioners are not expected to provide nursing care, food preparation services, medical care, or other specialized services being offered by other organizations. Rather, the role of the practitioner in those areas is to make sure that the care being given conforms to criteria and expectations established by the client. The task force envisions ElderCare as a coordination and valuation service coupled with financial services.

Are ElderCare services needed by persons who are in institutions?

Although ElderCare was initially designed as a service to allow elderly persons to live out their lives in their own homes with protection and security, the ElderCare concepts can also apply to institutionalized persons. Typically, in those situations, the practitioner might handle the financial services part of ElderCare. The practitioner might, however, be engaged by the responsible family member to test for certain care criteria he has established, for instance, a weekly visit to the institution to report back to the family on the status of the client, any noted changes from the prior week, and similar matters.

In addition, transfer of an ElderCare client from a home situation into an institutional situation would be no cause to terminate the engagement. Rather, the services to be rendered by the practitioner would probably change.



CPA ElderCare and the AICPA

Insert Firm Name Here

CPA ElderCare Services

Overview of Session

- AICPA Assurance Services
- The Need for Assurance
- Definition
- Types of Services
- Reporting
- Program Evaluation
- Scope of Engagement
- CPA Requirements
- Considerations
- Resources
- The Future

CPA ElderCare Services

AICPA Assurance Services

- Mission
  - "To provide services to the public that are in the public interest but that have not traditionally been considered services offered by the CPA."
    - AICPA Special Committee on Assurance Services, 1994

CPA ElderCare Services

AICPA Assurance Services

- Task Forces
  - Electronic Commerce
  - ElderCare Assurance
  - Healthcare Performance Measurements
  - Information System Reliability
  - Risk Assessment

CPA ElderCare Services

The Need for ElderCare Services

- America is aging—fast!
  - By the year 2010, approximately 39 million people will be 65 years and over.
- Wealth is concentrated.
  - Approximately $13 trillion are controlled by individuals 65 years and over.
- Our society continues to change.
  - We see more dual career families, more “beanpole” families, and distance from older family members is often a consideration
- Older adults could benefit from protection from unscrupulous individuals and businesses.

CPA ElderCare Services

What is ElderCare Assurance

- As defined by the Special Committee on Assurance Services:
  - "Eldercare is a service designed to provide assurance to family members that care goals are achieved for elderly family members no longer able to be totally independent. The service will rely on the expertise of other professionals, with the CPA serving as the coordinator and assurer of quality services based on criteria and goals set by the customer. The purpose of the service is to provide assurance in a professional, independent, and objective manner to third parties (children, family members, or other concerned parties) that the needs of the elderly person to whom they are attached are being met."

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What is ElderCare Assurance?

- Assist older adults in living safely with dignity in THEIR choice of living environment.
- Offer protection from those who would take advantage of the older adult's situation.
- Provide assurance that specified goals are being met.

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Types of Services

- Consulting Services
- Direct Services
- Assurance Services

CPA ElderCare Services

Examples of Consulting Services

- Establish standards of care with the individual or family
- Develop an inventory of community resources and services
- Assist individuals and families to develop and establish:
  - Goals of assistance
  - Customized delivery plan
  - Expected standards of performance
  - Communication of expectations to care providers

CPA ElderCare Services

Examples of Direct Services

- Routine accounting and supervision of tasks
- Accounting for client's income and deposits
- Payment of bills
- Conducting routine financial transactions
- Supervision of investments
- Accounting for estates
- Arranging, paying for care providers
- Arranging transportation
- Supervising household expenditures

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Examples of Assurance Services

- Review of routine financial transactions
- Investigate and provide information to responsible parties
- Inspect logs and diagrams of care providers to ensure agreed-upon performance criteria are met
- Report findings to client, family members, or other responsible parties

CPA ElderCare Services

Examples of Reporting

- Monthly: Complete accounting of all financial transactions
- Periodically: Measure care provider's efficiency and efficacy
  - NOTE: The FORM of reporting depends on what is being reported. Recall that any document that looks like a financial statement, i.e., cash receipts and disbursements, must follow SSARS

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Program Evaluation

- Feedback
  - Primarily for client, family member, or responsible party
  - Care providers
  - Other members of the multidisciplinary team
- Reevaluation and adjustment to the plan as necessary

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Scope of the Engagement

- Depends entirely upon the needs of the client
- Limited to the level of the professional's knowledge and skill as services are more comprehensive
- Scope must be clearly defined and described in an engagement letter

CPA ElderCare Services

What Does This Type of Service Require of the CPA?

- Adequate, current knowledge of the normal aging process
- Associations with other professionals and creation of a multidisciplinary team
- Thorough understanding of the needs and concerns of the older adult client and family
- Personal commitment to education and high standards of practice
- Crisis management skills

CPA ElderCare Services

Important Considerations

- Do you really want to work with older adults?
- Who is the client?
- Disagreements over levels/types of care and family dispute
- Theft of assets
- Transfer of affection: Use of influence to acquire all/part of residual estate

CPA ElderCare Services

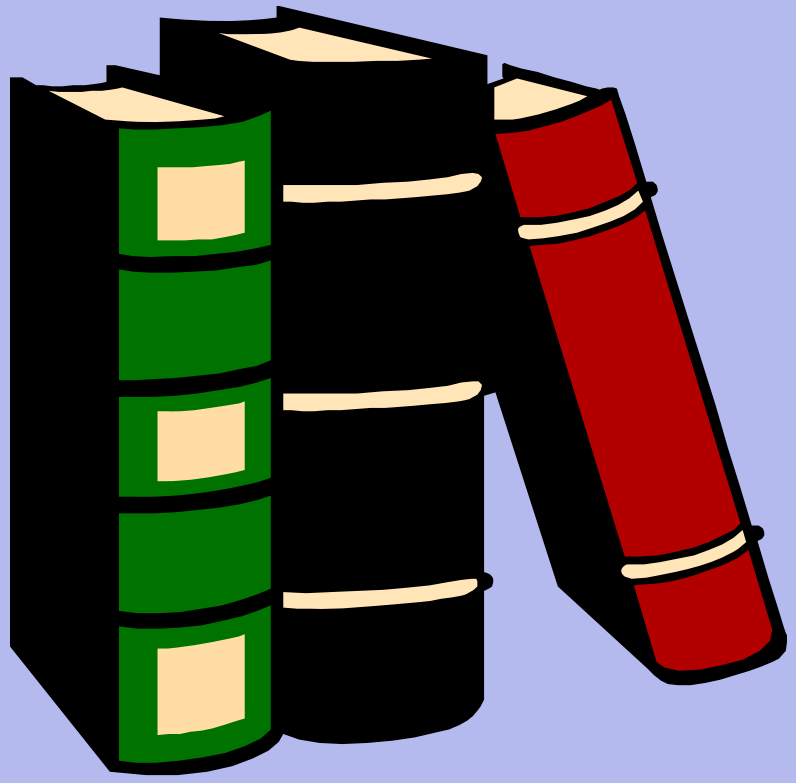
Important Considerations

- Understanding the need for independence of the older adult client
- Liability; do you have adequate coverage
- Skepticism of family members about CPA's intentions
- Associations with unqualified professionals or care providers

CPA ElderCare Services

Resources for the Practitioner

- AICPA courses on ElderCare Services
- AICPA ElderCare Alert
- Website: www.aicpa.org
- AICPA Annual ElderCare Conference
- AICPA Marketing Tool Kit
- This Practice Aid

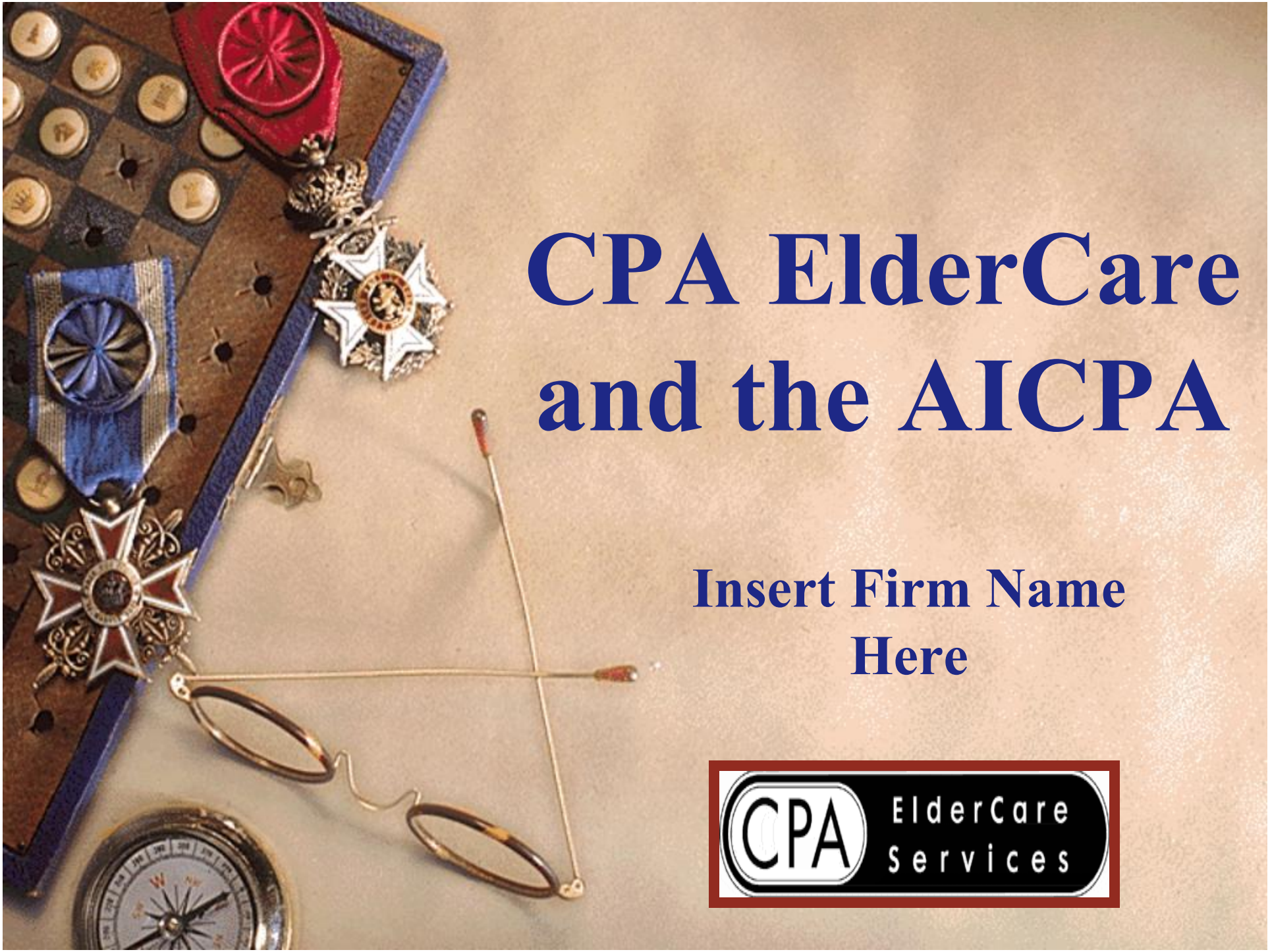


CPA ElderCare Services

The Future

- AICPA Web site: www.aicpa.org
- Taskforce
  - Name
  - Education and practice standards
  - Certification and designation for qualified practitioners

CPA ElderCare Services



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CPA ElderCare Services

A Multidisciplinary Approach to the Needs of Older Adults and Families

Provided Exclusively by Certified Public Accountants

Insert Firm Name Here

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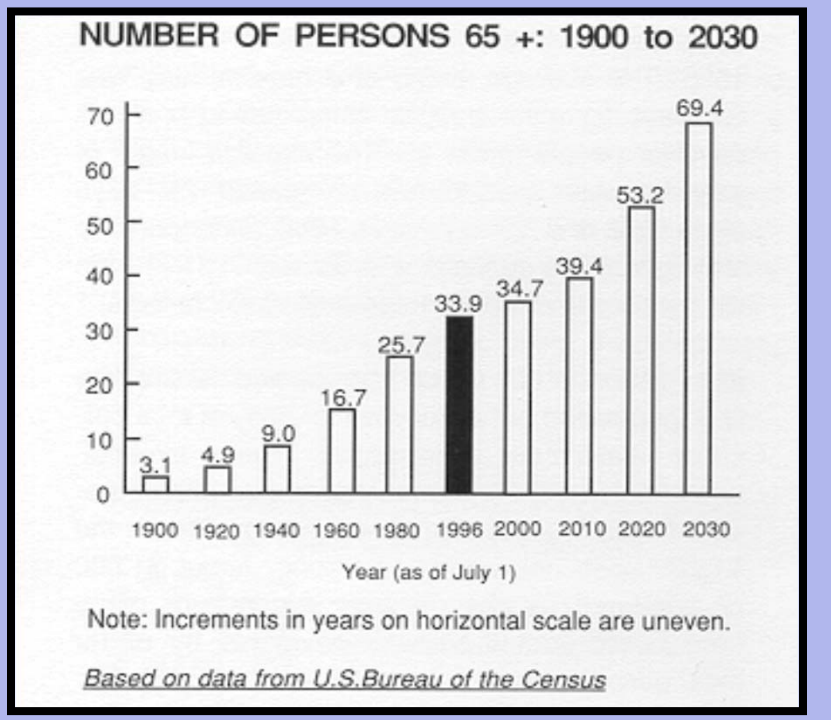
CPA Eldercare Services: Why Now?

- America is aging—fast!
  - By the year 2010, approximately 39 million people, or 13% of the population, will be 65 years and older; increasing to 20% by 2030
- Our society continues to change
  - Dual career families, "beanpole" families, distance
- Protection of the older adult



CPA ElderCare Services

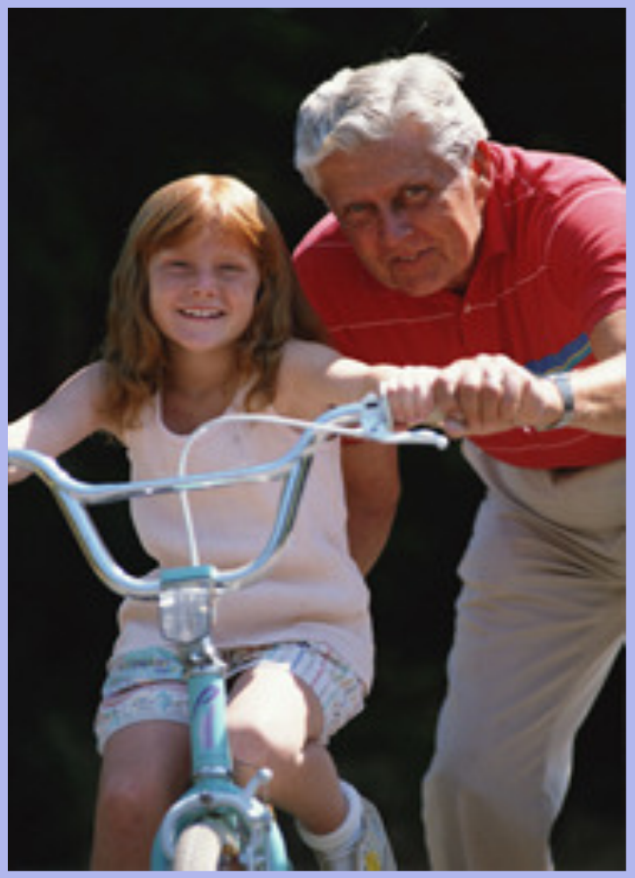
The Need for Our Services

- CPA ElderCare Services are designed to:
  - Provide support (financial, psychosocial, and environmental) through a multidisciplinary team approach to assist older adults in remaining independent in their preferred living environment
  - Collaborate with other professionals in an effort to satisfy the needs of the older adult, family, other responsible parties, and caregivers

CPA ElderCare Services

Our Client's Needs

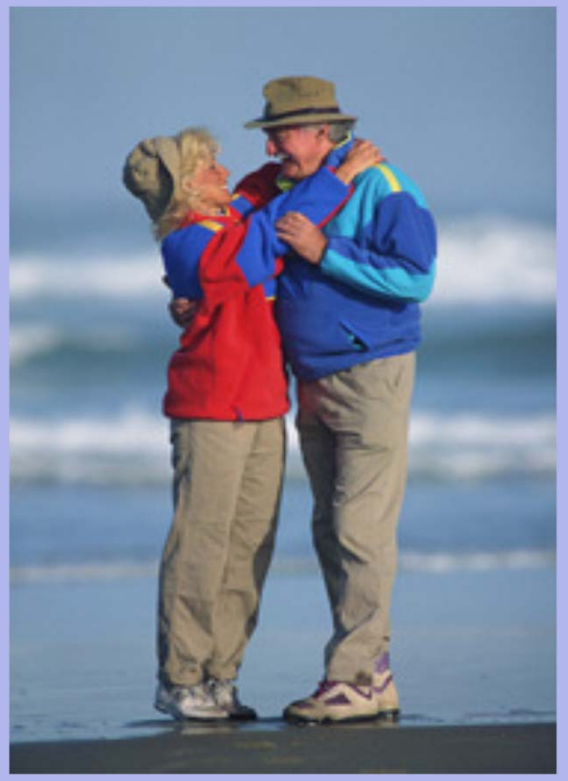
- Need to maintain independence and quality of life
- Need to access appropriate community services and resources
- Need to avoid crisis situations
- Need to remain safe and comfortable with adequate resources for care
- Need to feel confident that assets will remain secure by those providing services



CPA ElderCare Services

Successful Aging

- More people are living longer than ever before in history.
- Aging is a normal process of change that requires adaptation and accommodation.
- Planning is CRUCIAL.
- Making your own desires known is one of the best ways to avoid conflict.



CPA ElderCare Services

Our Firm's Strengths

- A Multidisciplinary Approach
  - Consultation with attorneys, physicians, service providers, and community organizations to maximize client functioning in their preferred environment
  - Degreed, licensed for professional practice by state boards of licensure and regulation
  - Memberships in professional organizations
  - Commitment to our own continuing education and professional growth

CPA ElderCare Services

Types of Services Available

- Consulting Services
- Direct Services
- Assurance Services

CPA ElderCare Services

Consulting Services

- Establish standards of care with individual/family
- Develop an inventory of community resources and services
- Assist individual/family to develop/establish:
  - Goals of assistance
  - Customized delivery plan
  - Expected standards of performance
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Direct Services

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Assurance Services

- Review routine financial transactions
- Investigate and provide information to responsible parties
- Inspect logs and diaries to ensure agreed upon performance criteria are met
- Report findings to clients, family, or other responsible parties

CPA ElderCare Services

Members of the Multidisciplinary Team

- Geriatric Care Management Services
  - Assessment of client functioning (physical, cognitive, psychosocial)
  - Design care plan
  - Coordinate/monitor services
  - Recommendations for environmental safety modifications
  - Provide referrals to programs, services, agencies
  - Assist with alternative living arrangements
- Legal Services
  - Document preparation
  - Guardianship, conservators
  - Knowledge of federal regulations and statutes related to federal/state programs, i.e., Medicaid, Medicare, etc.

CPA ElderCare Services

Members of the Multidisciplinary Team

- Personal care and assistance with Activities of Daily Living (ADLs) and Instrumental Activities of Daily Living (IADLs), such as:
  - Housekeeping
  - Shopping
  - Bathing
  - Dressing
  - Meal preparation
- Insurance services
  - Long-term care and Medigap policies
- Banking and other financial services

CPA ElderCare Services

Benefits of Assurance Services

- Offer protection from those who would take advantage of older adult's vulnerability
- Provide services based on a thorough assessment of the client's situation
- To the extent possible, assist the older adult age-in-place
- Reduce stress for family members and caregivers, time saving considerations
- Provide assurance that specific goals are being met

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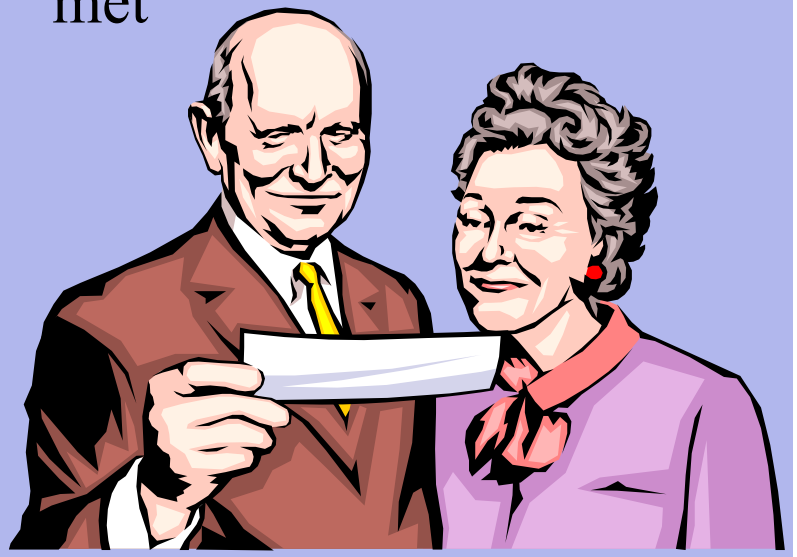

CPA ElderCare Services

YOUR PARTNER IN SUCCESSFUL AGING

Insert Firm Name Here

Insert address

Insert phone no.

Insert fax no. **Insert e-mail address**

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