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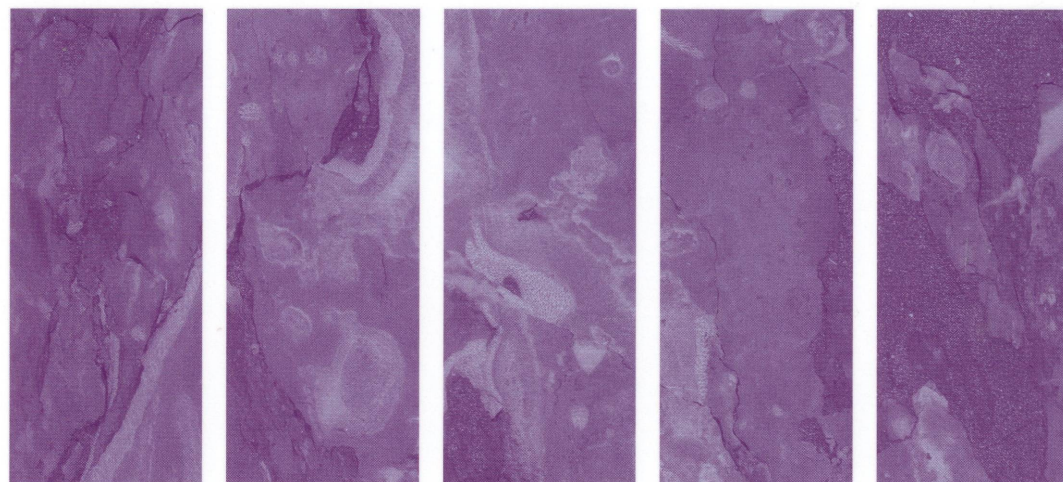
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CPA ElderCare/PrimePlus Services

A Practitioner's Resource Guide

Second Edition



Pamela W. Kaplan, MSW, LMSW

Jay H. Kaplan, CPA

George A. Lewis, CPA

AMERICAN INSTITUTE OF CERTIFIED PUBLIC ACCOUNTANTS

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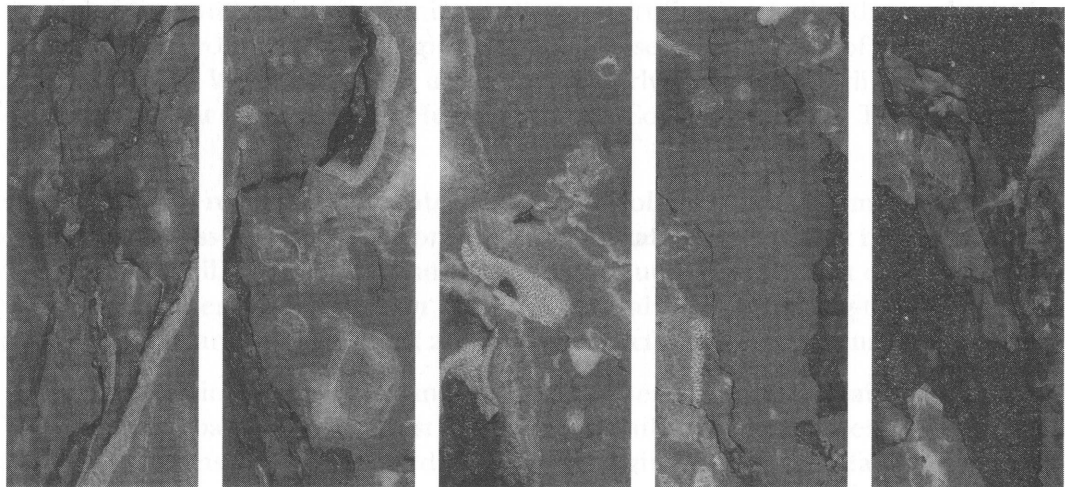
CPA ElderCare/PrimePlus Services: A Practitioner's Resource Guide presents the views of the authors and others who helped in its development. This publication has not been approved, disapproved, or otherwise acted upon by any senior technical committees of the American Institute of Certified Public Accountants.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

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AMERICAN INSTITUTE OF CERTIFIED PUBLIC ACCOUNTANTS

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In addition to their professional lives, Pam and Jay are representative of the "sandwich generation": They are the parents of two post college-aged children and have experienced, first-hand, the caregiving responsibilities required by their own aging parents and family members.

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PREFACE

This second edition of the *CPA ElderCare/PrimePlus Services: A Practitioner's Resource Guide* constitutes a complete revision. While the original scope and purpose of the Guide remains the same—to serve as a practical resource and reference tool for CPAs who are currently performing or are considering providing CPA ElderCare/PrimePlus services to elderly clients and their families—a number of new features and changes are embodied in this second edition:

- *Practice aids.* Included in the Guide are a selection of forms, sample engagement letters, and worksheets developed by leaders in the ElderCare/PrimePlus field that will assist practitioners in advising clients in prudent planning for the issues of aging. Use these practice aids to gather, organize, and analyze essential information for the development of a well-planned ElderCare/PrimePlus engagement.
- *Associations, organizations, agencies.* Information is the lifeblood of any profession. In the financial and non-financial services field, the information explosion has challenged CPAs to seek information in the fastest and most cost-effective way possible. Associations and organizations are one of the best sources of information for aging clients. They are generally focused on one specific area and produce accurate and often voluminous information. Each organization listed as a resource in the Guide includes contact information: name, address, phone (toll-free number if one exists), fax number, Web site (if one exists), and description.
- *Accompanying CD-ROM.* Using the CD-ROM, you can print and customize the practice aids, use the PowerPoint Presentation to introduce CPA ElderCare/PrimePlus services to your clients (the presentation helps standardize both the description and information provided to the public about these services), and instantly access targeted associations and organizations on the Internet.

The second edition of *CPA ElderCare/PrimePlus Services: A Practitioner's Resource Guide* also covers a broad range of timely topics that affect today's CPA:

- Updated and expanded information on federal and state programs for the elderly, including new rules covering Medicare, Medicaid, and Social Security that you and your aging clients need to know.
- Expanded discussion of CPA ElderCare/PrimePlus risk management and best practices.
- Expanded coverage of housing alternatives, including resources to help the older client and CPA determine what level of care may be needed, what finances must be made available, and who may be best qualified to provide the care.
- Expanded discussion of the advantages and disadvantages of having a long-term care policy.

About CPA ElderCare/PrimePlus Services

Surveys suggest that today's Baby Boomers will likely spend more years caring for a parent than their own children. These individuals know firsthand the meaning of the "sandwich generation," a phrase used to describe the growing number of adult children who feel the squeeze of caring

for the needs of an aging parent or other relative and the demands of their own children, spouses, and careers. CPA ElderCare/PrimePlus services cover clients who are younger than 65 but who can use the strengths and competencies of a qualified CPA in managing the financial details of aging, in cash flow planning and budgeting, pre- and post-retirement planning, insurance reviews, and other areas.

The aging of the Baby Boomers, the largest generation in American history, has begun. According to the Census Bureau's "middle series" projections, the elderly population will more than double between now and the year 2050, to 80 million. By that time, as many as one in five Americans could be elderly. Most of this growth in the age 65+ adult population will occur between 2010 and 2030, when the Baby Boom generation enters their retirement years. CPA ElderCare/PrimePlus services has three primary markets: the current 65+ age population, the adult children or relatives of the 65+ population, and families of special needs who need assistance with the process of aging in our society.

Even though practitioners may believe they have limited need for some of the material provided, we suggest that practitioners review each section of the Guide. To a great extent, a practitioner's ability to provide appropriate services and assistance depends on a high level of knowledge about the network on aging that exists in the United States.

The AICPA/CICA ElderCare/PrimePlus 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.

A NOTE ABOUT TERMS

For convenience, most of the references in this publication refer to CPA ElderCare/PrimePlus Services. However, many of the forms and documents included in the publication can be effectively used by Canadian chartered accountants. Therefore, the term *CPA* should be read as including CAs.

Also, the terms *elderly* and *older* are used interchangeably throughout the publication to refer to clients and potential clients of the service. In light of cultural sensitivities to the choice of terminology, practitioners can choose to use the latter term where occasion or usage concerns warrant.

Thank you.

American Institute of Certified Public Accountants, Inc.

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The talents of many skilled professionals have been brought together to help produce what we believe will be a valuable addition to your professional library.

Under the direction of the AICPA/CICA ElderCare/PrimePlus Services Task Force:

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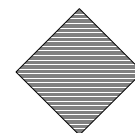
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National Aging Information Center
National Association of Insurance Commissioners
National Association of Professional Geriatric Care Managers
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CHAPTER 1:

CPA ElderCare/PrimePlus Services, the AICPA, and the Marketplace

DESCRIPTION AND BACKGROUND OF CPA ELDERCARE/PRIMEPLUS SERVICES

People are living longer and are usually healthier than similarly aged persons from previous generations. The longer life span demands that individuals plan earlier and smarter for the later years of their lives. CPA ElderCare/PrimePlus 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/PrimePlus services may be limited to only monthly bill paying when the client is 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.

The AICPA's Special Committee on Assurance Services identified ElderCare as an assurance service CPAs can provide. According to the United States Bureau of the Census projections, the senior population (65 years old and older) will more than double by the year 2050, to 85 million. Most of this growth should occur between 2010 and 2030.¹ 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.

CPAs can render 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/PrimePlus 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/PrimePlus services is an elderly person who requires care and assistance. A typical client for ElderCare/PrimePlus services is someone without an

¹ United States Bureau of the Census, "US Interim Projections," 2004.

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 age successfully either 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.

What Does the Target Market for These Services Look Like?

Some ElderCare/PrimePlus 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 ElderCare/PrimePlus services has 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/PrimePlus services. As a rule of thumb, anyone who needs estate-planning services would likely have the resources to afford ElderCare/PrimePlus 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 may be 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 to pay for CPA ElderCare/PrimePlus services, but if several children pool their resources, ElderCare/PrimePlus services may be affordable. Also, if this high level of care and the parent's ability to stay home are an adult child's top priorities, 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/PrimePlus 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/PrimePlus 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/PrimePlus services. Welfare agencies, geriatric specialists, trust officers, lawyers, and others provide some ElderCare/PrimePlus services today. However, none of them has demonstrated the ability or willingness to expand or dominate the market.

For those CPAs who want to research the size of the potential market for CPA ElderCare/PrimePlus services, the first place to start is with their own client base. Anecdotal evidence indicates that, at least initially, most ElderCare/PrimePlus clients will be developed within a firm's own clientele. Elderly clients and their families are more likely to trust and to have a close relationship with a practitioner who has been doing

their tax returns and helping them with estate planning for many years. And within the data accumulated by the practitioner on existing clients, the practitioner can determine which of those clients would have the financial resources to afford ElderCare/PrimePlus services.

If the practitioner wants to research the size of the potential market for CPA ElderCare/PrimePlus services in the area, the U.S. Census Bureau's Web site (www.census.gov) offers a wealth of information. The "State Fact Finder" 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, "Overview of Aging," in the section titled "The Older American Demographic."

What Are CPA PrimePlus Services and How Do They Differ From CPA ElderCare Services?

When ElderCare services were first introduced in 1998, the intent was to provide CPAs with an opportunity to grow their practices by offering a customizable package of lifestyle management services to their clients. While feedback on the service itself has generally been positive, a number of CPAs have noted that the brand name "ElderCare" tends to limit the target market. Market research indicated that persons between the ages of 66 and 80 felt that the term *elder* was not applicable to them and that the word *care* implied a need to rely on others, particularly for health and age-related issues. Therefore, they did not readily associate the ElderCare branding with a financial/lifestyle planning service.

In 2002, the AICPA/CICA ElderCare/PrimePlus Task Force selected the name "CPA PrimePlus services" as an alternative name for ElderCare services. This name not only eliminates the negative connotations of the name "ElderCare" but also covers clients who are younger than 65 who can use the strengths and competencies of CPAs in cash flow planning and budgeting, pre- and post-retirement planning, insurance reviews, and tax planning.

In the future, practitioners will have the option of calling the service either CPA ElderCare services or CPA PrimePlus services and the AICPA will continue to support both brand names.

ElderCare/PrimePlus Services and Personal Financial Planning

The AICPA/CICA ElderCare/PrimePlus Task Force reports to the AICPA's PFP Executive Committee. Personal financial planning is a skill demonstrated by CPAs for years. Until fairly recently, however, the planning revolved primarily around estate and retirement planning designed to accumulate resources for retirement and to transmit the maximum amount of the estate possible to heirs. In recent years, however, personal financial planning has also considered ways to provide funds for the care typically needed by an older person. This is referred to as planning for the costs of long-term care or sometimes as post-retirement planning. One of the goals of good financial planning is to provide sufficient funds to pay for care and for CPA ElderCare/PrimePlus services.

By becoming members of the PFP section of the AICPA, practitioners get discounts on various conferences and materials produced by the Institute. In addition, in the near future, it is anticipated that members of the PFP section will be able to participate in online forums concerning various planning issues, including the provision of ElderCare/PrimePlus services.

CASE STUDY

Successfully providing CPA ElderCare/PrimePlus 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/PrimePlus services challenge the practitioner to consider not only the elderly individual's financial needs, but also his or her physical, psychosocial, and environmental needs and the needs of the individual's family. Providing CPA ElderCare/PrimePlus 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.

Many practitioners may choose to offer only the financial services portion of ElderCare/PrimePlus, such as banking activities, bill paying, tax planning, and personal financial planning. Other practitioners may become more involved with their clients' needs, including enlisting the assistance of other professionals to create a service team designed to meet all of the elderly person's needs. The following is an example of how a CPA may become involved in providing CPA ElderCare/PrimePlus services to an elderly client and what those services entail.

Mr. Vandelay, a 77-year-old widower, had been a client of the CPA's firm for nine years. A retired mechanical engineer, Mr. Vandelay had no children and only one sister, with whom he had only sporadic communication for the past 30 years. A very private person, Mr. Vandelay lived 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 was not available. The client had reported no chronic health problems (subsequently verified by a comprehensive health assessment) and had excellent vision and hearing. He rode 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 also 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/PrimePlus 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 bequeathed 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/PrimePlus success story and of how the CPA can enlist and work with other professionals to meet the elderly client's needs.

UNDERSTANDING AGING AND OLD AGE

Before developing your CPA ElderCare/PrimePlus 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.* Practitioners 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 practitioners' ElderCare/PrimePlus practice depends on, among other things, their 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.* Although ElderCare/PrimePlus clients would not normally be eligible for 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 advance directives. In addition, the practitioner should have a working knowledge of the laws, costs, 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/PrimePlus 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.

CPA ELDERCARE/PRIMEPLUS TOPIC LIST

In its efforts to continue the development of the service, the AICPA/CICA Elder-Care/PrimePlus Task Force has created an ElderCare/PrimePlus topic checklist that allows the practitioner to identify information that is needed to provide various aspects of CPA ElderCare/PrimePlus services. This list is intended to aid the practitioner in providing CPA ElderCare/PrimePlus services:

- I. Standards and regulations
 - A. How the standards apply to ElderCare/PrimePlus
 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
 9. CPAs licensed with a broker/dealer to sell securities and/or annuities as well as those licensed to sell insurance must be familiar with their broker/dealer's professional compliance requirements.
- 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. Drug benefits
 - d. Costs
 - e. Eligibility

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
 - (a) Inter vivos and testamentary
 - (b) Revocable vs. irrevocable
 - (c) Charitable
 - (d) Life insurance
 - (9) Marital deduction
 - (10) Instruction letters
 - (11) 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
 - g. Sale and relocation option vs. reverse mortgage
 - 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
4. Financial services
5. Nonfinancial 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/PrimePlus 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/PrimePlus 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/PrimePlus 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. Setting 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/PrimePlus engagement
 - 2. Performing Web searches
 - 3. Using online resources in an ElderCare/PrimePlus engagement
 - a. Public resources
 - b. Private resources

Many of these topics are discussed in four continuing professional education courses available for self-study or group study from the AICPA specifically addressing CPA ElderCare/PrimePlus services:

- Developing and Managing an ElderCare/PrimePlus Practice
- ElderCare/PrimePlus: The Medical and Psychosocial Issues of Aging

- ElderCare/PrimePlus: The Financial Issues of Aging
- ElderCare/PrimePlus: The Legal Issues of Aging

In addition, other courses offered by the AICPA in personal financial planning and taxation may be of benefit to the practitioner in this area.

Finally, a tremendous amount of information pertaining to aging is available on the Internet.

CPA ElderCare/PrimePlus Competencies Checklist

The AICPA ElderCare/PrimePlus Task Force has developed a checklist of competencies needed by a practitioner to effectively render quality ElderCare/PrimePlus services. By objectively completing the ElderCare/PrimePlus competencies model, the practitioner can determine areas where additional information or education may be needed to fully understand the issues of aging. To access this checklist, proceed as follows:

1. Go to <http://www.cpa2biz.com/cat>
2. Sign in to access this product. To sign in, you need to know your AICPA membership number which is the last 8 digits on the *Journal of Accountancy* mailing label immediately following the zip code in the second line of the label.
3. Get started now.
4. Select a model: ElderCare/PrimePlus
5. Select a profile:
 - a. Entry level
 - b. Senior manager
 - c. Sole practitioner/Partner—Tax practice
 - d. Sole practitioner/Partner—ElderCare/PrimePlus—financial only
 - e. Sole practitioner/Partner—ElderCare/PrimePlus—both financial and nonfinancial
6. Select “next.”
7. Follow programs and enter your current level of expertise.
8. Complete your self-assessment.
9. Generate results:
 - a. Gap analysis
 - b. Assessment report
 - c. Build/edit your learning plan

If at any time you have difficulty accessing the competency model, call technical support at (888) 777-7077.

POWERPOINT PRESENTATION FOR PROFESSIONALS

The Microsoft® PowerPoint presentation included with *CPA Eldercare/PrimePlus Services: A Practitioner’s Resource Guide*, second edition, titled *CPA ElderCare/PrimePlus Services and the AICPA*, is to be used to familiarize CPAs and other professionals in a multidisciplinary team with the development of CPA ElderCare/PrimePlus services and the work of the AICPA/CICA ElderCare/PrimePlus Services 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.



- **CPA ElderCare/PrimePlus Services and the AICPA (PowerPoint Presentation for Professionals)—also see accompanying CD-ROM**

Note: The PowerPoint presentation included with your copy of *CPA Eldercare/PrimePlus Services: A Practitioner's Resource Guide*, second edition, titled *CPA ElderCare/PrimePlus Services and the AICPA*, requires PowerPoint 2002 to run properly. If you do not have PowerPoint 2002, please consult your software manual about converting the slides to another version of PowerPoint.

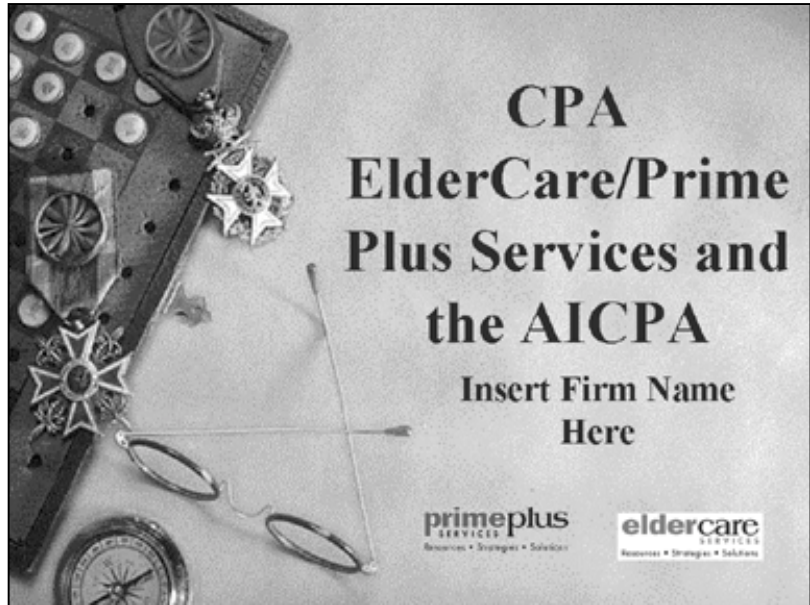
Personalizing Your Presentation

Follow these steps to personalize the ElderCare/PrimePlus 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/PrimePlus 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 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. When complete, click on FILE.
9. Click on SAVE AS.
10. Select the desired location on your hard drive.
11. Click on SAVE.

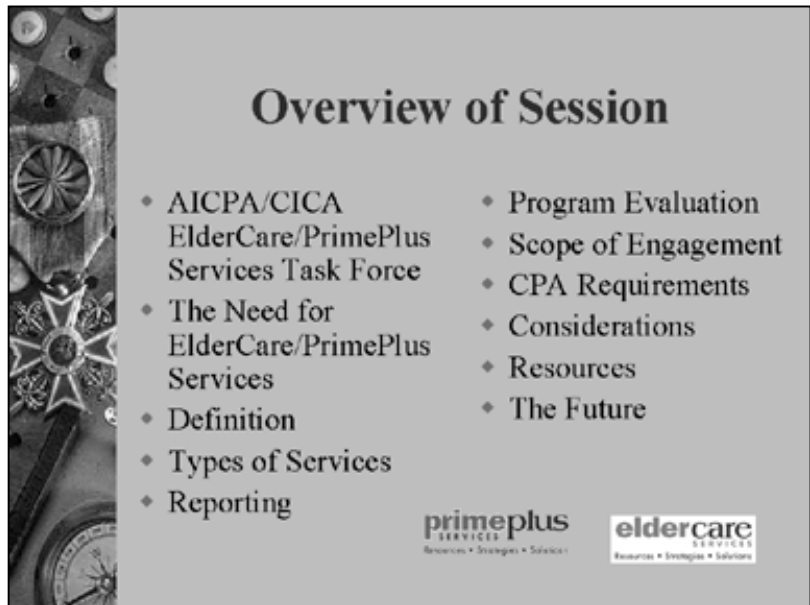
Slide 1

This slide begins your introduction to the concept of the relationship between the AICPA's CPA ElderCare/PrimePlus services, the AICPA, and the practitioner. This presentation is used to familiarize CPAs with the development of Elder Care/PrimePlus services and the AICPA/CICA ElderCare/PrimePlus Services Task Force.



Slide 2

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

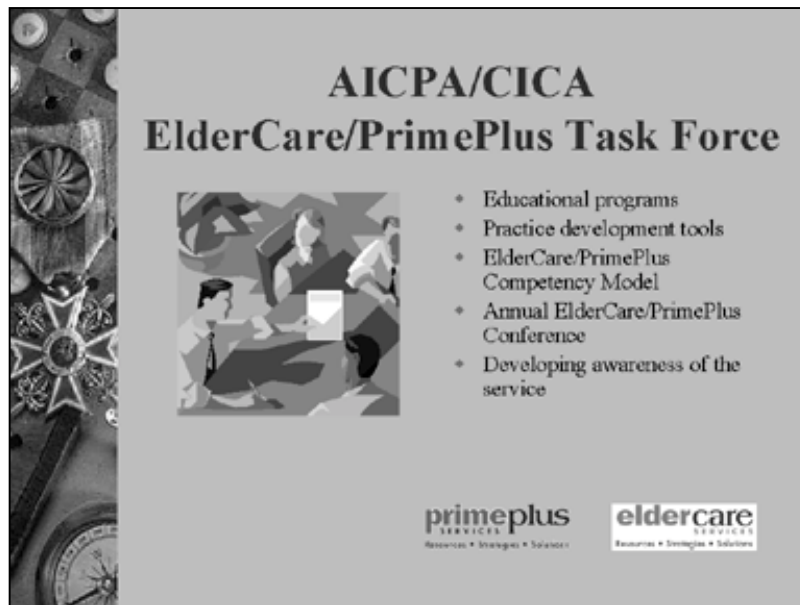


Slide 3

In connection with the Canadian Institute of Chartered Accountants (CICA), the AICPA/CICA ElderCare/PrimePlus Services Task Force has developed educational programs, practice development tools, and a competency model for CPA ElderCare/PrimePlus services.

The task force is currently working on raising awareness of ElderCare/PrimePlus services among practitioners, opinion leaders, decision makers, and consumers.

In addition, the task force is developing additional tools to assist the practitioner in providing CPA ElderCare/PrimePlus services.



The slide features a vertical decorative strip on the left with various mechanical and navigational icons. The main content area has a light gray background. At the top, the text 'AICPA/CICA ElderCare/PrimePlus Task Force' is displayed in a bold, sans-serif font. Below this, there is a central graphic showing three stylized figures in a meeting. To the right of the graphic is a bulleted list of five items. At the bottom right, there are two logos: 'primeplus SERVICES' and 'eldercare SERVICES', both with the tagline 'Resources • Strategies • Solutions'.

AICPA/CICA ElderCare/PrimePlus Task Force

- Educational programs
- Practice development tools
- ElderCare/PrimePlus Competency Model
- Annual ElderCare/PrimePlus Conference
- Developing awareness of the service

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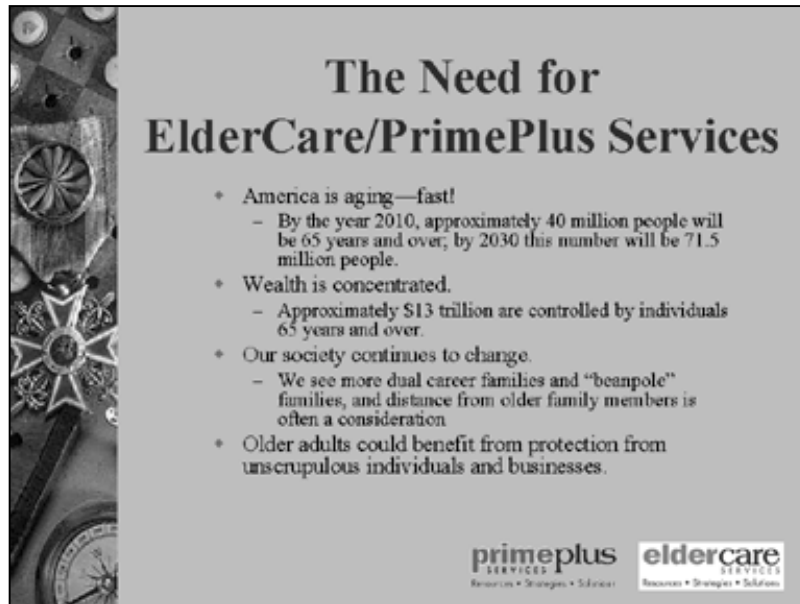
Slide 4

This slide illustrates the need for CPA ElderCare/PrimePlus 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.

In 2002, approximately 35.6 million adults were 65+ years of age; that number will more than double to 71.5 million by 2030.

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.



The slide features a vertical decorative strip on the left with various mechanical and navigational icons. The main content area has a light gray background. At the top, the text 'The Need for ElderCare/PrimePlus Services' is displayed in a bold, sans-serif font. Below this, there is a bulleted list of four items, with the second item having a sub-bullet. At the bottom right, there are two logos: 'primeplus SERVICES' and 'eldercare SERVICES', both with the tagline 'Resources • Strategies • Solutions'.

The Need for ElderCare/PrimePlus Services


- America is aging—fast!
 - By the year 2010, approximately 40 million people will be 65 years and over; by 2030 this number will be 71.5 million people.
- 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 and "beanpole" families, and distance from older family members is often a consideration
- Older adults could benefit from protection from unscrupulous individuals and businesses.

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Slide 5

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.



What Is ElderCare?

- 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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Slide 6

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

- Assist elderly persons with the process of aging, including such tasks as advising on portfolio allocation, consideration of long-term care insurance, planning for the loss of a spouse, in addition to income tax planning and preparation, etc.
- 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 multidisciplinary team of professionals, family members, and other responsible parties and provide assurance that specified goals are being met



- Assist clients in planning for the issues of aging.
- 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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Slide 7

In 2002, the ElderCare/PrimePlus Services Task Force adopted an alternative name for ElderCare services: CPA PrimePlus Services.


Many practitioners thought that the term *Eldercare* was negative in that it implied age and infirmity. It was decided that *PrimePlus* would be a good alternative name, one that would allow promotion of the service to younger clients who could not manage some of the duties that PrimePlus could provide:

Note: The names *ElderCare* and *PrimePlus* are interchangeable and both will continue to be supported by the AICPA.



What Are CPA PrimePlus Services?

- ◆ “Elder” restricted market to persons over age 65.
- ◆ “Care” implied health care.
- ◆ “PrimePlus” removes negative connotations and allows promotion of the services to a younger group of clients.
- ◆ Both names will continue to be supported by the AICPA.




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Slide 8


As described by the AICPA/CICA ElderCare/PrimePlus Services Task Force, CPA ElderCare/PrimePlus services are classified as:

- Consulting services
- Direct services
- Assurance services

Any of these services may include financial and nonfinancial services.





Types of CPA Eldercare/PrimePlus Services*



- ◆ Consulting Services
- ◆ Direct Services
- ◆ Assurance Services

*Any of these may include financial and nonfinancial services.




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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.

The practitioner's care plan can assist clients and their families by planning for the various issues of aging, including how to pay for the costs of aging, and how to plan to deal with the medical and psychosocial aspects of aging.



Examples of Consulting Services

- ◆ Assist clients and their families with the issues of aging.
- ◆ Establish standards of care with the client or family
- ◆ Develop an inventory of community resources and services
- ◆ Assist clients and families to develop and establish:
 - Goals of assistance
 - Customized delivery plan
 - Expected standards of performance
 - Communication of expectations to care providers

 
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Slide 10

ElderCare/PrimePlus services can involve two kinds of services: financial and nonfinancial. Financial services entail the financial requirements, such as statistical analysis; goal setting; funding analysis; cost management and needs assessment. Nonfinancial services include the service requirements, such as, interpersonal and relationship management, as well as interaction of service providers with the client.

Listed below are some of the financial and nonfinancial services that are offered under the ElderCare/PrimePlus umbrella, per the task force.



List of Financial Services

- Planning for fiduciary needs
- Evaluating financing options
- Receiving, depositing, and accounting for client receipts
- Ensuring that expected revenues are received
- Submitting claims to insurance companies
- Protecting elderly from predators
- Estate planning
- Income tax planning and preparation
- Gift tax return preparation
- Evaluating investments and trust activity
- Portfolio management
- Risk management and insurance planning



Examples of Direct Services

- ◆ Routine accounting and supervision of tasks
- ◆ Accounting for client's income and deposits
- ◆ Payment of bills
- ◆ Conducting routine financial transactions and monitoring revenue for timeliness and accuracy
- ◆ Supervision of investments
- ◆ Accounting for estates
- ◆ Arranging, paying for care providers
- ◆ Arranging transportation
- ◆ Supervising household expenditures

 
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(continued on following page)

List of Nonfinancial Services

- ElderCare/PrimePlus planning
- Lifestyle management Services
- Coordinating support and healthcare services
- Functioning as the “Quarterback” or as a member of the ElderCare/PrimePlus team-which consist of healthcare, legal and other professionals
- Helping family members monitor the elder’s care
- Communicating family expectations to care providers
- Establishing, in concert with the family, appropriate standards of care
- Establishing performance monitoring systems
- And Other ElderCare/PrimePlus consulting services, about which the CPA is competent

Note: The services included in each individual ElderCare/PrimePlus engagement will be based upon the needs and wants of each ElderCare/PrimePlus client, as well as the skill set of the ElderCare/PrimePlus practitioner.

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.

Since direct services are so important, there may not be a large demand for “assurance services” in the CPA ElderCare area.

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

Examples of Assurance Services

- ♦ Review of routine financial transactions
- ♦ Investigate and provide information to responsible parties
- ♦ Inspect logs and diaries of care providers to ensure agreed-upon performance criteria are met
- ♦ Report findings to client, family members, or other responsible parties


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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 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.



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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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 multi-disciplinary 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.



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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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.

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

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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

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

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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.



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

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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.



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

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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 11, "Associations, Organizations, Agencies, and Other Resources."

Resources for the Practitioner

- ♦ AICPA CPE courses on ElderCare/PrimePlus services
- ♦ AICPA Assurance Services Alert: CPA ElderCare Services
- ♦ Web site: www.aicpa.org/ecpp
- ♦ AICPA Annual ElderCare/PrimePlus Services Conference
- ♦ AICPA PrimePlus Marketing Tool Kit
- ♦ CPA ElderCare/PrimePlus Services: A Practitioner's Resource Guide

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Slide 19

The AICPA/CICA ElderCare/PrimePlus Services Task Force continues to work on issues, including the following:

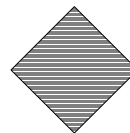
- Awareness efforts
- Additional training, practice development, and tools for the practitioner
- Referral network

The Future

- ♦ AICPA Web site: www.aicpa.org/ecpp
- ♦ AICPA/CICA ElderCare/PrimePlus Services Task Force

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CHAPTER 2:

Overview of Aging

As an accounting professional, your clients are likely to be a diverse group with varied and changing needs. But what about your aging clients? How can you best serve this population adequately? How can you enhance existing skills when working with older adults? Do you want to work with older adults? First, let's start with some basics.

TEST YOUR KNOWLEDGE OF AGING

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

TABLE 2.1 AGING QUESTIONNAIRE

-
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. Older adults do not need to be concerned about HIV/AIDs.
T F
 9. Older people take more medications than younger people.
T F
 10. People begin to lose interest in sex around age 55.
T F

(continued)

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
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.* Anyone can get HIV and AIDs—about 10 percent of all people diagnosed with the disease in the United States (about 75,000) are age 50 and older. Older Americans tend to know less about how HIV/AIDS is spread than younger groups;

- they are not tested on a regular basis and may not recognize the importance of using condoms. Doctors do not tend to ask older patients about sex or drug use.
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 35.6 million in 2002, representing 12.3 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 10.2 percent, since 1992. There were 50,364 persons aged 100 or more in 2002. This represents a 35 percent increase from the census figures of 1990.

Historical perspective. Since 1900, the percentage of senior citizens has more than tripled and their number has increased more than tenfold, from 3.1 million to 35.6 million. In 2002, the 65 to 74 age group (18.3 million) was eight times larger than it was in 1900. Furthermore, the 76 to 84 group (12.7 million) was 16 times larger, and the 85+ group (4.6 million) was 38 times larger! Individuals reaching age 65 now have an average life expectancy of an additional 18.1 years (19.4 for females and 16.4 for males). A child who was born in 2001 will live approximately 77.2 years, about 30 years longer than his or her 1900 counterpart.

The future. The senior citizen population will continue to grow significantly. Over 2 million people celebrated their 65th birthday in 2002. In the same year, about 1.8 million persons aged 65 or older died, which resulted in a net annual increase to the over 65 demographic of approximately 249,000 individuals.

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 2011 and 2029, when the baby boomers (those born between 1946 and 1964) reach age 65. It is estimated that the population will more than double, from 35 million (13 percent of the population) in 2000 to 71.5 million (20 percent of the population) in 2030. Additionally, minority populations are projected to represent approximately 26.4 percent of the aged in 2030, up from 16.4 percent in 2000. Between 2000 and 2030, the population of Caucasian Americans is projected to increase by 77 percent, compared with a 223 percent increase for older minorities, including Hispanics (342 percent); African Americans (164 percent); American Indians, Eskimos, and Aleuts (207 percent); and Asian and Pacific Islanders (302 percent).

Family status. In 2002, men age 65 and older were much more likely to be married than women, 73 percent compared to 41 percent. Almost half of elderly women in 2002 were widows and there were over four times as many widows as widowers. Only 10 percent of all older persons were divorced or separated in 2002; however that number has increased since 1980, when approximately 5.3 percent of the older population were divorced or separated/spouse absent.

Home setting. According to the study, over half (53.6 percent) of older noninstitutionalized persons lived with their spouse in 2002. This proportion tends to decrease with age, especially for women (only 28 percent of women 75+ years old lived with a spouse). About 30 percent of all noninstitutionalized older persons were living alone in 2002 (7.9 million women, 2.6 million men).

Living alone correlates with advanced age. For example, among women aged 75 and older, half (49.4 percent) lived alone in 2002. Although a relatively small percentage (4.5 percent) of the population over age 65 lived in nursing homes in 2000, the percentage increases 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. Approximately 5 percent of the elderly live in these types of settings.

Mobility. Activity limitation increases with age. More than half of the older population (54.5 percent) reported having at least one disability in 1997. Over a third (37.7 percent) reported at least one severe disability. The percentage of those with disabilities increases with age.

Over 27.3 percent of community-resident Medicare beneficiaries over age 65 in 1999 had difficulty in performing one or more activities of daily living (ADLs), and 13 percent reported having difficulty with instrumental activities of daily living (IADLs). ADLs include bathing, dressing, eating, transfer, and locomotion/ambulation. IADLs include preparing meals, shopping, managing money, using the telephone, doing housework, and taking medications. The most frequently occurring conditions in 2000 and 2001 were arthritis, hypertension, all types of heart disease, cancer, sinusitis, and diabetes.

In 2002, older consumers averaged \$3,586 in out-of-pocket health care expenditures, a 45 percent increase since 1992. Older Americans spent 12.8 percent of their income on health expenses, more than twice the amount spent by all consumers (5.8 percent).

Geographic locations. In 2002, 52 percent of older Americans lived in only nine states.

California	3.7 million
Florida	2.9 million
New York	2.5 million
Texas	2.2 million
Pennsylvania	1.9 million
Ohio, Illinois, Michigan, and New Jersey	More than 1.0 million each

Older Americans (age 65+) were more likely to live in metropolitan areas than younger persons in 2002. About 50 percent of older persons lived in the suburbs, 27.4 percent in central cities, and 22.6 percent in nonmetropolitan areas. The elderly are less likely to change residence than any other age group. Between 1995 and 2000, 22.8 percent of older persons had moved (compared with 47.7 percent of persons under age 65). A majority of these older adults (59.7 percent) had moved to another home in the same county; 18.8 percent moved to another state. The 85+ age group had a higher rate of moving (32.3 percent) and the majority of them (61.1 percent) moved within the same county.

Income. The median income of older persons in 2002 was \$19,436 for males and \$11,406 for females. Households containing families headed by persons 65 or older reported a median income of \$33,802. Additionally, 48 percent had incomes of \$35,000 or more, 19.6 percent had incomes of \$25,000-34,999, and one of every nine family households with an elderly head (11.6 percent) had incomes of less than \$15,000. Major sources of income reported in 2001 included Social Security, asset income, public and private pensions, and earnings. Social Security benefits accounted for 38 percent of the aggregate income of the older population in 2000. The bulk of the remainder consisted of earnings, assets, and pensions.

In 2002, 4.5 million Americans aged 65 and older were in the labor force, which represented 3.1 percent of the U.S. labor force.

Education level. The educational level of the older population will continue to rise steadily. Between 1970 and 2002, the percentage of high school graduates rose from 28 percent to 70 percent. The percentage of high school graduates varies considerably by race and ethnic origin, with 74 percent of Caucasians, 68 percent of Asian/Pacific Islanders, 51 percent of African Americans, and 35 percent of Hispanics finishing high school. (Almost 17 percent of all seniors hold a bachelor's degree or higher.)

Source: A Profile of Older Americans: 2003. Department of Health and Human Services, Administration on Aging. The full report is available at <http://www.aoa.gov/prof/Statistics/profile/2003/profiles2003.asp>.

AGING, BABY BOOMERS, AND THE SANDWICH GENERATION

For over 50 years, demographers have known that America was experiencing a large bulge in the U.S. population, created by the delayed childbearing during World War II. Labeled baby boomers, those persons born between 1946 and 1964 represent a cohort of more than 76 million people. The baby boomers are a diverse group who anticipate a

longer life span, which will create challenges for both public policy makers and the marketplace. The baby boomers have the attention of planners, retirement advisers, and public policy gurus.

In 2002 and 2003, the American Association of Retired Persons (AARP) commissioned two studies to explore what the baby boomers had to say about their lives, hopes, and expectations for the future. In its publication, *Boomers at Midlife: The AARP Life Stage Study* (2003), researchers conducted phone surveys with 2,016 people aged 39 to 57 and 748 people aged 58 and older. They found that despite the current global issues and a faltering economy, most boomers continue to be satisfied with the way things were going in their personal lives and were upbeat about their future. When discussing the future, boomers were looking to achieve balance in their lives; however, boomers were least confident that they will succeed in making gains in those areas they most wanted to improve. Boomers, in general, reported satisfaction with their lives overall and they continue to believe that their lives will be even better with time. Family, friends, and personal finances top the list of the most-thought-about life areas, while leisure and mental health were the least thought about. For the most part, boomers believe that they can shape their future and that their future depends on their own actions.

While boomers report that they are likely to continue to be in control of their own aging and long-term care, in an estimated 22.4 million households, care is already being provided to a relative or friend aged 50 or older. Surveys suggest that today's baby boomer will likely spend more years caring for a parent than for their own children. These individuals know firsthand the meaning of the Sandwich Generation, a term used to describe the growing number of adult children who feel the squeeze of caring for the needs of an aging parent or other relative and the demands of their own children, spouses, and careers. Members of the Sandwich Generation represent the largest growing segment of caregivers in the nation.

While most caregiving is unpaid, it is estimated at 257 billion dollars annually. Caregiving time can range from a few hours a week to 40 or more hours per week—essentially full-time care. It is not surprising that some caregivers report experiencing physical and emotional strain and financial hardship as a result of providing care to family and friends. The study *Caregiving in the U.S.* suggests that the typical caregiver is a 46-year-old woman who has at least some college experience and provides more than 20 hours of care per week to her mother. However, although the caregiving landscape is still dominated by women providing care for women, the proportion of caregivers who are male is significant and substantial. Estimates suggest that 4 in 10 caregivers are men.

In 1998, the National Alliance of Caregiving, with assistance from the Equitable Foundation, conducted a survey of baby boomer women caregivers to determine how the caregiving experience changed their own planning for long-term care. The study found that over half of the 260+ caregivers reported feeling unprepared for their own possible long-term care. Only 6 percent reported feeling very well prepared and 42 percent reported feeling somewhat prepared. These caregivers reported thinking more about saving money to meet their own needs as a result of their caregiving experience and they also think about the adequacy of their own insurance and the need to plan. Over one-third of the respondents indicated that they had taken some specific steps to plan for their own possible long-term care, mostly by increasing investments or obtaining additional insurance. Although only 3 percent reported that a financial adviser would be the most valuable source of information about aging and long-term care, one-quarter reported that financial information would be the most valuable type of information to help them prepare for their own long-term care. Most respondents stated that they

believe their own long-term care needs will be paid by private insurance, savings, investments, or government insurance, such as Medicare or Medicaid.

Clearly, many people do not have adequate knowledge or information to help them make appropriate choices. Aging and long-term care issues are complex and require specific knowledge. These areas can provide creative opportunities for the ElderCare/PrimePlus practitioner to assist clients over an extended period with important, positive results.

Sources:

Boomers at Midlife: The AARP Life Stage Study, 2003.

Caregiving in the U.S., National Alliance for Caregiving and AARP, 2004.

The Caregiving Boom: Baby Boomer Women Giving Care, National Alliance for Caregiving, 1998.

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: CENSUS SUMMARY 2002

State	Population 65+	State	Population 65+
Alabama	588,542	Missouri	757,197
Alaska	39,200	Montana	122,806
Arizona	701,243	Nebraska	232,134
Arkansas	376,387	Nevada	240,255
California	3,716,836	New Hampshire	152,577
Colorado	434,472	New Jersey	1,121,197
Connecticut	472,314	New Mexico	221,454
Delaware	105,488	New York	2,473,510
District of Columbia	68,534	North Carolina	998,391
Florida	2,854,838	North Dakota	94,076
Georgia	813,652	Ohio	1,513,372
Hawaii	166,910	Oklahoma	460,459
Idaho	151,141	Oregon	443,968
Illinois	1,499,249	Pennsylvania	1,908,962
Indiana	757,451	Rhode Island	152,286
Iowa	432,785	South Carolina	503,256
Kansas	355,094	South Dakota	108,322
Kentucky	509,476	Tennessee	719,177
Louisiana	520,446	Texas	2,152,896

(continued)

TABLE 2.2 (CONTINUED)

State	Population 65+	Sate	Population 65+
Maine	186,383	Utah	199,041
Maryland	616,699	Vermont	79,241
Massachusetts	863,695	Virginia	817,441
Michigan	1,231,920	Washington	677,532
Minnesota	601,741	West Virginia	2,575,974
Mississippi	346,251	Wisconsin	706,418
		Wyoming	59,222

Source: U.S. Census Bureau Population Estimates and the Current Population Survey, 2001, 2002, and 2003 Annual Social and Economic Supplements.

See: www.census.gov.

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 reduce 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 they 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 (for example, instead of planting a large garden, the individual can continue a similar activity with a container or window garden)
- Modifying the environment to accommodate changes in ability or health (for example, adding grab bars in bathroom to enhance safety or removing throw rugs to reduce the risk of falling)
- Seeking support from friends, family, neighbors, and community resources (for example, enrollment in local law enforcement “Keep Check” Program)
- Engaging in exercises that enhance strength and endurance
- Maintaining active interest and participation in social networks

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 ElderCare/PrimePlus 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 with 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 or 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 20 years. Currently, there is no cure for Alzheimer's; however, for some people certain drugs (for example, tacrine, THA, Cognex, Aricept, or Exelon) 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's 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 11, "Associations, Organizations, Agencies, and Other Resources."

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 Alzheimer's disease 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 a task.

Alzheimer's Association National Office
225 North Michigan Avenue
17th Floor
Chicago, IL 60601-7633
info@alz.org
<http://www.alz.org>
Tel: (312) 335-8700 (Nationwide Contact Center: (800) 272-3900)
Fax: (312) 335-1110

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 and 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 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.

Parkinson's Disease Foundation (PDF)
833 West Washington Boulevard
Chicago, IL 60607
<http://www.parkinson.org/>
Tel: (800) 457-6676; (312) 733-1893
Fax: (312) 664-2344

Normal Pressure Hydrocephalus

As many as 375,000 Americans with the same symptoms as dementia, Alzheimer's, or Parkinson's may actually have normal pressure hydrocephalus (NPH). This is a condition characterized primarily by gait (walking) problems, dementia, and urinary incontinence. Unfortunately, the disorder can be difficult to diagnose and many times goes untreated.

A type of hydrocephalus that normally occurs in older adults, NPH is an accumulation of cerebrospinal fluid (CSF) that causes the ventricles of the brain to enlarge. Although this may not cause increased intracranial pressure, as is the case with most types of hydrocephalus, the abnormal accumulation of fluid is thought to stretch the nerve tissue of the brain and result in several symptoms. NPH normally occurs in adults 60 years and older, and in as many as 10 percent of all patients with symptoms of dementia. Current information suggests that 250,000 Americans with some of the same symptoms as dementia, Alzheimer's, or Parkinson's may actually have NPH.

If a person exhibits symptoms of hydrocephalus, a physician may perform several tests using neuro-imaging devices such as CT or MRI and perform a careful clinical assessment.

Because NPH symptoms—gait problems, dementia, and urinary incontinence—are often associated with the aging process in general, and a majority of the NPH population is older than 60 years, people often assume that they must live with the problems or adapt to the changes occurring within their bodies. Symptoms can be present for months or even years before a person sees a physician. The symptoms of NPH seem to progress with time. The rate of progress is variable, and it is often a critical loss of function, or disability, that brings patients to their doctors. It seems that the longer the symptoms have been present, the less likely it is that treatment will be successful. As a rule, the earlier the diagnosis, the better the chance for successful treatment, but some people experiencing symptoms for years can improve with treatment. For more information, go to <http://www.allaboutnph.com> or contact the Hydrocephalus Association at:

The Hydrocephalus Association
870 Market Street
Suite 705
San Francisco, CA 94102
<http://www.hydroassoc.org>
<http://www.allaboutnph.com/>

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; 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 preventing 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. Medications may be required to control aggressive or agitated behaviors or behaviors that are dangerous to the person or to others. These are usually given in very low doses, with adjustment as required. Such medications may include antipsychotics (especially the newer atypical agents, olanzapine, and quetiapine), beta-blockers, and serotonin-affecting drugs such as trazodone (which may lower the blood pressure), buspirone, or fluoxetine.

National Institute of Neurological Disorders and Stroke (NINDS)
National Institutes of Health (NIH)
Office of Communications and Public Liaison
Bethesda, MD 20892-2540
Tel: (800) 352-9424
(301) 496-5751
Fax: (301) 402-2186
<http://www.ninds.nih.gov>

Creutzfeldt-Jakob Disease

A rare, degenerative, invariably fatal brain disorder, Creutzfeldt-Jakob Disease (CJD) 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).

Creutzfeldt-Jakob (CJD) Foundation Inc.
P.O. Box 5312
Akron, OH 44334
crjakob@aol.com
<http://www.cjdfoundation.org>
Tel: (800) 659-1991
Fax: (330) 668-2474; (305) 893-9050

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 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/PrimePlus 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.

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. Approximately 66 percent of victims of domestic elder abuse were white, while 19 percent were black. Hispanic elders accounted for 10 percent of elder abuse in 1996.

Physical Abuse

Physical abuse is defined as the use of physical force that may result in bodily injury, physical pain, or impairment. Physical abuse may include but is not limited to such acts of violence as striking (with or without an object), hitting, beating, pushing, shoving, shaking, slapping, kicking, pinching, and burning. In addition, inappropriate use of drugs and physical restraints, force-feeding, and physical punishment of any kind also are examples of physical abuse.

Signs and symptoms of physical abuse include but are not limited to:

- Bruises, black eyes, welts, lacerations, and rope marks
- Bone fractures, broken bones, and skull fractures
- Open wounds, cuts, punctures, untreated injuries in various stages of healing
- Sprains, dislocations, and internal injuries/bleeding
- Broken eyeglasses/frames, physical signs of being subjected to punishment, and signs of being restrained
- Laboratory findings of medication overdose or under-utilization of prescribed drugs
- An elder's report of being hit, slapped, kicked, or mistreated
- An elder's sudden change in behavior
- The caregiver's refusal to allow visitors to see an elder alone

Sexual Abuse

Sexual abuse is defined as nonconsensual sexual contact of any kind with an elderly person. Sexual contact with any person incapable of giving consent is also considered sexual abuse. It includes, but is not limited to, unwanted touching, all types of sexual assault or battery, such as rape, sodomy, coerced nudity, and sexually explicit photographing.

Signs and symptoms of sexual abuse include but are not limited to:

- Bruises around the breasts or genital area
- Unexplained venereal disease or genital infections
- Unexplained vaginal or anal bleeding
- Torn, stained, or bloody underclothing
- An elder's report of being sexually assaulted or raped

Emotional or Psychological Abuse

Emotional or psychological abuse is defined as the infliction of anguish, pain, or distress through verbal or nonverbal acts. Emotional/psychological abuse includes but is not limited to verbal assaults, insults, threats, intimidation, humiliation, and harassment. In addition, abuse includes treating an older person like an infant; isolating an elderly person from his or her family, friends, or regular activities; giving an older person the “silent treatment,” and enforced social isolation. Signs and symptoms of emotional/psychological abuse include but are not limited to:

- Being emotionally upset or agitated
- Being extremely withdrawn and noncommunicative or nonresponsive
- Demonstrating unusual behavior usually attributed to dementia (for example, sucking, biting, rocking)
- An elder’s report of being verbally or emotionally mistreated

Neglect

Neglect is defined as the refusal or failure to fulfill any part of a person’s obligations or duties to an elder. Neglect may also include failure of a person who has fiduciary responsibilities to provide care for an elder (for example, failure to pay for necessary home care services) or the failure on the part of an in-home service provider to provide necessary care.

Neglect typically means the refusal or failure to provide an elderly person with such life necessities as food, water, clothing, shelter, personal hygiene, medicine, comfort, personal safety, and other essentials included in an implied or agreed-upon responsibility to an elder.

Signs and symptoms of neglect include but are not limited to:

- Dehydration, malnutrition, untreated bed sores, and poor personal hygiene
- Unattended or untreated health problems
- Hazardous or unsafe living conditions/arrangements (for example, improper wiring, no heat, or no running water)
- Unsanitary and unclean living conditions (for example, dirt, fleas, lice on person, soiled bedding, fecal/urine smell, inadequate clothing)
- An elder’s report of being mistreated

Abandonment

Abandonment is defined as the desertion of an elderly person by an individual who has assumed responsibility for providing care for an elder, or by a person with physical custody of an elder.

Signs and symptoms of abandonment include but are not limited to:

- The desertion of an elder at a hospital, a nursing facility, or other similar institution
- The desertion of an elder at a shopping center or other public location
- An elder’s own report of being abandoned

Financial or Material Exploitation

Financial or material exploitation is defined as the illegal or improper use of an elder's funds, property, or assets. Examples include, but are not limited to, cashing an elderly person's checks without authorization or permission; forging an older person's signature; misusing or stealing an older person's money or possessions; coercing or deceiving an older person into signing any document (for example, contracts or wills); and the improper use of conservatorship, guardianship, or power of attorney.

The California Community Partnership for the Prevention of Financial Abuse has identified the following as typical of the crimes against older adults related to financial abuse:

1. Stolen ATM, debit, and credit cards by caregivers or family members
2. Deceiving an elderly person to sign loan papers or withdrawal slips
3. Elders who are deceived by relatives
4. Elders who are deceived by contractors
5. Abuse of Power of Attorney authorization. This is the one of the fastest growing crimes in America.
6. Telemarketing and sweepstakes scams
7. Investment fraud
8. Predatory lending
9. Identity theft

Source: CCPPFA.org, 2002

Signs and symptoms of financial or material exploitation include but are not limited to:

- Sudden changes in bank account or banking practice, including an unexplained withdrawal of large sums of money by a person accompanying the elder
- The inclusion of additional names on an elder's bank signature card
- Unauthorized withdrawal of the elder's funds using the elder's ATM card
- Abrupt changes in a will or other financial documents
- Unexplained disappearance of funds or valuable possessions
- Substandard care being provided or bills unpaid despite the availability of adequate financial resources
- Discovery of an elder's signature being forged for financial transactions or for the titles of his or her possessions
- Sudden appearance of previously uninvolved relatives claiming their rights to an elder's affairs and possessions
- Unexplained sudden transfer of assets to a family member or someone outside the family
- The provision of services that are not necessary
- An elder's report of financial exploitation

Self-Neglect

Self-neglect is characterized as an elderly person's behavior that threatens his or her own health or safety. Self-neglect generally manifests itself in an older person as a refusal or

failure to provide himself or herself with adequate food, water, clothing, shelter, personal hygiene, medication (when indicated), and safety precautions.

The definition of self-neglect excludes a situation in which a mentally competent older person, who understands the consequences of his or her decisions, makes a conscious and voluntary decision to engage in acts that threaten his or her health or safety as a matter of personal choice.

Signs and symptoms of self-neglect include but are not limited to:

- Dehydration, malnutrition, untreated or improperly attended medical conditions, and poor personal hygiene
- Hazardous or unsafe living conditions/arrangements (for example, improper wiring, no indoor plumbing, no heat, no running water)
- Unsanitary or unclean living quarters (for example, animal/insect infestation, no functioning toilet, fecal/urine smell)
- Inappropriate or inadequate clothing, lack of the necessary medical aids (for example, eyeglasses, hearing aids, dentures)
- Grossly inadequate housing or homelessness

Firm's Policy on Abuse

There may be instances either during the process of accepting clients or during an ElderCare/PrimePlus engagement when the practitioner or other member of the ElderCare/PrimePlus 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 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.

Why Does Elder Abuse Occur?

Risk Factors for Elder Abuse

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 elder maltreatment.

Because it is likely that each type (as well as each single incident) of maltreatment involves its own causal factors, the factors listed in the following sections cannot explain all types of elder maltreatment. However, they are some of the risk factors researchers say seem to be related to elder abuse.

Domestic Violence Grown Old

It is important to acknowledge that spouses make up a large percentage of elder abusers, and that a substantial proportion of these cases are domestic violence grown old: These are partnerships in which one member of a couple has traditionally tried to exert power and control over the other through emotional abuse, physical violence and threats, isolation, and other tactics.

Personal Problems of Abusers

Particularly in the case of adult children, abusers often depend on their victims for financial assistance, housing, and other forms of support. Often they need this support because of personal problems, such as mental illness, alcohol or drug abuse, or other dysfunctional personality characteristics.

The risk of elder abuse seems to be particularly high when these adult children live with the elder parent.

Living With Others and Isolation

Both living with someone else and being socially isolated have been associated with higher elder abuse rates. These seemingly contradictory findings may turn out to be related in that abusers who live with the elder have more opportunity to abuse and yet may be isolated from the larger community themselves or may seek to isolate the elders from others so the abuse is not discovered. Further research needs to be done to explore the relationship between these factors.

Other Theories

Many other theories about elder abuse have been developed. Few, unfortunately, have been tested enough to definitively say whether they raise the risk of elder abuse or not. It is possible each of the following theories will ultimately be shown to account for a small percentage of elder abuse cases.

- *Caregiver stress.* This commonly-stated theory holds that well-intentioned caregivers are so overwhelmed by the burden of caring for dependent elders that they strike, neglect, or otherwise harm the elder. Much of the small amount of research that has been done has shown that few cases fit this model.
- *Personal characteristics of the elder.* Theories that fall under this umbrella hold that dementia, disruptive behaviors, problematic personality traits, and significant needs for assistance may all raise an elder's risk of being abused. Research on these possibilities has produced contradictory or unclear conclusions.
- *Cycle of violence.* Some theorists hold that domestic violence is a learned problem-solving behavior transmitted from one generation to the next. This theory seems well-established in cases of domestic violence and child abuse, but no research to date has shown that it is a cause of elder abuse.

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. Information about specific organizations 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.* This includes police and sheriff departments and district attorney offices, as well as the court system.
- *Hospitals and medical offices.* This includes the medical examiner/coroner's office.
- *Health agencies.*
- *Area mental health centers.*

Often, people who want to help older relatives and friends do not 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

State	Domestic Elder Abuse	Institutional Elder Abuse	Website
Alabama	(800) 458-7214	(800) 458-7214	N/A
Alaska	(800) 478-9996 (907) 269-3666	(800) 730-6393 (907) 269-3666	http://www.state.ak.us/local/akpages/ADMIN/dss.aps.htm
Arizona	(877) 767-2385	(877) 767-2385	http://www.de.state.az.us/links.aaa/apsciu.asp
Arkansas	(800) 482-8049	(800) 582-4887	http://www.state.ar.us/dhs/aging/aps.html
California	(888) 436-3600	(800) 231-4024	http://www.dss.cahwnet.gov/cdssweb/protective175.htm
Colorado	(800) 773-1366	(800) 866-7689	http://www.cdhs.state.co.us/oss/ass/ass1.htm
Connecticut	(888) 385-4225	(860) 424-5241	http://www.dss.state.ct.us/svcs/socialwork/pg3.htm
Delaware	(800) 223-9074	(800) 223-9074	http://www.dsaapd.com/APS.htm
District of Columbia	(202) 541-3950	(202) 434-2140	http://dhs.dc.gov/serv/protective.shtm
Florida	(800) 962-2873	(800) 962-2873	http://www5.myflorida.com/cfweb/myflorida2/healthhuman/as
Georgia	(800) 677-1116	(404) 657-5726 or (404) 657-4076	http://www2.state.ga.us/departments/dhr/faceld/html
Guam	(671) 475-0268	(671) 475-0268	N/A
Hawaii	(808) 832-5115	Same (808) 243-5151 (808) 241-3432 (808) 241-3433 (808) 327-6280	http://www.hawaii.gov/dhs/phdhs.html
Idaho	(208) 334-3833	(208) 364-1899	http://www2.state.id.us/icoa/index.htm#adult
Illinois	(800) 252-8966	(800) 252-4343	http://www.state.il.us/aging/eldergts.htm
Indiana	(800) 992-6978	(800) 992-6978	http://www.in.gov/fssa/elderly
Iowa	(800) 362-2178	(515) 281-4115	N/A
Kansas	(800) 922-5330 (785) 296-0044	(800) 842-0078	http://www.srskansas.org/ees/adult.htm
Kentucky	(800) 752-6200	(800) 372-2991	http://cfc.state.ky.us/help/adultabuse.asp

State	Domestic Elder Abuse	Institutional Elder Abuse	Website
Louisiana	(800) 259-4900	(800) 259-4990	http://www.gov.state.la.us/depts/elderly.htm
Maine	(800) 624-8404	(800) 624-8404	http://www.state.me.us/dhs/beas/programs.htm
Maryland	(800) 917-7383	(800) 917-7383	http://www.dhr.state.md.us/csa/oas.htm
Massachusetts	(800) 922-2275	(800) 922-5540	http://www.mass.gov/portal/index.jsp?pageID=eldershomepage&L=1&sid=Elders&L0=Home
Michigan	(800) 996-6228	(800) 996-6006	http://www.michigan.gov/fia
Minnesota	(800) 333-2433	(800) 333-2433	http://www.dhs.state.mn.us/Agingint/Services/adultpsu.htm
Mississippi	(800) 222-8000	(800) 222-7308	http://www.mdhs.state.ms.us/fcsaps.html
Missouri	(800) 392-0210	(800) 392-0210	http://www.dhss.state.mo.us/SeniorServices/ps.htm
Montana	(800) 332-2272	None available	http://www.dphhs.state.mt.us/sltc/protective legal/07.02.elder.abus.htm
Nebraska	(800) 652-1999	(800) 652-1999	http://www.hhs.state.ne.us/ags/aps.htm
Nevada	(800) 992-5757	(800) 992-5757	N/A
New Hampshire	(800) 949-0470	(800) 442-5640	http://town.jaffrey.nh.us/police/adults protective services.htm
New Jersey	(800) 792-8820	(800) 792-8820	http://www.state.nj.us/health/senior/sacompro.htm
New Mexico	(800) 797-3260 (505) 841-6100	(800) 797-3260 (505) 841-6100	http://www.nmaging.state.nm.us
New York	(800) 342-9871	(800) 220-7184	http://www.ocfs.state.ny.us/main/psa/default.htm
North Carolina	(800) 662-7030	(800) 662-7030	http://www.dhhs.state.nc.us/dss/afs/afsh.htm
North Dakota	(800) 451-8693	(800) 451-8693	N/A
Ohio	(866) 886-3537	(800) 282-1206	http://www.state.oh.us/adjfs/factsheets/IC00protective.stm
Oklahoma	(800) 522-3511	(800) 522-3511	http://www.okdhs.org/aps
Oregon	(800) 232-3020	(800) 232-3020	http://www.sdsd.hr.state.or.us/programs/abuse.htm

(continued)

TABLE 2.3 (CONTINUED)

State	Domestic Elder Abuse	Institutional Elder Abuse	Website
Pennsylvania	(800) 490-8505	(800) 254-5164	http://www.aging.state.pa.us/aging/cwp/view.asp
Puerto Rico	(787) 725-9788 or (787) 721-8225		N/A
Rhode Island	(401) 462-0550	(401) 785-3340	N/A
South Carolina	(800) 868-7318	(800) 898-2850	http://www.state.sc.us/dss/aps/index.html
South Dakota	(605) 773-3656	(605) 773-3656	http://www.state.sd.us/social/ASA/protective/index.htm
Tennessee	(888) 277-8366	(888) 277-8366	http://www.state.tn.us/humanserv/
Texas	(512) 834-3784 (800) 252-5400	(512) 438-2633	http://www.tdprs.state.tx.us/Adult Protection
Utah	(801) 264-7669 (800) 371-7897	(801) 264-7669 (800) 371-7897	http://www.hsdaps.state.ut.us/default.htm
Vermont	(800) 564-1612	(800) 564-1612	http://www.dad.state.vt.us/lp/aps.htm
Virginia	(888) 832-3858 (804) 371-0896	(888) 832-3858 (804) 371-0896	http://www.dss.state.va.us/division/famserv
Virgin Islands	None available	None available	N/A
Washington	(866) 363-4276	(800) 562-6078	http://www.aasa.dshs.wa.gov/topics/abusesign.htm
West Virginia	(800) 352-6513	(800) 352-6513	http://www.wvdhhr.org/oss/adult/aps.htm
Wisconsin	(608) 266-2536	(800) 815-0015	http://www.dsfs.state.wi.us/aps/index.htm
Wyoming	(307) 777-6137	(307) 777-7123	http://dfsweb.state.wy.us/childsvc/toc1.htm

Source: National Center for Elder Abuse

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 statutes 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 covers only 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 statutes.

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): <http://www.prairienet.org/~scruffy/htm>
- U.S. House of Representatives: <http://www.law.house.gov/17.htm>
- American Law Sources online (ALSO): <http://www.lawsources.com/also/>
- Findlaw: <http://www.findlaw.com/casecode/state.html>
- National Association of Area Agencies on Aging: <http://www.n4a.org>
- Senior Law: <http://www.seniorlaw.com>

Also, see Chapter 11, "Associations, Organizations, Agencies, and Other Resources."

DISABLED ELDERS

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.

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.

Executive Order for Community-Based Alternatives for Individuals with Disabilities

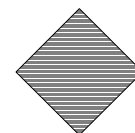
Additionally, on June 19, 2001, President Bush issued an executive order for Community-Based Alternatives for Individuals with Disabilities. The order restated the nation’s commitment to community-based alternatives for individuals with disabilities by effectively fostering independence and participation 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 in swiftly implementing 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.

In the Spotlight: The New Freedom Initiative

Announced by President Bush in February 2001, the New Freedom Initiative is a “nationwide effort to remove barriers to community living for people of all ages with disabilities and long-term illnesses. It represents a step in working to ensure that all Americans have the opportunity to learn and develop skills, engage in productive work, choose where to live, and participate in community life” (Executive Order 13217, June 18, 2001).

In April, 2004, HHS Secretary Tommy G. Thompson announced 12 grants to support state efforts to create “one stop” centers to help consumers learn about and access long-term supports ranging from in-home services to nursing facility care. A total of 24 states currently receive similar grants to develop improved access to long-term support services.

For additional information go to <http://www.hhs.gov/news/press/2004pres/20040416a.html>.



CHAPTER 3:

How to Build an ElderCare/PrimePlus Practice

ElderCare/PrimePlus 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/PrimePlus clients to flock to their practice simply because the practitioner has announced this new service. An individual using a CPA for ElderCare/PrimePlus services is driven by the trust already developed with the CPA, as well as the CPA's reputation for integrity, objectivity, and independence. Consequently, the initial ElderCare/PrimePlus 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.

To develop an ElderCare/PrimePlus practice, the practitioner will need to develop a coordinated marketing plan designed to both inform potential clients about the service and to approach those potential clients who indicate an interest in using the service. It is essential that the practitioner's entire firm understand what CPA ElderCare/PrimePlus services are and that all members of the firm participate in the marketing efforts. As discussed later in this chapter, a number of kinds of marketing can be used, some at little or no cost and some that have minimal to substantial costs. Before undertaking a marketing campaign, the practitioner should develop a marketing plan (which may use several different marketing tools) that he or she feels will be the most economical and effective in reaching potential clients.

The practitioner should also consider the timing of any marketing efforts. The timing of some marketing efforts, such as speeches, will depend on external parties; others may be timed to provide potential clients with information on the service just before a planned meeting with the potential client. For instance, information on ElderCare/PrimePlus services may be featured in the firm's newsletter that goes to clients just before tax preparation time. Or a letter confirming a personal financial planning appointment might include a brochure describing ElderCare/PrimePlus.

Finally, the very nature of an ElderCare/PrimePlus practice dictates that client turnover will be much more rapid than traditional areas of practice. For this reason, a continuing marketing effort is needed to maintain the 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/PrimePlus 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 recognizes 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.
- Your firm's client base includes potential clients for this service.
- 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.

A sample form, "Potential ElderCare/PrimePlus Clients' Worksheet," which can be used to assess possible clients from within the firm's existing client base, is included in Chapter 12, "Sample Documents and Checklists." Using this information on the number of potential clients already available to the firm, the practitioner can develop an estimate on the benefits and costs of including an ElderCare/PrimePlus practice as part of the firm's product mix. A sample worksheet, "Cash Flow Worksheet for Potential Offering of CPA ElderCare/PrimePlus Services," which can assist you in making such projections, is also included in Chapter 12. The form is not intended to be all-inclusive regarding possible costs but is to be considered as a starting point for developing such information that is unique to your own practice situation.



- **Potential ElderCare/PrimePlus Clients' Worksheet** (*also see accompanying CD-ROM*)
- **Cash Flow Worksheet for Potential Offering of CPA ElderCare/PrimePlus Services** (*also see accompanying CD-ROM*)

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,¹ 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/PrimePlus for them to understand and appreciate why these services could be valuable to their clients.

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

¹ The AICPA course, *ElderCare/PrimePlus: Developing and Managing an ElderCare Practice*, is an overview course on the information and issues involved. To order, go to <http://www.cpa2biz.com>.

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

The AICPA has developed a marketing kit for practitioners that includes brochures, advertisements, and direct mail pieces. This marketing kit is not a do-it-yourself kit; it must be used by a professional printer for professional results. The kit includes marketing messages targeting both the elderly and the adult children of the elderly. These pieces can be customized by the practitioner to incorporate the firm name, logo, and services specifically provided.²

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 probably be used in initial marketing. Invite contacts in for a free consultation or take them to lunch to explain your services. Mailing information concerning the services being offered to prospective clients before tax preparation time allows the potential client to inquire about the services when meeting with the practitioner for tax return preparation.

To be effective, the practitioner, working in cooperation with the partner handling the potential client's other business, should develop information on the prospective client and be fully prepared to demonstrate the benefits to the elder from the firm's ElderCare/PrimePlus services. A sample form, "Detailed Information on Potential ElderCare/PrimePlus Client," for accumulation of information is included in Chapter 12, "Sample Documents and Checklists."



- **Detailed Information on Potential ElderCare/PrimePlus Client**
(also see accompanying CD-ROM)

² Refer to <http://www.aicpa.org/assurance//PrimePlus/start.htm> for information on how to order this kit, or go directly to <http://www.cpa2biz.com>.

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/Prime-Plus 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 clients' minds right before they meet with you.

Brochures

Brochures are probably the most 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, displayed in the firm's reception area, and given to potential clients during tax time visits. See "Sample Marketing Brochure," included in Chapter 12, "Sample Documents and Checklists."



- **Sample Marketing Brochure** (*also see accompanying CD-ROM*)

Individualized Letters

Letters can be used for promoting CPA ElderCare/PrimePlus 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 more 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. See “Sample Direct Mail Letter to Elder Person” and “Sample Direct Mail Letter to Child of Elder Person,” included in Chapter 12, “Sample Documents and Checklists.”



- **Sample Direct Mail Letter to Elder Person** (*also see accompanying CD-ROM*)
- **Sample Direct Mail Letter to Child of Elder Person** (*also see accompanying CD-ROM*)

Advertising

Advertising on the local level may be an effective way to raise awareness of your CPA ElderCare/PrimePlus service. ElderCare/PrimePlus 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.

In undertaking an advertising campaign, careful consideration should be given to whether the advertising medium chosen will reach the targeted audience. For instance, a quarterly publication directed specifically to elderly persons might be an acceptable use of advertising dollars; a general circulation newspaper might not. Typically, an advertising campaign would not be undertaken by a practitioner unless he or she had already exhausted possible clients from within their own clientele and was entering the market for potential clients who used other CPAs.

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 reputation in the area of aging.

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 have a Web site, you should be sure to prominently feature your CPA ElderCare/PrimePlus services practice there. 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.

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/PrimePlus 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.

Elderly people fear losing control of their affairs. Stress the fact that each ElderCare/PrimePlus engagement is different—tailor-made for the needs of each individual client. Initially, a client may only need assistance with routine banking, bill paying, and accounting services. But as the client's abilities decline with increasing age, there may be a need for additional services, some of which the practitioner may be willing to provide and some which he or she can refer to other professionals.

Price Comparison Worksheet

"Monthly Price Comparison Worksheet," included in Chapter 12, "Sample Documents and Checklists," can be used as a planning tool and also as a marketing tool. In some areas, the cost of living in an institutionalized setting may be much less than the cost of living independently, but in many areas the cost will not vary widely from an institutionalized setting to living at home with CPA ElderCare/PrimePlus services.

Complete a sample worksheet based on average costs in your area, and if the difference is negligible, include a sample comparison as one of your marketing tools.



- **Monthly Price Comparison Worksheet** (*also see accompanying CD-ROM*)

GENERATING LEADS FROM EXISTING CLIENTS

The existing client base is undoubtedly the best source of potential clients for CPA ElderCare/PrimePlus 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/PrimePlus. For example, if someone is deducting medical expenses for the care of a parent, the parent is a potential ElderCare/PrimePlus 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/PrimePlus 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/PrimePlus services, you should explore the many other sources that exist to expand your ElderCare/PrimePlus practice.

Professional resources include the following:

- Physicians
 - Geriatricians
 - Neurologists
 - Psychiatrists
 - Nephrologists
 - Ophthalmologists

- Pulmonary specialists
- Ears, nose, and throat specialists
- Primary (family) care
- Internists
- Oncologists
- Urologists
- Cardiologists
- Orthopedic surgeons
- Dermatologists
- Attorneys
 - Elderlaw attorneys
 - 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 AARP and the 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:

- Senior 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 11, “Associations, Organizations, Agencies, and Other Resources,” contains a list of telephone 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 11 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/PrimePlus 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/PrimePlus 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

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 multi-disciplinary 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/PrimePlus 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

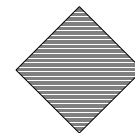
The adult children of the potential ElderCare/PrimePlus client may live a considerable distance from their parents. This presents a unique marketing issue: how to reach these potential interested parties. Marketing to adult children who do not live in your geographic area will be difficult. One approach 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. When the elderly client visits the practitioner's office for tax preparation or financial planning, obtain the names and addresses of their children. 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.

BUSINESS-TO-BUSINESS

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

This trend may present CPAs with a new market base for CPA ElderCare/PrimePlus 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

UNDERSTANDING WITH THE CLIENT AND ENGAGEMENT LETTERS

CPAs are strongly advised to document all CPA ElderCare/PrimePlus 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.

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), as amended, 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 No. 1, *Consulting Services: Definitions and Standards* (AICPA, *Professional Standards*, vol. 2, CS sec. 100.07), requires an understanding with the client to be established for consulting engagements.

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/PrimePlus 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. In some cases, the CPA's malpractice carrier can offer valuable assistance in drafting engagement letters.

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/PrimePlus client changes, the practitioner should review and revise the engagement agreement to reflect the change in his or her responsibilities to the ElderCare/PrimePlus 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/PrimePlus 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 Chapter 12, "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 or her 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. The client may 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 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 under which the engagement may be performed. 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 SSAE No. 10 (AT sec. 101.46) states that the understanding should include the engagement's objectives, client's responsibilities, and 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, the following matters (listed in

Chapter 2, “Agreed-Upon Procedures Engagements,” of SSAE No. 10 [AT sec. 201.10], as amended) 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. The understanding should also provide (1) that the engagement cannot be relied on to disclose errors, fraud, or illegal acts and (2) 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). See Chapter 6, “Engagement Services, Professional Standards, and Reporting,” of this publication for reporting requirements for compilation and review services in ElderCare/PrimePlus engagements. SSARS No. 8 modified SSARS No. 1, *Compilation and Review of Financial Statements* (AICPA, *Professional Standards*, vol. 2, AR sec. 100), by stating that if a CPA submits financial statements to a client that are *not* expected to be used by a third party, the communication can take two forms:

1. Issue a compilation report in accordance with SSARS No. 1.
2. Document an understanding with the entity through the use of an engagement letter, preferably signed by management, regarding the services to be performed and the limitations on the use of the financial statements.

Consulting engagements. If the ElderCare/PrimePlus 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/PrimePlus engagement would be performed under the AICPA’s auditing standards. Nevertheless, if the auditing standards do apply, 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/PrimePlus Engagement Letter

In addition to the matters previously described, the ElderCare/PrimePlus 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/PrimePlus 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/PrimePlus 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 their relative 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/PrimePlus 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/PrimePlus engagements 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 the Gramm-Leach-Bliley Act in Chapter 6, "Engagement Services, Professional Standards, and Reporting," and the form titled "Sample Privacy Notice Requirements and Distribution Form," in Chapter 12, "Sample Documents and Checklists."



- **Sample Privacy Notice Requirements and Distribution Form** (*also see accompanying CD-ROM*)

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 working papers and the client's records. The firm may want to develop a records retention policy specific to ElderCare/PrimePlus services. If a separate policy is developed, it should be clearly stated in the engagement letter and adhered to by all staff providing ElderCare/PrimePlus 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 includes a description of the firm's policy on termination of ElderCare/PrimePlus 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. In cases where the CPA can earn a commission based on the sale of insurance or investment products, the nature of these commissions should be clearly explained, together with an explanation of how they will affect other, noncommission, fees. Many broker/dealers have a specific form that a CPA's client must sign, explicitly consenting to the commissions to be earned.

Engagement letter updates. Provide a means by which the engagement letter can be updated, if the ElderCare/PrimePlus 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/PrimePlus 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/PrimePlus 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/PrimePlus engagement is different, sample engagement letters will be helpful. Chapter 12, "Sample Documents and Checklists," includes sample engagement letters for use in the ElderCare/PrimePlus practice.



- **Sample Engagement Letters (also see accompanying CD-ROM)**
 - Elderly Person Contracting With the CPA Directly
 - Attorney in Fact for Elderly Person Contracting With the CPA
 - Sample Engagement Letter With Agency Agreement
 - Sample Agency Agreement for Receipts and Disbursements

THE PLANNING PROCESS

When performing CPA ElderCare/PrimePlus 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 advance 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 12, "Sample Documents and Checklists," contains these forms to aid the CPA in gathering client information: "Sample Client Intake Form," "Sample Client Information Form," and "Sample Client Assessment Form."



- **Client Forms** (also see accompanying CD-ROM)

- Sample Client Intake Form
- Sample Client Information Form
- Sample Client Assessment Form

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 "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/PrimePlus 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/PrimePlus services. For example, will the practitioner be providing strictly

financial services, such as check writing/bill payment, or providing nonfinancial services, such as hiring home care staff or lawn maintenance services, as well?

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 a 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 care 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 "Sample Care Plan Form" and engagement letter are presented in Chapter 12, "Sample Documents and Checklists."



- **Sample Care Plan Form** (*also see accompanying CD-ROM*)

STAFFING

Because CPA ElderCare/PrimePlus 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/PrimePlus 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/PrimePlus engagement.

Willingness to Work With Older Adults

One of the first requirements for staffing ElderCare/PrimePlus 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/PrimePlus engagement is not at ease around an elderly person, he or she 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/PrimePlus engagement. Care has to be taken to remain in a professional relationship and avoid excessive emotional attachment to the elderly client. One of the facts in dealing with ElderCare/PrimePlus clients is that the relationship often ends with

the client's death. 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/PrimePlus 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/PrimePlus 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/PrimePlus engagements where they will be interacting with the elderly client.

Be aware of gender when assigning staff to ElderCare/PrimePlus engagements. The gender of the ElderCare/PrimePlus 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/PrimePlus client. Because of the wide variety of services involved in ElderCare/PrimePlus, 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/PrimePlus 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/PrimePlus 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/PrimePlus 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 “The Multidisciplinary Team”). When practitioners start a CPA ElderCare/PrimePlus 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/PrimePlus clients that the firm currently has and the involvement required of a specialist in those engagements. If there are only a few ElderCare/PrimePlus 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/PrimePlus 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/PrimePlus 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/PrimePlus engagements. Among the issues to be addressed would be the type and amount of documentation required in ElderCare/PrimePlus 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/PrimePlus client need the same type of ElderCare/PrimePlus 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/PrimePlus 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/PrimePlus practitioner. There is also a great deal of information available in books and at various Web sites. Refer to Chapter 11, “Associations, Organizations,

Agencies, and Other Resources,” for more information about ElderCare/PrimePlus training and information resources.

Practitioners who are going to be directly involved with ElderCare/PrimePlus 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/PrimePlus services offer the client an innovative approach to financial- and care-management planning. A multidisciplinary team of professionals who use their unique areas of expertise to serve the elderly client’s needs should be assembled. The clients, in most cases, have some members of their multidisciplinary team already in place. As an ElderCare/PrimePlus practitioner it is imperative that all disciplines needed are included.

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, reasonable assurance about the specialist’s competence in his or her field should be verified. 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 nonprofessionals) 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/PrimePlus 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 training and supervised work experience and may 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 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. For the names of GCMs by area, visit the Web site below. If a GCM is unavailable, the practitioner can contact a licensed social worker about performing these functions. Membership criteria as well as standards of practice for professional geriatric care managers are listed at the Web site.

National Association of Professional Geriatric Care Managers
1604 North Country Club Road
Tucson, AZ 85716-3102
Tel: (520) 881-8008
Fax: (520) 325-7925
E-mail: info@caremanager.org
<http://www.caremanager.org>

Membership categories are limited to care manager, affiliate, and leadership academy.

Care manager. This category includes those voting members currently practicing care management, or retired care managers. Members of this category must meet the following prerequisites:

1. A person who holds a baccalaureate, master's, or Ph.D. degree with at least one degree held in a field related to care management, that is, counseling, nursing, mental health, social work, psychology, or gerontology; is primarily engaged in the direct practice, administration, or supervision of client-centered services to the elderly and their families; and has two years of supervised experience in the field of gerontology following the completion of the degree.
2. Non-degreed RNs and other individuals with a baccalaureate, master's, or Ph.D. degree, who are primarily engaged in the direct practice, administration, or supervision of client-centered services to the elderly and their families and have three years of supervised experience in the field of gerontology.

Affiliate. This designates a nonvoting member who does not meet the criteria in the previous sections, but who has an interest in care management, including educators and researchers; practicing, degreed care managers not yet meeting the supervision criteria; nondegreed care managers, with a minimum of high school diploma, students, individuals not in direct practice of care management but who have any interest in the field (that is, individuals representing home health agencies, nursing homes, assisted living facilities, elder law attorneys, and so on).

No member shall have been convicted of, or have pled guilty or no contest to, a felony related to the professional activities of the member. Any member who is formally charged, through an indictment or similar process, with such a felony shall have his or her membership, and all rights and privileges thereof, automatically suspended pending resolution. A member formally charged as described previously shall immediately notify the Association.

Leadership academy. The National Association of Professional Geriatric Care Managers has developed the designation Fellow of the Leadership Academy, to recognize those geriatric care managers with comprehensive experience. The designation Fellow sets them apart from other professional geriatric care managers. It states that the individual has chosen to prepare and present himself or herself as an advanced practitioner and expert in his or her profession and that they are able and equipped to assist and handle even the most complex and difficult geriatric care management issues. Criteria for inclusion in the Leadership Academy include:

- A master's or Ph.D. in any field with at least one degree held in a field related to care management, such as counseling, nursing, mental health, social work, psychology and gerontology.
- Eight years of GCM membership at the care manager level.
- Certification (CMC, CCM, C-SWCM or C-ASWCM).
- Active participation at the national or chapter levels, with a minimum of 40 points overall.

The Professional Social Worker

Another relevant association is the National Association of Social Workers (NASW), which is the largest organization of professional social workers in the world. The NASW serves nearly 155,000 social workers in 55 chapters throughout the United States, Puerto Rico, the Virgin Islands, and abroad. Promoting high standards of practice and protecting the consumer of services are major association principles.

National Association of Social Workers
750 First Street, NE, Suite 700
Washington, DC 20002-4241
<http://www.naswdc.org>

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

The National Academy of Elder Law Attorneys has developed an experience registry to assist the public in finding qualified elder law attorneys. The attorneys subscribing to the registry have chosen to participate in this member service. Registry participants do not reflect a master list of members of the Academy, nor is it exhaustive of the elder law attorneys throughout the United States.

Participants in the experience registry include attorneys who have verified to the Academy that they meet or exceed a minimum level of experience in each field for which they are listed. The Academy makes no representation as to the skills or qualifications of the listed individuals.

Elder lawyers are listed by state at
<http://www.naela.org/Applications/ConsumerDirectory/index.cfm>

National Academy of Elder Law Attorneys, Inc. (NAELA)
1604 North Country Club Road
Tucson, AZ 85716
Tel: (520) 881-4005
Fax: (520) 325-7925
<http://www.naela.org>

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.

American Medical Association (AMA)
515 North State Street
Chicago, IL 60610
Tel: (800) 621-8335 (toll-free)
(312) 464-5000
Fax: (312) 464-5600
<http://www.ama-assn.org>

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.

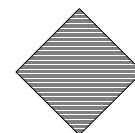
Health Insurance Association of America (HIAA)
1201 F Street, NW, 5th Floor
Washington, DC 20004
Tel: (202) 824-1600
(202) 824-1849 (publications information)
Fax: (202) 824-1722
<http://www.hiaa.org>

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 (14-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

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.

On rare occasions, an ElderCare/PrimePlus engagement may require the practitioner to perform 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), and practitioners need to have a system of quality control in place for those services in accordance with the AICPA Quality Control Standards. Typically, attestation engagements, audits and reviews, although they might arise from an ElderCare/PrimePlus client, would be treated as stand-alone engagements subject to the applicable standards rather than as part of an ElderCare/PrimePlus engagement.

It is highly recommended that the practitioner develop a system of quality control that encompasses his or her ElderCare/PrimePlus services, not just those services that fall under the purview of the SSAEs, SSARSs, and SASs. By having an overall system of quality control in place, practitioners increase the likelihood that their services will be competently delivered and their ElderCare/PrimePlus practice will be successful. Moreover, the nature of ElderCare/PrimePlus engagements will likely change over time, encompassing a different mix of services that may require a system of quality control. If practitioners have a system of quality control in place from the beginning, they 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/PrimePlus services are the same as with other accounting and auditing services.¹ 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

The AICPA *Guide for Establishing and Maintaining a System of Quality Control for a CPA Firm's Accounting and Auditing Practice* gives a full description of the five components of a system of quality control. This guide can be obtained by calling the AICPA Service Center Operations at (888) 777-7077 and asking for product number 067020 or by going online at <http://www.cpa2biz.com>. As discussed in the Guide, the nature, extent, and formality of a firm's quality control policies and procedures should be sufficiently comprehensive and suitably designed in relation to the firm's size, the number of its offices, the degree of authority allowed its personnel and its offices, the knowledge and experience of its personnel, the nature and complexity of the firm's practice, and appropriate cost-benefit considerations. Additionally, since the Guide is written for a firm's audit and accounting (including attestation) practice, the elements should be tailored to reflect professional standards when the ElderCare service is provided outside of the audit and accounting practice. For example, the concept of independence, as discussed below, is required when performing auditing and accounting services but it is not required if the practitioner is performing consulting services.

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/PrimePlus engagement. ElderCare/PrimePlus services are built on the premise that a CPA will handle the affairs of the elderly client with independence, integrity, and objectivity, always placing a high priority on the physical and financial well-being of the elderly person. It is important at all times that the professional and administrative staff keep the affairs of the ElderCare/PrimePlus client confidential. Gifts of any sort from the elderly client to the practitioner should be forbidden.

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

¹ See the Statements on Quality Control Standards (AICPA, *Professional Standards*, vol. 2, QC secs. 20.01-40.12) for the official quality control standards.

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/PrimePlus practice. Assignment of engagement personnel must meet the service needs of the CPA ElderCare/PrimePlus client on a timely basis. Personnel should be assigned to ElderCare/PrimePlus engagements in such a manner that the elderly person sees the same one or two practitioners on a continuous basis, rather than encountering a new team member every time services are performed. In addition, efforts should be made to select staff persons who have an understanding of the needs of the elderly client and who the client likes and trusts. Performance evaluations of staff should be carried out by designated reviewers on a periodic basis. The dynamics of an ElderCare/PrimePlus 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/PrimePlus client on their own account.

Acceptance and Continuance of Clients and Engagements

Before a CPA ElderCare/PrimePlus engagement is accepted, consideration has to be made of the firm's ability to provide the specified service in conducting the engagement without incurring an unacceptable level of risk. No engagement should be undertaken where the firm is unwilling or incompetent to provide the services required. If the ElderCare/PrimePlus client is a client of another CPA firm, the practitioner should communicate with the client's CPA to determine if there are any reasons or circumstances for not accepting the engagement. In addition, the practitioner should try to determine if there are any family conflicts or other matters that, during the course of the engagement, might make it impossible for the practitioner to perform the tasks assumed in the engagement.

Engagement Performance

It is important that an engagement letter be prepared for every CPA ElderCare/PrimePlus engagement assignment. This should be reviewed annually or when the nature of the ElderCare/PrimePlus services changes. Except for emergencies, the practitioner should not undertake any duties not specified in the signed engagement letter until the agreement has been modified. The engagement letter should be signed in the firm's name, on the firm's letterhead, and the ElderCare/PrimePlus client should receive a written acknowledgment. For further information on ElderCare/PrimePlus engagement letters, refer to the section later in this chapter called "Managing Professional Liability Risk." For additional information, see Chapter 12, "Sample Documents and Checklists" (under the section "Sample Engagement Letters") and Chapter 14, "Frequently Asked Questions" (under the section "Engagement Issues").

In the planning of a CPA ElderCare/PrimePlus 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 testing service providers, recording meetings both over the telephone and in person, listing financial information, and compiling monthly reporting. Separate files should be maintained for every CPA ElderCare/PrimePlus engagement and retained in accordance with the firm's working paper retention policies. All professional staff on an ElderCare/PrimePlus engagement must have an assigned partner responsible for the overall conduct in completion of the engagement. If more than one professional staff

member is assigned to a CPA ElderCare/PrimePlus engagement, team consultation is necessary so there is no gap in the services the firm has agreed to provide. Additionally, the team should document uncertainties about engagement issues and efforts undertaken to resolve those uncertainties.

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. In the ElderCare/PrimePlus engagement, monitoring might consist of, among other things, ensuring that services being provided are in accordance with the engagement agreement, making sure that all required documentation concerning meetings and the progress of the engagement have been prepared and properly filed, or simply visiting with the elderly client to see if the client's needs are being met.

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/PrimePlus services. Their internal control may be sufficient for their current activities but may not provide adequate control over client assets in regard to ElderCare/PrimePlus services. Practitioners 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 the ElderCare/PrimePlus practice.

Practice Administration

Only a 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/PrimePlus engagement files and related documentation should be protected from unauthorized access, and the ElderCare/PrimePlus partner must approve all requests for review of engagement documentation. Engagement documentation should not be made available to third parties unless the ElderCare/PrimePlus client has authorized disclosure in writing or there is a professional duty to disclose information, as in the case of judicial process.

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

Documentation is required on a CPA ElderCare/PrimePlus 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/PrimePlus client

- Change in key service providers
- Issues of abuse of the ElderCare/PrimePlus 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 promptly and properly recorded and that the opportunities for fraud and misappropriation of the CPA ElderCare/PrimePlus client's assets are eliminated or reduced.

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

Practitioners should discuss both the controls already in place and 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 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/PrimePlus client. Even though the CPA may feel uniquely qualified to provide this service, practitioners should evaluate a number of considerations even before accepting the responsibility of collecting cash receipts on behalf of a client and recording of transactions.

Practitioners should always check with their 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/PrimePlus engagement.

Handling of Currency

Practitioners should attempt to avoid, as much as possible, the handling of currency for the CPA ElderCare/PrimePlus 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. Practitioners 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/PrimePlus 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 accounting system to record the cash receipt transaction for the deposit. The entries should be coded to provide the Elder-Care/PrimePlus client with the information needed, for example, information necessary to facilitate preparation of the personal income tax returns.

A simple checklist showing anticipated sources of revenue and when that revenue is expected to be received (monthly, quarterly), should be prepared and the date of receipt of each type of revenue noted when received. In that way, the practitioner can identify revenue not received when anticipated and take immediate action to make sure the anticipated revenue has not been lost or stolen. A checklist, "Estimated Revenues" is included in Chapter 12, "Sample Documents and Checklists."



- **Estimated Revenues** (*also see accompanying CD-ROM*)

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/PrimePlus 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.

There should also be written understanding as part of the engagement letter describing the practitioner's responsibility for review of bills to be paid for the client. Is the practitioner simply to pay all bills presented for payment, or is the practitioner to review those bills for propriety and applicability? The appropriate coding for the payment should be made at the time the payment is recorded.

The ElderCare/PrimePlus practitioner should try to avoid accepting check-signing authority for ElderCare/PrimePlus clients. However, in the event that such responsibility cannot be avoided, practitioners should have a clear understanding with the ElderCare/PrimePlus client, in writing, of check-signing authority. If the client does not sign checks, appropriate procedures must be put in place to protect both the practitioner 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/PrimePlus 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.

Practitioners should consider discussing with the CPA ElderCare/PrimePlus client the feasibility and practicality of having a third party (for example the ElderCare/PrimePlus client, the client's agent-in-fact, or a trusted child or family member) 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/PrimePlus 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 canceled 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/PrimePlus engagement, a simple manual system may suffice. However, larger offices or practice units with a higher volume of CPA ElderCare/PrimePlus client engagements are likely to find computerized systems more efficient. Turnkey computer systems are available that enable separate record-keeping 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/PrimePlus 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 require a follow-up system and procedure.

Bookkeeping Records

The question of ownership of bookkeeping records may come up on occasion. When practitioners perform bookkeeping services for a CPA ElderCare/PrimePlus 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/PrimePlus 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/PrimePlus client.

Computer Records

The CPA ElderCare/PrimePlus client's records that are stored on computer disk or other electronic media also belong to the client. If the CPA provides the ElderCare/PrimePlus client with paper 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/PrimePlus Client's Records

Security of the ElderCare/PrimePlus 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/PrimePlus client in the practitioner's possession, it is essential to have a storage place in which to lock the checks for security purposes.

CPA ELDERCARE/PRIMEPLUS RISK MANAGEMENT

Following the quality control standards and the best practices previously discussed in this chapter helps reduce liability risk for the firm. The following section will address specific

risk exposures practitioners may face and how to address them when delivering service to their clients. For example, some of the risk management approaches will involve communications with the client. Engagement letters and the concept of full disclosure are important considerations. Other tactics involve risk transfer techniques such as commercial insurance. Practitioners need to protect themselves and their associates in a way that allows them to focus on practicing their profession in a manner satisfactory to both the practitioner and the client. It is impossible to extract all risks from the CPA practice; however, many risks can be mitigated so the practitioner can concentrate on delivering the best service to the 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 Elder-Care/PrimePlus practice. First, just as a geriatric care manager is crucial to the practice in ElderCare/PrimePlus management, an insurance agent is equally crucial for providing customer services. There are many insurance issues that concern the client and the practitioner 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 the firm is not a licensed insurance professional, the CPA should treat the referral to such a person as he or she would any other referral involving the elder.

Second, the role of the firm's insurance agent is expanded because an Elder-Care/Prime-Plus practice may expand traditional insurance risks as well as adding potential new exposures. A knowledgeable insurance agent is necessary for practitioners to obtain the necessary comprehensive coverage for their firm.

How ElderCare/PrimePlus Affects Traditional Property and Casualty Risks

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

Among the exposures as a CPA are property loss from fire and theft and the liability arising out of bodily injury to others that occurs in the practitioner's office or company-owned vehicle. Still other risks involve economic loss to the firm arising from the death or disability of his or her 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 at [http:// www.cpai.com/busneeds/syocpa.php#ic](http://www.cpaia.com/busneeds/syocpa.php#ic). It focuses on many issues, including professional liability, employment practices, and life insurance. Table 5.1 is a listing of general business insurance and its related exposure, as well as ways in which practicing ElderCare/Prime-Plus affects various insurance areas. It was developed by Aon Insurance Services and is

excerpted here. The list is on the Web at <http://www.asae-aon.com/askdetail.php>. The insurance agent may also have such a tool for the practitioner to use.

TABLE 5.1 GENERAL BUSINESS INSURANCES AND RELATED EXPOSURE

General Business Insurance and Related Exposure	ElderCare/PrimePlus Effect on Practice
<i>Building insurance.</i> Coverage should be for risks of direct physical loss on a replacement cost basis (no deduction for depreciation).	The ElderCare/PrimePlus practice will not change this insurance exposure unless the firm simply grows and requires more space.
<i>Contents insurance (business personal property).</i> Coverage is for risks of direct physical loss on a replacement costs basis (no deduction for depreciation). Coverage is purchased to cover office furnishings and equipment, improvements, and betterments.	No effect. Equipment in the office is probably not unique to the ElderCare/PrimePlus practice.
<i>Computer equipment.</i> Coverage is for computer hardware and software. It can also be amended to cover extra expenses needed to continue computer-based operations following a covered loss.	No effect.
<i>Valuable papers and records.</i> 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 the practice.	Records will become more imperative if the practice keeps wills and other documents on file for its ElderCare/PrimePlus clients.
<i>Business income.</i> This provides coverage for the loss of net profit/income as a result of a covered loss at the premises. For example, a fire that destroys the office would curtail the practice's ability to realize revenue.	Affects necessary coverage inasmuch as ElderCare/PrimePlus increases profits/losses.
<i>Extra expense.</i> Insurance provides reimbursement of those expenses necessarily incurred to keep the office functioning at its fullest capacity after an insured loss. This coverage can also be combined with business income insurance.	No effect.

General Business Insurance and Related Exposure	ElderCare/PrimePlus Effect on Practice
<p><i>Accounts receivable.</i> If billings and records of accounts receivable were destroyed, the firm would indeed be at a loss. Accounts receivable insurance would reimburse the firm for the outstanding accounts it would not be able to collect.</p>	No effect.
<p><i>Inland marine floaters.</i> Insurance available to cover camera equipment, valuable works of art in the offices and other property that can be taken away from the office premises.</p>	No effect.
<p><i>Crime insurance.</i> Crime protection is available in several different forms and can be tailored to cover each particular situation. Employee dishonesty (fidelity) insurance provides coverage in the event of a sustained loss resulting from the fraudulent or dishonest acts of an employee.</p>	<p>If employees visit the firm's ElderCare/PrimePlus clients at their residences and/or handle client assets, the practitioner needs to consider this insurance. It may be purchased as a stand-alone bond or as an endorsement on the professional liability insurance policy. (Professional liability is discussed in the next section of this chapter.)</p>
<p><i>Commercial general liability.</i> Insurance protection is available against third-party bodily injury and property damage claims arising from the 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:</p>	Affects ElderCare/PrimePlus practice in individual areas, as specified below.
<ul style="list-style-type: none"> • <i>Personal injury</i> provides protection against claims involving false arrest, detention, malicious prosecution, libel, slander, or defamation of character. 	No effect.
<ul style="list-style-type: none"> • <i>Products/completed operations</i> protects against claims arising from the selling, distribution, serving, or giving away of any type of product. 	No effect.
<ul style="list-style-type: none"> • <i>Fire legal liability</i> protects the practitioner if he or she does not own the building he or she occupies in the event he or she is held legally liable for fire damage to the premises. 	No effect.

(continued)

TABLE 5.1 (CONTINUED)

General Business Insurance and Related Exposure	ElderCare/PrimePlus Effect on Practice
<ul style="list-style-type: none"> • <i>Medical payments</i> will provide for the reimbursement of medical expenses for a third-party injury on the premises, regardless of legal liability. <p>Other important considerations with regard to commercial general liability coverage are as follows:</p> <ul style="list-style-type: none"> • Employees and volunteers should be included as additional insureds. • If the property is leased, the lease agreement may require that the landlord be named as an additional insured. • Claims arising out of “professional services” are normally excluded. 	More necessary due to frailty of elderly clients.
<p><i>Nonowned and hired automobile insurance.</i> This is protection for the firm if employees or other persons are involved in an accident while using their own automobiles on business or cars rented in the firm’s name for business trips. The injured party may very well name the firm as a party to the suit.</p>	If the practitioner or employees transport elder clients, this coverage is needed. From a liability perspective, transporting clients is a high-risk activity.
<p><i>Owned automobiles or long-term leased automobiles.</i> This is insurance for any automobiles owned or leased by the firm.</p>	No effect.
<p><i>Workers’ compensation.</i> Mandatory coverage for work-related injuries sustained by employees.</p>	Since employees may be visiting ElderCare/PrimePlus clients’ homes, and the home may be not in good condition, this coverage may become more crucial with the addition of an ElderCare/Prime-Plus practice.
<p><i>Umbrella liability.</i> This is additional liability coverage over and above the primary commercial general liability, automobile liability, and employer’s liability (under workers’ compensation). It increases the limits available on each underlying policy without otherwise changing the coverage.</p>	See individual categories, above.

In an ElderCare/PrimePlus engagement, the practitioner may be included in lawsuits having to do with bodily injury of the elder client, an exposure not normally associated with a CPA practice. As discussed later in this chapter, the AICPA Professional Liability Insurance Program offers a rider to cover such exposure.

Fidelity Bonds

Practitioners may want to consider obtaining a fidelity bond covering the firm and its employees who will have access to ElderCare/PrimePlus 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, a stand-alone insurance policy will have to be obtained to protect the CPA firm and the client.

Managing Professional Liability Risk

In addition to the traditional risks previously listed that are a part of any business, the practitioner also has a professional liability exposure related to his or her special expertise and the duty owed to 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 the client may hold the practitioner responsible. The risk of a professional liability claim against the practitioner and his or her firm will be the subject of the remainder of this chapter.

Much of the professional liability risk can be managed through common sense; some of the best risk management ideas are easily identified. Be technically proficient; be thorough and careful; keep good records; communicate often with the client; and disclose every relationship that might be viewed as a potential conflict of interest. The practitioner might even realize that it is necessary to 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. This is especially true in an ElderCare/PrimePlus engagement. There are certainly many other risk management principles. See Chapter 12, "Sample Documents and Checklists," for sample engagement letters and Chapter 14, "Frequently Asked Questions," for engagement letter advice and additional professional liability information.



- **Sample Engagement Letters** (*also see accompanying CD-ROM*)
 - Elderly Person Contracting With the CPA Directly
 - Attorney in Fact for Elderly Person Contracting With the CPA
 - Sample Engagement Letter With Agency Agreement
 - Sample Agency Agreement for Receipts and Disbursements

The Importance of Communication

One of the most important issues in ElderCare/PrimePlus engagements is communication. The elder client may have diminished mental capacity. Does the client understand the practitioner's 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 the practitioner 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, a risk management consultant with the underwriter of the AICPA Professional Liability Insurance Program, CNA.² Also, see the section titled “The AICPA Professional Liability Insurance Program,” at the end of this chapter for further information.

- Don't send the engagement letter through the mail. Before the work starts, meet with the client, explain its contents, and give the client an opportunity to ask questions.
- Before the work starts, meet with the client and explain the plan for the engagement. When will it start? How will it progress? When will it be completed? Explain what is needed from the client and when.
- 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 article can be found at http://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 <http://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.

The practitioner should tailor the letter to the engagement and avoid using a boilerplate 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 12, “Sample Documents and Checklists.”

The practitioner may employ the best risk management practices and still get sued. If that occurs, he or she 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 the insured's interests. Claims professionals are specialists and will move the process along as expeditiously as possible. Then, the practitioner can get on with his or her practice. The practitioner should, of

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course, stay involved in the claim process. However, representation by experts reduces the pressure on both practitioner and firm.

Case Studies: Exposure Issues Specific to ElderCare/PrimePlus

Beverlee Burrows, an accountants professional liability program manager with CNA, has studied the special risks associated with ElderCare services.³ In her article, “ElderCare Exposure Analysis,” Burrows presents four case studies with ascending professional liability exposure. The four are paraphrased here. The article can be found on the AICPA Insurance Programs Web site at http://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 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 before 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. The practitioner should be sure to check with the 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, may, for example, 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

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of the professional recommended. A consistent and careful screening of all service providers before recommending them will help to reduce this risk. CPAs should verify that such providers maintain adequate liability insurance and fidelity bond coverage before recommending them to clients. Thus, the firm will avoid being exposed to claims arising out of its 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/PrimePlus 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 here 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 definition of *professional services* 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. The CPA firm would 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 the practitioner's professional liability insurance policy to provide coverage for bodily injury and emotional distress, he or she will be unnecessarily exposed.

Guardianships

It is important to reiterate Burrows's admonition regarding guardianships. In an ElderCare/PrimePlus practice, the practitioner may be confronted with a request to become a legal guardian for an elderly person. This responsibility is great. Depending on the laws of the state, the practitioner 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, the practitioner is well advised to decline any request to become a guardian for one of his or her clients because such a role would put the practitioner too close to the client and possibly impair 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 the 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/PrimePlus engagement, the practitioner should consider carefully how, in hindsight, the trust beneficiaries may view his or her objectivity in performing these services if he or she is responsible for managing the assets of the trust upon the death of the client. Under most circumstances, it is prudent to assist the client with estate planning or serve as the trustee of their trusts rather than agreeing to perform both these services and other ElderCare/PrimePlus services once the client needs additional help.

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

The AICPA Professional Liability Insurance Program

The AICPA established the Accountants Professional Liability Insurance Program in 1967 so 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.

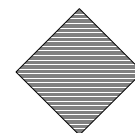
The plans available are:

- *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 Employee Retirement Income Security Act plan fiduciaries, life insurance agents, real estate agents, and registered representatives.
- *The Large Firm Unit Plan* is for the top 100 firms (excluding Big 4) and firms with specialized needs.

The AICPA Professional Liability Insurance Program can help practitioners address the aforementioned exposures they face when performing CPA ElderCare/PrimePlus services. If they are insured with another company, practitioners should be sure to speak with their agent about their exposure and how coverage will apply.

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

As the ElderCare/PrimePlus practice grows, practitioners should be certain to have considered the exposures associated with this service area, some of which ordinarily do not arise in the practice of public accountancy. They need to recognize they will be working with professionals outside the accounting profession who are not bound by similar rules of ethics and who may relate to clients differently. Some of the exposures associated with ElderCare/PrimePlus are unprecedented in the world of public accounting and must be addressed with the insurance agent and carrier. Practitioners can protect themselves, however, and engage in rewarding relationships with all their CPA ElderCare/PrimePlus services clients.



CHAPTER 6:

Engagement Services, Professional Standards, and Reporting

CPA ELDERCARE/PRIMEPLUS ENGAGEMENT SERVICES

ElderCare/PrimePlus services can involve three kinds of services: direct services, assurance services, and consulting services. Direct services include the more traditional aspects of accounting and financial services, as well as services not traditionally associated with CPAs. Consulting services include planning and evaluation of client needs.

As defined by the Special Committee on Assurance Services, assurance services are “independent professional services that improve the quality of information, or its context, for decision makers.” Under that definition, some of the ElderCare/PrimePlus services included in direct services and consulting services may improve the quality of information for decision makers and would be “assurance services.” However, assurance services, in the context of ElderCare/PrimePlus, primarily involve measurement and reporting on prescribed goals against stated criteria. Therefore, the services classified as assurance services consist mainly of attestation services, particularly, agreed-upon-procedures.

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

Direct Services

Direct services are 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
 - 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
- Carry out estate planning
- Prepare estate tax returns
- Prepare employment tax returns for caregivers and household help
- Nonfinancial services
 - 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
 - Review and analyze financial transactions and test for adherence to established criteria
 - Review investments and trust activity and test for adherence to established criteria
 - Verify third-party calculations, such as pension payments, insurance payments, and other annuity payments
 - Conduct portfolio management
 - Conduct risk management and insurance planning
 - Read and analyze reports from fiduciaries
- Nonfinancial services
 - Measure and report on care provider performance against established goals through inspection of logs, diaries, or other evidence
 - Evaluate and report on the performance of other outside parties, such as contractors and yard maintenance companies

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:

Financial services

- Planning for fiduciary needs. Practitioners evaluate the need for:
 - Financial (or durable) 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
 - Life settlements
 - Reverse mortgages
 - Sale or leaseback of home
 - Flexible spending accounts

Nonfinancial services

- ElderCare/PrimePlus planning
 - Plan for housing and support service needs
 - Plan for declining competency
 - Plan for death or disability of one or both spouses
 - Plan for dependent/disabled adult children
 - Evaluate alternative costs of retirement communities and other housing
 - Evaluate housing and care alternatives
 - Provide inventory of services available in the community
- Family facilitation
 - 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.
 - Assist in preparation of needs assessment
 - Other consulting services
 - Help family monitor care
 - Establish standards of care expected
 - Communicate expectations to care providers
 - Establish performance measurement systems

PROFESSIONAL STANDARDS AND REPORTING

Because ElderCare/PrimePlus 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, CPAs 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 for CPA ElderCare/PrimePlus services. 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/PrimePlus 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/PrimePlus 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/PrimePlus service being provided is an attestation or agreed-upon procedures engagement, independence is required. A lack of independence would preclude members from providing such services.

Interpretation No. 101-11, "Independence and the Performance of Professional Services Under the Statements on Standards for Attestation Engagements and Statement on Auditing Standards No. 75, *Engagements to Apply Agreed-Upon Procedures to Specified Elements, Accounts, or Items of a Financial Statement*," of ET section 101, *Independence* (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/PrimePlus 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/PrimePlus service is a consulting engagement that has no attestation component, 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 exists or occurs, decide whether you can perform the service with objectivity. If you cannot, 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 or her ElderCare/PrimePlus 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/Prime-Plus engagement that they will abide by the same provisions concerning residual estates and gifts.

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. Situations will arise in which 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. An understanding should be reached about who has authority to release information in circumstances when the client may be unavailable or incapable of acting. Ongoing instances (for example, sending monthly reports to children or guardians) may arise 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, situations will arise, as in all professional engagements, 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.

SSARS 1, as amended, now allows a practitioner to issue a compilation without a report when the practitioner does not reasonably expect the financial statement to be used by a third party (referred to as a *management-use-only compilation*). The performance requirements are the same for this type of compilation as for a compilation with a report; the difference is in the form of communication used. If a management-use-only compilation is to be performed, SSARS No. 1, as amended, *requires* a written understanding with management.

The Compilation and Review Alert, *Practical Guidance for Implementing SSARS 8: How to Understand and Apply the Amendments to SSARS 1, Compilation and Review of Financial Statements*, provides the following guidance on whether a management-use-only compilation is allowed in ElderCare/PrimePlus engagements and related situations:

- *ElderCare/PrimePlus Services*

[Such a compilation is allowed], as long as the financial statements are restricted to management-use-only. In this context, whoever is responsible for achieving the objectives of the individual and has the authority to establish policies and make decisions by which those objectives are to be pursued would be considered management.

- *Trusts or estates*

[Such a compilation is allowed], as long as the financial statements are restricted to management-use-only. In this context, whoever is responsible for achieving the objectives of the trust or estate and has the authority to establish policies and make decisions by which those objectives are to be pursued would be considered management. Generally, this would be the trustee or executor, but not the beneficiary.

- *Personal Financial Statements*

[Such a compilation is allowed], as long as the financial statements are restricted to management-use-only. In this context, only the individual whose financial statements are presented would be considered management. Note that the individual's advisers (for example, attorney, financial planner, banker) would be considered third parties.

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 Statements on Standards for Attestation Engagements (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), and SSAE No. 12, *Amendment to Statement on Standards for Attestation Engagements No. 10*, *Attestation Standards: Revision and Recodification* (AICPA, *Professional Standards*, vol. 1, AT sec. 101.17-18). Depending on the kind of attestation work you are performing on your ElderCare/PrimePlus engagement, you can consider the following chapters of SSAE No. 10:

- Chapter 1, "Attest Engagements" (AT sec. 101)
- Chapter 2, "Agreed-Upon Procedures Engagements" (AT sec. 201)
- Chapter 3, "Financial Forecasts and Projections" (AT sec. 301)
- Chapter 6, "Compliance Attestation" (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 because 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/PrimePlus engagement will probably be considered consulting services (see the list at the beginning of this chapter under “CPA ElderCare/PrimePlus 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/PrimePlus engagement.

Auditing Services

Financial statements on which the practitioner issues an auditor’s report would seldom arise as a CPA ElderCare/PrimePlus engagement. If by some rare chance an audit were required as a part of an ElderCare/PrimePlus engagement, you would need to comply with the requirements of the AICPA’s Statements on Auditing Standards or, if applicable, standards of the Public Company Accounting Oversight Board (PCAOB).

Reporting and Report Examples

When issuing the 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/PrimePlus 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 believe that such reports are best communicated orally so 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 (“Sample Nontraditional Report” and “Oral Report Memo to the File”) are contained in Chapter 12, “Sample Documents and Checklists.”



- **Sample Nontraditional Report** (*also see accompanying CD-ROM*)
- **Oral Report Memo to the File** (*also see accompanying CD-ROM*)

Where to Obtain the Professional Standards

To obtain the professional standards discussed in this chapter, call the AICPA Service Center Operations 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/PrimePlus practices provide nonbusiness financial products and services to their clients, such as 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?

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?

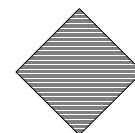
Other than the notice requirement, these provisions should have no effect on your practice. As a CPA, you are already bound by your state ethics requirements. Also, AICPA members are bound by Rule 301 of the AICPA Code of Professional Conduct, which is even more restrictive than the provisions of the 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 12, “Sample Documents and Checklists.”



- **Sample Privacy Notice Requirements and Distribution Form** (*also see accompanying CD-ROM*)



CHAPTER 7:

Federal and State Programs for the Elderly

Millions of older adults and disabled individuals rely on state and federal programs for services, benefits, and programming to help meet their medical, economic, and social needs. This chapter assists the ElderCare/PrimePlus practitioner gain understanding into these important programs. A working knowledge of Medicare and Medicaid, as well as other resources, will positively affect client outcomes. While the benefits and figures may change year to year, and there may be legislative changes, the practitioner should periodically check sources provided here for current figures. Even so, concepts discussed throughout this chapter remain the same. Numerous resources are provided so practitioners can check current benefits and figures.

MEDICARE

Medicare, the nation's largest health insurance program, is nationally managed by the Centers for Medicare and Medicaid Services (CMS), 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 Advantage 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/PrimePlus 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/PrimePlus practitioner will provide added value for your clients and will help differentiate you from your CPA competitors.

Medicare Snapshot

Prescription Drug Coverage Developments

One of the most glaring omissions in Medicare's benefits is the exceedingly weak 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. 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. 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.

On December 8, 2003, President Bush signed into law the Medicare Prescription Drug Improvement and Modernization Act of 2003. The law is intended to preserve and strengthen the current Medicare program, add important new prescription drug and preventive benefits, and provide extra help to people with low incomes.

Medicare-approved drug discount cards are currently available. Medicare has contracted with private companies to offer new drug discount cards until a Medicare prescription drug benefit starts in 2006. A discount card with Medicare's seal of approval helps seniors save 10 percent to 25 percent on prescription drugs. Enrollment continues until December 31, 2005. An additional credit of \$600 is available for low-income individuals who do not qualify for Medicaid, Tricare, or an employer group health plan.

While it is unlikely that the ElderCare/PrimePlus practitioner will make application for clients for these drug cards, it is important to be able to provide guidance to clients and family about the program.

The Web site www.medicare.gov provides up-to-date information about discount drug cards and other options that are available to Medicare recipients. Individuals without computer access should call (800) MEDICARE (800-633-4227) and an operator will assist them and mail a list of options to their address.

To compare cards, older adults should be sure to look for the Medicare-approved seal and keep in mind that they may order only one card. If the person is eligible for the \$600 credit, it can only be applied to an approved card. If the individual requires multiple drugs, he or she should check the total savings and savings by drug. Sometimes the best card does not discount every drug needed but could provide bigger discounts on the most expensive drugs. Generic alternatives for brand-name drugs may also provide greater savings. The individual should be sure that the pharmacy he or she intends to use

accepts the card he or she is considering. If the individual has addresses in more than one state, or near a state border, he or she should look at cards with national service areas.

Once the person determines which is the best card for his or her needs, an enrollment form is completed. Private companies that offer discount cards may charge an annual enrollment fee of no more than \$30 and new enrollment fees are paid every calendar year. It is important that enrollees maintain a discount drug list from the company they choose and provide it to their physician in the event medicine changes are required. Companies may, with written notice, terminate cards and individuals are required to pay additional enrollment fees for additional applications.

On September 15, 2004, Secretary of Health and Human Services Tommy G. Thompson announced new measures to help seniors get the lowest price possible for their medicines by allowing them to compare prices for similar drugs used to treat common diseases such as high cholesterol or blood pressure.

The **Lower Cost Rx Comparison Tool**—accessible at www.medicare.gov or by calling 1-800-MEDICARE—will help consumers compare lower-cost prescription drugs by category (cholesterol lowering drugs, blood pressure medicines, allergy medications, etc.) that are similar to the drugs they currently take and are used to treat the same conditions.

Medicare beneficiaries interested in using the comparison tool can go to the Prescription Drug and Other Assistance Programs (PDAP) section of www.medicare.gov and enter the medications they are currently taking. A customized report will be generated for each of their medications, including less expensive versions of the same drug and brand name and/or generic versions of similar but less expensive drugs that are available to treat the same condition.

A rigorous medical review process was used to develop the new lower-cost comparison tool. Physicians and pharmacists review all medical content on a monthly basis to ensure the information is up-to-date. Drug pricing data is updated weekly. All other information is updated on a monthly basis. The comparison tool includes drugs in classes for which substitutions between different drugs should present the lowest number of clinical challenges to patients and providers. The tool surveys a total of 52 drugs, representing about a quarter of all Medicare drug spending.

Other enhancements to the price compare features of the drug card program are also included on the Web site.

Sources: Guide to Choosing a Medicare-Approved Drug Discount Card, Centers for Medicare and Medicaid Services, 2004, Medicare Alert, 9/15/04

Medicare Advantage is the new name for Medicare + Choice plans. Rules and payments have been improved to provide more choices and better benefits. The plans vary by location.

What's New

Each year, the publication, *Medicare & You*, provides important information about Medicare benefits, rights, and health plan choices. The following information is new for *Medicare & You 2004* and can be found at <http://www.medicare.gov/publications/pubs/pdf/10050.pdf>.

- *A New Way to Get Your Medicare Summary Notices (MSNs)*. Medicare is testing electronic (on the Web) MSNs.

- *National Coverage Determinations and Local Medicare Review Policies.* The publication provides information about how Medicare payment decisions are made.
- *New Billing Requirements.* Doctors, suppliers, and providers must send Medicare claims electronically.
- *Medicare Specialty Plans.* The publication explains new types of focused care, like Disease Management Plans.
- *New Rights for Patients in Nursing Homes and Home Health Agencies.* There is a new “fast-track” appeals process if patients think services are ending too soon.
- *Generic Drug Message.* Here’s a note about the safety and efficiency of generic drugs.
- *A New Way to Get Information.* Medicare’s phone system [(800) MEDICARE] has a new speech-automated system for easy access to the information needed.

Medicare/Medicaid Administration: The Centers for Medicare and Medicaid Services

The Centers for Medicare and Medicaid Services (CMS) administers the Medicare program, and works in partnership with the states to administer Medicaid, the State Children’s Health Insurance Program (SCHIP), and health insurance portability standards (see Table 7.1 for regional office information). CMS is responsible for the administrative simplification standards from the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and quality standards in health care facilities through its survey and certification activity. Through Medicare, Medicaid, and SCHIP, about one in four Americans receives health care coverage. Nearly 40 million people are covered by Medicare, about 33 million are eligible for Medicaid, and SCHIP helps states expand health coverage to as many as 5 million uninsured children. These programs spend about one in three of the nation’s health care dollars, about \$429 billion in 2000 (of which the federal share was \$344 billion). CMS spends nearly one in five of the federal government’s dollars.

Source: CMS/HCFA History, Centers for Medicare and Medicaid Services; <http://www.cms.hhs.gov/about/history/>

TABLE 7.1 CENTERS FOR MEDICARE AND MEDICAID SERVICES REGIONAL OFFICES

States Served	Regional Office	Customer Services
Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, Vermont	Boston	Tel: (617) 565-3308 robosdb@cms.hhs.gov robosmcd@cms.hhs.gov
New York, New Jersey, Puerto Rico, Virgin Islands	New York	Tel: (212) 264-1121 ronyprovider@cms.hhs.gov ronydmch@cms.hhs.gov
Delaware; Washington, D.C.; Maryland; Pennsylvania; Virginia; West Virginia	Philadelphia	Tel: (215) 861-4248 rophihpp@cms.hhs.gov rophimso@cms.hhs.gov

TABLE 7.1 CENTERS FOR MEDICARE AND MEDICAID SERVICES REGIONAL OFFICES (CONTINUED)

States Served	Regional Office	Customer Services
Alabama, Florida, Georgia, Kentucky, Mississippi, North Carolina, South Carolina, Tennessee	Atlanta	Tel: (404) 562-7438 roatlbs@cms.hhs.gov roatlmso@cms.hhs.gov
Illinois, Indiana, Michigan, Minnesota, Ohio, Wisconsin	Chicago	Tel: (312) 353-9635 Rochiora@cms.hhs.gov
Arkansas, Louisiana, New Mexico, Oklahoma, Texas	Dallas	Tel: (214) 767-6321 rodalora@cms.hhs.gov
Iowa, Kansas, Missouri, Nebraska	Kansas City	Tel: (816) 426-3184 rokcmmo@cms.hhs.gov rokcmch@cms.hhs.gov
Colorado, Montana, North Dakota, South Dakota, Utah, Wyoming	Denver	Tel: (303) 844-4722 RODENPUB@CMS.HHS.GOV
Arizona, California, Hawaii, Nevada	San Francisco	Tel: (415) 744-3696 rosfodbs@cms.hhs.gov rosfomcd@cms.hhs.gov
Alaska, Idaho, Oregon, Washington	Seattle	Tel: (206) 615-2313 mdillon@cms.hhs.gov searodmch@cms.hhs.gov

Introduction to the Medicare Program

(Adapted from materials published by the Centers for Medicare and Medicaid Services 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 Advantage, 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 and B.

- Managed Care Plans that have contracts with Medicare (now known as Medicare Advantage, or in some circles, Part C). Dental costs, various levels of prescription coverage, vision coverage and routine physicals are offered with Medicare Advantage. 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 Advantage).

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 Advantage).

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 Advantage 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 premiums if they fulfill one of the following criteria:

1. They are already receiving retirement benefits from Social Security or the Railroad Retirement Board.
2. They 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 2004, the Part B premium is \$66.60 per month (increases to \$78.20 in January 2005). 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 2004 in Table 7.2; see the Medicare services and benefit amounts for 2004 in Table 7.3).

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

TABLE 7.2 HOSPITAL INSURANCE AND MEDICAL INSURANCE

Hospital Insurance (Part A)	2004
Deductible per each benefit period	\$876.00
Coinsurance (daily rate for days 61–90, per benefit period)	\$219.00
Coinsurance (daily rate for days 91–150 per benefit period—also known as the 60 “nonrenewable, lifetime reserve days”)	\$438.00
Skilled nursing facility coinsurance (daily rate for days 21–100, per benefit period)	\$109.50
Hospital insurance premium *	\$343.00
Reduced hospital insurance premium *	\$189.00

(continued)

TABLE 7.2 HOSPITAL INSURANCE AND MEDICAL INSURANCE (CONTINUED)

Medical Insurance (Part B)	2004
Deductible per year	\$100.00
Monthly premium	\$66.60 (\$78.20 in 2005)

*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 fewer than 30 quarters of Social Security coverage, the Part A premium will be \$343 a month for 2004. If the person has 30 to 39 quarters of Social Security coverage, the Part A premium will be \$189 a month for 2004.

TABLE 7.3 MEDICARE HOSPITAL AND MEDICAL INSURANCE—2004

Part A (Hospital)

Services	Benefit	Medicare Pays	Patient Pays
Hospitalization Semiprivate room and board; general nursing and other hospitalization services and supplies (Medicare payments based on benefit periods)	First 60 days	All but \$876	\$876
	61st to 90th day	All but \$219 a day	\$219 a day
	91st to 150th day*	All but \$438 a day	\$438 a day
	Beyond 150 days	Nothing	All costs
Skilled nursing facility care Semiprivate room and board; skilled nursing and rehabilitative services and other services and supplies**	First 20 days	100% of approved amount	Nothing
	Additional 80 days	All but \$109.50 a day	Up to \$109.50 a day
	Beyond 100 days	Nothing	All costs
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 20% of approved amount for durable medical equipment

*Sixty reserve days may be used only once.

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

TABLE 7.3 MEDICARE HOSPITAL AND MEDICAL INSURANCE—2004 (CONTINUED)

Part A (Hospital)

Services	Benefit	Medicare Pays	Patient Pays
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***

***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 physi- cal 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 MEDICARE HOSPITAL AND MEDICAL INSURANCE—2004 (CONTINUED)

Part B (Medical)

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 fourth 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, one can buy many types of private health insurance/coverage to supplement, or fill in the gaps. Supplemental insurance will pay for some or all of the health care costs 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

Private insurance designed to help pay for Medicare cost-sharing amounts, Medicare supplemental insurance, also known as Medigap, can be sold in only 10 standard policies, and each offers a different combination of benefits. (See Table 7.4 for a chart of the 10 standard Medigap plans and the benefits included in each.) 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 his or her 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.

Every company must make available Plan A. Some 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 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.

For additional information and comparison, see <http://www.medicare.gov/Publications/Pubs/pdf/02110.pdf>.

TABLE 7.4 CHART OF THE 10 STANDARD MEDIGAP SUPPLEMENTAL PLANS

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 drug benefit (\$3,000 limit)
				Preventive care					Preventive care

Help is available from the appropriate State Health Insurance Assistance Program (SHIP) if you or your clients 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 (see Table 7.5).

TABLE 7.5 CHART OF STATE HEALTH INSURANCE ASSISTANCE PROGRAM

State	Contact Information
Alabama	(800) 243-5463; ageline@adss.state.al.us
Alaska	(866) 465-3165
American Samoa	(808) 586-0100; eoamail@mail.health.state.hi.us
Arizona	(800) 432-4040
Arkansas	(800) 224-6330
California	(800) 434-0222; Visit CalMedicare.org .
Colorado	(888) 696-7213
Connecticut	(800) 994-9422
Delaware	(302) 739-6266; in state only (800) 336-9500
District of Columbia	(202) 739-0668
Florida	(800) 963-5337
Georgia	(800) 669-8387
Guam	(808) 586-0100
Hawaii	(808) 586-0100; eoamail@mail.health.state.hi.us
Idaho	(208) 334-4350
Illinois	(800) 548-9034; director@ins.state.il.us
Indiana	(800) 452-4800
Iowa	(877) 955-1212
Kansas	(800) 860-5260
Kentucky	(800) 595-6053
Louisiana	(800) 259-5300; in state only (800) 259-5301
Maine	(207) 624-8475; in state only (800) 300-5000
Maryland	(800) 243-3425
Massachusetts	(800) 243-4636
Michigan	(800) 803-7174
Minnesota	(800) 882-6262
Mississippi	(800) 345-6347
Missouri	(800) 390-3330
Montana	(406) 444-7781
Nebraska	(800) 234-7119; shiip@doi.state.ne.us .
Nevada	(800) 307-4444
New Hampshire	(800) 852-3388

TABLE 7.5 CHART OF STATE HEALTH INSURANCE ASSISTANCE PROGRAM (CONTINUED)

State	Contact Information
New Jersey	(800) 792-8820
New Mexico	(505) 476-4799 (800) 432-2080; nmaoa@state.nm.us
New York	(800) 333-4114
North Carolina	(800) 443-9354 (919) 733-0111; shiip@ncdoi.net
North Dakota	(800) 247-0560; ndshic@state.nd.us
Northern Mariana Islands	(808) 586-0100; eoa@mail.health.state.hi.us
Ohio	(800) 686-1578; oshiipmail@ins.state.oh.us
Oklahoma	(800) 763-2828 or (405) 521-6628
Oregon	(800) 722-4134 or (503) 947-7984; shiba.ins@state.or.us
Pennsylvania	(717) 783-1550; aging@state.pa.us
Puerto Rico	(787) 721-8590
Rhode Island	(401) 222-2880
South Carolina	(803) 898-2850
South Dakota	(800) 536-8197; shiine@cfag.org
Tennessee	(800) 525-2816
Texas	(800) 252-9240 ConsumerProtection@tdi.state.tx.us
Utah	(800) 541-7735
Vermont	(802) 748-5182 or (800) 642-5119
Virginia	(800) 552-3402; aging@vda.virginia.gov
Virgin Islands	(340) 778-6311, ext. 2338
Washington	(800) 397-4422
West Virginia	(202) 739-0668
Wisconsin	(800) 242-1060
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 Advantage

Scope of Coverage

Medicare Advantage 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 Advantage 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 required the secretary of the Department of Health and Human Services (DHHS) to establish standards, regulations, and rules for Medicare Advantage 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 Advantage. 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 Advantage 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 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. *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.
4. *Religious and fraternal benefit plans.* Fraternal and religious organizations may offer Medicare Advantage 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.

5. *Department of Defense demonstration plans.* Medicare treats a military installation as a type of coordinated care plan. Demonstration projects take place on six sites.

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 telephone numbers of Medicare carriers and other resources; Table 7.7 is a chart of where to get help with specific Medicare questions.

TABLE 7.6 MEDICARE RESOURCE DIRECTORY

State	Medicare Carrier	End Stage Renal Disease Network	Insurance Information	Quality Improvement Organization	Durable Medical Equip. Carrier
Alabama	(800) 318-8782	(601) 936-9260	(800) 243-5463	(800) 760-3540	(803) 763-5706
Alaska	(800) 999-1118	(800) 262-1514	(800) 478-6065	(800) 878-7170	(615) 782-4541
Arizona	(800) 318-8782	(800) 783-8818	(800) 432-4040	(800) 359-9909	(615) 782-4541
Arkansas	(800) 428-5525	(800) 472-8664	(800) 224-6330	(479) 649-8501	(800) 583-2236
California	(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	(866) 286-3773	(800) 553-7590	(800) 842-2052
Delaware	(800) 444-4606	(800) 548-9205	(800) 336-9500	(866) 475-9669	(800) 842-2052
District of Columbia	(800) 444-4606	(866) 651-6272	(202) 739-0668	(800) 645-0011	(800) 270-2313
Florida	(800) 333-7586	(800) 826-3773	(800) 963-5337	(800) 844-0795	(800) 583-2236
Georgia	(800) 727-0827	(800) 524-7139	(800) 669-8387	(800) 979-7217	(800) 583-2236
Guam	(800) 444-4606	(800) 232-3773	(888) 875-9229	(800) 524-6550	(800) 899-7095
Hawaii	(800) 444-4606	(800) 232-3773	(888) 875-9229	(800) 524-6550	(800) 899-7095
Idaho	(800) 627-2782	(800) 262-1514	(800) 247-4422	(800) 445-6941	(800) 899-7095
Illinois	(800) 642-6930	(800) 456-6919	(800) 548-9034	(800) 383-2856	(800) 270-2313
Indiana	(800) 622-4792	(800) 456-6919	(800) 452-4800	(800) 288-1499	(800) 270-1313
Iowa	(800) 532-1285	(800) 444-9965	(800) 351-4664	(800) 752-7014	(800) 899-7095
Kansas	(800) 432-3531	(800) 444-9965	(800) 860-5260	(800) 432-0407	(800) 899-7095
Kentucky	(800) 583-2236	(800) 456-6919	(877) 293-7447	(800) 288-1499	(800) 583-2236
Louisiana	(800) 462-9666	(800) 472-8664	(800) 259-5301	(800) 433-4958	(800) 583-2236
Maine	(800) 492-0919	(866) 286-3773	(800) 750-5353	(800) 772-0151	(800) 842-2052
Maryland	(800) 444-4606	(866) 651-6272	(800) 243-3425	(800) 492-5811	(800) 270-2313
Massachusetts	(800) 882-1228	(866) 286-3773	(800) 243-4636	(800) 252-5533	(800) 842-2052
Michigan	(800) 482-4045	(800) 973-3773	(800) 803-7174	(800) 365-5899	(800) 270-2313
Minnesota	(800) 352-2762	(800) 973-3773	(800) 333-2433	(800) 444-3423	(800) 270-2313
Mississippi	(800) 682-5417	(877) 936-9260	(800) 948-3090	(800) 844-0600	(800) 583-2236
Missouri	(800) 892-5900	(800) 444-9965	(800) 390-3330	(800) 347-1016	(800) 392-3070
Montana	(800) 332-6146	(800) 262-1514	(800) 551-3191	(800) 497-8232	(800) 899-7095
Nebraska	(800) 633-1113	(800) 444-9965	(800) 234-7119	(800) 458-4262	(800) 899-7095

TABLE 7.6 MEDICARE RESOURCE DIRECTORY (CONTINUED)

State	Medicare Carrier	End Stage Renal Disease Network	Insurance Information	Quality Improvement Organization	Durable Medical Equip. Carrier
Nevada	(800) 444-4606	(800) 783-8818	(800) 307-4444	(800) 748-6773	(800) 899-7095
New Hampshire	(800) 447-1142	(866) 286-3773	(800) 852-3388	(800) 772-0151	(800) 842-2052
New Jersey	(800) 462-9306	(888) 877-8400	(800) 792-8820	(800) 624-4557	(800) 842-2052
New Mexico	(800) 423-2925	(800) 783-8818	(800) 432-2080	(800) 279-6824	(800) 583-2236
New York	(800) 442-8430	(800) 238-3773	(800) 333-4114	(800) 331-7767	(800) 842-2052
North Carolina	(800) 672-3071	(800) 524-7139	(800) 443-9354	(800) 722-0468	(800) 583-2236
North Dakota	(800) 247-2267	(800) 973-3773	(800) 247-0560	(800) 472-2902	(800) 899-7095
Ohio	(800) 282-0530	(800) 456-6919	(800) 686-1578	(800) 589-7337	(800) 270-2313
Oklahoma	(800) 522-9079	(800) 472-8664	(800) 763-2828	(800) 522-3414	(800) 583-2236
Oregon	(800) 444-4606	(800) 262-1514	(800) 722-4134	(800) 344-4354	(800) 899-7095
Pennsylvania	(800) 633-4227	(800) 548-9205	(800) 783-7067	(877) 346-6180	(800) 842-2052
Puerto Rico	(800) 981-7015	(888) 877-8400	(877) 725-4300	(800) 981-5062	(800) 583-2236
Rhode Island	(800) 662-5170	(866) 286-3773	(401) 462-3000	(800) 662-5028	(800) 842-2052
South Carolina	(800) 583-2236	(800) 524-7139	(800) 868-9095	(800) 922-3089	(800) 583-2236
South Dakota	(800) 437-4762	(800) 973-3773	(800) 536-8197	(800) 658-2285	(800) 899-7095
Tennessee	(800) 342-8900	(877) 936-9260	(877) 801-0044	(800) 528-2655	(800) 583-2236
Texas	(800) 442-2620	(877) 886-4435	(800) 252-9240	(800) 725-8315	(800) 583-2236
Utah	(800) 426-3477	(800) 783-8818	(800) 541-7735	(800) 274-2290	(800) 899-7095
Vermont	(800) 447-1142	(866) 286-3773	(800) 642-5119	(800) 772-0151	(800) 842-2052
Virginia	(800) 444-4606	(866) 651-6272	(800) 552-3402	(800) 545-3814	(800) 270-2313
Virgin Islands	(800) 981-7015	(888) 877-8400	(340) 776-8311 x1005	(340) 712-2444	(800) 583-2236
Washington	(800) 444-4606	(800) 262-1514	(800) 397-4422	(800) 445-6941	(800) 899-7095
West Virginia	(800) 848-0106	(866) 651-6272	(877) 987-4463	(800) 642-8686 x2266	(800) 270-2313
Wisconsin	(800) 944-0051	(800) 973-3773	(800) 242-1060	(800) 362-2320	(800) 270-2313
Wyoming	(800) 442-2371	(800) 783-8818	(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 Advantage plans cover some of

these services, which motivates individuals to choose Medicare Advantage 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 7.3).

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 CMS. 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 includes information only on nursing homes that are Medicare or Medicaid certified. These nursing homes provide skilled nursing care; however, many other types of facilities provide various levels of health care and assistance with activities of daily living. Many of these facilities are licensed only at the state level. In addition, some nursing homes that provide a full range of care, including skilled nursing services, choose not to participate in Medicare or Medicaid. For information about any facility not found in this database, also see Chapter 8, “Hearth and Home Alternatives,” or contact your state survey agency.

The Complete Nursing Home Inspection

The data in this section of the Medicare Web site refers to the regulatory requirement that the nursing home failed to meet but does not reflect the entire inspection report (which, in some cases, may be well over 100 pages in length). The detailed inspection report contains the specific findings that support the state’s determination that the requirement was not met. A complete inspection report and the nursing home’s corresponding plan of correction to address the deficiencies found during the inspection are available from the state survey agency or from the nursing home itself.

In addition, each nursing home that provides Medicare or Medicaid services is required to make the results of its last full inspection available onsite for public review. Note: On the Medicare site’s nursing home report, the date of last inspection generally refers to the last life/safety inspection date.

The Results of the Nursing Home Inspection Report

CMS makes every attempt to ensure consistency among how the states report their findings. It is also important, while reading these results, to consider that the quality of a nursing home may improve or deteriorate significantly in a short period of time. These changes can occur when a nursing home’s administrator or ownership changes or when a nursing home’s financial health suddenly changes. Consider contacting your state’s ombudsman’s office or your state survey agency for the most current information about a nursing home.

Finally, findings of inspections do not present a complete picture of the quality of care provided by the nursing home. The inspection measures whether the nursing home meets the minimum standard for a particular set of requirements. If a nursing home has no deficiencies, it means that it met the minimum standards at the time of the inspection. However, this information cannot be used to identify nursing homes that provide outstanding care.

Additional information is available at <http://www.medicare.gov>.

Home Health Compare

This section of the Medicare Web site provides detailed information about Medicare-certified home health agencies that were certified as of January 2003. New home health agencies may not appear for several months after being approved by Medicare. Home Health Compare has information about the following.

- *Home Health Agency Characteristics.* These include:
 - Name, office, address, and phone number of the agency
 - Medicare-covered services offered by the agency (that is, nursing care, physical therapy, occupational therapy, speech pathology, medical/social services, and home health aide)
 - Agency's initial date of Medicare certification
 - Type of ownership (for profit, government, nonprofit)
- *Home Health Quality Measures.* Quality measures offer information about how well home health agencies provide care for some of their patients. The measures provide information about patients' physical and mental health, and whether their ability to perform basic daily activities is maintained or improved. Quality information can be used to help practitioners, clients, and/or families compare home health agencies. The quality measures available include:
 - Four measures related to improvement in getting around
 - Four measures related to meeting the patient's activities of daily living
 - Two measures related to patient medical emergencies
 - One measure related to improvement in mental health

Additional information is available at <http://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 7.5.)
A lost Medicare card	Social Security Administration (800) 772-1213

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 Advantage program	Insurance information, counseling and assistance programs (See state insurance listings in Table 7.5.)
Local seminars and health fairs on the new Medicare Advantage Program	Centers for Medicare and Medicaid Services (See regional office listing in Table 7.1.)
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 7.5.)
Medigap or Medicare Select policies available in your area	State insurance departments (See state insurance listings in Table 7.5.)

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 7.5.)
The quality of care from your doctor, hospital, nursing home, or managed care plan	Quality improvement organization (See Table 7.6.)
The quality of care from a kidney dialysis facility	End Stage Renal Disease (ESRD) Network Organization (See state ESRD network listings in Table 7.6.)
Any complaint you want to report directly to the CMS	The CMS regional office (See CMS regional listings in Table 7.1)

Additionally, each state's insurance counseling office can answer questions about Medicare and other health insurance. Services are free.

Medicare Appeals and Grievances

Medicare appeal rights. Recipients have the right to appeal any decision about their Medicare services whether they are in the Original Medicare Plan or a Medicare managed care plan. If Medicare does not pay for an item or service that was provided, or if the recipients were not given an item or service they think they should have received, they can appeal.

Appeal rights under the Original Medicare Plan. If enrolled in the Original Medicare Plan, the recipients can file an appeal if they think Medicare should have paid for, or did not pay enough for, an item or service received. If an appeal is filed, ask the doctor or provider for any information related to the bill that might help the case. Appeal rights are on the back of the Explanation of Medicare Benefits or Medicare Summary Notice that is mailed to recipients from a company that handles bills for Medicare. The notice will also indicate why the bill was not paid and what appeal steps can be taken.

Appeal rights under Medicare managed care plans. If enrolled in a Medicare managed care plan, the recipients can file an appeal if their plan will not pay for, does not allow, or stops a service that they think should be covered or provided. If the recipients think their health could be seriously harmed by waiting for a decision about a service, they (or a family member) should request the plan for a fast decision. The plan must respond within 72 hours.

The Medicare managed care plan must inform enrollees in writing how to appeal. After an appeal is filed, the plan will review its decision. Then, if the plan does not decide in the recipient's favor, the appeal is reviewed by an independent organization that works for Medicare, not for the plan. See the plan's membership materials or contact the plan for details about Medicare appeal rights.

If individuals have concerns or problems with their plan that are not about payment or service requests, they have a right to file a grievance. For example, if they believe their plan's hours of operation should be different, a grievance may be filed.

Recipients' protection when hospitalized. This is true whether the individual is enrolled in the Original Medicare Plan or a Medicare managed care plan. If admitted to a Medicare participating hospital, the recipient should be given a copy of *An Important Message From Medicare*, which explains their rights as a hospital patient. If not provided by the facility, ask for it.

Information in the message includes:

- Recipient rights to get all of the hospital care that they need, and any follow-up care after discharge from the hospital.
- What to do if they think the hospital is making them leave too soon.

For additional questions, call (800) MEDICARE. Ask that a quality improvement organization (QIO) review the case. The individual may be able to stay in the hospital at no charge during the review. The hospital cannot force the recipient to leave before the QIO makes a decision.

Medicare appeals forms are available on the Web at <http://www.medicare.gov/Basics/forms/default.asp>.

Additional Tips for the ElderCare/PrimePlus Practitioner

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 7.5 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 or visit <http://www.medicare.gov/Publications/Pubs/pdf/pubcatalog.pdf> and request a copy of the following free booklets to facilitate your practice (most are available in English and Spanish).
 - *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*
 - *2004 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 2004*, located at www.medicare.gov, has a tremendous amount of additional information to further facilitate Medicare administration.

What 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.

Source: Medicaid: A Brief Summary, Centers for Medicare and Medicaid Services, 2004;
<http://www.cms.hhs.gov/publications/overview-medicare-medicaid/default4.asp>

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.

Medicaid Snapshot

(Adapted from materials published by the Centers for Medicare and Medicaid Services and the U.S. Department of Health and Human Services. Also see: <http://www.cms.hhs.gov/medicaid/>)

Who Does Medicaid Serve?

Recent statistics indicate that Medicaid serves more than 4.1 million elderly persons and 5.9 million blind and disabled individuals, as well as more than 21.6 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.

How Extensive Is Medicaid Now?

Medicaid was initially formulated as a medical care extension of federally funded programs providing cash income assistance for the poor, with an emphasis on dependent children and their mothers, the disabled, and the elderly. Over the years, however, Medicaid eligibility has been incrementally expanded beyond its original ties with eligibility for cash programs. Legislation in the late 1980s assured Medicaid coverage to an expanded number of low-income pregnant women, poor children, and to some Medicare beneficiaries who are not eligible for any cash assistance program. Legislative changes also focused on increased access, better quality of care, specific benefits, enhanced outreach programs, and fewer limits on services.

In most years since its inception, Medicaid has had very rapid growth in expenditures. This rapid growth has been due primarily to the following factors:

- The increase in size of the Medicaid-covered populations as a result of federal mandates, population growth, and economic recessions.
- The expanded coverage and utilization of services.
- The increase in the number of very old and disabled persons requiring extensive acute and/or long-term health care and various related services.
- The results of technological advances to keep a greater number of very low-birth-weight babies and other critically ill or severely injured persons alive and in need of continued extensive and very costly care.
- The increase in drug costs and the availability of new expensive drugs.
- The increase in payment rates to providers of health care services, when compared to general inflation.

Most Medicaid beneficiaries incur relatively small average expenditures per person each year, and a relatively small proportion incurs very large costs. National data for 2000 show that average costs ranged from \$1,290 per person (for children) to \$11,345 per person (for the elderly).

Long-term care is an important provision of Medicaid that will be increasingly utilized as our nation's population ages. The Medicaid program paid for over 41 percent of the total cost of care for persons using nursing facility or home health services in 2001. National data for 2000 show that Medicaid payments for nursing facility services totaled \$34.4 billion for more than 1.7 million beneficiaries of these services—an average expenditure

of \$20,235 per nursing home beneficiary. The national data also show that Medicaid payments for home health services totaled \$3.1 billion for more than 995,000 beneficiaries—an average expenditure of \$3,115 per home health care beneficiary. With the percentage of our population who are elderly or disabled increasing faster than that of the younger groups, the need for long-term care is expected to increase.

Another significant development in Medicaid is the growth in managed care as an alternative service delivery concept different from the traditional fee-for-service system. Under managed care systems, HMOs, prepaid health plans (PHPs), or comparable entities agree to provide a specific set of services to Medicaid enrollees, usually in return for a predetermined periodic payment per enrollee. Managed care programs seek to enhance access to quality care in a cost-effective manner. Waivers may provide the states with greater flexibility in the design and implementation of their Medicaid managed care programs. Waiver authority under sections 1915(b) and 1115 of the Social Security Act is an important part of the Medicaid program. Section 1915(b) waivers allow states to develop innovative health care delivery or reimbursement systems. Section 1115 waivers allow statewide health care reform experimental demonstrations to cover uninsured populations and to test new delivery systems without increasing costs. Finally, the Balanced Budget Act provided states a new option to use managed care. The number of Medicaid beneficiaries enrolled in some form of managed care program is growing rapidly, from 14 percent of enrollees in 1993 to 58 percent in 2002.

More than 42.8 million persons received health care services through the Medicaid program in fiscal year 2000 (the last year for which beneficiary data are available). In fiscal year 2002, total outlays for the Medicaid program (federal and state) were \$258.2 billion, including direct payment to providers of \$185.8 billion, payments for various premiums (for HMOs, Medicare, etc.) of \$45.1 billion, payments to disproportionate share hospitals of \$15.4 billion, and administrative costs of \$11.9 billion. Outlays under the SCHIP program in fiscal year 2002 were \$5.4 billion. With no changes to either program, expenditures under Medicaid and SCHIP are projected to reach \$425 billion and \$7.5 billion, respectively, by fiscal year 2008.

Source: Medicaid: A Brief Summary, Centers for Medicare and Medicaid Services, 2004
<http://www.cms.hhs.gov/publications/overview-medicare-medicaid/default4.asp>

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 Janet Reno, 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 was 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 are complicated issues, 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 CMS. (See Table 7.8 for state Medicaid office telephone numbers.)

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

State	Web Address	Telephone
Alabama	http://www.medicaid.state.al.us	(800) 824-6584
Alaska	http://www.hss.state.ak.us	(907) 465-3355
Arizona	http://www.ahcccs.state.az.us	(800) 417-7100

(continued)

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

State	Web Address	Telephone
Arkansas	http://www.medicaid.state.ar.us	(800) 482-5431
California	http://www.dhs.cahwnet.gov/home/contactinfo	(888) 452-8609
Colorado	http://www.chcpf.state.co.us	(800) 688-7777
Connecticut	http://www.dss.state.ct.us	(800) 994-9422
Delaware	http://www.state.de.us/dhss	(800) 464-4357
District of Columbia	http://dchealth.dc.gov/index.asp	(202) 783-2118
Florida	None listed	(888) 419-3456
Georgia	http://www.communityhealth.state.ga.us	(800) 246-2757
Hawaii	http://www.med-quest.us	None
Idaho	http://www2.state.id.us/dhw	(800) 685-3757
Illinois	http://www.state.il.us/dpa/html/medicaid.htm	(217) 782-0963
Indiana	http://www.in.gov/fssa	(800) 433-0746
Iowa	http://www.dhs.state.ia.us	(800) 338-8366
Kansas	http://www.srskansas.org/hcp	(800) 933-6593
Kentucky	http://chs.ky.gov/dms	(800) 372-2991
Louisiana	http://www.dhh.state.la.us	(800) 327-3419
Maine	http://www.state.me.us/bms	(800) 321-5557
Maryland	http://www.dhr.state.md.us/fia/medicaid.htm	(800) 685-5861
Massachusetts	http://www.state.ma.us/dma	(888) 665-9993
Michigan	http://www.michigan.gov/mdch	(800) 292-2550
Minnesota	http://www.dhs.state.mn.us	(800) 657-3672
Mississippi	http://www.dom.state.ms.us	(800) 421-2408
Missouri	http://www.dss.state.mo.us/dms/pages/description.htm	(800) 392-1261
Montana	http://www.dphhs.state.mt.us	(800) 362-8312
Nebraska	http://www.hhs.state.ne.us	(800) 652-1999
Nevada	http://dhcfp.state.nv.us	(800) 992-0900
New Hampshire	http://www.dhhs.state.nh.us/DHHS/DHHS_SITE/default.htm	(800) 351-1888
New Jersey	http://www.state.nj.us/humanservices	(800) 356-1561
New Mexico	http://www.state.nm.us/hsd/mad/Index.html	(888) 997-2583

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

State	Web Address	Telephone
New York	http://www.health.state.ny.us/nysdoh/medicaid/medicaid.htm	(800) 342-3009
North Carolina	http://www.dhhs.state.nc.us/dma	(800) 662-7030
North Dakota	http://www.state.nd.us/humanservices/services/medicalserv/medicaid/index.html	(800) 755-2604
Ohio	http://www.state.oh.us/odjfs/aboutus/0002AboutUs.stm	(800) 686-6108
Oklahoma	http://www.ohca.state.ok.us	(800) 767-3949
Oregon	http://www.dhs.state.or.us	(800) 336-6016
Pennsylvania	http://www.dpw.state.pa.us/omap/dpwomap.asp	(800) 692-7462
Rhode Island	http://www.dhs.state.ri.us	(401) 462-1300
South Carolina	http://www.dhhs.state.sc.us/Default.htm	(800) 763-9087
South Dakota	http://www.state.sd.us/social/MedElig	(800) 452-7691
Tennessee	http://www2.state.tn.us/health	(800) 669-1851
Texas	http://www.hhsc.state.tx.us	(800) 252-8263
Utah	http://health.utah.gov/medicaid	(800) 662-9651
Vermont	http://www.dpath.state.vt.us	(800) 917-7787
Virginia	http://www.dss.state.va.us/benefit/medicaid_coverage.html	(800) 552-8627
Washington	http://fortress.wa.gov/dshs/maa	(800) 562-6188
West Virginia	http://www.wvdhhr.org/bms	(800) 688-5810
Wisconsin	http://www.dhfs.state.wi.us/medicaid/index.htm	(800) 888-7989
Wyoming	http://wdhfs.state.wy.us	(800) 251-1269

Transfer of Assets

Under the transfer of assets provisions (Section 1917(c) of the Social Security Act; U.S. Code Reference 42 U.S.C. 1396p(c)), states must withhold payment for various long-term care services for individuals who dispose of assets for less than fair market value. The term *assets* includes both resources and income.

These provisions apply when assets are transferred by individuals in long-term care facilities or receiving home and community-based waiver services, or by their spouses, or someone else acting on their behalf. At state option, these provisions can also apply to various other eligibility groups.

States can “look back” to find transfers of assets for 36 months before the date the individual is institutionalized or, if later, the date he or she applies for Medicaid. For certain trusts, this look-back period extends to 60 months.

If a transfer of assets for less than fair market value is found, the state must withhold payment for nursing facility care (and certain other long-term care services) for a period of time referred to as the penalty period.

The length of the penalty period is determined by dividing the value of the transferred asset by the average monthly private-pay rate for nursing facility care in the state. Example: A transferred asset worth \$90,000, divided by a \$3,000 average monthly private-pay rate, results in a 30-month penalty period. There is no limit to the length of the penalty period.

For certain types of transfers, these penalties are not applied. The principal exceptions are:

- Transfers to a spouse, or to a third party for the sole benefit of the spouse
- Transfers by a spouse to a third party for the sole benefit of the spouse
- Transfers to certain disabled individuals or to trusts established for those individuals
- Transfers for a purpose other than to qualify for Medicaid
- Transfers where imposing a penalty would cause undue hardship

For additional information concerning federal rules on transfers of assets for less than fair market value, go to <http://www.cms.hhs.gov/medicaid/eligibility/assets.asp>.

Estate Recovery Provision

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 defined estates and required 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.

For additional information, go to <http://www.cms.hhs.gov/medicaid/estaterec.asp>.

Treatment of Trusts

Where an individual, his or her spouse, or anyone 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 purposes 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 (Section 1917(d) of the Social Security Act; U.S. Code Reference 42 U.S.C. 1396p(d)).

How a trust is treated depends to some extent on what type of trust it is; for example, whether it is revocable or irrevocable, and what specific requirements and conditions the trust contains. In general, however, payments actually made to or for the benefit of the individual are treated as income to the individual. Amounts that could be paid to or for the benefit of the individual, but are not, 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. They are:

- 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.
- Trusts established by a disabled individual, parent, grandparent, guardian, or court for the disabled individual, using the individual's own funds, where the trust is made up of pooled funds and managed by a nonprofit organization for the sole benefit of each individual included in the trust.
- 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 of the above instances, 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 will not be counted as available to the individual where the state determines that counting the trust would work an undue hardship.

For additional information concerning federal rules for treatment of trusts, go to <http://www.cms.hhs.gov/medicaid/eligibility/trusts.asp>.

Spousal Impoverishment

The expense of nursing home care—which ranges from \$3,000 to \$6,000 a 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”

(Section 1924 of the Social Security Act; U.S. Code Reference 42 U.S.C. 1396r-5), which can leave the spouse who is still living at home in the community with little or no income or resources. These provisions help ensure that this situation will not occur and that community spouses are able to live out their lives with independence and dignity.

Resource Eligibility

The spousal impoverishment provisions apply when one member of a couple enters a nursing facility or other medical institution and is expected to remain there for at least 30 days. When the couple applies for Medicaid, an assessment of their resources is made. The couple's resources, regardless of ownership, are combined. The couple's home, household goods, an automobile, and burial funds are not included in the couple's combined resources. The result is the couple's combined countable resources. This amount is then used to determine the spousal share, which is one-half of the couple's combined resources.

To determine whether the spouse residing in a medical facility meets the state's resource standard for Medicaid, the following procedure is used. From the couple's combined countable resources, a protected resource amount (PRA) is subtracted. The PRA is the greatest of:

- The spousal share, up to a maximum established annually
- The state spousal resource standard, which a state can set at any amount within a range established annually
- An amount transferred to the community spouse for her or his support as directed by a court order
- An amount designated by a state hearing officer to raise the community spouse's protected resources up to the minimum monthly maintenance needs standard

After the PRA is subtracted from the couple's combined countable resources, the remainder is considered available to the spouse residing in the medical institution as countable resources. If the amount of countable resources is below the state's resource standard, the individual is eligible for Medicaid. Once resource eligibility is determined, any resources belonging to the community spouse are no longer considered available 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 income eligibility purposes. The state uses the income eligibility standard for one person rather than two, and the standard income eligibility process for Medicaid is used.

Post-Eligibility Treatment of Income

This process is followed after an individual in a nursing facility/medical institution is determined to be eligible for Medicaid. The post-eligibility process is used to determine how much the spouse in the medical facility must contribute toward his or her cost of nursing facility/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.

The process starts by determining the total income of the spouse in the medical facility. From that spouse's total income, the following items are deducted:

- A personal needs allowance of at least \$30
- A community spouse's monthly income allowance as long as the income is actually made available to him or her
- A family monthly income allowance, if there are other family members living in the household
- An amount for medical expenses incurred by the spouse who is in the medical facility

The community spouse's monthly income allowance is the amount of the institutionalized spouse's income that is actually made available to the community spouse. If the community spouse has income of his or her own, the amount of that income is deducted from the community spouse's monthly income allowance. Similarly, any income of family members, such as dependent children, is deducted from the family monthly income allowance.

Once the above items are deducted from the institutionalized spouse's income, any remaining income is contributed toward the cost of his or her care in the institution. For additional information concerning federal rules on spousal impoverishment, go to <http://www.cms.hhs.gov/medicaid/eligibility/trusts.asp>. If you have questions about how a specific state applies these rules, please contact the state directly. See Table 7.1 for a list of states and contact information.

Following are the monthly resource limits and spousal impoverishment standards for 2004:

- *SSI*: Individual, \$564.00; couple, \$846.00
- *300% cap limit*: Individual, \$1,692.00; couple, n/a
- *SSI break-even points*: Earned income—individual, \$1,213.00; couple, \$1,777.00; unearned income—individual, \$584.00; couple, \$866.00
- *Minimum community spouse income allowance*: \$1,515.00
- *Community spouse housing allowance*: \$454.50
- *Maximum community spouse income allowance*: \$2,319.00
- *Minimum community spouse resource standard*: \$18,552.00
- *Maximum community spouse resource standard*: \$92,760.00
- *Maximum spousal share*: \$92,760.00

For additional information, see <http://www.cms.hhs.gov/medicaid/eligibility/spousal.pdf>.

Nursing Facility Services for Individuals Age 21 and Older

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

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 after October 1, 1997. 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.

Medicaid Third-Party Liability

Third-party liability (TPL) refers to the legal obligation of third parties, i.e., certain individuals, entities, or programs, to pay all or part of the expenditures for medical

assistance furnished under a state plan. The Medicaid program by law is intended to be the payer of last resort; that is, all other available third-party resources must meet their legal obligation to pay claims before the Medicaid program pays for the care of an individual eligible for Medicaid. Examples of third parties that may be liable to pay for services include employment-related health insurance, court-ordered health insurance derived by non-custodial parents, workers' compensation, long-term care insurance, and other state and federal programs (unless specifically excluded by federal statute).

Individuals eligible for Medicaid assign their rights to third-party payments to the state Medicaid agency. States are required to take all reasonable measures to ascertain the legal liability of third parties to pay for care and services available under the state plan. Once states have determined that a potentially liable third party exists, the state is required to either "cost avoid" or "pay and chase" claims. *Cost avoidance* is where the provider of services bills and collects from liable third parties before sending the claim to Medicaid. *Pay and chase* is utilized when the state Medicaid agency pays the medical bills and then attempts to recover from liable third parties. States are generally required to cost avoid claims unless they have a waiver approved by CMS that allows them to use the pay and chase method. For additional information, go to <http://www.cms.hhs.gov/>.

THE MEDICARE/MEDICAID RELATIONSHIP

Medicare beneficiaries who have low incomes and limited resources may receive help paying for their Medicare premiums and out-of-pocket medical expenses through Medicaid. There are various benefits available to "dual eligibles," about six million Medicare beneficiaries who are eligible for some type of Medicaid benefit. For persons who are eligible for full Medicaid coverage, the Medicaid program supplements Medicare coverage by providing services and supplies that are available under their state's Medicaid program. For services that are covered by both programs, Medicare pays first, and Medicaid pays for the beneficiary's cost sharing (up to the state's payment limit). Medicaid also covers additional services. Limited Medicaid benefits are also available to pay for out-of-pocket expenses.

Source: Medicaid: A Brief Summary; <http://www.cms.hhs.gov/publications/overview-medicare-medicaid/default4.asp>

SOCIAL SECURITY

Social Security Snapshot

(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 Social Security beneficiaries, these changes are important. This section provides up-to-date information about the "built-in" changes that take place most years. For additional information, call the Social Security Administration at (800) 772-1213.

Information for People Who Are Working

Social Security and Medicare taxes are as follow:

	2004
Employee and employer (each)	7.65% up to \$87,900
Self-employed	15.3% up to \$87,900

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 40 credits to qualify for retirement benefits. For 2004, workers receive one credit for every \$900 earned.

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.

Additional information is available by telephone: (800) 772-1213. To find a local Social Security office, visit the Web at <http://s3abaca.ssa.gov/pro/fo/fo-home.html>.

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 50 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.

Estimated average monthly Social Security 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. Source: http://www.ssa.gov/policy/docs/chartbooks/fast_facts/2001/slide12-0.html.

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 who have not yet retired can find out how much they can expect to receive from Social Security based on their own earnings record by referring to their Personal Earnings and Benefit Estimate Statements (PEBES), which are mailed every year, three months before the individuals' birthday. To order the PEBES form at other times, 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/Iraqi Freedom: 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) or go to <http://www1.va.gov/directory/guide/home.asp?isFlash=1>.

TABLE 7.9 TOLL-FEE VETERANS ADMINISTRATION CONTACT INFORMATION FOR VETERANS AND DEPENDENTS

VA benefits	(800) 827-1000
Life insurance	(800) 669-8477
Education (GI Bill)	(888) 442-4551
Health care benefits	(877) 222-8387
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) 749-8387
Income verification center	(800) 929-8387
Web site	www.va.gov

ADVANCE DIRECTIVES

(Adapted from materials published by the Centers for Medicare and Medicaid Services 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 or she may wish to gather information about that state's laws from another source, such as the office of the state attorney general.

Advance Directives

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 11, "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 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. State 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 AAAs 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

ALABAMA

Region IV

Alabama Department of Senior Services (Off Site)
770 Washington Avenue
RSA Plaza, Suite 470
Montgomery, AL 36130
Tel: (334) 242-5743
Fax: (334) 242-5594
E-mail: ageline@adss.state.al.us

ALASKA

Region X

Division of Senior Services
Department of Administration
PO Box 110209
Juneau, AK 99811-0209
Tel: (907) 465-4879
Fax: (907) 465-4716
E-mail: acoa@admin.state.ak.us

AMERICAN SAMOA

Region IX

Territorial Administration on Aging
Government of American Samoa
Pago Pago, American Samoa 96799
Tel: 011-684-633-2207
Fax: 011-684-633-2533 or 011-684-633-7723

ARIZONA

Region IX

Aging and Adult Administration
Department of Economic Security
1789 West Jefferson Street, #950A
Phoenix, AZ 85007
Tel: (602) 542-4446
Fax: (602) 542-6575

ARKANSAS

Region VI

Division of Aging and Adult Services
Arkansas Dept of Human Services
PO Box 1437, Slot S-53
1417 Donaghey Plaza South
Little Rock, AR 72203-1437
Tel: (501) 682-2441
Fax: (501) 682-8155

(continued)

TABLE 7.10 STATE AGENCIES ON AGING (CONTINUED)

CALIFORNIA

Region IX

California Dept. of Aging
1600 K Street
Sacramento, CA 95814
Tel: (916) 322-5290
Fax: (916) 324-1903

COLORADO

Region VIII

Division of Aging and Adult Services
Department of Human Services
1575 Sherman Street
Ground Floor
Denver, CO 80203-1714
Tel: (303) 866-2636
Fax: (303) 866-2696

CONNECTICUT

Region I

Division of Elderly, Community and Social Work Services
Department of Social Services
25 Sigourney Street, 10th floor
Hartford, Connecticut 06106-5033
Tel: (860) 424-5277
Fax: (860) 424-5301 or (860)-424-4966
E-mail: adultserv.dss@po.state.ct.us

DELAWARE

Region III

Delaware Division of Services for Aging and Adults with Physical Disabilities
Dept of Health & Social Services
1901 North DuPont Highway
New Castle, DE 19720
Tel: (302) 577-4791
Fax: (302) 577-4793

DISTRICT OF COLUMBIA

Region III

District of Columbia Office on Aging
One Judiciary Square - 9th Floor
441 Fourth Street, N.W.
Washington, DC 20001
Tel: (202) 724-5622
Fax: (202) 724-4979

TABLE 7.10 STATE AGENCIES ON AGING (CONTINUED)

FLORIDA

Region IV

Department of Elder Affairs
Building B - Suite 152
4040 Esplanade Way
Tallahassee, FL 32399-7000
Tel: (850) 414-2000
Fax: (850) 414-2004
E-mail: information@elderaffairs.org

GEORGIA

Region IV

Division of Aging Services
Department of Human Resources
2 Peachtree Street N.E., 36th Floor
Atlanta, GA 30303-3176
Tel: (404) 657-5258
Fax: (404) 657-5285
E-mail: dhrconstituentservices@dhr.state.ga.us

GUAM

Region IX

Division of Senior Citizens
Department of Public Health & Social Services
PO Box 2816
Agana, Guam 96910
Tel: 011-671-475-0263
Fax: 011-671-477-2930

HAWAII

Region IX

Executive Office on Aging
No 1 Capitol District
250 South Hotel Street, Suite 109
Honolulu, HI 96813-2831
Tel: (808) 586-0100
Fax: (808) 586-0185

IDAHO

Region X

Idaho Commission on Aging
PO Box 83720
Boise, ID 83720-0007
Tel: (208) 334-3833
Fax: (208) 334-3033

(continued)

TABLE 7.10 STATE AGENCIES ON AGING (CONTINUED)

ILLINOIS

Region V

Department on Aging
421 East Capitol Avenue
Springfield, IL 62701
Tel: (217) 785-2870 or in state (800) 252-8966
Fax: (217) 785-4477

INDIANA

Region V

Bur. of Aging/In Home Services
402 W. Washington Street
PO Box 7083
Indianapolis, IN 46207-7083
Tel: (317) 232-7020
Fax: (317) 232-7867

IOWA

Region VII

Iowa Department of Elder Affairs
Clemens Building, 3rd Floor
200 Tenth Street
Des Moines, IA 50309-3609
Tel: (515) 242-3333
Fax: (515) 242-3300

KANSAS

Region VII

Department on Aging
New England Building
503 South Kansas
Topeka, KS 66603-3404
Tel: (785) 296-5222
Fax: (785) 296-0256

KENTUCKY

Region IV

Office of Aging Services
Cabinet for Families and Children
Commonwealth of Kentucky
275 East Main Street
Frankfort, KY 40621
Tel: (502) 564-6930
Fax: (502) 564-4595

LOUISIANA

Region VI

Governor's Office of Elderly Affairs
PO Box 80374
Baton Rouge, LA 70898-0374
Tel: (225) 342-7100
Fax: (225) 342-7133

TABLE 7.10 STATE AGENCIES ON AGING (CONTINUED)

MAINE

Region I

Bureau of Elder and Adult Services
Department of Human Services
35 Anthony Avenue
State House, Station #11
Augusta, ME 04333
Tel: (207) 624-5335
Fax: (207) 624-5361
E-mail: webmaster_beas@state.me.us

MARYLAND

Region III

Maryland Department of Aging
State Office Building, Room 1007
301 West Preston Street
Baltimore, MD 21201-2374
Tel: (410) 767-1100
Fax: (410) 333-7943
E-mail: ptc@mail.ooa.state.md.us

MASSACHUSETTS

Region I

Exec. Office of Elder Affairs
1 Ashburton Place, 5th floor
Boston, MA 02108
Tel: (617) 222-7451
Fax: (617) 727-6944

MICHIGAN

Region V

Office of Svcs to the Aging
PO Box 30676
7109 West Saginaw (Fed-Ex zip 48917)
Lansing, MI 48909-8176
Tel: (517) 373-8230
Fax: (517) 373-4092

MINNESOTA

Region V

Minnesota Board on Aging
444 Lafayette Road
Saint Paul, MN 55155-3843
Tel: (651) 296-2770
TTY: (800) 627-3529
Fax: (651) 297-7855

(continued)

TABLE 7.10 STATE AGENCIES ON AGING (CONTINUED)

MISSISSIPPI

Region IV

Division of Aging and Adult Services
750 N. State Street
Jackson, MS 39202
Tel: (601) 359-4925
Fax: (601) 359-9664
E-mail: webspinner@mdhs.state.ms.us

MISSOURI

Region VII

Director of Division of Senior Services
Department of Health and Senior Services
PO Box 570
615 Howerton Court
Jefferson City, MO 65102-0570
Tel: (573) 751-3082
Fax: (573) 751-8687

MONTANA

Region VIII

Senior and Long Term Care Division
Department of Public Health & Human Services
PO Box 4210
111 Sanders, Room 211
Helena, MT 59620
Tel: (406) 444-4077
Fax: (406) 444-7743

NEBRASKA

Region VII

Division of Aging Services
Dept of Health & Human Services
PO Box 95044
301 Centennial Mall-South
Lincoln, NE 68509
Tel: (402) 471-2307
Fax: (402) 471-4619

NEVADA

Region IX

Division for Aging Services
Department of Human Resources
3416 Goni Road, Building D-132
Carson City, NV 89706
Tel: (775) 687-4210
Fax: (775) 687-4264

TABLE 7.10 STATE AGENCIES ON AGING (CONTINUED)

NEW HAMPSHIRE

Region I

Division of Elderly and Adult Services
State Office Park South
129 Pleasant Street, Brown Building #1
Concord, NH 03301
Tel: (603) 271-4680
Fax: (603) 271-4643

NEW JERSEY

Region II

Division of Aging & Community Services
Division of Senior Affairs
Department of Health & Senior Services
PO Box 807
Trenton, NJ 08625-0807
Tel: (609) 943-3345
Fax: (609) 943-3343

NEW MEXICO

Region VI

State Agency on Aging
La Villa Rivera Building
228 East Palace Avenue, Ground Floor
Santa Fe, NM 87501
Tel: (505) 827-7640
Fax: (505) 827-7649
E-mail: nmaoa@state.nm.us

NEW YORK

Region II

Office for the Aging
Two Empire State Plaza
Albany, NY 12223-1251
Tel: (518) 474-7012
Fax: (518) 474-1398

NORTH CAROLINA

Region IV

Department of Health and Human Services
Division of Aging
2101 Mail Service Center
Raleigh, NC 27699-2101
Tel: (919) 733-3983
Fax: (919) 733-0443

(continued)

TABLE 7.10 STATE AGENCIES ON AGING (CONTINUED)

NORTH DAKOTA

Region VIII

Department of Human Services
Aging Services Division
600 South 2nd Street, Suite 1C
Bismarck, ND 58504
Tel: (701) 328-8910 or (800) 451-8693
TDD: (701) 328-8968
Fax: (701) 328-8989
E-mail: dhssrinf@state.nd.us

NORTH MARIANA ISLANDS

Region IX

CNMI Office on Aging, DC&CA
PO Box 2178
Saipan, MP 96950
Tel: 011 (671) 734-4361
Fax: 011 (670) 233-1327

OHIO

Region V

Ohio Department of Aging
50 West Broad Street - 9th Floor
Columbus, OH 43215-5928
Tel: (614) 466-5500
Fax: (614) 466-5741

OKLAHOMA

Region VI

Aging Services Division
Department of Human Services
PO Box 25352
312 N.E. 28th Street
Oklahoma City, OK 73125
Tel: (405) 521-2281 or 521-2327
Fax: (405) 521-2086

OREGON

Region X

Senior and Disabled Services Div.
500 Summer Street, NE, E02
Salem, OR 97301-1073
Tel: (503) 945-5811
Fax: (503) 373-7823

TABLE 7.10 STATE AGENCIES ON AGING (CONTINUED)

PENNSYLVANIA

Region III

Department of Aging
Forum Place
555 Walnut Street, 5th Fl
Harrisburg, PA 17101-1919
Tel: (717) 783-1550
Fax: (717) 772-3382

PUERTO RICO

Region II

Commonwealth of Puerto Rico
Governor's Office of Elderly Affairs
Call Box 50063
Old San Juan Station, PR 00902
Tel: (787) 721-5710, 721-4560, or 721-6121
Fax: (787) 721-6510
E-mail: administrator@ogave.prstar.net

RHODE ISLAND

Region I

Department of Elderly Affairs
John O. Pastore Center
Benjamin Rush Building, #55, 2nd Fl.
35 Howard Ave.
Cranston, RI 02920
Tel: (401) 462-0500
Fax: (401) 462-0503

SOUTH CAROLINA

Region IV

Dept of Health and Human Services
PO Box 8206
1801 Main Street
Columbia, SC 29202-8206
Tel: (803) 898-2513
Fax: (803) 898-4515

SOUTH DAKOTA

Region VIII

Office of Adult Services and Aging
Richard F. Kneip Building
700 Governors Drive
Pierre, SD 57501-2291
Tel: (605) 773-3656
Fax: (605) 773-6834
E-mail: asaging@dss.state.sd.us

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TABLE 7.10 STATE AGENCIES ON AGING (CONTINUED)

TENNESSEE

Region IV

Commission on Aging and Disability
Andrew Jackson Building, 9th Floor
500 Deaderick Street
Nashville, Tennessee 37243-0860
Tel: (615) 741-2056
Fax: (615) 741-3309

TEXAS

Region VI

Texas Department on Aging
4900 North Lamar, 4th Floor
Austin, TX 78751-2316
Tel: (512) 424-6840
Fax: (512) 424-6890
E-mail: mail@tdoa.state.tx.us

UTAH

Region VIII

Division of Aging and Adult Services
Box 45500
120 North 200 West
Salt Lake City, UT 84145-0500
Tel: (801) 538-3910
Fax: (801) 538-4395
E-mail: DAAS@hs.state.ut.us

VERMONT

Region I

Vermont Department of Aging and Disabilities
Waterbury Complex
103 South Main Street
Waterbury, VT 05671-2301
Tel: (802) 241-2400
Fax: (802) 241-2325

VIRGINIA

Region III

Virginia Department for the Aging
1600 Forest Avenue, Suite 102
Richmond, VA 23229
Tel: (804) 662-9333
Fax: (804) 662-9354
E-mail: aging@vdh.state.va.us

TABLE 7.10 STATE AGENCIES ON AGING (CONTINUED)

VIRGIN ISLANDS

Region II

Senior Citizen Affairs
Department of Human Services
#19 Estate Diamond Fredericksted
Saint Croix, VI 00840
Tel: (340) 692-5950
Fax: (340) 692-2062

WASHINGTON

Region X

Aging and Adult Services Administration
Department of Social & Health Services
PO Box 45050
Olympia, WA 98504-5050
Tel: (360) 725-2310; in-state only: (800) 422-3263
Fax: (360) 438-8633
E-mail: askdshs@dshs.wa.gov

WEST VIRGINIA

Region III

West Virginia Bureau of Senior Services
Holly Grove, Building 10
1900 Kanawha Boulevard East
Charleston, WV 25305
Tel: (304) 558-3317
Fax: (304) 558-5699
E-mail: info@boss.state.wv.us

WISCONSIN

Region V

Bureau of Aging and Long Term Care Resources
Department of Health and Family Services
1 West Wilson Street
Room 450
Madison, WI 53707-7850
Tel: (608) 266-2536
Fax: (608) 267-3203

WYOMING

Region VIII

WDH, Division on Aging
Department of Health
6101 Yellow Stone Road, #259B
Cheyenne, WY 82002
Tel: (307) 777-7986 or 800-442-2766
Fax: (307) 777-5340

GLOSSARY OF MEDICARE AND MEDICAID TERMS

(Adapted from materials published by the Centers for Medicare and Medicaid Services 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 does something on purpose that causes the individual mental, physical, or financial harm.

Access: The individual's ability to get needed medical care and services.

Accessibility of services: The individual's ability to get medical care and services when he or she needs them.

Accessory dwelling unit (ADU): A separate housing arrangement within a single-family home. The ADU is a complete living unit and includes a private kitchen and bath.

Accredited (accreditation): Having a seal of approval. Being accredited means that a facility or health care organization has met certain quality standards. These standards are set by private, nationally recognized groups that check on the quality of care of health care facilities and organizations.

Act, law, statute: Legislation that passed through Congress and was signed by the President or passed over his veto.

Activities of daily living (ADL): Activities usually done during a normal day, such as 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. This amount 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): How premium rates are decided, based on members' use of benefits and not their individual use of benefits.

Administrative law judge (ALJ): A hearings officer who presides over appeal conflicts between providers of services, or beneficiaries, and Medicare contractors.

Admitting physician: The doctor responsible for admitting a patient to a hospital or other inpatient health facility.

Advance beneficiary notice (ABN): A notice that a doctor or supplier should give a Medicare beneficiary to sign in the following cases. The individual's doctor gives him or her a service that the doctor believes that Medicare does not consider medically necessary; and the individual's doctor gives him or her a service that the doctor believes Medicare will not pay for. If the individual does not get an ABN to sign before he or she gets the service from the doctor, and Medicare does not pay for it, the individual does not have to pay for it. If the doctor does give the individual an ABN that he or she signs before getting the service, and Medicare does not pay for it, the individual will have to pay

the doctor for it. The ABN applies only if the individual is in the Original Medicare Plan. It does not apply if the individual is in a Medicare Managed care plan or Private Fee-for-Service Plan.

See also: *Medicare managed care plan; Original Medicare Plan.*

Advance coverage decision: A decision that the Private Fee-for-Service Plan makes on whether or not it will pay for a certain service.

Advance directive (health care): A document written ahead of time that says how the individual wants medical decisions to be made if he or she loses the ability to make decisions. A health care advance directive may include a living will and a durable power of attorney for health care.

Advocate: A person who gives an individual support or protects his or her rights.

Affiliated provider: A health care provider or facility paid by a health plan to give service to plan members.

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

Ambulatory surgical center: A place other than a hospital that does outpatient surgery. At an ambulatory (in and out) surgery center, individuals may stay for only a few hours or for one night.

Ancillary services: Professional services by a hospital or other inpatient health program. These may include x-ray, drug, laboratory, or other services.

Anesthesia: Drugs an individual gets before and during surgery so he or she will not feel pain. Anesthesia should always be given by a doctor or a specially trained nurse.

Annual election period: For Medicare beneficiaries, the month of November each year. Enrollment will begin the following January. Starting in 2002, this is the only time in which all Medicare Advantage health plans will be open and accepting new members.

See also: *Election periods.*

Appeal: A special kind of complaint made if an individual disagrees with any decision about his or her health care services. For example, an individual would file an appeal if Medicare doesn't pay or doesn't pay enough for a service received, a service not received, or an item or service the individual thinks he or she should receive. This complaint is made to the Medicare health plan or the Original Medicare Plan. There is usually a special process to make the complaint.

See also: *Appeal process.*

Appeal process: The process used if the individual disagrees with any decision about his or her health care services. If Medicare does not pay for an item or service given, or if the individual is not given an item or service he or she thinks he or she should get, the individual can have the initial Medicare decision reviewed again. If the individual is in the Original Medicare Plan, his or her appeal rights are on the back of the Explanation of Medicare Benefits (EOMB) or Medicare Summary Notice (MSN) that is mailed to him or her from a company that handles bills for Medicare. If the individual is in a Medicare managed care plan, he or she can file an appeal if his or her plan will not pay for, does not allow, or stops a service that he or she thinks should be covered or provided. The Medicare managed care plan must tell the individual in writing how to appeal. The

individual should refer to his or her plan's membership materials or contact the plan for details about Medicare appeal rights.

See also: *Organizational determination*.

Approved amount: The fee Medicare sets as reasonable for a covered medical service. This is the amount a doctor or supplier is paid by the individual and Medicare for a service or supply. It may be less than the actual amount charged by a doctor or supplier. The approved amount is sometimes called the "approved charge."

See also: *Actual charge; Assignment*.

Area Agency on Aging (AAA): State and local programs that help older people plan and care for their life-long needs. These needs include adult day care, skilled nursing care/therapy, transportation, personal care, respite care, and meals.

Assessment: The gathering of information to rate or evaluate the individual's health and needs, such as in a nursing home.

Assignment: In the Original Medicare Plan, a doctor agreeing to accept Medicare's fee as full payment. If the individual is in the Original Medicare Plan, it can save him or her money if the doctor accepts assignment. The individual still pays his or her share of the cost of the doctor's visit.

See also: *Actual charge; Approved amount; Coinsurance*.

Assisted living: A type of living arrangement in which personal care services such as meals, housekeeping, transportation, and assistance with activities of daily living are available as needed to people who still live on their own in a residential facility. In most cases, the "assisted living" residents pay a regular monthly rent. Then, they typically pay additional fees for the services they get.

Balance billing: A situation in which Private Fee-for-Service Plan providers (doctors or hospitals) can charge and bill 15 percent more than the plan's payment amount for services.

Basic benefits (Medigap policy): Benefits provided in Medigap Plan A. They are also included in all other standardized Medigap policies.

See also: *Medigap policy*.

Beneficiary: The name for a person who has health insurance through the Medicare or Medicaid program.

Benefit period: The way that Medicare measures use of hospital and skilled nursing facility services. A benefit period begins the day the individual goes to a hospital or skilled nursing facility. The benefit period ends when the individual hasn't received hospital or skilled nursing care for 60 days in a row. If the individual goes into the hospital after one benefit period has ended, a new benefit period begins. He or she must pay the inpatient hospital deductible for each benefit period. There is no limit to the number of benefit periods the individual can have.

See also: *Deductible; Skilled nursing facility*.

Benefits: The money or services provided by an insurance policy. In a health plan, benefits are the health care the individual gets.

Board and care home: A type of group living arrangement designed to meet the needs of people who cannot live on their own. These homes offer help with some personal care services.

Board-certified: This means a doctor has special training in a certain area of medicine and has passed an advanced exam in that area of medicine. Both primary care doctors and specialists may be board-certified.

Capitation: A specified amount of money paid to a health plan or doctor. This is used to cover the cost of a health plan member's health care services for a certain length of time.

Care plan: A written plan for the individual's care. It tells what services the individual will get to reach and keep his or her best physical, mental, and social well being.

Carrier: A private company that has a contract with Medicare to pay the individual's Medicare Part B bills.

See also: *Medicare Part B*.

Case management: A process used by a doctor, nurse, or other health professional to manage the individual's health care. Case managers make sure that the individual gets needed services, and track the individual's use of facilities and resources.

Case manager: A nurse, doctor, or social worker who arranges all services that are needed to give proper health care to a patient or group of patients.

Catastrophic illness: A very serious and costly health problem that could be life threatening or cause life-long disability. The cost of medical services alone for this type of serious condition could cause the individual financial hardship.

Catastrophic limit: The highest amount of money the individual has to pay out of pocket during a certain period of time for certain covered charges. Setting a maximum amount the individual will have to pay protects him or her.

Centers for Medicare and Medicaid Services (CMS): The federal agency that runs the Medicare program. In addition, CMS works with the states to run the Medicaid program. CMS works to make sure that the beneficiaries in these programs are able to get high-quality health care.

Certified (certification): State government agency-inspected health care providers, including home health agencies, hospitals, nursing homes, and dialysis facilities home health agencies, as well as other health care providers. These providers are certified if they pass inspection. Medicare or Medicaid only covers care provided by certified providers. Being certified is not the same as being accredited. Medicare or Medicaid only covers care in a certified facility or program.

Certified nursing assistant (CNA): Trained and certified to help nurses by providing nonmedical assistance to patients, such as help with eating, cleaning and dressing.

Certified registered nurse anesthetist: A nurse who is trained and licensed to give anesthesia. Anesthesia is given before and during surgery so a person does not feel pain.

See also: *Anesthesia*.

Civilian Health and Medical Program (CHAMPUS): See *Tricare*.

Claim: A request for payment for services and benefits received. Claims are also called bills for all Part A and Part B services billed through fiscal intermediaries. *Claim* is the word used for Part B physician/supplier services billed through the carrier.

See also: *Carrier; Fiscal intermediary; Medicare Part A; Medicare Part B.*

Clinical breast exam: An exam by the doctor/health care provider to check for breast cancer. This exam is not the same as a mammogram and is usually done in the doctor's office during the patient's pap test and pelvic exam.

Clinical practice guidelines: Reports written by experts who have carefully studied whether a treatment works and which patients are most likely to be helped by it.

Cognitive impairment: A 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 the individual has to pay after paying the deductible for Part A and/or Part B. In the Original Medicare Plan, the coinsurance payment is a percentage of the approved amount for the service (for example, 20 percent).

Coinsurance (assignment): The percentage of the Medicare-approved amount that the individual has to pay after paying 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 for Part B services).

See also: *Assignment; Deductible (Medicare); Original Medicare Plan; Medicare Part A; Medicare Part B.*

Coinsurance (Medicare Private Fee-for-Service Plan): The percentage of the Private Fee-for-Service Plan charge for services that the individual may have to pay after paying any plan deductibles. In a Private Fee-for-Service Plan, the coinsurance payment is a percentage of the cost of the service (for example, 20 percent).

Coinsurance (outpatient prospective payment system): The percentage of the Medicare payment rate or a hospital's billed charge that the individual has to pay after paying the deductible for Medicare Part B services.

Community mental health center: A place where Medicare patients can go to receive partial hospitalization services.

Complaint: See *Grievance.*

Comprehensive outpatient rehabilitation facility (CORF): A facility that provides a variety of services including physicians' services, physical therapy, social or psychological services, and outpatient rehabilitation.

Conditional payment: A payment made by Medicare in certain circumstances if the insurance company or other payer does not pay the bill within 120 days.

Confidentiality: The individual's right to talk with his or her health care provider without anyone else finding out what has been said.

Consolidated Omnibus Budget Reconciliation Act (COBRA): COBRA is a law that makes an employer let the individual remain covered under the employer's group health plan for a period of time after divorce, the death of a spouse, losing a job, or having work

hours reduced. The individual may have to pay both his or her share and the employer's share of the premium.

Consumer Assessment of Health Plans Study (CAHPS): An annual nationwide survey used to report information on Medicare beneficiaries' experiences with managed care plans. The results are shared with Medicare beneficiaries and the public.

Continuing care retirement community (CCRC): A housing community that provides different levels of care based on what each resident needs over time. This is sometimes called "life care" and can range from independent living in an apartment to assisted living to full-time care in a nursing home. Residents move from one setting to another based on their needs but continue to live as part of the community. Care in CCRCs is usually expensive. Generally, CCRCs require a large payment before a resident moves in and then charge monthly fees.

Coordination of benefits: Process for determining the respective responsibilities of two or more health plans that have some financial responsibility for a medical claim. Also called cross-over.

Coordination period: A period of time when the individual's employer group health plan will pay first on his or her health care bills and Medicare will pay second. If the employer group health plan doesn't pay 100 percent of the health care bills during the coordination period, Medicare may pay the remaining costs.

Copayment: In some Medicare health plans, the amount the individual pays for each medical service, such as a doctor's visit. A copayment is usually a set amount paid for a service. For example, this could be \$5 or \$10 for a doctor's visit. Copayments are also used for some hospital outpatient services in the Original Medicare Plan.

Cost sharing: The cost for medical care that the individual pays like a copayment, coinsurance, or deductible.

See also: *Coinsurance; Copayment; Deductible.*

Covered benefit: A health service or item included in the individual's health plan, and paid for either partially or fully.

Covered charges: Services or benefits for which a health plan makes either partial or full payment.

Creditable coverage: Any previous health insurance coverage that can be used to shorten the pre-existing condition waiting period.

See also: *Pre-existing Conditions.*

Critical access hospital: A small facility that gives limited outpatient and inpatient hospital services to people in rural areas.

Custodial care (home health): Nonskilled care, such as help with activities like grocery shopping, cleaning, and cooking. Medicare home health does not pay for custodial care.

See also: *Personal care.*

Deductible (Medicare): The amount the individual must pay for health care before Medicare begins to pay, either for each benefit period for Part A, or each year for Part B. These amounts can change every year.

See also: *Benefit period; Medicare Part A; Medicare Part B.*

Deductible (Medigap policy): The amount the individual must pay for health care, before Medicare or some Medigap policies begin to pay. Some Medicare deductibles can change every year.

See also: *Medigap policy*.

Deficiency (nursing home): A finding that a nursing home failed to meet one or more federal or state requirements.

Dehydration: A serious condition where the body's loss of fluid is more than the body's intake of fluid.

Diabetic durable medical equipment: Purchased or rented ambulatory items, such as glucose meters and insulin infusion pumps, prescribed by a health care provider for use in managing a patient's diabetes, as covered by Medicare.

Diagnosis: The name for the health problem the individual has.

Diagnosis-related groups: A way to pay hospitals for health care based on diagnosis, age, gender, and complications.

Diethylstilbestrol (DES): A drug given to pregnant women from the early 1940s until 1971 to help with common problems during pregnancy. The drug has been linked to cancer of the cervix or vagina in women whose mother took the drug while pregnant.

Discharge planning: A process used to decide what a patient needs for a smooth move from one level of care to another. This is done by a social worker or other health care professional. It includes moves 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: Ending the individual's health care coverage with a health plan.

Dual eligibles: Persons who are entitled to Medicare (Part A and/or Part B) and who are also eligible for Medicaid.

Durable medical equipment (DME): Medical equipment 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 and Part A for home health services.

Durable medical equipment regional carrier (DMERC): A private company that contracts with Medicare to pay bills for durable medical equipment.

Elder law: The group of laws about rights and issues of the health, finances, and well-being of the elderly.

Eldercare: Public, private, formal, and informal programs and support systems, government laws, and finding ways to meet the needs of the elderly, including housing, home care, pensions, Social Security, long-term care, health insurance, and elder law.

Election: The individual's decision to join or leave the Original Medicare Plan or a Medicare Advantage plan.

Election periods: Time when an eligible person may choose to join or leave the Original Medicare Plan or a Medicare Advantage plan. There are four types of election periods in which the individual may join and leave Medicare health plans: annual election period, initial coverage election period, special election period, and open enrollment period.

See also: *Annual election period; Initial coverage election period; Special election period; Open enrollment period.*

Eligibility/Medicare Part A: Eligibility for premium-free (no cost) Medicare Part A (Hospital Insurance). The individual is eligible if:

- He or she is 65 or older and receiving, or is eligible for, retirement benefits from Social Security or the Railroad Retirement Board, or
- He or she is under 65 and has received Railroad Retirement disability benefits for the prescribed time and meets the Social Security Act disability requirements, or
- He or she and his or her spouse had Medicare-covered government employment, or
- He or she is under 65 and has End-Stage Renal Disease (ESRD).

If the individual is not eligible for premium-free Medicare Part A, he or she can buy Part A by paying a monthly premium if:

- He or she is age 65 or older, and
- He or she is enrolled in Part B, and
- He or she is a resident of the United States, and is either a citizen or an alien lawfully admitted for permanent residence who has lived in the United States continuously during the five years immediately before the month in which he or she applies.

Eligibility/Medicare Part B: Automatic if the individual is eligible for premium-free Part A. The individual is also eligible for Part B if he or she is not eligible for premium-free Part A, but is age 65 or older and a resident of the United States or a citizen or an alien lawfully admitted for permanent residence. In this case, the individual must have lived in the United States continuously during the five years immediately before the month during which he or she enrolls in Part B.

Emergency care: Care given for a medical emergency when the individual believes that his or her health is in serious danger when every second counts.

Employer group health plan (GHP): A health plan that:

- Gives health coverage to employees, former employees, and their families, and
- Is from an employer or employee organization.

End-stage renal disease (ESRD): Kidney failure that is severe enough to need lifetime dialysis or a kidney transplant.

Enroll: To join a health plan.

Enrollment period: A certain period of time when the individual can join a Medicare health plan if it is open and accepting new Medicare members. If a health plan chooses to be open, it must allow all eligible people with Medicare to join.

Enrollment/Part A: Periods during which the individual can enroll in premium Part A. There are four in total.

See also: *Initial enrollment period; General enrollment period; Special enrollment period.*

Episode of care: The health care services given during a certain period of time, usually during a hospital stay.

Evidence: Signs that something is true or not true. Doctors can use published studies as evidence that a treatment works or does not work.

Excess charges: The difference between a doctor's or other health care provider's actual charge (which may be limited by Medicare or the state) and the Medicare-approved payment amount.

See also: *Actual charge; Approved amount; Medigap policy.*

Exclusions (Medicare): Items or services that Medicare does not cover, such as most prescription drugs, long-term care, and custodial care in a nursing or private home.

Expedited appeal: A Medicare Advantage organization's second look at whether it will provide a health service. A beneficiary may receive a fast decision within 72 hours when life, health, or ability to regain function may be jeopardized.

Expedited organization determination: A fast decision from the Medicare Advantage organization about whether it will provide a health service. A beneficiary may receive a fast decision within 72 hours when life, health, or ability to regain function may be jeopardized.

Explanation of Medicare benefits (EOMB): A notice that is sent to the individual after the doctor files a claim for Part B services under the Original Medicare Plan. This notice explains what the provider billed for, the Medicare-approved amount, how much Medicare paid, and what the individual must pay. This is being replaced by the Medicare Summary Notice (MSN), which sums up all the services (Parts A and B) that were given 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 give low cost health care. Medicare pays for some health services in FQHCs that are not usually covered, like 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 health plans to pay doctors or other providers.

Fiscal intermediary: A private company that has a contract with Medicare to pay Part A and some Part B bills; also called "intermediary."

Fiscal year: For Medicare, a year-long period that 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 health 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 produced. *Abuse:* Payment for items or services that are billed by mistake by providers, but should not be paid for by Medicare. This is not the same as fraud.

Free look (Medigap policy): A period of time (usually 30 days) when the individual can try out a Medigap policy. During this time, if the individual changes his or her mind about keeping the policy, it can be cancelled. If the individual cancels, he or she will get his or her money back.

Freedom of Information Act (FOIA): A 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.

Gaps: The costs or services that are not covered under the Original Medicare Plan.

Gatekeeper: In a managed care plan, this is another name for the primary care doctor. This doctor gives the individual basic medical services and coordinates proper medical care and referrals.

General enrollment period (GEP): The GEP is January 1 through March 31 of each year. If the individual enrolls in Part B or Part A (if the individual doesn't get it automatically without paying a premium) during the GEP, coverage starts on July 1.

See also: *Enrollment.*

Gerontology: The study of, and learning about, older people and the process of aging.

Grievance: A complaint about the way a Medicare health plan is giving care. For example, the individual may file a grievance if he or she has a problem with the cleanliness of the health care facility, problems calling the plan, staff behavior, or operating hours. A grievance is not the way to deal with a complaint about a treatment decision or a service that is not covered.

Group health plan: A health plan that provides health coverage to employees, former employees, and their families, and is supported by an employer or employee organization.

Group or network HMO: A health plan that contracts with group practices of doctors to give services in one or more places.

Guaranteed issue rights: Also called "Medigap protections," rights the individual has in certain situations when insurance companies are required by law to sell or offer a Medigap policy. In these situations, an insurance company cannot deny the individual insurance coverage or place conditions on a policy, must cover the individual for all pre-existing conditions, and cannot charge the individual more for a policy because of past or present health problems.

Guaranteed renewable: A right the individual has that requires his or her insurance company to allow him or her to automatically renew or continue a Medigap policy, unless the individual commits fraud or does not pay his or her premiums.

Health Care Financing Administration (HCFA): Former name of the government agency now called the Centers for Medicare and Medicaid Services.

Health care provider: A person who is trained and licensed to give health care. Also, a place licensed to give health care. Doctors, nurses, hospitals, skilled nursing facilities, some assisted living facilities, and certain kinds of home health agencies are examples of health care providers.

Health employer data and information set (HEDIS): A set of standard performance measures that can give the individual information about the quality of a health plan. The individual can find out about the quality of care, access, cost, and other measures to

compare managed care plans. The Centers for Medicare and Medicaid Services (CMS) collects HEDIS data for Medicare plans.

See also: *Centers for Medicare and Medicaid Services*.

Health Insurance Portability and Accountability Act (HIPAA): A law passed in 1996 that is also sometimes called the “Kassebaum-Kennedy” law. This law expands the individual’s health care coverage if he or she has lost a job or moves from one job to another. HIPAA protects the individual and his or her family if he or she has pre-existing medical conditions, and/or problems getting health coverage, and the individual thinks it is based on past or present health.

Home health agency: An organization that gives home care services, like skilled nursing care, physical therapy, occupational therapy, speech therapy, and care by home health aides.

Home health care: Skilled nursing care and certain other health care the individual gets in his or her home for the treatment of an illness or injury.

See also: *Activities of daily living*.

Homebound: Normally unable to leave home. Leaving home takes considerable and taxing effort. A person may leave home for medical treatment or short, infrequent absences for nonmedical reasons, such as a trip to the barber or to attend religious services. A need for adult day care does not keep the individual from getting home health care for other medical conditions.

Hospice: Hospice is a special way of caring for people who are terminally ill, and for their family. This care includes physical care and counseling. Hospice care is covered under Medicare Part A (Hospital Insurance).

Hospital Insurance (Part A): The part of Medicare that pays for inpatient hospital stays, care in a skilled nursing facility, hospice care, and some home health care.

Hospitalist: A doctor who primarily takes care of patients when they are in the hospital. This doctor will take over the individual’s care from his or her primary doctor when he or she is in the hospital, keep the individual’s primary doctor informed about his or her progress, and will return the individual to the care of his or her primary doctor when he or she leaves the hospital.

Hydration: The level of fluid in the body.

Information, Counseling, and Assistance Program: See *State Health Insurance Assistance Program*.

Initial coverage election period: The three months immediately before the individual is entitled to Medicare Part A and enrolled in Part B. The individual may choose a Medicare health plan during his or her initial coverage election period. The plan must accept the individual unless it has reached its limit in the number of members. This limit is approved by the Centers for Medicare and Medicaid Services. The initial coverage election period is different from the initial enrollment period.

See also: *Election periods; Enrollment/Part A; Initial enrollment period*.

Initial enrollment period (IEP): The first chance the individual has to enroll in Part B or Part A (if the individual does not receive it automatically without paying a premium). The IEP starts three months before the individual first meets all the eligibility requirements

for Medicare and continues for seven months. The IEP is different from the initial coverage election period.

See also: *Enrollment/Part A; Election periods; Initial coverage election period.*

Initial enrollment questionnaire (IEQ): A questionnaire sent to the individual when the individual becomes eligible for Medicare to find out if the individual has other insurance that should pay the individual's medical bills before Medicare.

Inpatient care: Health care that the individual gets when he or she is admitted to a hospital.

Insolvency: When a health plan has no 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.

See also: *Fiscal intermediary.*

Internist: A doctor who finds and treats health problems in adults.

Large group health plan: A group health plan that covers employees of either an employer or employee organization that has 100 or more employees.

Liability insurance: Liability insurance is insurance that protects against claims based on negligence or inappropriate action or inaction, which results in bodily injury or damage to property.

Licensed (licensure): A long-term care facility that has met certain standards set by a state or local government agency.

Lifetime reserve days (Medicare): Sixty days that Medicare will pay for when the individual is in a hospital for more than 90 days. These 60 reserve days can be used only once during the individual's lifetime. For each lifetime reserve day, Medicare pays all covered costs except for a daily coinsurance (\$438 in 2004).

Limiting charge: The highest amount of money the individual can be charged for a covered service by doctors and other health care providers who don't accept assignment. The limit is 15 percent over Medicare's approved amount. The limiting charge only applies to certain services and does not apply to supplies or equipment.

See also: *Approved amount; Assignment.*

Long-term care: A "variety" of services that help people with health or personal needs and activities of daily living over a period of time. Long-term care can be provided at home, in the community, or in various types of facilities, including nursing homes and assisted living facilities. Most long-term care is custodial care. Medicare does not pay for this type of care.

Long-term care insurance: A private insurance policy to help pay for some long-term medical and nonmedical care, like help with activities of daily living. Because Medicare generally does not pay for long-term care, this type of insurance policy may help provide coverage for long-term care that you may need in the future. Some long-term care insurance policies offer tax benefits; these are called tax-qualified policies.

Long-term care ombudsman: An independent advocate (supporter) for nursing home and assisted living facility residents who works to solve problems between residents and nursing homes or assisted living facilities.

Malnutrition: A health problem caused by the lack (or too much) of needed nutrients.

Mammogram: A special x-ray of the breasts. Medicare covers the cost of a mammogram once every 12 months for women over 40 who are enrolled in Medicare.

Managed care plan with a point of service option (POS): A managed care plan that lets the individual use doctors and hospitals outside the plan for an additional cost.

See also: *Medicare managed care plan.*

Mediate: To settle differences between two parties.

Medicaid: A joint federal and state program that helps with medical costs for some people with low incomes and limited resources. Medicaid programs vary from state to state, but most health care costs are covered if the individual qualifies for both Medicare and Medicaid.

Medical Insurance (Part B): The part of Medicare that covers doctors' services and outpatient hospital care. It also covers other medical services that Part A does not cover, such as physical and occupational therapy.

See also: *Medicare Part B.*

Medical underwriting: The process that an insurance company uses to decide whether or not to take the individual's application for insurance, whether or not to add a waiting period for pre-existing conditions (if the individual's state law allows it), and how much to charge the individual for that insurance.

Medically necessary: Services or supplies that are proper and needed for the diagnosis or treatment of the individual's medical condition; are provided for the diagnosis, direct care, and treatment of the individual's medical condition; meet the standards of good medical practice in the local area; and are not mainly for the convenience of the individual or the individual's doctor.

Medicare: The federal health insurance program for people 65 years of age or older, certain younger people with disabilities, and people with End-Stage Renal Disease (permanent kidney failure with dialysis or a transplant, sometimes called ESRD).

Medicare benefits notice: A notice the individual gets after his or her doctor files a claim for Part A services in the Original Medicare Plan. It says what the provider billed for, the Medicare-approved amount, how much Medicare paid, and what the individual must pay. The individual 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 pay Part B bills.

Medicare coverage: Made up of two parts: Hospital Insurance (Part A) and Medical Insurance (Part B).

See also: *Medicare Part A (Hospital Insurance); Medicare Part B (Medical Insurance).*

Medicare managed care plan: These are health care choices (like HMOs) in some areas of the country. In most plans, the individual can only go to doctors, specialists, or hospitals on the plan's list. Plans must cover all Medicare Part A and Part B health care. Some plans cover extras, like prescription drugs. The individual's costs may be lower than in the Original Medicare Plan.

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 the individual pay medical bills.

Medicare Part A (hospital insurance): Hospital insurance that pays for inpatient hospital stays, care in a skilled nursing facility, hospice care and some home health care.

See also: *Hospital Insurance (Part A)*.

Medicare Part B (medical insurance): Medical insurance that helps pay for doctors' services, outpatient hospital care, and other medical services not covered by Part A.

See also: *Medical Insurance (Part B)*.

Medicare premium collection center (MPCC): The contractor that handles all Medicare direct billing payments for direct billed beneficiaries. MPCC is located in Pittsburgh, Pennsylvania.

Medicare Private Fee-for-Service plan: A private insurance plan that accepts people with Medicare. The individual may go to any Medicare-approved doctor or hospital that accepts the plan's payment. The insurance plan, rather than the Medicare program, decides how much it will pay and what the individual will pay for the services he or she gets. The individual may pay more for Medicare-covered benefits. The individual may have extra benefits the Original Medicare Plan does not cover.

Medicare savings program: Medicaid programs that help pay some or all Medicare premiums and deductibles.

Medicare select: A type of Medigap policy that may require the individual to use hospitals and, in some cases, doctors within its network to be eligible for full benefits.

Medicare Summary Notice (MSN): A notice the individual gets after the doctor files a claim for Part A and Part B services in the Original Medicare Plan. It explains what the provider billed for, the Medicare-approved amount, how much Medicare paid, and what the individual must pay. The individual might also get a notice called an Explanation of Medicare Benefits (EOMB) for Part B services or a notice of utilization.

See also: *Explanation of Medicare Benefits; Medicare Benefits Notice*.

Medicare supplement insurance: Medicare supplement insurance is a Medigap policy. It is sold by private insurance companies to fill "gaps" in Original Medicare Plan coverage. Except in Minnesota, Massachusetts, and Wisconsin, there are 10 standardized policies, labeled Plan A through Plan J. Medigap policies work only with the Original Medicare Plan.

See also: *Gaps; Medigap Policy*.

Medicare Advantage: A Medicare program that gives only more choices among health plans. Everyone who has Medicare Parts A and B is eligible, except those who have End-Stage Renal Disease.

Medicare Advantage plan: A health plan, such as a Medicare managed care plan or private fee-for-service plan offered by a private company and approved by Medicare. It is an alternative to the Original Medicare Plan.

Medicare-approved amount: The fee Medicare sets as reasonable for a covered medical service. This is the amount a doctor or supplier is paid by the individual and Medicare for a service or supply. It may be less than the actual amount charged by a doctor or supplier. The approved amount is sometimes called the approved charge.

Medigap policy: A Medicare supplement insurance policy sold by private insurance companies to fill “gaps” in Original Medicare Plan coverage. Except in Massachusetts, Minnesota, and Wisconsin, there are 10 standardized plans, labeled Plan A through Plan J. Medigap policies work only with the Original Medicare Plan.

See also: *Gaps*.

Multiemployer group health plan: A group health plan that is sponsored jointly by two or more employers or by employers and employee organizations.

National Committee for Quality Assurance (NCQA): A nonprofit organization that accredits and measures the quality of care in Medicare health plans. NCQA does this by using the Health Employer Data and Information Set (HEDIS) data reporting system.

See also: *Health Employer Data and Information Set (HEDIS)*.

National median charge: The exact middle amount of the amounts charged for the same service. This means that half of the hospitals and community mental health centers charged more than this amount and the other half charged less than this amount for the same service.

Neglect: When care givers do not give a person they care for the goods or services needed to avoid harm or illness.

Network: A group of doctors, hospitals, pharmacies, and other health care experts hired by a health plan to take care of its members.

No-fault insurance: Insurance that pays for health care services resulting from bodily injury or damage to the individual's property regardless of who is at fault for causing the accident.

Nonparticipating physician: A doctor or supplier who does not accept assignment on all Medicare claims.

See also: *Assignment*.

Notice of Medicare benefits: A notice the individual receives to show what action was taken on a claim.

See also: *Explanation of Medicare Benefits; Medicare Benefits Notice; Medicare Summary Notice*.

Notice of Medicare premium payment due (HCFA 500): The billing notice sent to Medicare beneficiaries who must pay their Medicare premium directly. Notices are sent either monthly or quarterly.

Nurse practitioner (NP): A nurse who has two or more years of advanced training and has passed a special exam. A nurse practitioner often works with a doctor and can do some of the things a doctor does.

Nursing home: A residence that provides a room, meals, and help with activities of daily living and recreation. Generally, nursing home residents have physical or mental problems that keep them from living on their own. They usually require daily assistance.

Nutrition: Getting enough of the foods with vitamins and minerals a body needs to stay healthy. Malnutrition, or the lack of proper nutrition, can be a serious problem for older people.

Occupational therapy: Services given to help the individual return to usual activities (such as bathing, preparing meals, housekeeping) after illness either on an inpatient or outpatient basis.

Ombudsman: An advocate (supporter) who works to solve problems between residents and nursing homes, as well as assisted living facilities. Also called long-term care ombudsman.

Open enrollment period (Medigap policy): A one-time-only six-month period when the individual can buy any Medigap policy he or she wants that is sold in his or her state. It starts when the individual signs up for Medicare Part B and is age 65 or older. The individual cannot be denied coverage or charged more due to present or past health problems during this time period.

Open enrollment periods: A certain period of time when the individual can join a Medicare health plan. The plan must be open and accepting new members. If a health plan chooses to be open, it must allow all eligible beneficiaries to join.

See also: *Election periods.*

Organizational determination: A health plan's decision on whether to pay all or part of a bill, or to give medical services, after the individual files an appeal. If the decision is not in the individual's favor, the plan must give the individual a written notice. This notice must give a reason for the denial and a description of steps in the appeals process.

See also: *Appeal process.*

Original Medicare Plan: A pay-per-visit health plan that lets the individual go to any doctor, hospital, or other health care provider that accepts Medicare. The individual must pay the deductible. Medicare pays its share of the Medicare-approved amount, and the individual pays his or her share (coinsurance). The Original Medicare Plan has two parts: Part A (hospital insurance) and Part B (medical insurance).

See also: *Deductible (Medicare); Approved amount; Coinsurance; Medicare Part A; Medicare Part B.*

Out-of-pocket costs: Health care costs that the individual must pay on his or her own because he or she is not covered by Medicare or other insurance.

Outpatient care: Medical or surgical care that does not include an overnight hospital stay.

Outpatient hospital services (Medicare): Medicare or surgical care that Medicare Part B helps pay for and does not include an overnight hospital stay, including:

- Blood transfusions
- Certain drugs
- Hospital billed laboratory tests
- Mental health care

- Medical supplies such as splints and casts
- Emergency room or outpatient clinic, including same day surgery
- X-rays and other radiation services

Outpatient prospective payment system: The way that Medicare will pay for most outpatient services at hospitals or community mental health centers under Medicare Part B.

Outpatient services: A service the individual gets in one day (24 hours) at a hospital outpatient department or community mental health center.

Pap test: A test to check for cancer of the cervix, the opening to a woman's womb. It is done by removing cells from the cervix. The cells are then prepared so they can be seen under a microscope.

Part A (Medicare): Hospital insurance that pays for inpatient hospital stays, care in a skilled nursing facility, hospice care, and some home health care.

See also: *Hospital insurance (Part A)*.

Part B (Medicare): Medicare medical insurance that helps pay for doctors' services, outpatient hospital care, durable medical equipment, and some medical services not covered by Part A.

See also: *Medicare Part B (medical insurance)*.

Partial hospitalization (mental health): A structured program of active treatment for psychiatric care that is more intense than the care the individual gets in his or her doctor's or therapist's office.

Participating physician or supplier: A doctor or supplier who agrees to accept assignment on all Medicare claims. These doctors or suppliers may bill the individual only for Medicare deductible and/or coinsurance amounts.

See also: *Assignment*.

Patient advocate: A person whose job is to speak on a patient's behalf and help patients get any information or services they need.

Payment rate: The total payment that a hospital or community mental health center gets when they give outpatient services to Medicare patients.

Peer review organization (PRO): Former name for quality improvement organizations (QIOs).

Pelvic exam: An exam to check if internal female organs are normal by feeling their shape and size.

Periods of care (hospice): A set period of time during which the individual can get hospice care after his or her doctor says that the individual is eligible and still needs hospice care.

Personal care: Nonskilled, personal care, such as help with activities of daily living like bathing, dressing, eating, getting in and out of bed or chair, moving around, and using the bathroom. It may also include care that most people do themselves, like using eye drops. The Medicare home health benefit does pay for personal care services.

Physical therapy: Treatment of injury and disease by mechanical means, such as heat, light, exercise, and massage.

Physician assistant (PA): A person who has two or more years of advanced training and has passed a special exam. A physician assistant works with a doctor and can do some of the things a doctor does.

Physician services: Services provided by an individual licensed under state law to practice medicine or osteopathy. Physician services given while in the hospital that appear on the hospital bill are not included.

Plan of care: The individual's doctor's written plan saying what kind of services and care the individual needs for his or her health problem.

Pre-existing condition (Medigap policy): A health problem the individual had before the date a new insurance policy starts.

Preferred provider organization (PPO): A managed care in which the individual uses doctors, hospitals, and providers that belong to the network. The individual can use doctors, hospitals, and providers outside of the network for an additional cost.

Premium: The periodic payment to Medicare, an insurance company, or a health care plan for health care coverage.

Preventive care: Care to keep the individual healthy or to prevent illness, such as colorectal cancer screening, yearly mammograms, and flu shots.

Preventive services: Health care to keep the individual healthy or to prevent illness. For example, Pap tests, pelvic exams, 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 doctor who is trained to give the individual basic care. The individual's primary care doctor is the doctor the individual sees first for most health problems. The doctor makes sure the individual gets the care he or she needs to keep healthy. The doctor also may talk with other doctors and health care providers about the individual's care and refer the individual to them. In many Medicare managed care plans, the individual must see his or her primary care doctor before the individual sees any other health care provider.

Primary payer: An insurance policy, plan, or program that pays first on a claim for medical care. This could be Medicare or other health insurance.

Private contract: A contract between the individual and a doctor who has decided not to offer services through the Medicare program. This doctor cannot bill Medicare for any services or supplies given to the individual and other Medicare patients for at least two years. There are no limits on what the individual can be charged for services under a private contract. The individual must pay the full amount of the bill.

Procedure: Something done to fix a health problem or to learn more about it. For example, surgery, tests, and putting in an IV (intravenous line) are procedures.

Programs of all-inclusive care for the elderly (PACE): Medical, social, and long-term care services combined for frail people. PACE is available only in states that have chosen to offer it under Medicaid. To be eligible, the individual must:

- Be 55 years old, or older
- Live in the service area of the PACE program
- Be certified as eligible for nursing home care by the appropriate state agency
- Be able to live safely in the community

The goal of PACE is to help people stay independent and live in their community as long as possible, while getting the high-quality care they need.

Pros and cons: The good and bad parts of treatment for a health problem. For example, a medicine may help the individual's pain (pro), but it may cause an upset stomach (con).

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 that agree to give health care to Medicare beneficiaries for a set amount of money from Medicare every month. This type of managed care plan is run by the doctors and providers themselves, and not by an insurance company.

See also: *Managed care plan.*

Qualified Medicare beneficiary (QMB): A Medicaid program for beneficiaries who need help in paying for Medicare services. The beneficiary must have Medicare Part A and limited income and resources. For those who qualify, the Medicaid program pays Medicare Part A premiums, Part B premiums, and Medicare deductibles and coinsurance amounts for Medicare services.

Qualifying individuals (1) (QI-1s): A Medicaid program for beneficiaries who need help in paying for Medicare Part B premiums. The beneficiary must have Medicare Part A and limited income and resources and not be otherwise eligible for Medicaid. For those who qualify, the Medicaid program pays full Medicare Part B premiums only.

Qualifying individuals (2) (QI-2s): A Medicaid program for beneficiaries who need help in paying for Medicare Part B premiums. The beneficiary must have Medicare Part A and limited income and resources and not be otherwise eligible for Medicaid. For those who qualify, Medicaid pays a percentage of Medicare Part B premiums only.

Quality: How well the health plan keeps its members healthy or treats them when they are sick. Good quality health care means doing the right thing at the right time, in the right way, for the right person and getting the best possible results.

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 then checking to see if what was done worked.

Quality improvement organizations (QIOs): Groups of practicing doctors and other health care experts. They are paid by the federal government to check and improve the care given to Medicare patients. They must review the individual's complaints about the quality of care given by inpatient hospitals, hospital outpatient departments, hospital emergency rooms, skilled nursing facilities, home health agencies, private fee-for-service plans, and ambulatory surgical centers.

Referral: Approval from the individual's primary care doctor for the individual to see a specialist or get certain services. In many Medicare managed care plans, the individual needs to get a referral before he or she gets care from anyone except the primary care doctor. If the individual does not get a referral first, the plan may not pay for his or her care.

See also: *Emergency care; Primary care doctor; Urgently needed care.*

Regional home health intermediary (RHHI): A private company that contracts with Medicare to pay home health bills and check on the quality of home health care.

Reserve days: See *Lifetime reserve days.*

Respite care: Temporary or periodic care provided in a nursing home, assisted living residence, or other type of long-term care program so the usual caregiver can rest or take some time off.

Restraint: Any physical or chemical way to stop a patient from being free to move. These are used to prevent patient injury and are not used for treating medical symptoms.

Risk adjustment: The way that payments to health plans are changed to take into account a person's health status.

Second opinion: When another doctor gives his or her view about what the individual has and how it should be treated.

Secondary payer: An insurance policy, plan, or program that pays second on a claim for medical care. This could be Medicare, Medicaid, or other health insurance depending on the situation.

Service area: The area where a health plan accepts members. For plans that require the individual to use their doctors and hospitals, it is also the area where services are provided. The plan may disenroll the individual if he or she moves out of the plan's service area.

Service area (private fee-for-service): The area where a Medicare private fee-for-service plan accepts members.

Side effect: A problem caused by treatment. For example, medicine the individual takes for high blood pressure may make him or her feel sleepy. Most treatments have side effects.

Skilled care: A type of health care given when the individual needs skilled nursing or rehabilitation staff to manage, observe, and evaluate his or her care.

Skilled nursing care: A level of care that must be given or supervised by registered nurses. All the individual's needs are taken care of with this type of service. Examples of skilled nursing care are getting intravenous injections, tube feeding, oxygen to help the individual breathe, and changing sterile dressings on a wound. Any service that could be safely done by an average nonmedical person (or one's self) without the supervision of a registered nurse is not considered skilled care.

Skilled nursing facility (SNF): A nursing facility with the staff and equipment to give skilled nursing care and/or skilled rehabilitation services and other related health services.

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; homemaker, personal care services, and medical transportation; eyeglasses, hearing aids, and dental benefits.

Special election period: A set time that a beneficiary can change health plans or return to the Original Medicare Plan, such as the following: the individual moves outside the service area, the individual's organization violates its contract with him or her, the organization does not renew its contract with CMS, or other exceptional conditions determined by CMS. The special election period is different from the special enrollment period (SEP).

See also: *Election periods; Enrollment; Special enrollment period (SEP).*

Special enrollment period (SEP): A set time when the individual can sign up for Medicare Part B if he or she did not take Part B during the initial enrollment period, because the individual or his or her spouse currently work and have group health plan coverage through the employer or union. The individual can sign up at any time he or she is covered under the group plan. If the employment or group health coverage ends, the individual has 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 SEP is different from the special election period.

See also: *Enrollment; Election periods; Special election period.*

Specialist: A doctor who treats only certain parts of the body, certain health problems, or certain age groups. For example, some doctors treat only heart problems.

Specified low-income Medicare beneficiaries (SLMB): A Medicaid program that pays for Medicare Part B premiums for individuals who have Medicare Part A, a low monthly income, and limited resources.

State Health Insurance Assistance Program (SHIP): A state program that gets money from the federal government to give free health insurance counseling and assistance to people with Medicare.

State insurance department: A state agency that regulates insurance and can provide information about Medigap policies and any insurance-related problem.

State medical assistance office: A state agency that is in charge of the state's Medicaid program and can provide information about programs to help pay medical bills for people with low incomes. Also provides help with prescription drug coverage.

Subsidized senior housing: A type of program, available through the Federal Department of Housing and Urban Development and some states, to help people with low or moderate incomes pay for housing.

Supplier: Generally, any company, person, or agency that gives the individual a medical item or service, such as a wheelchair or walker.

Telemedicine: The use of medical information exchanged from one site to another using electronic communications for the health and education of patients or providers and to improve patient care.

Treatment: Something done to help with a health problem. For example, medicine and surgery are treatments.

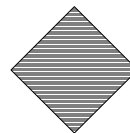
Treatment options: The choices the individual has when there is more than one way to treat his or her health problem.

Tricare: The health care program for active duty members of the military, military retirees, and their eligible dependents. Tricare was called Champus in the past.

Urgently needed care: Care that the individual gets for a sudden illness or injury that needs medical care right away, but is not life threatening. The individual's primary care doctor generally provides urgently needed care if the individual is in a Medicare health plan other than the Original Medicare Plan. If the individual is out of his or her plan's service area for a short time and cannot wait until he or she returns home, the health plan must pay for urgently needed care.

Waiting period: The time between when the individual signs up with a Medigap insurance company or Medicare health plan and when the coverage starts.

Workers' Compensation: Insurance that employers are required to have to cover employees who get sick or injured on the job.



CHAPTER 8:

Hearth and Home Alternatives

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. Now more than ever, older adults have an increasing number of living options available. This chapter addresses those options.

In addition, older adults may also develop health conditions that require special attention that may not be available outside of various facilities staffed by health care professionals. Myriad resources are available to help the older client and practitioner determine what level of care may be needed, what finances must be made available, and who may be best qualified to provide the care. This chapter gives detailed information about the housing alternatives available for all needs.

HOUSING OPTIONS

The discussion that follows describes housing options available to older adults.

Independent Living Communities

Independent communities cater to seniors who are very independent and have few medical problems. Residents live in fully equipped private apartments. A variety of apartment sizes may be available, from studios to large two bedrooms. Fine dining services are offered with custom-designed meal packages. Often, residents can choose to pay for a specified number of meals per day. Frequently, there are numerous social outings and events to choose from for entertainment.

Also known as: Independent communities; congregate care; independent living

Payment sources: Mostly private pay; some government funded through Section 202

Price range: \$1,300–\$2,500 per month

Assisted Living Facilities

Assisted living communities are designed for seniors who are no longer able to live on their own safely, but do not require the high level of care provided in a nursing home. Assistance with medications, activities of daily living, meals, and housekeeping are routinely provided. Three meals per day are provided in a central dining room. Residents live in their own private apartments, which frequently have a limited kitchen area. Staff are usually available 24 hours per day for additional safety. Most assisted living communities provide licensed nursing services; hours can vary greatly. Social activities and scheduled transportation are also available in most communities. A special unit for Alzheimer's residents may be available in some, but not all, communities.

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, ALFs may be considered. Instead of nursing home shared rooms, seniors live in private homes with their own bedroom, or in apartments with 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 ALFs varies 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. 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 before 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, the resident 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 because approximately 75 percent of assisted living residents eventually leave because they need a higher level of care.

Also known as: Assisted care community

Payment sources: Mostly private pay; some take Medicaid.

Price range: \$1,800–\$3,500 per month, depending on the size of apartment and level of assistance required; Alzheimer’s care is \$2,800–\$3,800 per month for a shared suite.

The Consumer Consortium on Assisted Living

The Consumer Consortium on Assisted Living (CCAL) is the only national consumer education and advocacy organization focused solely on the needs, rights, and protection of assisted living consumers and their loved ones. CCAL educates consumers, professionals, and the general public about assisted living issues and works collaboratively with a broad spectrum of people and organizations supporting quality assisted living and options for individuals with low incomes. For more information call (703) 533-8121 or visit <http://www.ccal.org>.

Nursing Homes

Nursing homes provide round-the-clock skilled nursing care for the frail elderly who require a high level of medical care and assistance. Twenty-four-hour skilled nursing services are available from licensed nurses. Many nursing homes now provide short-term rehabilitative stays for those recovering from an injury or illness. Longer-term residents generally have high care needs and complex medical conditions that require routine skilled nursing services. Residents typically share a room and are served meals in a central dining area unless they are too ill to participate. Activities are also available. Some facilities have a separate unit for Alzheimer’s residents.

Also known as: Convalescent care; nursing center; long-term care facility

Payment sources: Private; Medicare; Medicaid

Price range: \$3,000–\$6,000 per month

Nursing Home Compare

The nursing homes previously described provide skilled nursing care, however, many other types of facilities provide various levels of health care and assistance with activities of daily living. The Medicare Web site offers a tool called Nursing Home Compare that allows you to compare information on nursing homes that are Medicare and Medicaid certified. Many other facilities are licensed only at the state level. In addition, some nursing homes that provide a full range of care, including skilled nursing services, choose not to participate in Medicare or Medicaid. See Table 8.1 for contact information by state.

Personal Care Homes

Personal care homes are private homes that typically have a small number of residents who live together and receive care from live-in caretakers. Adult family homes offer room and board for seniors who want a more private, home-like community. Assistance with activities of daily living such as bathing and dressing are usually provided. Amenities and nursing services vary greatly between homes.

Also known as: Board and care homes; group homes; adult foster care

Payment sources: Private pay; Medicaid in some instances

Price range: \$1,500–\$3,000 per month depending on the services and level of care provided.

Respite Care

Respite care provides a temporary break for caregivers by allowing residents to have a short-term stay in a community that can meet their needs. Many assisted living communities and nursing homes have a respite care program. Residents typically stay from a week to a month, depending on the situation. They will receive all the services of the community. Many residents find that they enjoy their stay and decide to move in soon after the short-term visit. Respite programs are available for assisted living and Alzheimer's residents.

Also known as: Short-term stay programs

Payment sources: Private pay; Medicaid

Price range: \$75–\$150 per day

Other Living Arrangements for Older Adults

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 at least 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 home 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.

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 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 ask what the process is 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; call (202) 783-7286 or go to <http://www.ccaonline.org/>. 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.

If a client or family has decided that a CCRC is the best option, it is best for them to visit a few facilities. Here is a checklist of things for them to keep in mind and questions to consider when visiting selected facilities. The client or family should:

- Find out what kinds of services the facility offers and which ones are included at no extra cost. Sometimes, extra services are available for additional fees.
- Ask about what kinds of contracts are available to the consumer. The CCRC contract is a legal agreement between the consumer and a continuing care retirement community. This agreement generally secures living accommodations and services, including health care services, over the long term. The three most common types of CCRC agreements are:
 - *Extensive contract.* This offers unlimited long-term nursing care for little or no substantial increase in usual monthly payments.

- *Modified contract.* This includes a specified amount of long-term nursing care beyond which the resident is responsible for payment.
- *Fee-for-service.* The resident pays full daily rates for all long-term nursing care required.
- Determine what fee structure and contract option best suits the client’s personal circumstances.
- Find out if the CCRC is subject to licensure. The client or family should ask to see the most recent inspection reports.
- Find out what the payment schedule is. Also, they should find out if the residents own or rent their living space.
- Find out if the CCRC is accredited by the Continuing Care Accreditation Commission, the only accrediting body for CCRCs.
- Before signing a contract, the client or family should have their accountant or lawyer review the contract.

Note: Accreditation represents a certification by a private-sector organization (such as the Joint Commission on the Accreditation of Healthcare Organizations) that a facility meets certain standards it has established. Accreditation is voluntary for hospitals, nursing homes, and other health care providers and facilities. Accreditation does not affect the home or facility’s eligibility to act as a Medicare or Medicaid care provider.

Resources: Organizations and Associations

The following organizations can provide practitioners, clients, and families with additional information about local facilities and providers of health care services.

The American Association of Homes and Services for the Aging. The American Association of Homes and Services for the Aging (AAHSA) is committed to advancing the vision of healthy, affordable, ethical aging services for America. The association represents 5,600 mission-driven, not-for-profit nursing homes; continuing care retirement communities; assisted living and senior housing facilities; and home and community-based service providers. Every day, the AAHSA’s members serve one million older persons across the country. The AAHSA has state association partners that represent AAHSA members in most states.

Table 8.1 is a listing of AAHSA-affiliated state associations. For more information about homes and services for the aging in a specific state, use this contact list. If there is no association in your state, contact the AAHSA at (202) 508-9438 or memberservices@aahsa.org.

TABLE 8.1 AAHSA STATE ASSOCIATIONS

State/Association	Address	Telephone/Fax	Web Sites
Alabama Alabama Association of Homes and Services for the Aging, Inc.	1555 Taylor Rd Montgomery, AL 36117	Tel: (334) 657-7463 Fax: (334) 272-5774	
Arizona Arizona Association of Homes and Housing for the Aging	3839 N 3rd St Ste. 201 Phoenix, AZ 85012	Tel: (602) 230-0026 Fax: (602) 230-0563	http://www.azaha.org/
California California Association of Homes and Services for the Aging	7311 Greenhaven Dr Ste. 175 Sacramento, CA 95831-3572	Tel: (916) 392-5111 Fax: (916) 428-4250	http://www.aging.org/i4a/pages/index.cfm?pageid=1
Colorado Colorado Association of Homes and Services for the Aging	1888 Sherman St Ste. 610 Denver, CO 80203-1160	Tel: (303) 837-8834 Fax: (303) 837-8836	http://www.cahsa.org/
Connecticut Connecticut Association of Not-for-Profit Providers for the Aging	300 Research Pkwy Meriden, CT 06450-7137	Tel: (203) 237-4556 Fax: (203) 237-4908	http://www.canpfa.org/
Delaware Delaware Association of Homes and Services for the Aging	c/o Ingleside Homes 1010 N Broom St Wilmington, DE 19806-4514	Tel: (302) 777-0130 Fax: (302) 777-0131	
Florida Florida Association of Homes for the Aging	1812 Riggins Rd Tallahassee, FL 32308-4885	Tel: (850) 671-3700 Fax: (850) 671-3790	http://www.faha.org/
Georgia Georgia Association of Homes and Services for the Aging	1705 Commerce Drive Ste. 117 Atlanta, GA 30318	Tel: (404) 605-8453 Fax: (404) 352-0595	
Illinois Life Services Network of Illinois	911 N Elm St Ste. 228 Hinsdale, IL 60521-3634	Tel: (630) 325-6170 Fax: (630) 325-0749	http://www.lsnri.org/
Indiana Indiana Association of Homes and Services for the Aging	P O Box 68829 Indianapolis, IN 46268-0829	Tel: (317) 733-2380 Fax: (317) 733-2385	http://www.iahsa.com/
Iowa Iowa Association of Homes and Services for the Aging	1701 48th St Ste. 203 West Des Moines, IA 50266	Tel: (515) 440-4630 Fax: (515) 440-4631	http://www.ageiowa.org

TABLE 8.1 AAHSA STATE ASSOCIATIONS (CONTINUED)

State/Association	Address	Telephone/Fax	Web Sites
Kansas Kansas Association of Homes and Services for the Aging	217 SE 8th St Topeka, KS 66603	Tel: (785) 233-7443 Fax: (785) 233-9471	http://www.kahsa.org/
Kentucky Kentucky Association of Homes and Services for the Aging	2501 Nelson Miller Pkwy Louisville, KY 40223	Tel: (502) 992-4380 Fax: (502) 992-4390	http://www.kahsa.com/kahsa/
Louisiana Gulf States Association of Homes and Services for the Aging	P.O. Box 14615 Baton Rouge, LA 70898	Tel: (225) 757-1350 Fax: (225) 757-1399	http://www.gulfstatesahsa.org/
Maine Northern New England Association of Homes and Services for the Aging	540 Lafayette Rd Hampton, NH 03842	Tel: (603) 926-7596 Fax: (603) 926-7597	http://www.nneahsa.com/
Maryland MANPHA—A Senior Service Alliance	10280 Old Columbia Rd Ste. 250 Columbia, MD 21046-1709	Tel: (410) 381-1176 Fax: (410) 381-0240	http://www.manpha.org/
Massachusetts Massachusetts Aging Services Association, Inc.	135 S Huntington Ave Boston, MA 02130	Tel: (617) 739-3235 Fax: (617) 739-3236	http://www.massaging.org/
Michigan Michigan Association of Homes and Services for the Aging	6512 Centurion Drive Ste. 380 Lansing, MI 48917	Tel: (517) 323-3687 Fax: (517) 323-4569	http://www.mahsahome.org/
Minnesota Minnesota Health and Housing Alliance	2550 University Avenue West Ste. 350 S St. Paul, MN 55114-1900	Tel: (651) 645-4545 Fax: (651) 645-0002	http://www.mhha.com/
Mississippi Gulf States Association of Homes and Services for the Aging	PO Box 14615 Baton Rouge, LA 70898	Tel: (225) 757-1350 Fax: (225) 757-1399	http://www.gulfstatesahsa.org/
Missouri Missouri Association of Homes for the Aging	515 East High Street Ste. 101 West Jefferson City, MO 65101	Tel: (573) 635-6244 Fax: (573) 635-6618	
Montana MHA—An Association of Health Care Providers	P O Box 5119 Helena, MT 59601-4657	Tel: (406) 442-1911 Fax: (406) 443-3894	http://www.mtha.org/

(continued)

TABLE 8.1 AAHSA STATE ASSOCIATIONS (CONTINUED)

State/Association	Address	Telephone/Fax	Web Sites
Nebraska Nebraska Association of Homes and Services for the Aging	1701 K Street, Ste B Lincoln, NE 68508-2699	Tel: (402) 436-2165 Fax: (402) 436-2169	
New Hampshire Northern New England Association of Homes and Services for the Aging	540 Lafayette Road Hampton, NH 03842	Tel: (603) 926-7596 Fax: (603) 926-7597	http://www.nneahsa.com/
New Jersey New Jersey Association of Non-Profit Homes for the Aging	13 Roszel Road Ste. A-104 Princeton, NJ 08540-6211	Tel: (609) 452-1161 Fax: (609) 452-2907	http://www.njanpha.org/
New York New York Association of Homes and Services for the Aging	150 State Street, Ste 301 Albany, NY 12207-1698	Tel: (518) 449-2707 Fax: (518) 455-8908	http://www.nyahsa.org/
North Carolina North Carolina Association of Non-Profit Homes for the Aging, Inc.	3700 National Drive Ste. 218 Raleigh, NC 27612-4842	Tel: (919) 571-8333 Fax: (919) 571-1297	http://www.ncanpha.org/
Ohio Association of Ohio Philanthropic Homes, Housing and Services for Aging	855 S Wall St Columbus, OH 43206-1921	Tel: (614) 444-2882 Fax: (614) 444-2974	http://www.aopha.org/
Oklahoma Oklahoma Association of Homes and Services for the Aging	P O Box 1383 El Reno, OK 73036-5699	Tel: (405) 640-8040 Fax: (405) 262-5252	
Oregon Oregon Alliance of Senior and Health Services	7340 South West Hunziker St. Ste. 104 Tigard, OR 97223-8288	Tel: (503) 684-3788 Fax: (503) 624-0870	http://www.oashs.org/
Pennsylvania Pennsylvania Association of Non-Profit Homes for the Aging	1100 Bent Creek Blvd Bent Creek Office Park Mechanicsburg, PA 17050	Tel: (717) 763-5724 Fax: (717) 763-1057	http://www.panpha.org/
South Carolina South Carolina Association of Non-Profit Homes for the Aging	2711 Middleburg Dr Ste. 309A Columbia, SC 29204	Tel: (803) 988-0005 Fax: (803) 988-1017	

TABLE 8.1 AAHSA STATE ASSOCIATIONS (CONTINUED)

State/Association	Address	Telephone/Fax	Web Sites
South Dakota South Dakota Association of Healthcare Organizations	3708 Brook Place Ste. 1 Sioux Falls, SD 57106-4211	Tel: (605) 361-2281 Fax: (605) 361-5175	http://www.sdaho.org/
Tennessee Tennessee Association of Homes and Services for the Aging	500 Interstate Boulevard South Nashville, TN 37210-4634	Tel: (615) 256-1800 Fax: 615-726-3082	http://www.tha.com/
Texas Texas Association of Homes and Services for the Aging	2205 Hancock Dr Austin, TX 78756-2508	Tel: (512) 467-2242 Fax: (512) 467-2275	http://www.tahsa.org/
Vermont Northern New England Association of Homes and Services for the Aging	540 Lafayette Road Hampton, NH 03842	Tel: (603) 926-7596 Fax: (603) 926-7597	http://www.nneahsa.com/
Virginia Virginia Association of Non-Profit Homes for the Aging	4201 Dominion Blvd Ste 100 Glen Allen, VA 23060	Tel: (804) 965-5500 Fax: (804) 965-9089	http://www.vanha.org/ public/pages/index.cfm? pageid=1
Washington Washington Association of Housing and Services for the Aging	545 Andover Park West Ste 211 Seattle, WA 98188	Tel: (206) 204-0040 Fax: (206) 204-0046	http://www.wahsa.com/
Wisconsin Wisconsin Association of Homes and Services for the Aging, Inc.	204 South Hamilton Street Madison, WI 53703-3212	Tel: (608) 255-7060 Fax: (608) 255-7064	http://www.wahsa.org/
Wyoming Quality Health Care Foundation of Wyoming	520 Randall Ave PO Box 3050 Cheyenne, WY 82003	Tel: (307) 637-7575 Fax: (307) 634-0804	

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.

Chapter 12, "Sample Documents and Checklists," contains the document "Nursing Home Checklist," which can be used by the practitioner, individual, or family as a resource in the selection process.



- **Nursing Home Checklist** (*also see accompanying CD-ROM*)

The Continuing Care Accreditation Commission (CCAC). A not-for-profit organization founded in 1985, the CCAC is the nation's only accrediting body for aging services continuums, including continuing care retirement communities. The CCAC's accreditation program is based on the belief that accreditation promotes and maintains quality and integrity in the aging services profession. On January 31, 2003, the CCAC merged with the Commission on Accreditation of Rehabilitation Facilities (CARF), a not-for-profit organization founded in 1966 that accredits a wide range of human service organizations, to create a new enterprise that will help consumers identify high-quality care providers—from children's services to those for older adults.

Continuing Care Accreditation Commission (CCAC)
2519 Connecticut Avenue, NW
Washington, DC 20008-1520
(202) 783-7286
<http://www.ccaonline.org/>

The Joint Commission on Accreditation of Health Care Organizations (JCAHO). An independent, not-for-profit organization, established more than 50 years ago, the JCAHO is governed by a board that includes physicians, nurses, and consumers. The JCAHO sets the standards by which health care quality is measured in America and around the world. The JCAHO accredits nearly 16,000 health care organizations in the United States and many other countries. Accredited organizations include:

- Ambulatory care organizations
- Assisted living facilities
- Behavioral health care organizations
- Critical access hospitals
- Clinical laboratories
- Health care networks
- Home care organizations
- Hospitals
- Long-term care facilities
- Office-based surgery practices

By asking for accreditation, an organization agrees to be measured against national standards set by health care professionals. An accredited organization substantially

complies with JCAHO standards and continuously makes efforts to improve the care and services it provides.

Health care organizations seek JCAHO accreditation because it:

- Enhances community confidence.
- Provides a report card for the public.
- Offers an objective evaluation of the organization's performance.
- Stimulates the organization's quality improvement efforts.
- Aids in professional staff recruitment.
- Provides a staff education tool.
- May be used to meet certain Medicare certification requirements.
- Expedites third-party payment.
- Often fulfills state licensure requirements.
- May favorably influence liability insurance premiums.
- Favorably influences managed care contract decisions.

Specially trained surveyors evaluate each health care organization's compliance with JCAHO standards and identify the organization's strengths and weaknesses. The surveyors' goal is not merely to find problems, but also to provide education and consultation so health care organizations can improve.

Joint Commission on Accreditation of Healthcare Organizations
601 13th Street, NW
Suite 1150N
Washington, DC 20005
Tel: (202) 783-6655
fax: (202) 783-6888
<http://www.jcaho.org>

The Commission on Accreditation of Rehabilitative Facilities (CARF). An independent, not-for-profit accrediting body, the CARF provides accreditation in the human services field, focusing on the areas of rehabilitation, employment, child and family, and aging services. The CARF accredits providers for their specific services. Many providers seek CARF accreditation in more than one service area.

- Adult day services
- Assisted living
- Behavioral health
- Comprehensive blind rehabilitation services
- Employment and community services
- Medical rehabilitation
- Network administration and access centers
- Opioid treatment programs

Commission on Accreditation of Rehabilitative Facilities (CARF)
4891 E. Grant Road
Tucson AZ 85712
Tel: (888) 281-6531
Fax: (520) 318-1129
<http://www.carf.org/>

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 document "Home Evaluation Checklist" (see Chapter 12, "Sample Documents and Checklists") 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.



- **Home Evaluation Checklist** (*also see accompanying CD-ROM*)

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/PrimePlus 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/PrimePlus 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 12, "Sample Documents and Checklists," contains a questionnaire, "Helping Clients Stay at Home Questionnaire," that can be used when assessing an ElderCare/PrimePlus client's ability to remain at home.



- **Helping Clients Stay at Home Questionnaire** (*also see accompanying CD-ROM*)

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 for 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 or her 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, such services 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.

Because 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 12, "Sample Documents and Checklists," contains a checklist of questions, "Home Care Agency Checklist," which can be used when considering home care providers.



- **Home Care Agency Checklist** (*also see accompanying CD-ROM*)

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 20 days, Part A insurance pays all covered costs. For the next 80 days, Part A insurance pays all covered costs beyond \$109.50 per day in 2004. 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/PrimePlus 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/PrimePlus 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 Centers for Medicare and Medicaid Services)

The Centers for Medicare and Medicaid Services

Notice to the Reader: The Centers for Medicare and Medicaid Services, 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 8.2 for a listing of agency contact information.)

TABLE 8.2 STATE AGENCY RESOURCES

State	Long-Term Care Ombudsman	State Survey Agency*	Insurance Counseling and Assistance	Website
Alabama	(334) 242-5743	(334) 206-5111	(800) 243-5463	
Alaska	(800) 730-6393	(907) 334-2483	(800) 478-6065	
Arizona	(602) 542-4446	(602) 364-3064	(800) 432-4040	http://www.hs.state.az.us/als/ltc/index.htm
Arkansas	(501) 682-8952	(501) 682-8430	(800) 224-6330	http://www.medicaid.state.ar.us/general/units/oltc/index.htm
California	(916) 322-3286	(916) 552-8700	(800) 434-0222	http://www.calnhs.org/
Colorado	(303) 722-0300	(303) 692-2800	(800) 544-9181	http://www.cdph.state.co.us/hf/static/nfc.htm
Connecticut	(860) 509-7400	(860) 424-5200	(800) 994-9422	http://www.dph.state.ct.us/BHCS/Complaints/complaints.htm
Delaware	(302) 255-9390	(302) 577-6661	(800) 336-9500	http://www.dsaapd.com/nursing.htm
District of Columbia	(202) 434-2120	(202) 442-5833	(202) 739-0668	
Florida	(850) 414-2323	(888) 419-3456	(800) 963-5337	http://www.fdhc.state.fl.us/Nursing_Home_Guide/index.shtml
Georgia	(404) 657-5258	(404) 657-5850	(800) 669-8387	http://www2.state.ga.us/Departments/DHR/ORS/
Guam	(808) 586-0100	(808) 692-7420	(888) 875-9229	
Hawaii	(808) 586-0100	(808) 692-7420	(888) 875-9229	http://www.state.hi.us/health/resource/ohca/medicare/nursing/directory-snficf.html
Idaho	(208) 334-3833	(208) 334-6626	(800) 247-4422	
Illinois	(217) 524-6911	(217) 785-0321	(800) 548-9034	http://www.idph.state.il.us/healthca/nursing/hometestjava.htm
Indiana	(317) 232-7134	(317) 233-7442	(800) 452-4800	http://www.in.gov/isdh/regsvcs/ltc/directory/index.htm

* Numbers may be for regional offices.

TABLE 8.2 STATE AGENCY RESOURCES (CONTINUED)

State	Long-Term Care Ombudsman	State Survey Agency*	Insurance Counseling and Assistance	Website
Iowa	(515) 242-3333	(515) 281-4115	(800) 351-4664	https://www.dia-hfd.state.ia.us/
Kansas	(785) 296-3017	(785) 296-4986	(800) 860-5260	http://www.kdhe.state.ks.us/bhfr/index.html
Kentucky	(502) 564-6930	(502) 564-2800	(877) 293-7447	
Louisiana	(225) 342-7100	(225) 342-0114	(800) 259-5301	http://www.dhh.state.la.us/offices/?ID=112
Maine	(207) 621-1079	(207) 287-9300	(800) 750-5353	
Maryland	(410) 767-1100	(410) 402-8201	(800) 243-3425	http://209.219.237.235/index.htm
Massachusetts	(617) 727-7750	(617) 753-8000	(800) 243-4636	http://www.mass.gov/dph/qtool/qthome.htm
Michigan	(517) 373-8230	(517) 241-4712	(800) 803-7174	http://www.michigan.gov/cis/0,1607,7-154-10568_17576_17590--,00.html
Minnesota	(651) 296-0382	(651) 215-8701	(800) 333-2433	http://www.health.state.mn.us/divs/fpc/consinfo.html
Mississippi	(601) 359-4929	(601) 354-7300	(800) 948-3090	
Missouri	(573) 526-0727	(573) 751-4842	(800) 390-3330	
Montana	(406) 444-4077	(406) 444-2099	(800) 551-3191	
Nebraska	(402) 471-2307	(402) 471-3324	(800) 234-7119	
Nevada	(702) 486-3545	(702) 687-4475	(800) 307-4444	http://health2k.state.nv.us/BLC/healthfacilities.htm
New Hampshire	(603) 271-4375	(603) 271-4592	(800) 852-3388	
New Jersey	(609) 943-4023	(609) 633-8991	(800) 792-8820	http://www.state.nj.us/health/ltc/nurshome.htm
New Mexico	(505) 255-0971	(505) 476-9025	(800) 432-2080	
New York	(518) 474-7329	(518) 478-1020	(800) 333-4114	http://www.health.state.ny.us/nysdoh/nursing/main.htm
North Carolina	(919) 733-8395	(919) 733-7461	(800) 443-9354	

(continued)

* Numbers may be for regional offices.

TABLE 8.2 STATE AGENCY RESOURCES (CONTINUED)

State	Long-Term Care Ombudsman	State Survey Agency*	Insurance Counseling and Assistance	Website
North Dakota	(701) 328-8910	(701) 224-2352	(800) 247-0560	http://www.health.state.nd.us/hf/North_Dakota_Skilled_Nursing_Homes.htm
Ohio	(614) 466-1221	(614) 752-9524	(800) 686-1578	http://www4.state.oh.us/longtermcareguide/consumer/index.asp
Oklahoma	(405) 521-6734	(405) 271-6868	(800) 763-2828	
Oregon	(503) 378-6533	(503) 945-5832	(800) 722-4134	
Pennsylvania	(717) 783-7247	(717) 787-1816	(800) 783-7067	http://www.dsf.health.state.pa.us/health/cwp/browse.asp?a=188&bc=0&c=35675&healthPNavCtr= #4560
Puerto Rico	(787) 725-1515	(787) 721-3461	(877) 725-4300	
Rhode Island	(401) 785-3340	(401) 222-2566	(401) 462-3000	http://www.healthri.org/hsr/facilities/nursing_homes/home.htm
South Carolina	(803) 898-2850	(803) 898-2590	(800) 868-9095	
South Dakota	(605) 773-3656	(605) 773-3356	(800) 822-8804	
Tennessee	(615) 741-2056	(615) 741-7221	(877) 801-0044	http://www2.state.tn.us/health/HCF/Facilities_Listings/facilities.htm
Texas	(512) 438-3200	(512) 438-2633	(800) 252-9240	http://www.dhs.state.tx.us/nhconsumer.html
Utah	(801) 538-3910	(801) 538-6158	(800) 541-7735	
Vermont	(802) 863-2316	(802) 241-2345	(800) 642-5119	http://www.dad.state.vt.us/lcinfo/
Virginia	(804) 644-2804	(804) 367-2106	(800) 545-3814	
Virgin Islands	(787) 725-1515	(340) 777-3303	(340) 712-2400	
Washington	(253) 838-6810	(360) 725-2300	(800) 445-6941	
West Virginia	(304) 558-3317	(304) 558-0050	(800) 642-8686	
Wisconsin	(608) 246-7012	(608) 266-8481	(800) 362-2320	http://www.dhfs.state.wi.us/rl_DSL/NHs/NHintro.htm
Wyoming	(307) 322-5553	(307) 777-7123	(800) 497-8232	

* Numbers may be for regional offices.

Step-by-Step Process for 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. Although difficult for clients to admit, they may spend several years 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 Center for Medicare and Medicaid Services 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.

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 thorough 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 8.2 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.)
- Health Maintenance Organization 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, 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. Nursing home care is financed in several ways.

- *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 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 the section in Chapter 9 titled "A Shopper's Guide to Long-Term Care Insurance."
- *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 *Medicare & You 2004* from the Centers for Medicare and Medicaid Services at (800) 633-4227 or on the Internet at <http://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 8.2, "State Agency Resources."

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 "Nursing Home Checklist–Comprehensive," included in Chapter 12, "Sample Documents and Checklists," provides additional ideas for questions to ask.



- **Comprehensive Nursing Home Checklist** (*also see accompanying CD-ROM*)

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.

The 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 they request it?

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 advance 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, people and agencies are available to provide help and assistance.

LONG-TERM CARE RESOURCES

Long-Term Care Ombudsmen

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 8.2, "State Agency Resources," 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 ongoing presence in long-term care facilities, monitoring care and conditions and providing a voice for those who are unable to speak for themselves. These individuals investigate nursing home complaints, act as advocates for nursing home residents, and mediate disputes between nursing homes and residents or their families.

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. See Table 8.2, "State Agency Resources," for individual state nursing home survey information.

Insurance Counseling and Assistance

Programs provide free help with questions on long-term care costs. If you need clarification 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 (see Table 8.2, "State Agency Resources," for additional information).

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, the CPA can offer some protection to a client who has fallen victim 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.

SUGGESTED PUBLICATIONS

The following section identifies publications that can offer additional help in deciphering the various housing alternatives.

The American Health Care Association (AHCA) offers the following:

- A Consumer's Guide to Nursing Facilities
http://www.longtermcareliving.com/planning_ahead/nursing/nursing1.htm
- Understanding Long-Term Care Insurance
http://www.longtermcareliving.com/pdf/ltc_insurance.pdf

The Centers for Medicare and Medicaid Services (CMS) publish the following:

- Choosing Long-Term Care
<http://www.medicare.gov/Library/PDFNavigation/PDFInterim.asp?Language=English&Type=Pub&PubID=02223>
- Medicare & You 2004
<http://www.medicare.gov/Library/PDFNavigation/PDFInterim.asp?Language=English&Type=Pub&PubID=10050>
- Medicare and Home Health Care
<http://www.medicare.gov/Library/PDFNavigation/PDFInterim.asp?Language=English&Type=Pub&PubID=10969>

- Medicare Coverage of Skilled Nursing Facility Care
<http://www.medicare.gov/Library/PDFNavigation/PDFInterim.asp?Language=English&Type=Pub&PubID=10153>
- Nursing Homes
<http://www.medicare.gov/Library/PDFNavigation/PDFInterim.asp?Language=English&Type=Pub&PubID=10121>
- Guide to Choosing a Nursing Home
<http://www.medicare.gov/Library/PDFNavigation/PDFInterim.asp?Language=English&Type=Pub&PubID=02174>

Consumer Reports offers the following:

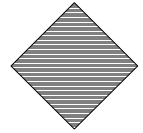
- Do You Need Long-Term Care Insurance?
http://www.consumerreports.org/main/content/display_report.jsp?FOLDER%3C%3Efolder_id=344775&bmUID=1069685562912

The Health Insurance Association of America (HIAA) has published the following:

- Guide to Long-Term Care
http://www.consumerreports.org/main/content/display_report.jsp?FOLDER%3C%3Efolder_id=344775&bmUID=1069685562912

The National Center for Assisted Living (NCAL) offers the following publications:

- A Consumer's Guide to Assisted Living and Residential Care Facilities
<http://www.lon>
- Understanding Long-Term Care Insurance
http://www.longtermcareliving.com/financial_information/insurance1.htm



CHAPTER 9:

Long-Term Care Insurance

When communicating about long-term care, the information usually entails care for an individual who is physically or mentally disabled to the degree that he or she is unable to function or live without assistance from others. Long-term care planning refers to the process of preparing to meet the financial, medical, housing, and personal needs of a person who can no longer function independently. Typically such care is not provided in the hospital. The plan must address the level of care needed by the individual, determination of the location where care can best be provided, and how the care will be financed.

LONG-TERM CARE OPTIONS

Care that is needed by an individual who is unable to function independently usually falls into one of the following categories.

Acute care. Medical needs of the individual warrant hospital admission so appropriate care can be provided.

Intermediate and skilled care. Care at this level is typically provided in a nursing home. If the individual is a private-pay patient, the doctor and family determines whether the facility is appropriate. If Medicaid payment is sought, the individual must meet the “medically necessary” criterion of the state program.

Residential care or assisted living. Generally, individuals who require this level of care do not meet the criteria for skilled or intermediate care of a nursing facility. Typically referred to as residential care facilities (RCFs), these facilities are more moderately priced than nursing homes. Some states provide payment assistance to individuals who seek this type of care.

Home care. Generally limited to those individuals who can operate with some degree of independence and who have a family support system that encourages them to remain in their home, home care can be provided with some payment assistance from Medicare or Medicaid.

PAYMENT OPTIONS

Usually long-term care is paid out of one of three sources: private pay, Medicaid, Medicare, and Medigap, or long-term care insurance. Some limited services may be initially covered by Medicare or the Veterans Administration; however, these programs should not be considered as long-term funding sources.

Private pay. Currently nursing homes charge approximately \$3,000 to \$6,000 per month for care. Maintaining a person at home with full-time care is even more costly. Financing the entire bill can be prohibitively expensive if the individual relies solely on private pay.

Medicaid, Medicare, and Medigap. Usually, Medicare and Medigap policies cover portions of the first 100 days of nursing home care. These sources are extremely restrictive and should never be considered a long-term solution to paying for long-term care needs.

Long-term care insurance. A relatively new product in the insurance market, long-term care insurance is similar to life insurance policies; the holder pays monthly premiums to the insurance company, and if long-term care becomes necessary, the insurance company pays the bill as dictated by the policy provisions. Individuals must be in reasonably good health to qualify for a policy and depending on age and health, premiums can be high. In addition, the insurance company may restrict the facilities from which individuals can choose, and the services received may be limited.

LONG-TERM CARE INSURANCE FACTS

Many people think they will never need long-term care, are unaware of the cost, or think that the government will pay. Unfortunately, the facts don't support these assumptions:

- Over half of women and nearly one-third of men 65 and older will stay in a nursing home sometime during their lifetime ("The Risk of Nursing Home Use Later in Life," *Medical Care* 28(10): 952-62).
- The estimated risk of a 65 year old entering a nursing home at some point in his or her life is about 48.6 percent (Lewin-VHI, based on the Brookings-ICF Long-Term Care Financing Model, cited in Long-Term Care: Knowing the Risk, Paying the Price, HIAA, 1997, p. 132).
- The lifetime risk of nursing home admission is 36 percent at age 45 and 56 percent at age 85 (Murtaugh, Kemper, Spillman, & Carlson, "The Amount, Distribution, and Timing of Lifetime Nursing Home Use," *Medical Care*, 35 (3), 204-218).
- Today about one in five Americans older than 65 and almost half of Americans 85 and older who live in the community require assistance with their everyday activities (65+ in the United States, Current Population Reports, Bureau of the Census, 1996, as cited in *Who Will Pay for the Baby Boomers' Long-Term Care Needs?* American Council of Life Insurance, April 1998, p.12).
- Of those needing long-term care, 57 percent are elderly, 40 percent are working age, and 3 percent are children (GAO/HEHS-95-109 Long-Term Care Issues, p. 7).
- The current national average cost of a nursing home is over \$40,000 per year and in some parts of the country can be much higher—amounting to \$60,000 or \$80,000 per year (*Long-Term Care Planning: A Dollar and Sense Guide*, United Seniors Health Cooperative, August, 1997, p. 64).

- In many states, a single person needs to spend his or her assets until as little as \$2,000 is left. An individual is also allowed \$1,500 for a burial fund. In about half of the states, the individual is eligible for Medicaid as soon as his or her assets are spent. (*Long-Term Care Planning: A Dollar and Sense Guide*, United Seniors Health Cooperative, August, 1997, p. 51).

Source: <http://gltc.jhancock.com/lcbasics/quiz.cfm#quiz>.

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 PrimePlus/ElderCare CPAs become knowledgeable about current products and issues.

UNDERSTANDING LONG-TERM HEALTH CARE INSURANCE

Long-term care refers to the many services used by people who have disabilities or chronic (long-lasting) illnesses. Long-term care insurance helps pay for these services, which can be very expensive. A policy should also ensure that individuals can make their own choices about what long-term care services they receive and where they receive them.

Ordinary health insurance policies and Medicare usually do not pay for long-term care expenses. Medicaid, a federal/state health insurance program, will pay for long-term care only when an individual has already spent most of his or her savings or other assets. Long-term care insurance should cover the cost of:

- Help in the home with daily activities, such as bathing and dressing.
- Community programs, such as adult day care.
- Assisted living services that are provided in a special residential setting other than a personal residence. These services can include meals, health monitoring, and help with daily activities.
- Care in a nursing home.

Deciding Whether to Buy a Policy

Long-term care insurance is not for everyone. Your clients should learn as much as they can about the various policy options before making a purchase. Encourage clients to keep the following in mind:

- Is there a good reason to buy long-term care insurance? Clients' goals may be to protect assets, minimize their dependence on other family members, and control where and how they receive long-term care services.

- What is the cost? Long-term care insurance is expensive. An individual who is 65 years old and in good health can expect to pay between \$2,000 and \$3,000 a year for a policy that covers nursing home care and home care; those premiums are adjusted for inflation. Clients should be wary of buying long-term care insurance if the cost of premiums will lower their standard of living or force them to give up other things they need. Make sure clients will be able to afford the premiums if their income declines.

Deciding When to Buy a Policy

Middle age is, perhaps, the best time to consider whether to buy long-term care insurance. That is when an individual is most likely to be eligible for a policy, and when premiums costs will be at their lowest. Many people do not think about long-term care until they get into their 70s and 80s and their health begins to fail. At that age, it may be too late to purchase insurance. Some long-term care insurance policies have restrictions on the age and health status of potential buyers. Even if an individual can obtain long-term care insurance in old age, it will be more expensive than if it were purchased when they were younger.

Resources

State Health Insurance Assistance Program (SHIP) is a free program that counsels older adults about health insurance-related topics. SHIP counselors can help individuals decide if they need long-term care insurance. They can also help clients understand the insurance policy they are thinking about purchasing. For the SHIP program nearest you, call the Eldercare Locator (800) 677-1116 or see Chapter 7, "Federal and State Programs for the Elderly," Table 7.5, "Chart of State Health Insurance Assistance Program."

National Center on Women and Aging, located at Brandeis University, focuses attention on the special concerns of women as they age. The center published a guide to long-term care insurance in its *Women and Aging* newsletter. View the report at <http://heller.brandeis.edu/national/ltc.html>.

Administration on Aging (AoA), has a Web site where you can access information about the agency, its mission, budget, and organizational structure. In addition, you can learn more about the Older Americans Act, the federal legislation establishing the AoA and authorizing a range of programs that offer services and opportunities for older Americans and their caregivers. See <http://www.aoa.gov>.

American Association of Retired Persons (AARP) is a nonprofit membership organization dedicated to addressing the needs and interests of persons 50 and older. Through information and education, advocacy and service, AARP seeks to enhance the quality of life for all by promoting independence, dignity, and purpose. Visit its Web site at <http://www.aarp.org/bulletin/longterm/>.

Insurance Calculators

The Internet abounds with personal insurance calculators. The following have been identified for work with long-term care insurance issues, premiums, and benefits:

- Cost of Care in Your Area, John Hancock Insurance Company;
<http://gltc.jhancock.com/resources/costofcare.cfm>
- Long Term Care Calculator, New York Life Insurance Company;
<http://www.newyorklife.com/file/other/LongtermCare.html>

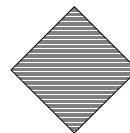
- Long Term Care Calculator, CPA2CLIENT Internet/Software Company;
<http://www.cpa2client.com/calculators1/LongtermCare.html>
- Federal Long Term Care Insurance Program;
https://www.ltcfed.com/NASApp/ltc/do/assessing_your_needs/ratecalc
- The SmartMoney.com LTC Insurance Evaluators;
<http://www.smartmoney.com/insurance/longtermcare/index.cfm?story=evaluators#calculators>

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

NAIC

National Association of Insurance Commissioners

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ABOUT THE NAIC . . .

The National Association of Insurance Commissioners (NAIC) is the oldest association of state government officials. Its members consist of the chief insurance regulators in all 50 states, the District of Columbia and four U.S. territories. The primary responsibility of the state regulators is to protect the interests of insurance consumers, and the NAIC helps regulators fulfill that obligation in a number of different ways. This guide is one example of work done by the NAIC to assist states in educating and protecting consumers.

Another way the NAIC lends support to state regulators is by providing a forum for the development of uniform public policy when uniformity is appropriate. It does this through a series of model laws, regulations and guidelines, developed for the states' use. States that choose to do so may adopt the models intact or modify them to meet the needs of their marketplace and consumers. As you read through this guide, you will find several references to such NAIC model laws or regulations related to long-term care insurance. You may check with your state insurance department to find out if these NAIC models have been enacted in your state.

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A Shopper's Guide to Long-Term Care Insurance

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ABOUT THIS SHOPPER'S GUIDE

The **National Association of Insurance Commissioners** (NAIC) has written this guide to help you understand long-term care and the insurance options that can help you pay for long-term care services. The decision to buy long-term care insurance is very important and one you shouldn't make in a hurry. In most states, state law requires insurance companies or agents to give you this guide to help you better understand long-term care insurance and decide which, if any, policy to buy. Some states produce their own guide.

Take a moment to look at the table of contents and you'll see the questions this guide answers and the information that is in it. Then, read the guide carefully. If you see a term you don't understand, look in the glossary starting on page 9-38. (Terms in bold in the text are in the glossary.) Take your time. Decide if buying a policy might be right for you. If you decide to shop for a long-term care insurance policy, start by getting information about the long-term care services and facilities you might use and how much they charge. Use the first worksheet that starts on page 9-44 to write down this information. Then, as you shop for a policy, use Worksheet 2, starting on page 9-46. There you can write down the information you collect to compare policies and buy the one that best meets your needs.

If you have questions, call your state insurance department or the insurance counseling program in your state. The telephone numbers are listed starting on page 9-58 of this guide.

WHAT IS LONG-TERM CARE?

Someone with a prolonged physical illness, a disability, or a **cognitive impairment** (such as **Alzheimer's disease**) often needs long-term care. Many different services help people with chronic conditions overcome limitations that keep them from being independent. Long-term care is different from traditional medical care. Long-term care helps one live as he or she is now; it may not help to improve or correct medical problems. Long-term care services may include help with **activities of daily living, home health care, respite care, hospice care, adult day care**, care in a **nursing home**, and care in an **assisted living facility**. Long-term care may also include care management services, which will evaluate your needs and coordinate and monitor the delivery of long-term care services. Someone with a physical illness or disability often needs **hands-on** or **stand-by assistance** with activities of daily living (see page 9-24). People with cognitive impairments usually need supervision, protection, or verbal reminders to do everyday activities. The way long-term care services are provided is changing. Skilled care and personal care are still the terms used most often to describe long-term care and the type or level of care you may need.

People usually need **skilled care** for medical conditions that require care by medical personnel such as registered nurses or professional therapists. This care is usually needed 24 hours a day, a physician must order it, and the care must follow a plan. Individuals usually get skilled care in a nursing home but may also receive it in other places. For example, you might get skilled care in your home with help from visiting nurses or therapists. Examples of skilled care including physical therapy, caring for a wound, or supervising the administration of intravenous medication.

Note: Medicare and Medicaid have their own definitions of skilled care. Please refer to *The Guide to Health Insurance for People with Medicare* or *The Medicare Handbook* to find out how Medicare defines skilled care. Contact your local social services office for questions about Medicaid's definition of skilled care. For copies of these publications, contact your state insurance department or **State Health Insurance Assistance Program** listed on page 9-58.

Personal care (sometimes called custodial care) helps one with activities of daily living (ADLs.) These activities include bathing, eating, dressing, toileting, continence, and transferring. Personal care is less involved than skilled care, and it may be given in many settings.

HOW MUCH DOES LONG-TERM CARE COST?

Long-term care can be expensive. The cost depends on the amount and type of care you need and where you get it. Below are some average annual costs for care provided in a nursing home, in an assisted living facility and in your own home.

Nursing Home Costs

In 2001, the national average cost of nursing home care was \$56,000 per year,¹ or about \$153 per day. This cost does not include items such as therapies and medications, which could make the cost much higher.

Assisted Living Facility Costs

In 2001, assisted living facilities reported charging an average fee of \$1,873 per month, or \$22,476 per year, including rent and most other fees.² Some residents in the facilities may pay a lot more if their care needs are higher.

Home Care Costs

In 2001, the national average cost of part-time basic home care ranged from \$12,000 to \$16,000 per year.³ Skilled care provided by a nurse is more expensive than care provided by a home health aide. Annual costs for home health care will vary based on the number of days per week the caregiver visits, the type of care required and the length of each visit. Home health care can be expensive if round-the-clock care is required. These costs are different across the country. Your state insurance department or the insurance counseling program in your state may have costs for your area. (See directory starting on page 9-58.)

WHO PAYS FOR LONG-TERM CARE?

People pay for long-term care in a variety of ways. These include: using the personal resources of individuals or their families, long-term care insurance, and some assistance from **Medicaid** for those who qualify. **Medicare**, **Medicare supplement insurance**, and the health insurance you may have at work usually *will not pay* for long-term care.

Individual Personal Resources

Individuals and their families generally pay for part or all of the costs of long-term care from their own funds. Many use savings and investments. Some people sell assets, such as their homes, to pay for their long-term care needs.

Medicare and Medicare Supplement Insurance

Medicare. Medicare’s skilled nursing facility (SNF) benefit does not cover most nursing home care.⁴ Medicare will pay the cost of some skilled care in an approved nursing home or in your home but only in specific situations. The SNF benefit only covers you if a medical professional says you need daily skilled care after you have been in the hospital for at least three days and you are receiving that care in a nursing home that is a Medicare-certified skilled nursing facility. While Medicare may cover *up to 100 days* of skilled nursing home care per benefit period when these conditions are met, after 20 days beneficiaries must pay a coinsurance fee. In 2002, that coinsurance was \$101.50 per day.⁵ While Medicare may pay for nursing home care sometimes, it doesn’t cover the costs of care in assisted living facilities.

While many people would like to receive care in their own homes, Medicare does not cover **homemaker services**. In addition, Medicare doesn’t pay for home health aides to give you **personal care** unless you are homebound and are also getting skilled care such as nursing or therapy. The personal care must also relate to the treatment of an illness or injury and you can only get a limited amount of care in any week.

You should not rely on Medicare to pay for your long-term care needs.

Medicare Supplement Insurance

Medicare supplement insurance is private insurance that helps pay for some of the gaps in Medicare coverage, such as hospital deductibles and excess physicians’ charges above what Medicare approves. Medicare supplement policies do not cover long-term care costs. However, four Medicare supplement policies—Plans D, G, I, and J—do pay up to \$1,600 per year⁶ for services to people recovering at home from an illness, injury, or surgery. The benefit will pay for short-term, at home help with activities of daily living. You must qualify for Medicare-covered home health services before this Medicare supplement benefit is available.

MEDICAID

Medicaid is the government-funded program that pays nursing home care only for individuals who are low income and who have spent most of their assets. Medicaid pays for nearly half of all nursing home care on an aggregate basis, but many people who need long-term care never qualify for Medicaid assistance.⁷ Medicaid also pays for some home and **community-based services**. To get Medicaid help, you must meet federal and state guidelines for income and assets. Many people start paying for nursing home care out of their own funds and **“spend down”** their income until they are eligible for Medicaid. Medicaid may then pay part or all of their nursing home costs. You may have to use up most of your assets on your health care before Medicaid is able to help. Some assets and income can be protected for a spouse who remains at home. In addition, some of your assets may be protected if you have long-term care insurance approved under one of the state programs. (See section on “Other Options” on page 9-18.)

State laws differ about how much money and assets you can keep and be eligible for Medicaid. (Some assets, such as your home, may not count when deciding if you are eligible for Medicaid.) However, federal law requires your state to recover from your estate the costs of the Medicaid-paid benefits you receive.⁸ **Contact your state Medicaid office, office on aging, or state department of social services to learn about the rules in your state. The insurance counseling program in your state also may have some Medicaid information.** (Please see the list of offices on aging and counseling programs on page 9-58.)

Long-Term Care Insurance

Long-term care insurance is one other way you may pay for long-term care. This type of insurance will pay for some or all of your long-term care. It was introduced in the 1980s as nursing home insurance but has changed a lot and now covers much more than nursing home care. The rest of this Shopper's Guide will give you information on long-term care insurance. You should know that a federal law, the **Health Insurance Portability and Accountability Act** of 1996, or HIPAA, gives some federal income tax advantages to people who buy certain long-term care insurance policies. These policies are called Tax-Qualified Long-Term Care Insurance Contracts, or simply Qualified Contracts. The tax advantages of these policies are outlined on page 9-19. There may be other tax advantages in your state. **You should check with your state insurance department or insurance counseling program for information about tax-qualified policies. (Please see the list of state insurance departments and counseling programs on page 9-58.) Check with your tax advisor to find out if the tax advantages make sense for you.**

WHO MAY NEED LONG-TERM CARE?

The need for long-term care may begin gradually as you find that you need more and more help with activities of daily living, such as bathing and dressing. Or you may suddenly need long-term care after a major illness, such as a stroke or a heart attack.

If you do need care, you may need nursing home or home health care for only a short time. Or, you may need these services for many months, years, or the rest of your life.

It is hard to know if and when you will need long-term care, but there are some statistics that may help. **For example:**

- Life expectancy after age 65 has now increased to 17.9 years, up from 1940 when life expectancy after 65 was only 13 extra years. The longer people live, the greater the chances they will need assistance due to chronic conditions.⁹
- About 12.8 million Americans of all ages require long-term care, but only 2.4 million live in nursing homes.¹⁰
- About 44% of people reaching age 65 are expected to enter a nursing home at least once in their lifetime.¹¹ Of those who do enter a nursing home about 53% will stay for one year or more.¹²

DO YOU NEED LONG-TERM CARE INSURANCE?

Whether you should buy a long-term care insurance policy will depend on your age, health status, overall retirement goals, income, and assets. For instance, if your only source of income is a Social Security benefit or Supplemental Security Income (SSI), you

probably shouldn't buy long-term care insurance since you may not be able to afford the premium.

On the other hand, if you have a large amount of assets but don't want to use them to pay for long-term care, you may want to buy a long-term care insurance policy. Many people buy a policy because they want to stay independent of government aid or the help of family. They don't want to burden anyone with having to care for them. However, you should not buy a policy if you can't afford the premium or aren't sure you can pay the premium for the rest of your life.

If you already have health problems that are likely to mean you will need long-term care (for example, Alzheimer's disease or Parkinson's disease), you probably won't be able to buy a policy. Insurance companies have medical **underwriting** standards to keep the cost of long-term care insurance affordable. Without such standards, most people would not buy coverage until they needed long-term care services.

Some states have a regulation requiring the insurance company and the agent to go through a worksheet with you to decide if long-term care insurance is right for you. The worksheet describes the premium for the policy you're thinking about buying and asks you questions about the source and amount of your income and the amount of your savings and investments. Some states require that you fill out the worksheet and send it to the insurance company. Even if you aren't required to fill out this worksheet, it might help you decide if long-term care insurance is right for you.

Remember, not everyone should buy a long-term care insurance policy. For some, a policy is affordable and worth the cost. For others, the cost is too great, or the policy they can afford doesn't offer enough benefits to make it worthwhile. You should not buy long-term care insurance if the only way you can afford to pay for it is by not paying other important bills. Look closely at your needs and resources, and discuss it with a family member to decide if long-term care insurance is right for you. (There are several worksheets at the back of this book that will help you as you think about whether you should buy long-term care insurance).

IS LONG-TERM CARE INSURANCE RIGHT FOR YOU?

You should NOT buy Long-Term Care Insurance if:

- You can't afford the premiums.
- You have limited assets.
- Your only source of income is a Social Security benefit or Supplemental Security Income (SSI).
- You often have trouble paying for utilities, food, medicine, or other important needs.
- You are on Medicaid.

You should CONSIDER buying Long-Term Care Insurance if:

- You have significant assets and income.
- You want to protect some of your assets and income.
- You can pay premiums, including possible premium increases, without financial difficulty.
- You want to stay independent of the support of others.
- You want to have the flexibility of choosing care in the setting you prefer or will be most comfortable in.

For further determination of whether you should or should not consider buying long-term care insurance, please refer to the Personal Worksheet found in the back of this Shopper's Guide. In addition to the personal worksheet, consumer worksheets #1 through #4 should be used to help you decide.

If, after careful consideration, you decide that long-term care insurance is right for you, check out the company and the agent, if one is involved, before you buy a policy. Insurance companies and agents must be licensed in your state to sell long-term care insurance. If you're not sure, contact your state insurance department. (Please see the list of state insurance departments starting on page 9-58.)

HOW CAN YOU BUY LONG-TERM CARE INSURANCE?

Private insurance companies sell long-term care insurance policies. You can buy an individual policy from an agent or through the mail. Or, you can buy coverage under a group policy through an employer or through membership in an association. The federal government and several state governments offer long-term care insurance coverage to their employees, retirees and their families. This program is voluntary and premiums are paid by participants. You can also get long-term care benefits through a life insurance policy.

Individual Policies

Today, most long-term care insurance policies are sold to individuals. Insurance agents sell many of these policies but companies also sell policies through the mail or by telephone. You will find that individual policies can be very different from one company to the next. Each company may also offer policies with different combinations of benefits. Be sure to shop among policies, companies and agents to get the coverage that best fits your needs.

Policies From Your Employer

Your employer may offer a group long-term care insurance plan or offer individual policies at a group discount. An increasing number of employers offer this benefit,¹³ especially since the passage of the Health Insurance Portability and Accountability Act (HIPAA). HIPAA allows employers the same type of federal tax benefit when they pay for

their employee's long-term care insurance as when they pay for their health insurance (except for Section 125 cafeteria plans).

The employer-group plan may be similar to what you could buy in an individual policy. If you are an active employee, one advantage of an employer-group plan is you may not have to meet any medical requirements to get a policy or there may be a relaxed screening process for active employees. Many employers also let retirees, spouses, parents, and parents-in-law apply for this coverage. Relatives must usually pass the company's medical screening to qualify for coverage and must pay the premium.

Generally, insurance companies must let you keep your coverage after your employment ends or your employer cancels the group plan. In most cases, you will be able to continue your coverage or convert it to another long-term care insurance policy. Your premiums and benefits may change, however.

If an employer offers long-term care insurance, be sure to think about it carefully. An employer-group policy may offer you options you can't find if you buy a policy on your own.

Federal Government

Federal and U.S. Postal Service employees and annuitants, members and retired members of the uniformed services, and qualified relatives are eligible to apply for long-term care insurance coverage under the Federal Long Term Care Insurance Program. Private insurance companies underwrite the insurance, and the federal government does not pay any of the premiums. The group rates under this program may or may not be lower than individual rates and the benefits may also be different.¹⁴

State Government

If you or a member of your family is a state or public employee or retiree, you may be able to buy long-term care insurance under a state government program.

Association Policies

Many associations let insurance companies and agents offer long-term care insurance to their members. These policies are like other types of long-term care insurance and typically require medical underwriting. Like employer-group policies, association policies usually give their members a choice of benefit options. In most cases, policies sold through associations must let members keep or convert their coverage after leaving the association. Be careful about joining an association just to buy any insurance coverage. Review your rights if the policy is terminated or canceled.

Policies Sponsored by Continuing Care Retirement Communities

Many **Continuing Care Retirement Communities** (CCRC) offer or require you to buy long-term care insurance. A CCRC is a retirement complex that offers a broad range of services and levels of care. You must be a resident or on the waiting list of a CCRC and meet the insurance company's medical requirements to buy its long-term care insurance policy. The coverage will be similar to other group or individual policies.

Life Insurance Policies

Some companies let you use your life insurance death benefit to pay for specific conditions such as terminal illness or for qualified long-term care expenses such as home health care, assisted living, or nursing home care. A life insurance death benefit you use while you are alive is known as an **accelerated death benefit**. A life insurance policy that uses an accelerated death benefit to pay for long-term care expenses may also be known as a “life/long-term care” policy. It may be an individual or a group life insurance policy. The company pays you the actual charges for care when you receive long-term care services, but no more than a certain percent of the policy's death benefit per day or per month. Policies may pay part or all of the death benefit for qualified long-term care expenses. Some companies let you buy more long-term care coverage than the amount of your death benefit in the form of a **rider**.

Some policies may allow you to withdraw the cash value of your policy to pay for specific conditions and expenses. It is important to remember that if you use money from your life insurance policy to pay for long-term care, it will reduce the death benefit the beneficiary will get. For example, if you buy a policy with a \$100,000 death benefit, using \$60,000 for long-term care will cut the death benefit of your policy to \$40,000. It may also affect the cash value of your policy. Ask your agent how this may affect other aspects of your life insurance policy. If you bought life insurance to meet a specific need after your death, your survivors may not be able to meet that need if you use your policy to pay for long-term care. If you never use the long-term care benefit, the policy will pay the full death benefit to your beneficiary.

Other Options

Some states have long-term care insurance programs designed to help people with the financial impact of spending down to meet Medicaid eligibility standards. Under these programs (sometimes called “**partnership programs**”), when you buy a specially approved insurance policy, you will receive full or partial protection against the normal Medicaid requirement to spend down your assets to become eligible. **Check with your state insurance department or counseling program to see if these policies are available in your state.** Please keep in mind that these programs have specific requirements in each state in which they are offered.

WHAT TYPES OF POLICIES CAN I BUY?

You may be asked to choose between a “tax-qualified” long-term care insurance policy and one that is “non-tax-qualified.” There are important differences between the two types of policies. These differences were created by the Health Insurance Portability and Accountability Act (HIPAA). A federally tax-qualified long-term care insurance policy, or a qualified policy, offers certain federal income tax advantages. If you have a qualified long-term care policy, and you itemize your deductions, you may be able to deduct part or all of the premium you pay for the policy. You may be able to add the premium to your other deductible medical expenses. You may then be able to deduct the amount that is more than 7.5% of your adjusted gross income on your federal income tax return. The amount depends on your age, as shown in the table.

Your Age	Maximum Amount That You Can Claim
40 years old or younger	\$250
More than 40 but not more than 50	\$470
More than 50 but not more than 60	\$940
More than 60 but not more than 70	\$2,510
More than 70	\$3,130

2003 figures.¹⁵ These amounts will increase annually based on the Medical Consumer Price Index.

Regardless of which policy you choose, make sure that you understand how the **benefits** and **triggers** will work and that they are acceptable to you. For example, benefits paid by a qualified long-term care insurance policy are generally not taxable as income. Benefits from a long-term care insurance policy that is not qualified may be taxable as income.

If you bought a long-term care insurance policy before January 1, 1997, that policy is probably qualified. HIPAA allowed these policies to be “grandfathered,” or considered qualified, even though they may not meet all of the standards that new policies must meet to be qualified. The tax advantages are the same whether the policy was sold before or after 1997. You should carefully examine the advantages and disadvantages of trading a grandfathered policy for a new policy. In most cases, it will be to your advantage to keep your old policy.

Long-term care insurance policies that are sold on or after January 1, 1997 as tax-qualified must meet certain federal standards. To be qualified, policies must be labeled as tax-qualified, must be **guaranteed renewable**, include a number of consumer protection provisions, cover only qualified long-term care services, and generally **can provide only limited cash surrender values**. (See **Benefit Triggers**, page 9-23.)

Qualified long-term care services are those generally given by long-term care providers. These services must be required by chronically ill individuals and must be given according to a plan of care prescribed by a licensed health care practitioner.

You are considered **chronically ill** if you are expected to be unable to do at least two activities of daily living without substantial assistance from another person for at least 90 days. Another way you may be considered to be chronically ill is if you need **substantial supervision** to protect your health and safety because you have a cognitive impairment. A policy issued to you before January 1, 1997, doesn’t have to define chronically ill this way. (See **Benefit Triggers**, page 9-23.)

Some life insurance policies with long-term care benefits may be tax-qualified. You may be able to deduct the premium you pay for the long-term care benefits that a life insurance policy provides. However, be sure to check with your personal tax advisor to learn how much of the premium can be deducted as a medical expense.

The long-term care benefits paid from a tax-qualified life insurance policy with long-term care benefits are generally not taxable as income. Tax-qualified life insurance policies with long-term care benefits must meet the same federal standards as other tax-qualified policies, including the requirement that you must be chronically ill to receive benefits.

Federally Tax-Qualified Policies	Federally Non-Tax-Qualified Policies
1. Premiums can be included with other annual uncompensated medical expenses for deductions from your income in excess of 7.5% of adjusted gross income up to a maximum amount adjusted for inflation.	1. You may or may not be able to deduct any part of your annual premiums. Congress and the U.S. Department of the Treasury have not clarified this area of the law.
2. Benefits that you receive and use to pay for long-term care services generally will not be counted as income. For policies that pay benefits using the expense incurred method, benefits that you receive in excess of the costs of long-term care services may be taxable. For policies that pay benefits using the indemnity or disability methods, all benefit payments up to the federally approved per diem (daily) rate are tax free even if they exceed your expenses.	2. Benefits that you receive may or may not count as income. Congress and the U.S. Department of the Treasury have not clarified this area of the law.
3. To trigger the benefits under your policy, the federal law requires you to be unable to do 2 ADLs without substantial assistance.	3. Policies can offer a different combination of benefit triggers. Benefit triggers are not restricted to 2 ADLs.
4. "Medical necessity" can't be used as a trigger for benefits.	4. "Medical necessity" and/ or other measures of disability can be offered as benefit triggers.
5. Chronic illness or disability must be expected to last for at least 90 days.	5. Policies don't have to require that the disability be expected to last for at least 90 days.
6. For cognitive impairment to be covered, a person must require "substantial supervision."	6. Policies don't have to require "substantial supervision" to trigger benefits for cognitive impairments.

Whether you are considering buying a tax-qualified or a non-tax-qualified policy, consult with your tax consultant or legal advisor regarding the tax consequences in your situation.

HOW DO LONG-TERM CARE INSURANCE POLICIES WORK?

Long-term care insurance policies are not standardized like Medicare supplement insurance. Companies sell policies that combine benefits and coverage in different ways.

How Benefits Are Paid

Insurance companies that sell long-term care insurance generally pay benefits using one of three different methods: **the expense-incurred method**, the **indemnity method**, or the **disability method**. It is important to read the literature that accompanies your policy (or certificate for group policies) and to compare the benefits and premiums.

When the **expense-incurred method** is used, the insurance company must decide if you are eligible for benefits and if your claim is for eligible services. Your policy or certificate will pay benefits only when you receive eligible services. Once you have incurred an expense for an eligible service, benefits are paid either to you or your provider. The

coverage will pay for the lesser of the expense you incurred or the dollar limit of your policy. Most policies bought today pay benefits using the expense incurred method.

When the **indemnity method** is used, the benefit is a set dollar amount. The benefit is not based on the specific services received or on the expenses incurred. The insurance company only needs to decide if you are eligible for benefits and if the services you are receiving are covered by the policy. Once the company decides you are eligible **and** you are receiving eligible long-term care services, the insurance company will pay that set amount directly to you up to the limit of the policy. When the **disability method** is used, you are only required to meet the benefit eligibility criteria. Once you do, you receive your full daily benefit, even if you are not receiving any long-term care services.

Pooled Benefits and Joint Policies

You may be able to buy a long-term care insurance policy that covers more than just one person, or more than one kind of long-term care service. The benefits provided by these policies are often called “pooled benefits.” One type of pooled benefit covers more than one person, such as a husband and wife, or two partners, or two or more related adults. This type of benefit is sometimes called a “joint policy” or a “joint benefit.” This pooled benefit usually has a total benefit that applies to all of the individuals covered by the policy. If one of the covered individuals collects benefits, that amount is subtracted from the total policy benefit. For example, if a husband and wife have a policy that provides \$150,000 in total long-term care benefits, and the husband uses \$25,000 in benefits from the policy, \$125,000 would be left to pay benefits for either the husband or the wife, or both.

Another kind of “pooled benefit” provides a total dollar amount that can be used for various long-term care services. These policies pay a daily, weekly, or monthly dollar limit for one or more covered services. You can combine benefits in ways that best meet your needs. This gives you more control over how your benefits are spent. For example, you may choose to combine the benefit for home care with the benefit for community-based care instead of using the nursing home benefit.

Some policies provide both types of pooled benefits. Other policies provide one or the other.

What Services Are Covered

It is important that you understand what services your long-term care insurance policy covers and how it covers the many types of long-term care services you might need to use. Policies may cover the following:

- Nursing home care
- Home health care
- Respite care
- Hospice care
- Personal care in your home
- Services in assisted living facilities
- Services in adult day care centers
- Services in other community facilities

There are several ways policies may cover home health care. Some long-term care insurance policies only pay for care in your home from licensed home health agencies. Some also will pay for care from licensed health care providers not from a licensed agency. These include licensed practical nurses; occupational, speech, or physical therapists; or licensed home health care aides. Other policies may pay for services from home health care aides who may not be licensed or are not from licensed agencies. Home health care aides help with personal care. You may find a policy that pays for homemaker or chore worker services. This type of benefit, though not available in all policies, would pay for someone to come to your home to cook meals and run errands. Generally, adding home care benefits to a policy also adds to the cost of the policy.

Note: Some policies pay benefits to family members who give care in the home.

Where Services Are Covered

You should know *what* types of facilities are covered by your long-term care insurance policy. If you're not in the right type of facility, the insurance company can refuse to pay for eligible services. New kinds of facilities may be developed in the future and it is important to know whether your policy will cover them.

Some policies may pay for care in *any* state-licensed facility. Others only pay for care in *some* state-licensed facilities, such as a licensed nursing facility. Still others list the types of facilities where services will not be covered, which may include state licensed facilities. (For example, some places that care for elderly people are referred to as homes for the aged, rest homes, and personal care homes, and are often not covered by long term care policies). Some policies may list specific points about the kinds of facilities they will cover. Some will say the facilities must care for a certain number of patients or give a certain kind of care. When shopping for a long-term care policy, check these points carefully and compare the types of services and facilities covered in the policy. Also, be aware that many states, companies and policies define assisted living facilities differently. Policies that cover assisted living facilities in one state may not cover services provided in an assisted living facility in another state. Before you move or retire to another state, ask if your policy covers the types of services and facilities available in your new state. Also, if your policy lists kinds of facilities, be sure to check if your policy requires the facility to have a license or certification from a government agency.

Note: If you do NOT reside in the kind of facility specified by your policy, the insurance company may not pay for the services you require.

What Services Are Not Covered (Exclusions and Limitations)

Most long-term care insurance policies usually do not pay benefits for:

- a mental or nervous disorder or disease, other than Alzheimer's disease or other dementia;
- alcohol or drug addiction;
- illness or injury caused by an act of war;
- treatment the government has provided in a government facility or already paid for; or
- attempted suicide or intentionally self-inflicted injuries.

Note: In most states, regulations require insurance companies to pay for covered services for Alzheimer’s disease that may develop after a policy is issued. Ask your state insurance department if this applies in your state. Nearly all policies specifically say they will cover Alzheimer’s disease. Read about Alzheimer’s disease and eligibility for benefits in the section on benefit triggers on page 9-23.

Note: Many policies exclude or limit coverage for care outside of the United States.

How Much Coverage You Will Have

The policy or certificate may state the amount of coverage in one of several ways. A policy may pay different amounts for different types of long-term care services. Be sure you understand how much coverage you will have and how it will cover long-term care services you receive.

Maximum Benefit Limit. Most policies limit the total benefit they will pay over the life of the policy, but a few don’t. Some policies state the maximum benefit limit in years (one, two, three, or more, or even lifetime). Others write the policy maximum benefit limit as a total dollar amount. Policies often use words like “total lifetime benefit,” “maximum lifetime benefit,” or “total plan benefit” to describe their maximum benefit limit. When you look at a policy or certificate be sure to check the total amount of coverage. In most states, the minimum benefit period is one year. Most nursing home stays are short, but illnesses that go on for several years could mean long nursing home stays. You will have to decide if you want protection for very long stays. Policies with longer maximum benefit periods cost more. Read your long-term care insurance policy carefully to learn what the benefit period is.

Daily/Weekly/Monthly Benefit Limit. Policies normally pay benefits by the day, week or month. For example, in an expense-incurred plan, a policy might pay a daily nursing home benefit of up to \$200 per day or \$6,000 per month, and a weekly home care benefit of up to \$1,400 per week. Some policies will pay one time for single events, such as installing a home medical alert system.

When you buy a policy, insurance companies let you choose a benefit amount (usually \$50 to \$350 a day, \$350 to \$2,450 a week, or \$1,500 to \$10,500 a month) for care in a nursing home. If a policy covers home care, the benefit is usually a portion of the benefit for nursing home care (e.g., 50% or 75%), although a growing number of policies pay the same benefit amounts for care at home as in a facility. Often, you can select the home care benefit amount that you prefer. It is important to know how much skilled nursing homes, assisted living facilities, and home health care agencies charge for their services **BEFORE** you choose the benefit amounts in your long-term care insurance policy. Check the facilities in the area where you think you may be receiving care, whether they are local, near a grown child, or in a new place where you may retire. The worksheet on page 9-44 can help you track these costs.

When You Are Eligible for Benefits (Benefit Triggers)

The term usually used to describe the way insurance companies decide when to pay benefits is “Benefit triggers”. This term refers to the criteria and the methods that the insurance company uses to evaluate when you are eligible for benefits, and the conditions you must meet to receive benefits. This is an important part of a long-term care insurance

policy. Look at it carefully as you shop. The policy and the outline of coverage usually describe the benefit triggers. Look for a section called “Eligibility for the Payment of Benefits” or simply “Eligibility for Benefits.” Different policies may have different benefit triggers. Some states require certain benefit triggers, and the benefit triggers for tax-qualified contracts are also fairly standardized across insurance policies. Check with your state insurance department to find out what your state requires.

Note: Companies may use different benefit triggers for home health care coverage than for nursing home care, although most do not do so. If they do, they generally have a more restrictive benefit trigger for nursing home care than for home care.

Types of Benefit Triggers

Activities of Daily Living. The inability to do activities of daily living, or ADLs, is the most common way insurance companies decide when you are eligible for benefits. The ADLs most companies use are **bathing, continence, dressing, eating, toileting and transferring**. Typically, a policy pays benefits when you can't do a certain number of the ADLs, such as two of the six or three of the six. The more ADLs you must be unable to do, the harder it will be for you to become eligible for benefits. Federally tax-qualified policies are required to use being unable to do certain ADLs as a benefit trigger. A qualified policy requires that a person be unable to perform at least two of their ADLs to collect benefits. The ADLs that trigger benefits in a tax-qualified policy must come from the list above. These triggers are specified in your policy.

If the policy you're thinking of buying pays benefits when you can't do certain ADLs, be sure you understand what that means. Some policies spell out very clearly what it means to be unable to feed or bathe oneself. Some policies say that you must have someone actually help you do the activities. That's known as hands-on assistance. Specifying hands-on assistance will make it harder to qualify for benefits than if only standby assistance is required. The more clearly a policy describes its requirements, the less confusion you or your family will have when you need to file a claim.

Note: The six activities of daily living (ADLs) have been developed through years of research. This research also has shown that bathing is usually the first ADL that a person can't do. While most policies use all six ADLs as benefit triggers, qualifying for benefits from a policy that uses five ADLs may be more difficult if bathing isn't one of the five.

Cognitive Impairment. Most long-term care insurance policies also pay benefits for “**cognitive impairment**”. The policy usually pays benefits if you can't pass certain tests of cognitive function.

Coverage of cognitive impairment is especially important if you develop Alzheimer's disease or other dementia. If being unable to do ADLs is the only benefit trigger your policy uses, it may not pay benefits if you have Alzheimer's disease but can still do most of the ADLs on your own. But if your policy also uses a test of your cognitive ability as a benefit trigger, it is more likely to pay benefits if you have Alzheimer's disease. Most states do not allow policies to limit benefits solely because you have Alzheimer's disease.

Doctor Certification of Medical Necessity. Some long-term care insurance policies will pay benefits if your doctor orders or certifies that the care is medically necessary. However, tax qualified policies can't use this benefit trigger.

Prior Hospitalization. Long-term care insurance policies sold in the past required a hospital stay of at least three days before paying benefits. Most companies no longer sell policies that require a hospital stay.

Note: Medicare still requires a three-day hospital stay to be eligible for Medicare payment of skilled nursing facility benefits.

When Benefits Start (Elimination Period)

With many policies, your benefits won't start the first day you go to a nursing home or start using home care. Most policies have an **elimination period** (sometimes called a deductible or a waiting period). That means benefits can start 0, 20, 30, 60, 90, or 100 days after you start using long-term care or become disabled. Elimination periods for nursing home and home health care may be different, or there may be a single elimination period that applies to any covered service. How many days you have to wait for benefits to start will depend on the elimination period you pick when you buy your policy. You might be able to choose a policy with a zero-day elimination period, but expect it to cost more.

Some policies calculate the elimination period using calendar days while other policies count only the days on which you receive a covered service. Under the calendar days method, every day of the week would count in determining the elimination period regardless of whether you received any services on those days. Under the days of service method, only days when you receive services will count toward the elimination period. This means if you only receive services three days a week, it will take longer for your benefits to start and it could mean that you have more out-of-pocket expenses before your benefits begin. Also, some policies have an elimination period that you only need to satisfy once in your lifetime, while other policies require that you satisfy the elimination period with each "episode of care." Some policies allow you to accumulate non-consecutive days toward satisfying the elimination period and some policies require consecutive days. Make sure you know how the policy defines the elimination period.

During an elimination period, the policy will not pay the cost of long-term care services. You may owe the cost of your care during the elimination period. You may choose to pay a higher premium for a shorter elimination period. If you choose a longer elimination period, you'll pay a lower premium but must pay the cost of your care during the elimination period.

For example, if a nursing home in your area costs \$150 a day and your policy has a 30-day elimination period, you'd have to pay \$4,500 before your policy starts to pay benefits. A policy with a 60-day elimination period would mean you'd have to pay \$9,000 of your own money, while a policy with a 90-day elimination period would mean you'd have to pay \$13,500 of your own money.

If you only need care for a short time and your policy has a long elimination period, your policy may not pay any benefits. If, for example, your policy had a 100-day elimination period, and you received long-term care services for only 60 days, you would not receive any benefits from your policy.

On the other hand, if you can afford to pay for long-term care services for a short time, a longer elimination period might be right for you. It would protect you if you need extended care and also keep the cost of your insurance down.

You may also want to think about how the policy pays if you have a repeat stay in a nursing home. Some policies count the second stay as part of the first one as long as you leave and then go back within 30, 90 or 180 days. Find out if the insurance company requires another elimination period for a second stay. Some policies only require you to meet the elimination period once per lifetime.

What Happens When Long-Term Care Costs Rise (Inflation Protection)?

Inflation protection can be one of the most important additions you can make to a long-term care insurance policy. Inflation protection increases the premium. However, unless your benefits increase over time, years from now you may find that they haven't kept up with the rising cost of long-term care. The cost of nursing home care has been rising at an annual rate of 5% for the past several years.¹⁶ This means that a nursing home that cost \$150 a day in 2000 will cost \$398 a day in 20 years, if inflation is 5% a year. Obviously, the younger you are when you buy a policy, the more important it is for you to think about adding inflation protection.

You can usually buy inflation protection in one of two ways: automatically or by special offer.

Automatic Inflation Protection. The first way automatically increases your benefits each year. Generally, there would be no increase in premium when the benefit is automatically increased. Policies that increase benefits for inflation automatically may use simple or compound rates. Either way, the daily benefit increases each year by a fixed percentage, usually 5%, for the life of the policy or for a certain period, usually 10 or 20 years.

The dollar amount of the increase depends on whether the inflation adjustment is "simple" or "compound." If the inflation increase is simple, the benefit increases by the same dollar amount each year. If the increase is compounded, the dollar amount of the benefit increase goes up each year. For example, a \$100 daily benefit that increases by a simple 5% a year will go up \$5 a year and be \$200 a day in 20 years. If the increase is compounded, the annual increase will be higher each year and the \$100 daily benefit will be \$265 a day in 20 years.

Automatic inflation increases that are compounded are a good idea but not all policies offer them. Some states now require policies to offer compound inflation increases.

Check with your state insurance department to find out if this applies in your state. All individual and some group tax-qualified policies must offer compound inflation increases as an option. Compounding can make a big difference in the size of your benefit.

Special Offer or Non-Automatic Inflation Protection. The second way to buy inflation protection lets you choose to increase your benefits periodically, such as every two or three years. With a periodic increase option, you usually don't have to show proof of good health, if you regularly use the option. Your premium will increase if you increase your benefits. How much it increases depends on your age at the time and on the amount of additional benefit you want to buy. Buying more benefits every few years may help you afford the cost of the additional coverage. If you turn down the option to increase your benefit one year, you may not get the chance again. If you get the chance later, you may have to prove good health, or it may cost you more money. If you don't accept the offer, you need to check your policy to see how it will affect future offers. Some policies

continue the inflation offers while you are receiving benefits, but most do not. So check your policy carefully before you buy.

The following charts and graphs illustrate the effects of inflation in two different formats.

EFFECT OF INFLATION ON DAILY RATES FOR NURSING HOME CARE

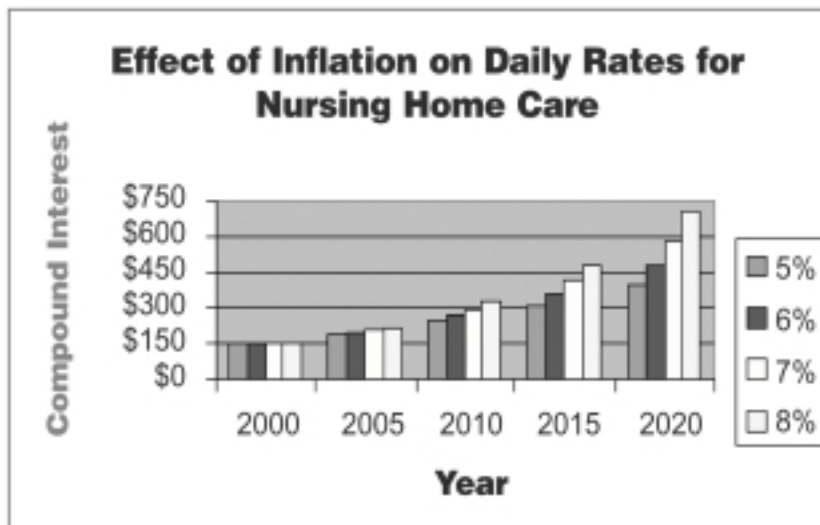
Compound Interest

Rate of inflation	2000	2005	2010	2015	2020
5%	\$150	\$191	\$244	\$312	\$398
6%	\$150	\$201	\$269	\$359	\$481
7%	\$150	\$210	\$295	\$414	\$580
8%	\$150	\$220	\$324	\$476	\$699

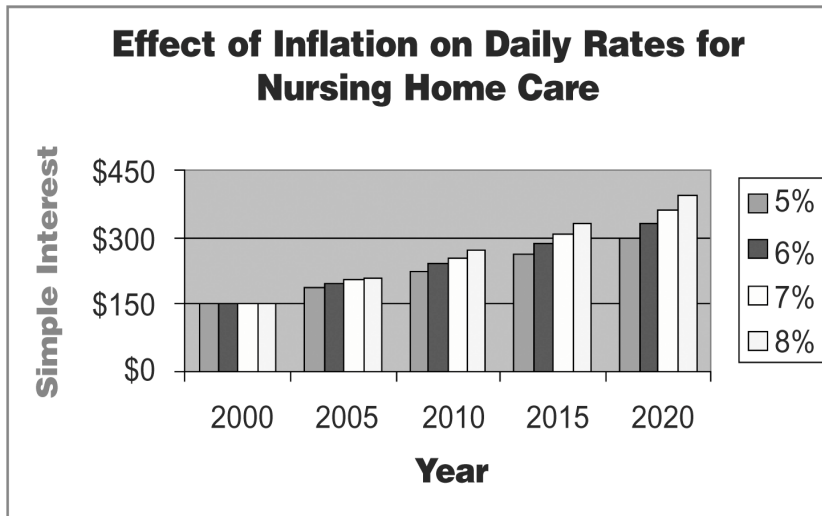
Simple Interest

Rate of inflation	2000	2005	2010	2015	2020
5%	\$150	\$188	\$225	\$263	\$300
6%	\$150	\$195	\$240	\$285	\$330
7%	\$150	\$203	\$255	\$308	\$360
8%	\$150	\$210	\$270	\$330	\$390

The chart is for demonstration purposes only. It shows inflation increases over a 20-year period.



The graph is for demonstration purposes only. It shows compounded inflation increases over a 20-year period.



The graph is for demonstration purposes only. It shows simple inflation increases over a 20-year period.

Note: Most states have adopted regulations that require companies to offer inflation protection. It's up to you to decide whether to buy the coverage. If you decide not to take the protection, you may be asked to sign a statement saying you didn't want it. Be sure you know what you're signing.

Additional Benefits

Third Party Notice. This benefit lets you name someone who the insurance company would contact if your coverage is about to end because you forgot to pay the premium. Sometimes people with cognitive impairments forget to pay the premium and lose their coverage when they need it the most. You can choose a relative, friend, or a professional (a lawyer or accountant, for example) as your third party. After the company contacts the person you choose, he or she would have some time to arrange for payment of the overdue premium. You can usually name a contact person without paying extra. Some states require insurance companies to give you the chance to name a contact and to update your list of contacts from time to time. You may be required to sign a waiver if you choose not to name anyone to be contacted if the policy is about to lapse.

Other Long-Term Care Insurance Policy Options You Might Choose

You can probably choose other policy features, but keep in mind that not all insurers offer all of the policy options. Each may add to the cost of your policy. Ask your insurer what features increase your policy's cost.

Waiver of Premium. Many policies automatically include this feature, but some may only offer it as an additional optional benefit. Premium waiver lets you stop paying the premium once you are eligible for benefits and the insurance company has started to pay benefits. Some companies waive the premium as soon as they make the first benefit payment. Others wait until you have received benefits for 60 to 90 days.

Restoration of Benefits. This option gives you a way to keep the maximum amount of your original benefit even after your policy has paid you benefits. With this option, if you fully recover after a prior disability and go for a stated period without needing or receiving more long-term care services, your benefit goes back to the amount you first

bought. For example, assume your policy paid you \$5,000 in long-term care benefits out of a policy maximum of \$75,000. You would have \$70,000 in benefits left. With a restoration of benefits option, if you fully recovered and didn't need or use any long-term care services for a specified time (usually 6 months), your maximum benefit would go back to the original \$75,000.

Premium Refund At Death. This benefit pays to your estate any premiums you paid minus any benefits the company paid. To get a refund at death, you must have paid premiums for a certain number of years. Some companies refund premiums only if the policyholder dies before a certain age, usually 65 or 75. The premium refund option may also add to the cost of a policy.

Downgrades. While it may not always appear in the contract, most insurers let policyholders reduce their coverage if they have trouble paying the premium. When you downgrade to a less comprehensive policy, you will pay a lower premium, usually based on your age at the time you purchased your original policy. This may allow you to keep the policy in force instead of dropping it.

What Happens If You Can't Afford the Premiums Anymore?

Nonforfeiture Benefits. If, for whatever reason, you drop your coverage and you have a nonforfeiture benefit in your policy, you will receive some benefit value for the money you've paid into the policy. Without this type of benefit, you get nothing even if you've paid premiums for 10 or 20 years before dropping the policy.

Some states may require insurance companies to offer long-term care insurance policies with a written offer of nonforfeiture benefit. In this case, you may be given benefit options with different premium costs including **reduced paid up policies**, **shortened benefit period policies** and **extended term policies**. Under these benefit options, when you stop paying your premiums, the company gives you a **paid-up policy**. Depending on the option you chose, your paid-up policy either will have the same benefit period but with a lower daily benefit (reduced paid up policy) or will have the same daily benefit but with a shorter benefit period (shortened benefit period policy or extended term policy). Under all of these options, the level of benefits you will receive depends on how long you paid premiums and the amount of premiums you have paid. Since it's paid-up, you won't owe any more premiums.

Other insurers may offer a "return of premium" nonforfeiture benefit. They pay back to you all or part of the premiums that you paid in if you drop your policy after a certain number of years. This is generally the most expensive type of nonforfeiture benefit. A nonforfeiture benefit can add roughly 10% to 100% (and sometimes more) to a policy's cost. How much it adds depends on such things as your age at the time you bought the policy, the type of nonforfeiture benefit, and whether the policy has inflation protection.

You have the option to add a nonforfeiture benefit if you're buying a tax-qualified policy. The "return of premium" nonforfeiture benefit, the "reduced paid-up policy" and the "shortened benefit period policy" may be available options under a tax-qualified policy if you drop the policy. You should consult a tax advisor to see if adding a nonforfeiture benefit would be good for you.

Contingent Nonforfeiture. In some states, if you don't accept the offer of a nonforfeiture benefit, a company is required to provide a "contingent benefit upon lapse." This means that when your premiums increase to a certain level (based on a table of increases), the

“contingent benefit upon lapse” will take effect. For example, if you bought the policy at age 70 and did **not** accept the insurance company’s offer of a nonforfeiture benefit, if the premium rises to 40% more than the original premium you will be offered the opportunity to accept one of the “contingent benefits upon lapse.” The benefits offered are: 1) a reduction in the benefits provided by the current policy so that premium costs stay the same; *or* 2) a conversion of the policy to paid-up status with a shorter benefit period. You may also choose to keep your policy and continue to pay the higher premium.

WILL YOUR HEALTH AFFECT YOUR ABILITY TO BUY A POLICY?

Companies that sell long-term care insurance medically “underwrite” their coverage. They look at your health and health history before they decide to issue a policy. You may be able to buy coverage through an employer or another type of group without any health underwriting or with more relaxed underwriting. Insurance companies’ underwriting practices affect the premiums they charge you now and in the future. Some companies do what is known as “short-form” underwriting. They ask you to answer a few questions on the insurance application about your health. For example, they may want to know if you have been in a nursing home or received care at home in the last 12 months.

Sometimes companies don’t check your medical record until you file a claim. Then they may try to refuse to pay you benefits because of information found in your medical record after you file your claim. This practice is called “post-claims underwriting.” It is illegal in many states. Companies that thoroughly check your health before selling you a policy aren’t as likely to do post-claims underwriting.

Some companies do more underwriting. They may ask more questions, look at your current medical records, and ask your doctor for a statement about your health. These companies may insure fewer people with health problems. If you have certain conditions that are likely to mean you’ll soon need long-term care (Parkinson’s disease, for example), you probably can’t buy coverage from these companies.

No matter how the company underwrites, you must answer certain questions that the company uses to decide if it will insure you. When you fill out your application, be sure to answer all questions correctly and completely. A company depends on the information you put on your application. If the information is wrong, an insurance company may decide to rescind your policy and return the premiums you have paid. It can usually do this within two years after you buy the policy. Most states require the insurance company to give you a copy of your application when it delivers the policy. At this time, you can review your answers again. You should keep this copy of the application with your insurance papers.

WHAT HAPPENS IF YOU HAVE PRE-EXISTING CONDITIONS?

A long-term care insurance policy usually defines a **pre-existing condition** as one for which you received medical advice or treatment or had symptoms within a certain period before you applied for the policy. Some companies look further back in time than others. That may be important to you if you have a pre-existing condition. A company that learns you didn’t tell it about a pre-existing condition on your application might not pay for treatment related to that condition and might even cancel your coverage. A company can

usually do this within two years after you buy the policy, or in some cases later, if you intentionally mislead the insurer.

Many companies will sell a policy to someone with a pre-existing condition. However, the company may not pay benefits for long-term care related to that condition for a period after the policy goes into effect, usually six months. Some companies have longer pre-existing condition periods; others have none.

CAN YOU RENEW YOUR LONG-TERM CARE INSURANCE POLICY?

In most states, long-term care insurance policies sold today must be guaranteed renewable. When a policy is **guaranteed renewable**, it means that the insurance company guarantees you a chance to renew the policy. It does not mean that it guarantees you a chance to renew at the same premium. Your premium may go up over time as your company pays more claims and more expensive claims.

Insurance companies can raise the premiums on their policies but only if they increase the premiums on all policies that are the same in that state. **No individual can be singled out for a rate increase**, no matter how many claims have been filed. In some states, the premium can't increase just because you are older.

If you bought a policy in a group setting and you leave the group, you may be able to keep your group coverage or convert it to an individual policy but you may pay more. **You can ask your state insurance department if your state requires this option.**

HOW MUCH DO LONG-TERM CARE INSURANCE POLICIES COST?

A long-term care insurance policy can be expensive. Be sure you can pay the premiums and still afford your other health insurance and other expenses.

Premiums will vary based on a variety of factors. These factors include your age and health when you buy a policy and the level of coverage, benefits and options you select for your policy. If you buy a policy with a large daily benefit, a longer maximum benefit period, or a home health care benefit, it will cost you more. Inflation protection and nonforfeiture benefits can increase premiums for long-term care substantially. Inflation protection can add 25% to 40% to the premium. Nonforfeiture benefits can add 10% to 100% to the premium, as noted on page 9-29. In fact, either of these options can easily double your premium depending on your age when you buy a policy.

The older you are when you buy long-term care insurance, the higher your premiums will be since it's more likely you will need long-term care services. (See "Who May Need Long Term Care" on page 9-14.) If you buy at a younger age, your premiums will be lower, but you will pay premiums for a longer period of time. Recent studies have found the average age of purchasers was age 65 in the individual market and age 43 in the employer-sponsored market.¹⁷

Here is an example of how much premiums can fluctuate based on your age and your coverage options:¹⁸

The average annual premiums for basic long-term care insurance (\$100 daily benefit amount, four years of coverage, and a 20-day elimination period) that does not include a 5% compound inflation protection option or a nonforfeiture benefits option were:

- \$300 for a 40-year old;
- \$409 for a 50-year old;
- \$1,002 for a 65-year old; and
- \$4,166 for a 79-year old.

The average annual premiums for the same policy with the 5% compound inflation protection option but no nonforfeiture benefit option were:

- \$649 for a 40-year old;
- \$881 for a 50-year old;
- \$1,802 for a 65-year old; and
- \$5,895 for a 79-year old.

The average annual premiums for the same policy with the nonforfeiture benefits option but no inflation protection were:

- \$382 for a 40-year old;
- \$506 for a 50-year old;
- \$1,196 for a 65-year old; and
- \$5,067 for a 79-year old.

The average annual premiums for the same policy with both the 5% compound inflation protection option and the nonforfeiture benefits option were:

- \$798 for a 40-year old;
- \$1,087 for a 50-year old;
- \$2,130 for a 65-year old; and
- \$7,000 for a 79-year old.

Remember, your actual premium may be very different if it's based on other factors.

Another issue to keep in mind is that long-term care insurance policies may not cover the entire cost of your care. For example, your policy may cover \$110 per day in a nursing home, but the total cost of care may be \$150 per day. You must pay the difference. Remember, medications and therapies will increase your total daily costs for care. The costs of long-term care in your state should influence the amount of coverage you buy and the premiums you will pay. (See "How Much Does Long-Term Care Cost?" on page 9-12.)

When you buy a long-term care policy, think about how much your income is and how much you could afford to spend on a long-term care insurance policy now. Also try to think about what your future income and living expenses are likely to be and how much premium you can pay then. If you don't expect your income to increase, it probably isn't a good idea to buy a policy if you can barely afford the premium now.

You also need to think about whether you could afford a rate increase on your policy some time in the future. Remember, while a company cannot raise your rates based on your age or health, the company can raise the rates for an entire class of policies. Some states have laws that limit rate increases. **Check with your insurance department to learn how your state regulates rate increases.** A directory of state insurance departments begins on page 9-58. Again, it probably isn't a good idea to buy a policy if you can barely afford the premium now.

Note: Don't be misled by the term "level premium." You may be told that your long-term care insurance premium is "level". That doesn't mean that it will never increase. Except for **whole life insurance** policies and **noncancellable policies** or riders, companies can't guarantee premiums will never increase. Many states have adopted regulations that don't let insurance companies use the word "level" to sell guaranteed renewable policies. **Companies must tell consumers that premiums may go up.** Look for that information on the outline of coverage and the policy's face page when you shop.

WHAT OPTIONS DO I HAVE TO PAY THE PREMIUMS ON THE POLICY?

If you decide you can afford to buy a long-term care insurance policy, there are two main ways in which you may be able to pay your premiums—the **continuous payment option** and the **limited payment option**.

Under the continuous payment option, you would pay the premiums on your policy until you trigger your benefits, traditionally on a monthly, quarterly, semi-annual or annual basis. The policy is not cancelable except in the event of nonpayment of premiums; however, the insurance company can increase premiums on an entire class of policies. Premiums are usually the lowest available under this payment option.

In addition to the continuous payment option, you may be able to pay your premiums under a limited payment option. Under this option, you would pay premiums for a set time period using one of the following ways:

- **Single pay.** This allows you to make one lump-sum payment.
- **Ten-pay and 20-pay.** This allows you to complete payment of your premiums in 10 or 20 years, depending on the option you chose. You might choose this option if your income will be lower in 10 or 20 years.
- **Pay-to-65.** You pay higher than usual premiums, but payments end when you reach age 65.

After the last premium payment, neither you nor the company can cancel the policy. Policies with the limited payment option are more expensive than continuous payment policies, because your premium is set at a higher rate than it would have been had you paid over a longer period of time. In addition, unless the contract fixes your premium for the pay period, it could increase. However, the guaranteed fixed payment and the no-cancel features make limited payment premiums attractive to some clients. You should consult your tax adviser for information on the tax treatment of accelerated premium payments.

It is important to note that not all of these payment options are offered by all companies or are available in all states. Check with the insurance company to see what payment options it offers. **Also check with your state insurance department to find out what options your state allows.** A directory of state insurance departments begins on page 9-58.

IF YOU ALREADY OWN A POLICY, SHOULD YOU SWITCH PLANS OR UPGRADE THE COVERAGE YOU HAVE NOW?

Before you switch to a new long-term care insurance policy, make sure it is better than the one you already have. Even if your agent now works for another company, think carefully before making any changes. First check to see if you can upgrade the coverage on your current policy. If not, you may replace your current policy with a different one that gives you more benefits, or even choose a second policy. Be sure to discuss any change in your coverage with your financial advisor.

If you decide to switch to a new long-term care insurance policy, make sure the new company has accepted your application and issued the new policy before you cancel the old one. When you cancel a policy in the middle of its term, many companies will not give back any premiums you have paid. If you switch policies, new restrictions on pre-existing conditions may apply. You may not have coverage for some conditions for a certain period.

Switching may be right for you if your old policy requires you to stay in the hospital or to receive other types of care before it pays benefits. Before you decide to change, though, make sure you are in good health and can qualify for another policy. If you bought a policy when you were younger, you might ask the insurance company if you can improve it. For example, you might add inflation protection or take off the requirement that you stay in the hospital. It might cost less to improve a policy you have now than to buy a new one.

WHAT SHOPPING TIPS SHOULD YOU KEEP IN MIND?

Here are some points to keep in mind as you shop.

Ask Questions

If you have questions about the agent, the insurance company, or the policy, **contact your state insurance department or insurance counseling program.** (A directory starts on page 9-58.) Make sure the company is reputable and is licensed to sell long-term care insurance policies in your state.

Check With Several Companies and Agents

Contacting several companies (and agents) before you buy is wise. Be sure to compare benefits, the types of facilities you have to be in to get coverage, the limits on your coverage, what's excluded, and, of course, the premium. (Policies that have the same coverage and benefits may not cost the same.)

Check Out the Companies' Rate Increase Histories

Ask companies about their rate increase histories and whether they have increased the rates on the long-term care insurance policies that they sell. Ask to see a company's personal worksheet that includes this information.

Some state Insurance Commissioners annually prepare a consumer rate guide for long-term care insurance. These guides may include an overview of long-term care insurance, a list of companies selling long-term care insurance in your state, the types of benefits and policies you can buy (both as an individual and as a member of a group), and a rate history of each company that sells long-term care insurance in your state. Some guides even include examples of different coverage types and combinations and provide rates to assist consumers in comparing policies. **Contact your state insurance department or insurance counseling program for information.** A list of insurance departments and counseling programs starts on page 9-58.

Take Your Time and Compare Outlines of Coverage

Never let anyone pressure or scare you into making a quick decision. Don't buy a policy the first time you see an agent. Ask for an outline of coverage. It outlines the policy's benefits and points out important features. Compare outlines of coverage for several policies and make sure the outlines are similar (if not the same) when comparing premiums. In most states the agent must leave an outline of coverage when he or she first contacts you.

Understand the Policies

Make sure you know what the policy covers and what it doesn't. If you have any questions, call the insurance company before you buy.

If you receive any information that confuses you or is different from the information in the company literature, don't hesitate to call or write the company to ask your questions. Don't trust any sales presentation or literature that claims you have only one chance to buy a policy.

Some companies sell their policies through agents, and others may sell their policies through the mail, skipping agents entirely. No matter how you buy your policy, check with the company if you don't understand how the policy works.

Talk about the policy with a friend or relative. **You may also want to contact your state insurance department or insurance counseling program.** A list of insurance departments and counseling programs starts on page 9-58.

Don't Be Misled by Advertising

Most celebrity endorsers are professional actors paid to advertise. They are not insurance experts.

Medicare does not endorse or sell long-term care insurance policies. Be wary of any advertising that suggests Medicare is involved.

Don't trust cards you get in the mail that look like official government documents until you check with the government agency identified on the card. Insurance companies or

agents trying to find buyers may have sent them. Be careful if anyone asks you questions over the telephone about Medicare or your insurance. They may sell any information you give to long-term care insurance marketers, who might call you, come to your home, or try to sell you insurance by mail.

Don't Buy More Coverage Than You Need

You don't have to buy more than one policy to get enough coverage. One good policy is enough. Also, don't buy more insurance than you need. For example, buying a policy with a \$500 daily benefit in order to prepare for inflation is not necessary. You should choose the daily benefit that matches the cost of long-term care. For more information, reread the section "If You Already Own a Policy, Should You Switch Plans or Upgrade the Coverage You Have Now?" on page 9-34. Be sure to discuss any change in your coverage with your financial advisor.

Be Sure You Accurately Complete Your Application

Don't be misled by long-term care insurance marketers who say your medical history isn't important—it is! Give correct information. If an agent fills out the application for you, don't sign it until you have read it. Make sure that all of the medical information is accurate and complete. If it isn't and the company used that information to decide whether to insure you, it can refuse to pay your claims and can even cancel your policy.

Never Pay in Cash

Use a check or an electronic bank draft made payable to the insurance company.

Be Sure To Get the Name, Address, and Telephone Number of the Agent and the Company.

Get a local or toll-free number for both the agent and the company.

If You Don't Get Your Policy Within 60 days, Contact the Company or Agent

You have a right to expect prompt delivery of your policy. When you get it, keep it somewhere you can easily find it. Tell a trusted friend or relative where it is.

Be Sure You Look at Your Policy During the Free-Look Period

If you decide you don't want the policy soon after you bought it, you can cancel it and get your money back. You must tell the company you don't want the policy within a certain number of days after you get it. How many days you have depends on the "free-look" period. In some states the insurance company must tell you about the free-look period on the cover page of the policy. In most states you have 30 days to cancel, but in some you have less time. **Check with your state insurance department to find out how long the free-look period is in your state.** If you want to cancel:

- Keep the envelope the policy was mailed in. Or ask the agent for a signed delivery receipt when he or she hands you the policy.
- Send the policy to the insurance company along with a short letter asking for a refund.
- Send both the policy and the letter by certified mail. Keep the mailing receipt.
- Keep a copy of all letters.

It usually takes four to six weeks to get your refund.

Read the Policy Again and Make Sure it Gives You the Coverage You Want

Check the policy to see if the benefits and the premiums are what you expected. If you have any questions, call the agent or company right away. Also, reread the application you signed. It is part of the policy. If it's not filled out correctly, contact the agent or company right away. You may want to fill out Worksheet 3 on page 9-51.

Think About Having the Premium Automatically Taken Out of Your Bank Account

Automatic withdrawal may mean that you won't lose your coverage if an illness makes you forget to pay your premium. If you decide not to renew your policy, be sure you tell the bank to stop the automatic withdrawals.

Check on the Financial Stability of the Company You're Thinking About Buying From

Several insurer rating services analyze the financial strength of insurance companies. The ratings can show you how some analysts see the financial health of individual insurance companies. Different rating services use different rating scales. Be sure to find out how the agency labels its highest ratings and the meaning of the ratings for the companies you are considering.

You can get ratings from some insurer rating services for free at most public libraries. Or you can call the services directly at the numbers listed below. (Note that calls to a "900" number will mean an extra charge on your telephone bill.) And now you can get information from these services on the Internet.

Rating Agencies

- A.M. Best Company
(900) 439-2200 (billed to telephone) or (800) 424-BEST (charged to credit card or on the Internet at <http://www.ambest.com>)
- Fitch IBCA, Duff & Phelps, Inc.
(212) 908-0800 or on the Internet at <http://www.bankwatch.com>
- Moody's Investor Service, Inc.
(212) 553-0377 or on the Internet at <http://www.moody.com>
- Standard & Poor's Insurance Rating Services
(212) 488-2000 or on the Internet at <http://www.standardandpoors.com>
- Weiss Ratings, Inc.
(800) 289-9222 or on the Internet at <http://www.WeissRatings.com>

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- 2 National Center for Assisted Living. "Facts and Trends: The Assisted Living Sourcebook, 2001".
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- 4 U.S. Department of Labor, 2000. Medicare will pay less than 10 percent of nursing home costs.
- 5 Centers for Medicaid and Medicare Services, *Medicare & You 2002 Guide*.

- 6 Centers for Medicare and Medicaid Services. *2002 Guide to Health Insurance for People with Medicare*, page 25.
- 7 CMS National Health Expenditures, January 2002. Medicaid pays for 48% of all nursing home care.
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- 9 *The Older Population, A Profile of Older Americans: 2001*, Administration on Aging. Information in profile based on data gathered in the 2000 U.S. Census.
- 10 National Academy on Aging, 1997.
- 11 Stillman and Lubitz, "Medical Care" 40 (10):965-967 (2002).
- 12 Stillman and Lubitz, "Medical Care" 40 (10):965-967 (2002).
- 13 Health Insurance Association of America (HIAA) survey. "Research Findings: Long Term Care Insurance in 1998-1999" February 2002, pages 3, 5, 13, 17, 27. The employer-sponsored market contributed 25% of the sales in 1999. By the end of 1999, more than 1 million policies had been sold through more than 3,200 employers. This represents a 35% average annual growth rate. There were more than 770 employer-sponsored plans introduced in 1999 alone.
- 14 Members of the federal family can obtain information on this program from the United States Office of Personnel Management by calling the toll-free number 1-800-582-3337 or by accessing the website at <http://www.opm.gov/insure/ltc/>.
- 15 Internal Revenue Service, Revenue Procedure 97-57.
- 16 U.S. Department of Labor, Bureau of Labor Statistics, 2000. Data shows that between 1995 and 2001, the average nursing home costs have risen about 5%.
- 17 Health Insurance Association of America (HIAA) survey. "Research Findings: Long Term Care Insurance in 1998-1999". February 2002.
- 18 Health Insurance Association of America (HIAA) survey. "Research Findings: Long Term Care Insurance in 1998-1999" February 2002. Table 5. p. 26. "Average Annual Premiums for Leading Long-Term Care Insurance Sellers in 1999."

GLOSSARY

Accelerated Death Benefit—A feature of a life insurance policy that lets you use some of the policy's death benefit prior to death.

Activities of Daily Living (ADLs)—Everyday functions and activities individuals usually do without help. ADLs functions include bathing, continence, dressing, eating, toileting and transferring. Many policies use the inability to do a certain number of ADLs (such as 2 of 6) to decide when to pay benefits.

Adult Day Care—Care provided during the day at a community-based center for adults who need assistance or supervision during the day including help with personal care, but who do not need round-the-clock care.

Alzheimer's Disease—A progressive, degenerative form of dementia that causes severe intellectual deterioration.

Assisted Living Facility—A residential living arrangement that provides individualized personal care and health services for people who require assistance with activities of daily living. The types and sizes of facilities vary; they can range from a small home to a large apartment-style complex. They also vary in the levels of care and services that can be provided. Assisted living facilities offer a way to keep a relatively independent lifestyle for people who don't need the level of care provided by nursing homes.

Bathing—Washing oneself by sponge bath, in either a tub or shower. This activity includes the task of getting into or out of the tub or shower.

Benefit Triggers (Triggers)—Term used by insurance companies to describe the criteria and methods they use to determine when you are eligible to receive benefits.

Benefits—Monetary sum paid or payable to a recipient for which the insurance company has received the premiums.

Care Management Services—A service in which a professional, typically a nurse or social worker, may arrange, monitor, or coordinate long-term care services (also referred to as care coordination services).

Cash Surrender Value—The amount of money you may be entitled to receive from the insurance company when you terminate a life insurance or annuity policy. The amount of cash value will be determined as stated in the policy.

Chronic Illness—An illness with one or more of the following characteristics: permanency, residual disability, requires rehabilitation training, or requires a long period of supervision, observation, or care.

Chronically Ill—A term used in a tax-qualified long-term care contract to describe a person who needs long-term care either because of an inability to do everyday activities of daily living (ADLs) without help or because of a severe cognitive impairment.

Cognitive Impairment—A deficiency in a person's short-or long-term memory; orientation as to person, place and time; deductive or abstract reasoning; or judgment as it relates to safety awareness.

Community-Based Services—Services designed to help older people stay independent and in their own homes.

Continence—The ability to maintain control of bowel and bladder function; or when unable to maintain control of these functions, the ability to perform associated personal hygiene (including caring for catheter or colostomy bag).

Continuing Care Retirement Communities (CCRC)—A retirement complex that offers a broad range of services and levels of care.

Continuous Payment Option—A premium payment option that requires you to pay premiums until you trigger your benefits. Premiums are usually paid on a monthly, quarterly, semi-annual or annual basis. The policy is not cancelable except when premiums aren't paid; however, the insurance company can increase premiums on an entire class of policies. Premiums are usually the lowest available.

Custodial Care (Personal Care)—Care to help individuals meet personal needs such as bathing, dressing, and eating. Someone without professional training may provide care.

Daily Benefit—The amount of insurance benefit in dollars a person chooses to buy for long-term care expenses.

Dementia—Deterioration of intellectual faculties due to a disorder of the brain.

Disability Method—Method of paying benefits that only requires you to meet the benefit eligibility criteria. Once you do, you receive your full daily benefit.

Dressing—Putting on and taking off all items of clothing and any necessary braces, fasteners or artificial limbs.

Eating—Feeding oneself by getting food into the body from a receptacle (such as a plate, cup or table) or by a feeding tube or intravenously.

Elimination Period—A type of deductible; the length of time the individual must pay for covered services before the insurance company will begin to make payments. The longer the elimination period in a policy, the lower the premium. Sometimes also called a “waiting period.”

Expense-Incurred Method—Method of paying benefits where the insurance company must decide if you are eligible for benefits and if your claim is for eligible services. Your policy or certificate will pay benefits only when you receive eligible services. Once you have incurred an expense for an eligible service, benefits are paid either to you or your provider. The coverage will pay for the lesser of the expense you incurred or the dollar limit of your policy. Most policies bought today pay benefits using the expense-incurred method.

Extended Term Benefits—Full benefits for a reduced time period, applicable for use during a certain period of time. If not used in a set number of years after the lapse, then you lose it. Once the period has expired, the contract terminates.

Guaranteed Renewable—When a policy cannot be cancelled by an insurance company and must be renewed when it expires unless benefits have been exhausted. The company cannot change the coverage or refuse to renew the coverage for other than nonpayment of premiums (including health conditions and/or marital or employment status). In a guaranteed renewable policy, the insurance company may increase premiums, but only on an entire class of policies, not just on your policy.

Hands-On Assistance—Physical assistance (minimal, moderate or maximal) without which the individual would not be able to perform the activity of daily living.

Health Insurance Portability and Accountability Act (HIPAA)—Federal health insurance legislation passed in 1996 that allows, under specified conditions, long-term care insurance policies to be qualified for certain tax benefits.

Home Health Care—Services for occupational, physical, respiratory, or speech therapy, or nursing care. Also included are medical, social worker, home health aide, and homemaker services.

Homemaker Services—Household services done by someone other than yourself because you're unable to do them.

Home for the Aged—A general term for a facility that cares for elderly people. It is often not covered under a long-term care policy.

Hospice Care—Continuous care provided at home or in a facility with a homelike setting for a terminally ill person. A terminally ill person has a life expectancy of six months or less.

Indemnity Method—Method of paying benefits where the benefit is a set dollar amount and is not based on the specific service received or on the expenses incurred. The insurance company only needs to decide if you are eligible for benefits. Once the company determines you are eligible and you have received eligible long-term care services, the insurance company will pay that set amount directly to you up to the limit of the policy.

Inflation Protection—A policy option that provides for increases in benefit levels to help pay for expected increases in the costs of long-term care services.

Lapse—Termination of a policy when a renewal premium is not paid.

Limited Payment Option—A premium payment option in which the person pays premiums for a set time period. After the last premium payment, neither the company nor the person can cancel the policy. These plans are more expensive than continuous payment policies; however, their guaranteed fixed payment and no-cancel features make them attractive to some persons.

Medicaid—A joint federal/state program that pays for health care services for those with low incomes or very high medical bills relative to income and assets.

Medicare—The federal program providing hospital and medical insurance to people aged 65 or older and to certain ill or disabled persons. Benefits for nursing home and home health services are limited.

Medicare Supplement Insurance—A private insurance policy that covers many of the gaps in Medicare coverage (also called Medigap insurance coverage).

National Association of Insurance Commissioners (NAIC)—Membership organization of state insurance commissioners. One of its goals is to promote uniformity of state regulation and legislation related to insurance.

Noncancelable Policies—Insurance contracts that cannot be cancelled by the insurance company and the rates cannot be changed by the insurance company.

Nonforfeiture Benefits—A policy feature that returns at least part of the premiums to you if you cancel your policy or let it lapse.

Nursing Home—A licensed facility that provides general nursing care to those who are chronically ill or unable to take care of daily living needs. May also be referred to as a Long Term Care Facility.

Paid-up Policy—When you prematurely stop paying your premiums, your insurance policy is deemed to be paid-in-full. You do not pay any more premiums, but the benefits you receive under this policy will be determined based on the amount of premiums you have already paid, not on the level of benefits that you originally purchased.

Partnership Policy—A type of policy that allows you to protect (keep) some of your assets if you apply for Medicaid after using your policy's benefits. Only a few states have these policies.

Personal Care (Custodial care)—Care to help individuals meet personal needs such as bathing, dressing, and eating. Someone without professional training may provide care.

Personal Care Home—A general term for a facility that cares for elderly people. It is often not covered under a long term care policy.

Pre-existing Condition—Illnesses or disability for which you were treated or advised within a time period before applying for a life or health insurance policy.

Reduced Paid-up Benefits—A nonforfeiture option that reduces your daily benefit but retains the full benefit period on your policy until death. For example, you buy a policy for three years of coverage with \$150 daily benefit. Then if you let the policy lapse, the daily benefit will be reduced to \$100. The exact amount of the reduction depends upon how much premium you have paid on the policy. The benefit period on your policy continues to be three years. Unlike extended term benefits, which must be used in a certain amount of time after the lapse, you can use reduced paid-up benefits at any time after you lapse (until death).

Rescind—When the insurance company voids (cancels) a policy.

Respite Care—Care provided by a third party that relieves family caregivers for a few hours to several days and gives them an occasional break from daily caregiving responsibilities.

Rest Home—A general term for a facility that cares for elderly people. It is often not covered under a long term care policy.

Rider—Addition to an insurance policy that changes the provisions of the policy.

Shortened Benefit Period—A nonforfeiture option that reduces the benefit period but retains the full daily maximums applicable until death. The period of time for which benefits are paid will be shorter. For example, you buy a policy for three years of coverage with \$150 daily benefit, but if you let the policy lapse, the benefit period is reduced to one year, with full daily benefits paid. The exact amount of the reduction depends upon how much premium you have paid on the policy. Unlike extended term benefits, which must be used in a certain amount of time after the lapse, you can use shortened benefits at any time after you let the premium lapse (until death).

Skilled Care—Daily nursing and rehabilitative care that can be performed only by, or under the supervision of, skilled medical personnel. This care is usually needed 24 hours a day, must be ordered by a physician, and must follow a plan of care. Individuals usually get skilled care in a nursing home but may also receive it in other places.

Spend Down—A requirement that an individual use up most of his or her income and assets to meet Medicaid eligibility requirements.

Stand-by Assistance—Caregiver stays close to the individual to watch over the individual and to provide physical assistance if necessary.

State Health Insurance Program—Federally funded program to train volunteers to provide counseling on the insurance needs of senior citizens. See page 9-58 for a list of State Health Insurance Programs.

Substantial Assistance—Hands-on or standby help required to do ADLs.

Substantial Supervision—The presence of a person directing and watching over another who has a cognitive impairment.

Tax-Qualified Long-Term Care Insurance Policy—A policy that conforms to certain standards in federal law and offers certain federal tax advantages.

Term Life Insurance—Covers a person for a period of one or more years. It pays a death benefit only if you die during that term. It generally does not build a cash value.

Third Party Notice—A benefit which lets you name someone who the insurance company would notify if your coverage is about to end because the premium hasn't been paid. This can be a relative, friend, or professional such as a lawyer or accountant, for example.

Toileting—Getting to and from the toilet, getting on and off the toilet and performing associated personal hygiene.

Transferring—Moving into and out of a bed, chair or wheelchair.

Triggers (Benefit Triggers)—Term used by insurance companies to describe when to pay benefits.

Underwriting—The process of examining, accepting, or rejecting insurance risks, and classifying those selected, to charge the proper premium for each.

Universal Life Insurance—A kind of flexible policy that lets you vary your premium payments and adjust the face amount of your coverage.

Waiver of Premium—A provision in an insurance policy that relieves the insured of paying the premiums while receiving benefits.

Whole Life Insurance—Policies that build cash value and cover a person for as long as he or she lives if premiums continue to be paid.

WORKSHEET 1

Information About the Availability and Cost of Long-Term Care in Your Area

Find out what facilities and services provide long-term care in your area (or in the area where you would be most likely to receive care) and what the costs are for these services. List the information below.

Home Health Agency

Name of one Home Health Agency
you might use

Name of *another* Home Health Agency
you might use

Address _____

Address _____

Phone number _____

Phone number _____

Contact person _____

Contact person _____

Check which types of care are available and list the cost

Skilled Nursing Care

Cost/Visit \$ _____

Skilled Nursing Care

Cost/Visit \$ _____

Home Health Care

Cost/Visit \$ _____

Home Health Care

Cost/Visit \$ _____

Personal/Custodial Care

Cost/Visit \$ _____

Personal/Custodial Care

Cost/Visit \$ _____

Homemaker Services

Cost/Visit \$ _____

Homemaker Services

Cost/Visit \$ _____

Nursing Facility

Name of one Home Health Agency
you might use

Name of *another* Home Health Agency
you might use

Address _____

Address _____

Phone number _____

Phone number _____

Contact person _____

Contact person _____

Check which types of care are available and list the cost

Skilled Nursing Care
Cost/Visit \$ _____

Skilled Nursing Care
Cost/Visit \$ _____

Personal/Custodial Care
Cost/Visit \$ _____

Personal/Custodial Care
Cost/Visit \$ _____

Other Facility

Other Facility or Service you might use
(e.g. adult day care center, assisted living, etc.)

Other Facility or Service you might use
(e.g. adult day care center, assisted living, etc.)

Address _____

Address _____

Phone number _____

Phone number _____

Contact person _____

Contact person _____

What services are available? _____

What services are available? _____

What are the costs for those services?

What are the costs for those services?

WORKSHEET 2

How to Compare Long-Term Care Insurance Policies

Fill in the information below so that you can compare long-term care insurance policies. Most of the information you need is in the outline of coverage provided in the policies you are comparing. Even so, you will need to calculate some information and talk to the agent or a company representative to get the rest.

	Policy 1	Policy 2
Insurance Company Information		
1. Name of the insurance company's agent.		
2. Is the company licensed in your state?	Yes / No	Yes / No
3. Insurance rating service and rating. (Refer to Page 9-37)		
What levels of care are covered by this policy? (Refer to Page 9-21)		
4. Does the policy provide benefits for these levels of care?		
—Skilled nursing care?	Yes / No	Yes / No
—Personal / custodial care?	Yes / No	Yes / No
(In many states, both levels of care are required)		
5. Does the policy pay for any nursing home stay, no matter what level of care you receive?	Yes / No	Yes / No
—If not, what levels aren't covered?		
Where can you receive care covered under the policy? (Refer to Page 9-22)		
6. Does the policy pay for care in any licensed facility?	Yes / No	Yes / No
—If not, what doesn't it pay for?		
7. Does the policy provide home care benefits for:		
—Skilled nursing care?	Yes / No	Yes / No
—Personal care given by home health aides?	Yes / No	Yes / No
—Homemaker services?	Yes / No	Yes / No
—other _____?	Yes / No	Yes / No
8. Does the policy pay for care received in:		
—adult day care centers?	Yes / No	Yes / No
—assisted living facilities?	Yes / No	Yes / No
—other settings? (list)		

(continued)

	Policy 1	Policy 2
How long are benefits paid and what amounts are covered? * (Refer to Page 9-23)		
9. How much will the policy pay per day for:		
—nursing home care?	\$	\$
—assisted living facility care?	\$	\$
—home care?	\$	\$
10. Are there limits on the number of days or visits per year for which benefits will be paid?	Yes / No	Yes / No
If yes, what are the limits for:		
—nursing home care?	Days	Days
—assisted living facility care?		
—home care? (days or visits?)		
11. What is the length of the benefit period that you are considering?	Yrs.	Yrs.
12. Are there limits on the amounts the policy will pay during your lifetime?	Yes / No	Yes / No
If yes, what are the limits for:		
—nursing home care?	\$	\$
—assisted living facility care?	\$	\$
—home care? (days or visits?)	\$	\$
—total lifetime limit	\$	\$

How does the policy decide when you are eligible for benefits? (Refer to Page 9-23)

13. Which of the “benefit triggers” does the policy use to decide your eligibility for benefits? (It may have more than one)		
—unable to do activities of daily living (ADLs)	Yes / No	Yes / No
—cognitive impairment (older policies may discriminate against Alzheimer’s; newer ones don’t)	Yes / No	Yes / No
—doctor certification of medical necessity	Yes / No	Yes / No
—prior hospital stay	Yes / No	Yes / No
—bathing is one of the ADLs	Yes / No	Yes / No

* You may be considering a policy that pays benefits on a different basis, so you may have to do some calculations to determine comparable amounts.

	Policy 1	Policy 2
When do benefits start? (Refer to Page 9-25)		
14. How long is the waiting period before benefits begin for:		
—nursing home care?	Days	Days
—assisted living facility care?	Days	Days
—home health care?	Days	Days
—waiting period—service days or calendar days?	Service days	Service days
15. Are the waiting periods for home care cumulative or consecutive?		
16. How long will it be before you are covered for a pre-existing condition? (Usually 6 months)	Months	Months
17. How long will the company look back in your medical history to determine a pre-existing condition? (Usually 6 months)	Months	Months
Does the policy have inflation protection? (Refer to Page 9-26)		
18. Are the benefits adjusted for inflation?	Yes / No	Yes / No
19. Are you allowed to buy more coverage? If yes,	Yes / No	Yes / No
—When can you buy more coverage?		
—How much can you buy?	\$	\$
—When can you no longer buy more coverage?		
20. Do the benefits increase automatically? If yes,		
—What is the rate of increase?	%	%
—Is it a simple or compound increase?		
—When do automatic increases stop?		
21. If you buy inflation coverage, what daily benefit would you receive for:		
Nursing home care:		
—5 years from now?	\$	\$
—10 years from now?	\$	\$
Assisted living facility care:		
—5 years from now?	\$	\$
—10 years from now?	\$	\$
Home health care:		
—5 years from now?	\$	\$
—10 years from now?	\$	\$
22. If you buy inflation coverage, what will your premium be:		
—5 years from now?	\$	\$
—10 years from now?	\$	\$
—15 years from now?	\$	\$

(continued)

	Policy 1	Policy 2
What other benefits are covered under the policy?		
23. Is there a waiver of premium benefit? (Refer to Page 9-28)	Yes / No	Yes / No
If yes,		
—How long do you have to be in a nursing home before it begins?		
—Does the waiver apply when you receive home care?	Yes / No	Yes / No
24. Does the policy have a nonforfeiture benefit? If yes, what kind (Refer to Page 9-29)	Yes / No	Yes / No
25. Does the policy have a return of premium benefit? (Refer to Page 9-29)	Yes / No	Yes / No
26. Does the policy have a death benefit?	Yes / No	Yes / No
If yes, are there any restrictions before the benefit is paid? (Refer to Page 9-29)	Yes / No	Yes / No
27. Will the policy cover one person or two?	One / Two	One / Two
Tax-qualified status		
28. Is the policy tax-qualified? (Refer to Page 9-19)	Yes / No	Yes / No
What does the policy cost? (Refer to Page 9-18)		
29. What is the premium excluding all riders?		
—monthly	\$	\$
—yearly	\$	\$
30. What is the premium if home care is covered?		
—monthly	\$	\$
—yearly	\$	\$
31. What is the premium if assisted living is covered?		
—monthly	\$	\$
—yearly	\$	\$
32. What is the premium if you include an inflation rider?		
—monthly	\$	\$
—yearly	\$	\$
33. What is the premium if you include a nonforfeiture benefit?		
—monthly	\$	\$
—yearly	\$	\$
34. Is there any discount if you and your spouse both buy policies?	Yes / No	Yes / No
—If yes, what is the amount of the discount?	\$	\$
—Do you lose the discount when one spouse dies?	Yes / No	Yes / No

	Policy 1	Policy 2
35. What is the total annual premium including all riders and discounts?		
—total monthly premium	\$	\$
—total annual premium	\$	\$
36. When looking at the results of Questions 29 through 35, how much do you think you are willing to pay in premiums?	\$	\$

WORKSHEET 3

Facts About Your Long-Term Care Insurance Policy

For use after you buy a long-term care policy. Fill out this form and put it with your important papers. You may want to make a copy for a friend or a relative.

1. Insurance Policy Date

Policy Number _____

Date Purchased _____

Annual Premium \$ _____

2. Insurance Company Information

Name of Company _____

Address _____

Phone Number _____

3. Agent Information

Agent's Name _____

Address _____

Phone Number _____

4. Type of Long-Term Care Policy

Nursing home only

Facilities only

Home care only

Comprehensive (nursing home, assisted living, home and community care)

Other

Tax-qualified

5. How long is the waiting period before benefits begin?

6. How do I file a claim? (Check all that apply)

I need prior approval Contact the company Fill out a claim form

Submit a plan of care Doctor notifies the company

Assessment by company Assessment by care manager

7. How often do I pay premiums: Annually Semi-annually Other

Specify Other: _____

8. The person to be notified if I forget to pay the premium

Name _____

Address _____

Phone number _____

9. Are my premiums deducted from my bank account? Yes No

Name of my bank _____

Address _____

Phone Number _____

Bank account number _____

10. Where do I keep this long-term care policy?

Other information _____

11. Friend or relative who knows where my policy is:

Name _____

Address _____

Phone number _____

WORKSHEET 4

Long-Term Care Riders To Life Insurance Policies

The purpose of this worksheet is to help you to evaluate one or more life long-term care insurance policies. Fill out the form so you can compare your options. In addition, you will want to fill out Worksheet 2 regarding the long-term care benefits provided by the policy.

Insurance Company Information

- | | | |
|---|----------|----------|
| 1. Name of the insurance company's agent. | | |
| 2. Is the company licensed in your state? | Yes / No | Yes / No |
| 3. Insurance rating service and rating.
(Refer to Page 9-37) | | |

Policy Information

- | | | |
|--|----------|----------|
| 4. What kind of life insurance policy is it? | | |
| Whole life insurance | Yes / No | Yes / No |
| Universal life insurance | Yes / No | Yes / No |
| Term life insurance | Yes / No | Yes / No |
| 5. What is the policy's premium? | \$ | \$ |
| 6. How often is the premium paid? | | |
| One time / single premium | Yes / No | Yes / No |
| Annually for life | Yes / No | Yes / No |
| Annually for 10 years only | Yes / No | Yes / No |
| Annually for 20 years only | Yes / No | Yes / No |
| Other | Yes / No | Yes / No |
| 7. Is there a separate premium for the long-term care benefit provided by the life insurance policy? | Yes / No | Yes / No |
| If not, how is the premium paid? | | |
| —Included in life insurance premium? | Yes / No | Yes / No |
| —Deducted from the cash value of the life insurance policy? | Yes / No | Yes / No |
| 8. How many people will the policy cover? | | |
| 9. Will the payment of long-term care benefits decrease the death benefit and cash value of the policy? | Yes / No | Yes / No |
| 10. Will an outstanding loan affect the long-term care benefits? | Yes / No | Yes / No |
| 11. Did you receive an illustration of guaranteed values? If yes, do the policy values equal zero at some age on a guaranteed or midpoint basis? If so, at what age? | Yes / No | Yes / No |

LONG TERM CARE INSURANCE

Personal Worksheet

People buy long-term care insurance for many reasons. Some don't want to use their own assets to pay for long-term care. Some buy insurance to make sure they can choose the type of care they get. Others don't want their family to have to pay for care or don't want to go on Medicaid. But long-term care insurance may be expensive, and may not be right for everyone.

By state law, the insurance company must fill out part of the information on this worksheet and **ask** you to fill out the rest to help you and the company decide if you should buy this policy.

Premium Information

Policy Form Numbers _____

The premium for the coverage you are considering will be [\$_____ per month, or \$_____ per year,] [a one-time single premium of \$_____.]

Type of Policy (noncancellable/guaranteed renewable): _____

The Company's Right to Increase Premiums: _____

[The company cannot raise your rates on this policy.] [The company has a right to increase premiums on this policy form in the future, provided it raises rates for all policies in the same class in this state.] [Insurers shall use appropriate bracketed statement. Rate guarantees shall not be shown on this form.]

Rate Increase History

The company has sold long-term care insurance since [year] and has sold this policy since [year]. [The company has never raised its rates for any long-term care policy it has sold in this state or any other state.] [The company has not raised its rates for this policy form or similar policy forms in this state or any other state in the last 10 years.] [The company has raised its premium rates on this policy form or similar policy forms in the last 10 years. Following is a summary of the rate increases.]

Drafting Note: A company may use the first bracketed sentence above only if it has never increased rates under any prior policy forms in this state or any other state. The issuer shall list each premium increase it has instituted on this or similar policy forms in this state or any other state during the last 10 years. The list shall provide the policy form, the calendar years the form was available for sale, and the calendar year and the amount (percentage) of each increase. The insurer shall provide minimum and maximum percentages if the rate increase is variable by rating characteristics. The insurer may provide, in a fair manner, additional explanatory information as appropriate.

QUESTIONS RELATED TO YOUR INCOME

How will you pay each year's premium?

- From my Income From my Savings/Investments My Family will Pay

[Have you considered whether you could afford to keep this policy if the premiums went up, for example, by 20%?]

Drafting Note: The issuer is not required to use the bracketed sentence if the policy is fully paid up or is a noncancellable policy.

- What is your annual income? (check one) Under \$10,000 \$[10-20,000] \$[20-30,000]
 \$[30-50,000] Over \$50,000

Drafting Note: The issuer may choose the numbers to put in the brackets to fit its suitability standards.

How do you expect your income to change over the next 10 years? (check one)

- No change Increase Decrease

If you will be paying premiums with money received only from your own income, a rule of thumb is that you may not be able to afford this policy if the premiums will be more than 7% of your income.

Will you buy inflation protection? (check one) Yes No

If not, have you considered how you will pay for the difference between future costs and your daily benefit amount?

- From my Income From my Savings/Investments My Family will Pay

The national average annual cost of care in [insert year] was [insert \$ amount], but this figure varies across the country. In ten years the national average annual cost would be about [insert \$ amount] if costs increase 5% annually.

Drafting Note: The projected cost can be based on federal estimates in a current year. In the above statement, the second figure equals 163% of the first figure.

What elimination period are you considering? Number of days _____ Approximate cost \$_____ for that period of care.

How are you planning to pay for your care during the elimination period? (check one)

- From my Income From my Savings/Investments My Family will Pay

QUESTIONS RELATED TO YOUR SAVINGS AND INVESTMENTS

Not counting your home, about how much are all of your assets (your savings and investments) worth? (check one)

- Under \$20,000 \$20,000-\$30,000 \$30,000-\$50,000 \$Over \$50,000

How do you expect your assets to change over the next ten years? (check one)

- Stay about the same Increase Decrease

If you are buying this policy to protect your assets and your assets are less than \$30,000, you may wish to consider other options for financing your long-term care.

DISCLOSURE STATEMENT

The answers to the questions above describe my financial situation.
Or
 I choose not to complete this information.
 (Check one.)

I acknowledge that the carrier and/or its agent (below) has reviewed this form with me including the premium, premium rate increase history and potential for premium increases in the future. [For direct mail situations, use the following: I acknowledge that I have reviewed this form including the premium, premium rate increase history and potential for premium increases in the future.] I understand the above disclosures. **I understand that the rates for this policy may increase in the future.**
 (This box must be checked)

Signed: _____ (Applicant) _____ (Date)

[I explained to the applicant the importance of completing this information.

Signed: _____ (Agent) _____ (Date)

Agent's Printed Name: _____]

[In order for us to process your application, please return this signed statement to [name of company], along with your application.]

[My agent has advised me that this policy does not seem to be suitable for me. However, I still want the company to consider my application.

Signed: _____ (Applicant) _____ (Date)

Drafting Note: Choose the appropriate sentences depending on whether this is a direct mail or agent sale.

The company may contact you to verify your answers.

Drafting Note: When the Long-Term Care Insurance Personal Worksheet is furnished to employees and their spouses under employer group policies, the text from the heading "Disclosure Statement" to the end of the page may be removed.

LIST OF STATE INSURANCE DEPARTMENTS, AGENCIES ON AGING AND STATE HEALTH INSURANCE ASSISTANCE PROGRAMS

Each state has its own laws and regulations governing all types of insurance. The insurance departments, which are listed in the left column, are responsible for enforcing these laws, as well as providing the public with information about insurance. The agencies on aging, listed in the right column, are responsible for coordinating services for older Americans. Centered below each state listing is the telephone number for the insurance counseling programs. Please note that calls to 800 numbers listed here can only be made from within the respective state.

Insurance Departments	State Health Insurance Assistance Programs	Agencies On Aging
Alabama Department of Insurance 201 Monroe Street, Suite 1700 Montgomery, Alabama 36104 (334) 269-3550 Fax: (334) 241-4192	ALABAMA (334) 242-5788 Fax: (334) 242-5594	Department of Senior Services P.O. Box 301851 770 Washington Avenue, Suite 470 Montgomery, AL 36130-1851 1-800-243-5463 (334) 242-5743 Fax: (334) 242-5788
Alaska Division of Insurance 550 West 7th Avenue, Suite 1560 Anchorage, Alaska 99501-3567 (907) 269-7900 Fax: (907) 269-7912	ALASKA (907) 269-3669 Fax: (907) 269-3690	Division of Senior Services Department of Administration P.O. Box 110209 Juneau, AK 99811-0209 (907) 465-4879 Fax: (907) 465-4716
Office of the Governor American Samoa Government Pago Pago, American Samoa 96799 011-684-633-4116 Fax: 011-684-633-2269	AMERICAN SAMOA	
Arizona Department of Insurance 2910 North 44th Street, Suite 210 Phoenix, Arizona 85018-7256 (602) 912-8400 Fax: (602) 912-8452	ARIZONA 1-800-432-4040 Fax: (602) 542-6575	Aging and Adult Administration Department of Economic Sec. 1789 W Jefferson-#950A Phoenix, AZ 85007 (602) 542-4446 Fax: (602) 542-6575
Arkansas Department of Insurance 1200 West 3rd Street Little Rock, Arkansas 72201-1904 (501) 371-2600 Fax: (501) 371-2629	ARKANSAS 1-800-224-6330 (501) 371-2782 (501) 371-2781	Division of Aging & Adult Serv Arkansas Dept of Human Serv P.O. Box 1437, Slot 1412 7th and Main Streets Little Rock, AR 72203-1437 (501) 682-2441 Fax: (501) 682-8155
California Department of Ins 300 Capitol Mall, Suite 1500 Sacramento, California 95814 (916) 492-3500 Fax: (916) 445-5280	CALIFORNIA 1-800-434-0222 (916) 323-6525 Fax: (916) 327-208	Department of Aging 1600 K Street Sacramento, CA 95814 (916) 322-5290 Fax: (916) 324-1903
Colorado Division of Insurance 1560 Broadway, Suite 850 Denver, Colorado 80202 (303) 894-7490 1-800-930-3745 Fax: (303) 894-7455	COLORADO 1-800-544-9181 (888) 696-7213 (303) 894-7553 Fax: (303) 894-7455	Division of Aging and Adult Services Department of Human Services 1575 Sherman Street, Ground Fl Denver, CO 80203-1714 (303) 866-2800 Fax: (303) 866-2696

Insurance Departments	State Health Insurance Assistance Programs	Agencies On Aging
COMMONWEALTH OF THE NORTHERN MARIANA ISLANDS		Department of Community and Cultural Affairs, Civic Center Commonwealth of the Northern Mariana Islands Saipan, CM 96950 (607) 234-6011
Connecticut Department of Ins PO Box 816 Hartford, Connecticut 06142-0816 (860) 297-3800 Fax: (860) 566-7410	CONNECTICUT (860) 424-5232 Fax: (860) 424-4966 1-800-994-9422 (in state only)	Elderly Services Division Department of Social Services 25 Sigourney St. Hartford, CT 06106 (860) 424-5277 Fax: (860) 424-5301
Delaware Department of Ins Rodney Building 841 Silver Lake Boulevard Dover, Delaware 19904 (302) 739-4251 Fax: (302) 739-5280	DELAWARE (302) 739-6266 Fax: (302) 739-5280	Division of Services for Aging & Adults W/Physical Disabilities Dept of Health & Social Services 1901 North DuPont Highway New Castle, DE 19720 (302) 577-4791 Fax: (302) 577-4793
Dept. of Ins & Securities Reg. Government of the District of Columbia 810 First Street, N. E., Suite 701 Washington, DC 20002 (202) 727-8000 x3018 Fax: (202) 535-1196	DISTRICT OF COLUMBIA (202) 496-6240 Fax: (202) 293-4043	Office on Aging One Judiciary Square 441 4th St., N.W., 9th Fl. Washington, DC 20001 (202) 724-5622 Fax: (202) 724-4979
Florida Department of Insurance State Capitol Plaza Level Eleven Tallahassee, Florida 32399-0300 (850) 413-2804 Fax: (850) 413-2950	FLORIDA 1-800-963-5337 (850) 414-2060 Fax: (850) 414-2002	Department of Elder Affairs Building B–Suite 152 4040 Esplanade Way Tallahassee, FL 32399 (850) 414-2000 Fax: (850) 414-2004
Georgia Department of Insurance 2 Martin Luther King, Jr. Drive Floyd Memorial Building 704 West Tower Atlanta, Georgia 30334 (404) 656-2056 Fax: (404) 657-7493	GEORGIA 1-800-669-8387 (404) 657-5347 Fax: (404) 657-5285	Division of Aging Services #2 Peachtree St. N.W. #36-385 Atlanta, GA 30303 (404) 657-5258 Fax: (404) 657-5285
Dept. of Revenue & Taxation Insurance Branch Government of Guam Building 13-3, 1st Floor Mariner Avenue Tiyán, Barrigada, Guam 96913 (671) 475-1843 Fax: (671) 472-2643	GUAM 1-800-586-7299	Administrator Division of Senior Citizens Dept of Public Health & Social Services Government of Guam P.O. Box 2816 Hagaina, Guam 96932 011 (671) 475-0263 Fax: (671) 477-2930
Hawaii Insurance Division Dept. of Commerce & Consumer Affairs 250 S. King Street, 5th Floor Honolulu, Hawaii 96813 (808) 586-2790 Fax: (808) 586-2806	HAWAII (808) 586-7300 Fax: (808) 586-0185	Executive Office on Aging No 1 Capitol District 250 South Hotel St., Ste 109 Honolulu, HI 96813-2831 (808) 586-0100 Fax: (808) 586-0185

(continued)

Insurance Departments	State Health Insurance Assistance Programs	Agencies On Aging
Idaho Department of Insurance 700 West State Street, 3rd Floor Boise, Idaho 83720-0043 (208) 334-4250 Fax: (208) 334-4398	IDAHO S.W. 1-800-247-4422 North 1-800-488-5725 S.E. 1-800-488-5764 C. 1-800-488-5731 (208) 334-4350 Fax: (208) 334-4389	Commission on Aging 3380 Americana Terrace, Suite 120 P.O. Box 83720 Boise, ID 83720-0007 (208) 334-2423 Fax: (208) 334-3033
Illinois Department of Insurance 320 West Washington St., 4th Fl Springfield, Illinois 62767-0001 (217) 782-4515 Fax: (217) 524-6500	ILLINOIS 1-800-548-9034 (217) 785-9021 Fax: (217) 782-4105	Department on Aging 421 East Capitol Avenue Springfield, IL 62701 (217) 785-2870 Fax: (217) 785-4477
Indiana Department of Insurance 311 W. Washington Street, Suite 300 Indianapolis, Indiana 46204-2787 (317) 232-2385 Fax: (317) 232-5251	INDIANA 1-800-452-4800 (317) 233-3551 Fax: (317) 232-5251	Bureau of Aging/In Home Serv 402 W. Washington St. P.O. Box 7083 Indianapolis, IN 46207-7083 (317) 232-7020 Fax: (317) 232-7867
Iowa Insurance Division 330 Maple Des Moines, Iowa 50319-0065 (877) 955-1212 (in-state only) (515) 281-5705 Fax: (515) 281-3059	IOWA 1-800-351-4664 (515) 281-6867 Fax: (515) 281-3059	Iowa Dept of Elder Affairs 200 10th St., 3rd Fl. Des Moines, Iowa 50309-3609 1-800-532-3213 Fax: (515) 242-3300
Kansas Department of Insurance 420 S.W. 9th Street Topeka, Kansas 66612-1678 (785) 296-7801 Fax: (785) 296-2283	KANSAS 1-800-860-5260 (316) 337-7386 Fax: (316) 337-6018	Department on Aging New England Building 503 South Kansas Topeka, KS 66603-3404 (785) 296-4986 1-800-432-3535 Fax: (785) 296-0256
Kentucky Department of Insurance PO Box 517 215 West Main Street Frankfort, Kentucky 40602-0517 (502) 564-6027 Fax: (502) 564-1453	KENTUCKY (502) 564-7372 Fax: (502) 564-4595	Office of Aging Services Cabinet for Health Services 275 East Main Street, 5 West Frankfort, KY 40621 (502) 564-6930 Fax: (502) 564-4595
Louisiana Department of Insurance 950 North 5th Street Baton Rouge, Louisiana 70802 (225) 342-5423 Fax: (225) 342-8622	LOUISIANA (225) 342-6334 Fax: (225) 342-7401	Office of Elderly Affairs Elderly Protective Services P.O. Box 80374, 412 N 4th St. Baton Rouge, LA 70898-0374 (225) 342-9722 Fax: (225) 342-7144
Maine Bureau of Insurance Dept. of Professional & Fin. Reg. State Office Building, Station 34 Augusta, Maine 04333-0034 (207) 624-8475 Fax: (207) 624-8599	MAINE (207) 624-5335 Fax: (207) 624-5361	Bureau of Elder & Adult Serv Department of Human Services #11 State House Station Augusta, ME 04333-0011 (207) 624-5335 Fax: (207) 624-5361
Maryland Insurance Admin 525 St. Paul Place Baltimore, Maryland 21202-2272 (410) 468-2090 Fax: (410) 468-2020	MARYLAND 1-800-243-3425 (410) 767-1109 Fax: (410) 333-7943	Department of Aging State Office Building, Rm 1007 301 West Preston Street Baltimore, MD 21201 (410) 767-1100 Fax: (410) 333-7943

Insurance Departments	State Health Insurance Assistance Programs	Agencies On Aging
Division of Insurance Commonwealth of Massachusetts One South Station, 4th Floor Boston, Massachusetts 02110 (617) 521-7301 Fax: (617) 521-7758	MASSACHUSETTS 1-800-882-2003 (617) 222-7435 Fax: (617) 727-9368	Executive Office of Elder Affairs 1 Ashburton Place, 5th floor Boston, MA 02108 (617) 727-7750 Fax: (617) 727-6944
Office of Financial and Insurance Services State of Michigan 611 W. Ottawa St., 2nd Floor N. Lansing, Michigan 48933-1020 (517) 335-3167 Fax: (517) 373-4870	MICHIGAN 1-800-803-7174 (517) 886-0899 Fax: (517) 886-1305	Office of Services to the Aging P.O. Box 30676 Lansing, MI 48909-8176 (517) 373-8230 Fax: (517) 373-4092
Minnesota Department of Comm 85 7th Place East, Suite 500 St. Paul, Minnesota 55101-2198 651-296-2488 Fax: 651-296-4328 1-800-657-3602 www.commerce.state.mn.us	MINNESOTA 1-800-333-2433	Executive Director Board on Aging 444 Lafayette Road St. Paul, MN 55155-3843 (651) 296-2770 Fax: (651) 297-7855
Mississippi Insurance Dept 501 N. West Street Woolfolk State Office Bldg., 10th Fl. Jackson, MS 39201 (601) 359-3569 Fax: (601) 359-2474	MISSISSIPPI 1-800-948-3090 (601) 359-4929 Fax: (601) 359-9664	Council on Aging Div of Aging & Adult Services 750 N. State St. Jackson, MS 39202 (601) 359-4925 Fax: (601) 359-4370
Missouri Department of Ins 301 West High Street, Suite 530 Jefferson City, Missouri 65101 1-800-726-7390 (573) 751-2640 Fax: (573) 526-4898	MISSOURI 1-800-390-3330 (573) 893-7900 Fax: (573) 893-5827	Division of Aging Department of Social Services P.O. Box 1337 615 Howerton Court Jefferson City, MO 65102-1337 (573) 751-3082 Fax: (573) 751-8687
Montana Department of Insurance 840 Helena Avenue Helena, Montana 59601 (406) 444-2040 Fax: (406) 444-3497	MONTANA 1-800-332-2272 (406) 585-0773 Fax: (406) 585-0773	Office on Aging Senior Long Term Care Division 111 Sanders Street P.O. Box 4210 Helena, MT 59604 (406) 444-7788 Fax: (406) 444-7743
Nebraska Department of Insurance Terminal Building, Suite 400 941 'O' Street Lincoln, Nebraska 68508 (402) 471-2201 Fax: (402) 471-4610	NEBRASKA 800-234-7119 (402) 471-4506 Fax: (402) 471-6559	Division of Aging Services Dept of Health & Human Serv P.O. Box 95044 301 Centennial Mall-South Lincoln, NE 68509 (402) 471-2307 Fax: (402) 471-4619
Nevada Division of Insurance 788 Fairview Drive, Suite 300 Carson City, Nevada 89701-5753 (775) 687-4270 Fax: (775) 687-3937	NEVADA (702) 486-3545 Fax: (702) 486-3572	Division For Aging Services Department of Human Resources 3416 Goni Road, Building D-132 Carson City, NV 89706 (775) 687-4210 Fax: (775) 687-4264

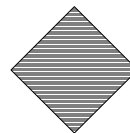
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Insurance Departments	State Health Insurance Assistance Programs	Agencies On Aging
Department of Insurance New Hampshire Insurance Dept 56 Old Suncook Road Concord, NH 03301 (603) 271-2261 Fax: (603) 271-1406	NEW HAMPSHIRE (603) 271-3944 Fax: (603) 271-4643	Division of Elderly & Adult Serv State Office Park South Brown Building–129 Pleasant St. Concord, NH 03301-3857 (603) 271-4394 Fax: (603) 271-4643
New Jersey Department of Ins 20 West State Street CN325 Trenton, New Jersey 08625 (609) 292-5360 Fax: (609) 984-5273	NEW JERSEY (609) 943-3378 Fax: (609) 943-4033	Division of Senior Affairs Department of Health & Senior Services P.O. Box 807 Trenton, NJ 08625-0807 (609) 943-3345 Fax: (609) 943-3343
New Mexico Department of Insurance PO Drawer 1269 Santa Fe, New Mexico 87504-1269 (505) 827-4601 Fax: (505) 476-0326	NEW MEXICO 1-800-432-2080 (505) 827-7640 Fax: (505) 827-7649	Michelle Lujan-Grisham, Dir State Agency on Aging La Villa Rivera Bldg 228 East Palace Avenue, Grd Fl. Santa Fe, NM 87501 (505) 827-7640 Fax: (505) 827-7649
New York Department of Ins 25 Beaver Street New York, New York 10004-2319 (212) 480-2292 Fax: (212) 480-2310	NEW YORK 1-800-333-4114 (518) 473-5108 Fax: (518) 486-2225	Office for the Aging Two Empire State Plaza Albany, NY 12223-1251 (518) 474-5731 Fax: (518) 474-1398
	PALAU	State Agency on Aging Department of Social Services Republic of Palau P.O. Box 100 Koror, Palau 96940
North Carolina Dept. of Insurance PO Box 26387 Raleigh, North Carolina 27611 (919) 733-3058 Fax: (919) 733-6495	NORTH CAROLINA 1-800-443-9354 (919) 733-0111 Fax: (919) 733-3682	Division of Aging 2101 Mail Service Center 693 Palmer Drive (Fedex only-zip 27603) Raleigh, NC 27699-2101 (919) 733-3983 Fax: (919) 733-0443
North Dakota Dept. of Insurance 600 E. Boulevard Bismarck, North Dakota 58505-0320 (701) 328-2440 Fax: (701) 328-4880	NORTH DAKOTA 1-800-755-8521 (701) 328-2977 Fax: (701) 328-4880	Aging Services Division Department of Human Services 600 South 2nd St., Suite 1C Bismarck, ND 58504 (701) 328-8910 Fax: (701) 328-8989
Ohio Department of Insurance 2100 Stella Court Columbus, Ohio 43215-1067 (614) 644-2658 Fax: (614) 644-3743	OHIO 1-800-686-1578 (614) 644-3399 Fax: (614) 752-0740	Department of Aging 50 West Broad Street–9th Fl Columbus, OH 43215-5928 (614) 466-5500 Fax: (614) 995-1049
Oklahoma Department of Ins 2401 NW 23rd St., Suite 28 Oklahoma City, Oklahoma 73107 (405) 521-2828 Fax: (405) 521-6635	OKLAHOMA 1-800-763-2828 (405) 521-6628 Fax (405) 522-4492	Aging Services Division Department of Human Services P.O. Box 25352, 312 N.E. 28th St Oklahoma City, OK 73105 (405) 521-2327 Fax: (405) 521-2086

Insurance Departments	State Health Insurance Assistance Programs	Agencies On Aging
Oregon Insurance Division 350 Winter Street NE, Room 440 Salem, Oregon 97301-3883 (503) 947-7980 Fax: (503) 378-4351	OREGON 1-800-722-4134 (503) 947-7984 Fax: (503) 378-435	Seniors and People With Disabilities 500 Summer St. NE, E13 Salem, OR 97301-1073 (503) 945-5811 Fax: (503) 378-8966
Pennsylvania Insurance Dept 1326 Strawberry Square, 13th Fl Harrisburg, Pennsylvania 17120 (717) 783-0442 Fax: (717) 772-1969	PENNSYLVANIA 1-800-783-7067 (717) 783-8975 Fax: (717) 772-2730	Department of Aging Forum Place 555 Walnut Street, 5th Fl Harrisburg, PA 17101-1919 (717) 783-1550 Fax: (717) 772-3382
Puerto Rico Dept of Insurance Cobian's Plaza Building 1607 Ponce de Leon Avenue Santurce, Puerto Rico 787-722-8686 Fax: 787-722-4400	PUERTO RICO (787) 721-8590 Fax: (787) 721-6510	Governors Office For Elderly Affairs P.O. Box 50063 Old San Juan Station San Juan, PR 00902 (787) 721-6121 Fax: (787) 721-6510
	REPUBLIC OF THE MARSHALL ISLANDS	State Agency on Aging Department of Social Services Republic of the Marshall Islands Marjuro, Marshall Islands 96960
Rhode Island Insurance Division Dept. of Business Regulation 233 Richmond Street, Suite 233 Providence, Rhode Island 02903-4233 (401) 222-2223 Fax: (401) 222-5475	RHODE ISLAND 401-462-0508 Fax: (401) 222-2130	Department of Elderly Affairs John O. Pastore Center, Benjamin Rush (Bldg. #55) 35 Howard Avenue Cranston, RI 02920 (401) 462-3000 Fax: (401) 462-0503 TTY: (401) 462-4000
South Carolina Dept. of Insurance 300 Arbor Lake Drive, Ste 1200 Columbia, South Carolina 29223 (803) 737-6160 Fax: 803-737-6229	SOUTH CAROLINA 1-800-868-9095 (803) 898-2850 Fax: (803) 898-4513	Dept of Health & Human Services P.O. Box 8206, 1801 Main St. Columbia, SC 29202-8206 (803) 898-2501 Fax: (803) 898-4515
South Dakota Division of Ins Dept. of Commerce & Reg 118 West Capitol Avenue Pierre, South Dakota 57501-2000 (605) 773-3563 Fax: 605-773-5369	SOUTH DAKOTA (605) 773-3656 Fax: (605) 773-6834	Office of Adult Services & Aging 700 Governors Drive Pierre, SD 57501 (605) 773-3656 Fax: (605) 773-6834
Tennessee Dept. of Comm & Ins. Davy Crockett Tower, Fifth Fl 500 James Robertson Parkway Nashville, Tennessee 37243-0565 (615) 741-2241 Fax: (615) 532-6934	TENNESSEE 1-800-525-2816 (615) 741-4955 Fax: (615) 253-1159	Commission on Aging Andrew Jackson Building 500 Deaderick Street, 9th Fl. Nashville, TN 37243-0860 (615) 741-2056 Fax: (615) 741-3309
Texas Department of Insurance 333 Guadalupe Street Austin, Texas 78701 1-800-252-3439 Consumer Help (512) 463-6464 Fax: 512-475-2005	TEXAS 1-800-252-9240 Fax: (512) 305-7463	Department on Aging 4900 North Lamar, 4th Fl Austin, TX 78751-2316 1-800-252-9240 (512) 424-6840 Fax: (512) 424-6890

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Insurance Departments	State Health Insurance Assistance Programs	Agencies On Aging
Utah Department of Insurance 3110 State Office Building Salt Lake City, Utah 84114-1201 (801) 538-3800 Fax: 801-538-3829	UTAH (801) 538-3910 Fax: (801) 538-4395	Division of Aging & Adult Serv Department of Human Services Box 45500, 120 North-200 W. Salt Lake City, UT 84145-0500 (801) 538-3910 Fax: (801) 538-4395
Vermont Division of Insurance Dept. of Banking, Ins. & Sec. 89 Main Street, Drawer 20 Montpelier, Vermont 05620-3101 802/828-2900 Fax: 802/828-2949 Consumer Service: 1-800-631-7788	VERMONT (802) 241-4425 Fax: (802) 241-2325	Aging and Disabilities 103 South Main Street Waterbury, VT 05671-2301 (802) 241-2400 Fax: (802) 241-2325
State Corporation Commission Bureau of Insurance Commonwealth of Virginia PO Box 1157 Richmond, Virginia 23218 (804) 371-9694 Fax: (804) 371-9873	VIRGINIA 1-800-552-3402 (804) 662-7048 Fax: (804) 662-9354	Department For The Aging 1600 Forest Avenue Preston Building, Suite 102 Richmond, VA 23229 (804) 662-9333 Fax: (804) 662-9354
Attn.: Marileen Thomas #18 Kongens Gade, Charlotte Amalie St. Thomas, Virgin Islands 00802 (340) 774-7166 Fax: (340) 774-9458 or (340) 774-6953	VIRGIN ISLANDS (340) 778-6311 x2338 Fax: (340) 778-5500	Senior Citizen Affairs Department of Human Services #19 Estate Diamond Fredericksted St. Croix, VI 00840 (340) 692-5950 Fax: (340) 692-2062
Washington State Office of the Insurance Commissioner 14th Avenue & Water Streets PO Box 40255 Olympia, Washington 98504-0255 (360) 586-7515 Fax: (360) 586-3535	WASHINGTON 1-800-397-4422 (206) 654-1833 Fax: (206) 389-2745	Aging & Adult Services Admin Department of Social & Health Services P.O. Box 45050 1115 Washington Street, SE Olympia, WA 98504-5050 (360) 902-7797 Fax: (360) 902-7848
West Virginia Dept. of Insurance PO Box 50540 Charleston, West Virginia 25305-0540 (304) 558-3354 Fax: (304) 558-0412	WEST VIRGINIA 1-800-642-9004 (304) 558-3317 Fax: (304) 558-5609	Bureau of Senior Services 1900 Kanawha Blvd, East Holly Grove-Building 10 Charleston, WV 25305-0160 (304) 558-3317 Fax: (304) 558-5609
Office of the Commissioner of Ins. State of Wisconsin 121 E. Wilson Madison, Wisconsin 53702 (608) 267-1233 Fax: (608) 261-8579	WISCONSIN 1-800-242-1060	Bureau of Aging & LTC Resources Department of Health and Family Services One West Wilson St. P.O. Box 7851 Madison, WI 53707-7851 (608) 266-2536 Fax: (608) 267-3203
Wyoming Department of Ins. Herschler Building 122 West 25th Street, 3rd East Cheyenne, Wyoming 82002-0440 (307) 777-7401 Fax: (307) 777-5895	WYOMING 1-800-856-4398 (307) 856-6880 Fax: (307) 856-4466	Aging Division 6101 Yellowstone Road 259B; Qwest Building Cheyenne, WY 82002 1-800-442-2766 (307) 777-7986 Fax: (307) 777-5340



CHAPTER 10:

Funeral Planning

Few subjects are more fraught with emotion than funerals. Also, few industries are as subject to complaints and controversy. With average funeral costs ranging from \$5,000 to \$10,000 and rising, this is a significant expense for clients or their families. Whether funeral arrangements are needed immediately, or whether you have the rare client who is comfortable with the idea of planning his or her own funeral in advance, you can be of great assistance. As an objective observer who can provide information to the client or the family members at a vulnerable time and make sure their rights are respected, you can provide a valuable service.

FEDERAL TRADE COMMISSION RULE

The Federal Trade Commission (FTC) issued the Funeral Rule in 1984 and amended it in 1994. This rule requires funeral homes to give consumers accurate, itemized price information and various other disclosures about funeral goods and services. The FTC's Funeral Rule applies to pre-need and at-need funeral arrangements. It does not address prepayment for funerals.

The rule prohibits funeral homes from:

- Misrepresenting legal, crematory, and cemetery requirements.
- Embalming for a fee without permission.
- Requiring the purchase of a casket for direct cremation.
- Requiring consumers to buy certain funeral goods or services as a condition for furnishing other funeral goods or services.
- Engaging in other deceptive or unfair practices.

Violations of the Funeral Rule may cause a funeral home to be subject to penalties of up to \$10,000 per violation.

The General Price List

The key to the FTC Funeral Rule is the general price list (GPL). The GPL should be printed or typewritten and must contain the following identifying information:

- The name, address, and telephone number of the funeral provider's place of business, including (where relevant) the address and telephone number for each branch
- The caption "General Price List"
- The effective date of the price list

The Rule requires funeral homes to itemize the prices for certain goods and services so consumers may choose only those elements of a funeral that they want. The following 16 specified items of goods and services *must be listed* on the GPL, together with the price for each item:

1. Forwarding of remains to another funeral home
2. Receiving remains from another funeral home
3. Direct cremation
4. Immediate burial
5. Basic services of funeral director and staff, and overhead
6. Transfer of remains to funeral home
7. Embalming
8. Other preparation of the body
9. Use of facilities and staff for viewing
10. Use of facilities and staff for funeral ceremony
11. Use of facilities and staff for memorial service
12. Use of equipment and staff for graveside service
13. Hearse
14. Limousine
15. Either individual casket prices or the range of casket prices that appear on the casket price list
16. Either individual outer burial container prices or the range of outer burial container prices that appear on the outer burial container price list

In addition to these 16 items, funeral services providers may list other items they offer, such as acknowledgment cards and cremation urns. They also may provide on the GPL prices for package funerals; however, any package funerals must be offered *in addition to and not in place of* the required itemized prices.

Items 1 through 4 in the list are considered minimal services, and the prices for these services should include all charges relating to each service, including any basic services fee and any facilities and equipment fees. All services rendered in connection with the quoted price should be enumerated in the GPL.

Item 5, the basic services fee, should include services that are common to virtually all forms of disposition or arrangements that are offered, such as:

- Conducting the arrangements conference
- Securing the necessary permits
- Preparing the notices
- Sheltering of remains
- Coordinating the arrangements with the cemetery, crematory, or other third parties

The basic services fee should *not* include charges related to other items that must be separately listed on the GPL and that the customer may decline to purchase. The basic services fee may also include overhead from various aspects of the business operation.

The Funeral Rule expressly states that the basic services fee is the *only nondeclinable* fee allowed for services, facilities, or unallocated overhead, unless state or local law requires otherwise. Other than the basic services fee, funeral homes cannot charge any separate fee for overhead. Charging a second nondeclinable fee, such as a basic facilities fee or a casket handling fee, in addition to the basic services fee would violate the rule. Moreover, fees for additional services of the funeral director and staff cannot be listed, if those fees should be included in the basic services fee or in one of the other items required to be listed on the GPL.

Instead of charging a separate basic services fee, funeral homes may include the fee in the casket prices. With this alternative, the fee also must include all charges for the recovery of unallocated overhead. The amount of the basic services fee that is included in the price of the caskets must be included in the required disclosures. If the customer provides a casket obtained elsewhere, that same basic services fee must be added to the total cost of the arrangements selected.

Funeral service providers must list items 6 through 16 separately with their respective prices. The charge for each item should include all service fees and any equipment or facility charges for providing that particular item or service. These prices should not include the basic services fee.

The rule also requires funeral homes to make six disclosures on their GPL. These disclosures discuss:

1. The consumer's right to select only the goods and services desired
2. Embalming
3. Alternative containers for direct cremation
4. The basic services fee
5. The casket price list
6. The outer burial container price list

1. *The consumer's right to select only the goods and services desired.* The first disclosure informs consumers that they have a right to select only the items they want to buy, besides a nondeclinable basic services fee. This disclosure should be placed immediately above the prices of the goods and services that are offered. The recommended wording from the FTC is as follows:

The goods and services shown below are those we can provide to our customers. You may choose only the items you desire. *However, any funeral arrangements you select will include a charge for our basic services and overhead.* If legal or other requirements mean you must buy any items you did not specifically ask for, we will explain the reason in writing on the statement we provide describing the funeral goods and services you selected.

2. *Embalming.* The required disclosure regarding embalming, as prepared by the FTC, is as follows:

Except in certain special cases, embalming is not required by law. Embalming may be necessary, however, if you select certain funeral arrangements, such as a funeral with viewing. If you do not want embalming, you usually have the right to choose an arrangement that does not require you to pay for it, such as direct cremation or immediate burial.

This disclosure must appear adjacent to the listed price for embalming, not on a separate page.

3. *Alternative containers for direct cremation.* The third disclosure relates to direct cremation and this disclosure needs to be adjacent to direct cremation on the general price list, not on a separate page. It notifies consumers that in the case of direct cremation, an alternative container can be used, what the container is made of, and what type of alternative container the funeral home provides.
4. *The basic services fee.* This required disclosure depends on how the funeral home has chosen to allocate this fee. The two options allowable under the FTC Funeral Rule are as follows:

Option 1

If the Funeral Home lists a separate basic services fee (as previously discussed) and the charge is nondeclinable, the following disclosure must appear on the GPL together with the price and a full description of the services included in the fee:

This fee for our *basic services and overhead* will be added to the total cost of the funeral arrangements you select. (This fee is already included in our charges for direct cremations, immediate burials, and forwarding or receiving remains.)

If this basic services fee is nondeclinable, the price also must include all charges for the recovery of overhead that have not been allocated elsewhere.

Option 2

Instead of charging a separate basic services fee, the services fee can be included in the casket prices. With this alternative, the following disclosure must be included:

Please note that a fee of [*specify dollar amount*] for the use of our basic services *and overhead* is included in the price of our caskets. This same fee shall be added to the total cost of your funeral arrangements if you provide the casket. Our services include [*specify*].

The disclosure must appear on the GPL together with the prices for the individual caskets or, if there is a separate casket price list, with the casket price range.

5. *The casket price list.* This disclosure tells consumers that a casket price list is available. Casket prices may be listed either on the GPL or on a separate casket price list. If there is a separate casket price list, the GPL should state the range of prices for the caskets for sale, together with the following disclosure:

A complete price list will be provided at the funeral home.

6. *The outer burial container price list.* This disclosure informs consumers that an outer burial container price list is available. The prices for the outer burial containers can be on the GPL or a separate outer burial container price list. If there is a separate price list, the GPL should state the range of prices for the outer burial containers for sale, together with the following disclosure:

A complete price list will be provided at the funeral home.

If the prices for the outer burial containers are on the GPL, it must include the following disclosure in immediate conjunction with (directly next to) the outer burial container prices:

In most areas of the country, state or local law does not require that you buy a container to surround the casket in the grave. However, many cemeteries require that you have such a container so that the grave will not sink in. Either a grave liner or a burial vault will satisfy these requirements.

If there is a separate price list for outer burial containers, the above disclosure must be on that list.

There are additional requirements for the casket price list and outer burial container price list and for working with certain special circumstances, such as memorial groups, government groups, and relatives of deceased infants and children.

The GPL and all other related lists must be provided to all who inquire about funeral arrangements, not just as part of a pre-need or at-need consultation. In addition, all telephone inquiries about the costs of funeral arrangements must be responded to from the GPL and related lists.

Prohibited Misrepresentations

The Funeral Rule prohibits specific misrepresentations in six areas.

Embalming

A funeral services provider cannot tell consumers that state or local law requires embalming if it is not true. If state law does require embalming, the family may be told that embalming is required due to the specific circumstances, such as in the case of certain infectious diseases.

Note: If state law requires either refrigeration or embalming after a certain period of time and refrigeration facilities are available, the consumer must be given the option of either refrigeration or embalming.

Unless state or local law requires embalming, a funeral services provider may not tell consumers that embalming is required for practical purposes in the following situations:

- When the consumer wants a direct cremation
- When the consumer wants an immediate burial
- When refrigeration is available and the consumer wants a closed-casket funeral with no formal viewing or visitation

Casket for Direct Cremation

Funeral services providers cannot tell consumers that state or local law requires them to buy a casket if they are arranging a direct cremation. (A direct cremation is one that occurs without any formal viewing of the remains or any visitation or ceremony with the body present.) In the case of direct cremations, consumers cannot be told that they must buy a casket for any other reason.

If the provider offers direct cremations, an alternative container must be available and consumers must be informed that such containers are available for direct cremations. An alternative container is an unfinished wood box or other nonmetal receptacle or enclosure, without ornamentation or a fixed interior lining, which is designed for the encasement of human remains. It is made of fiberboard, pressed-wood, composition, or like materials, with or without an outside covering.

Note: The rule also prohibits crematories from requiring that a casket be purchased for direct cremation. However, the rule allows crematories to set standards for the kind of alternative containers that they will accept. For example, a crematory might stipulate that it will accept only rigid containers.

Outer Burial Container

Funeral homes cannot tell consumers that state or local law requires them to buy an outer burial container if it is not true. Funeral homes may not tell consumers that a particular cemetery requires an outer burial container if it is not true. If the particular cemetery does require a container, that should be explained to the consumer.

Legal and Cemetery Requirements

Funeral services providers cannot tell consumers that any federal, state, or local law or a particular cemetery or crematory requires them to buy a particular good or service if it is not true. If a consumer is told that he or she must buy a particular item because of any legal, cemetery, or crematory requirement, it must be identified and described in writing on the statement of funeral goods and services selected.

Preservative and Protective Value Claims

Funeral services providers cannot make any representations to consumers that funeral goods or services will delay the natural decomposition of human remains for a long or indefinite period. Funeral services providers cannot tell consumers that funeral goods (such as caskets or vaults) have protective features or will protect the body from gravesite substances when it is not true. All warranty information must be available to consumers.

Cash Advance Items

If there is a mark-up charge on cash advance items or the funeral services provider receives a commission, discount, or rebate that is not passed on to the consumer, the provider cannot state that the price charged for the cash advance item is the same as cost. If there *is* an added charge, or the provider receives and keeps a rebate, commission, or trade or volume discount, the provider must tell the consumer that the price is not the same as cost.

Other kinds of misrepresentations, though not specifically prohibited by the Funeral Rule, are nonetheless illegal. The FTC Act prohibits deceptive acts or practices. Likewise, the consumer protection laws of most states prohibit deceptive practices.

STATEMENT OF FUNERAL GOODS AND SERVICES SELECTED: COST INFORMATION AND DISCLOSURES

The statement of funeral goods and services selected (statement) is an itemized list of the goods and services that the consumer has selected during the arrangements conference. The statement allows consumers to evaluate their selections and to make any desired changes.

The rule does not require any specific form, heading, or caption on the statement. The information required on the statement, described further in this section, can be included on a contract or any other document given to customers at the conclusion of the arrangements discussion. The categories of goods and services listed on the statement (or

other similar document) should generally correspond to the items listed on the GPL, so customers can easily compare the two documents.

The consumer must be given a completed statement at the end of the arrangements discussion. If arrangements are made in person, the statement should be given at this time. Giving a consumer a copy of the statement at the funeral or mailing it to the consumer at some later date does *not* meet rule requirements.

Note: The rule does not address the manner or timing of payment. That is between the funeral services provider and the customer.

If arrangements are made over the telephone, the consumer should be given the statement at the earliest possible date.

If a consumer makes all funeral arrangements by telephone, a reasonable attempt should be made to give a completed statement to the consumer before a final disposition of the remains occurs. If the consumer does not visit the funeral home in person before the final disposition, a completed statement should be mailed or sent to the consumer as soon as possible.

The Funeral Rule requires cost information and specific disclosures on the statement.

Cost Information

The statement should list all of the individual goods and services that the consumer will purchase, together with the price for each item. The statement cannot simply lump together goods and services that are listed separately on the GPL.

Note: A statement would violate the rule if it listed only three broad categories for services, facilities, and automotive equipment.

A funeral services provider may still offer funeral packages, as long as they are offered *in addition to, not in place of*, itemized prices. If the consumer selects a package, the statement should describe the package, listing individually each of the goods and services included in the package, and state the package price.

The statement must list each cash advance item separately on the statement, together with the price for each item. Cash advance items are items of service or merchandise that are described to a consumer as:

- Cash advance
- Accommodation
- Cash disbursement
- Any similar term
- Obtained from a third party and paid for on the consumer's behalf

Cash advance items may include cemetery or crematory services, pallbearers, public transportation, clergy honoraria, flowers, musicians or singers, nurses, obituary notices, gratuities, and death certificates.

If the price of a particular cash advance item is not known at the time of the preparation of the statement, a good faith estimate should be included. A written statement of the actual charges must be prepared before the final bill is paid. The statement must give the consumer the total cost of the arrangements selected (individual goods and services plus cash advance items).

Disclosures

The following three disclosures must appear on the statement. They should be set out, word-for-word, *exactly* as the rule prescribes.

Legal Requirements

The first disclosure states that consumers will be charged only for the items they have selected and that the funeral services provider will explain any legal, cemetery, or crematory requirements in writing:

Charges are only for those items that you selected or that are required. If we are required by law or by a cemetery or crematory to use any items, we will explain the reasons in writing below.

The form should leave enough space to identify and explain in writing any legal, cemetery, or crematory requirement that compels the consumer to purchase a specific funeral item or service. This information should be entered on the statement before it is given to the customer.

Embalming

The second disclosure relates to embalming and the need for prior approval:

If you selected a funeral that may require embalming, such as a funeral with viewing, you may have to pay for embalming. You do not have to pay for embalming you did not approve if you selected arrangements such as a direct cremation or immediate burial. If we charged for embalming, we will explain why below.

The form should leave enough space for an explanation of the reason for embalming, and the information should be entered on the statement before giving it to the customer.

Cash Advance Items

The third disclosure relates to charges for the funeral home's services in buying cash advance items. If the provider charges for purchasing a cash advance item, or if the provider receives and retains a rebate, commission, or trade or volume discount for a cash advance item, the following disclosure must be included on the statement:

We charge you for our services in obtaining: (specify cash advance items).

This disclosure must be placed in immediate conjunction with (directly next to) the list of itemized cash advance items on the statement and specify those cash advance items to which the disclosure applies. The disclosure should not be on a separate page or elsewhere on the statement apart from the list of itemized cash advance items.

PRE-NEED PLANNING

Thinking ahead can help your client make informed and thoughtful decisions about funeral arrangements. It allows the client to choose the specific items he or she wants and make sure that his or her personal preferences or religious practices are observed. You could assist the client by comparing the prices offered by several funeral providers and by helping him or her avoid aggressive or disadvantageous sales techniques sometimes employed in the funeral industry.

Arrangements can be made directly with a funeral establishment or through a funeral planning or memorial society, a nonprofit organization that provides information about funerals and disposition but does not offer funeral services.

Another important consideration when planning a funeral pre-need is where the remains will be buried, entombed, or scattered. In the short time between the death and burial of a loved one, many family members find themselves rushing to buy a cemetery plot or grave, often without careful thought or a personal visit to the site. That is why it is in the family's best interest to buy cemetery plots before they are actually needed.

Preferences should be put in writing, the practitioner should keep a copy, and copies should be given to family members and the client's attorney. Advise clients not to designate their preferences in their will, because a will is often not found or read until after the funeral. Advise them not to put their copy of their preferences in a safe deposit box, because the family may have to make arrangements on a weekend or holiday, before the box can be opened.

The funeral services provider must comply with requirements of the FTC Funeral Rule at the time funeral arrangements are preplanned. The funeral home also needs to comply with the rule after the death of the individual who made pre-need arrangements. If the survivors inquire about goods or services, alter the preplanned arrangements, or are required to pay additional sums of money, they must be given all relevant disclosures and price lists. For example, survivors may be asked to pay additional amounts if the prepaid plan does not guarantee prices at the time of death. In other cases, survivors may change arrangements specified in the pre-need plan, adding or subtracting certain goods or services. In both situations, the requirements of the rule apply. The survivors must receive relevant price lists, as well as an itemized statement of funeral goods and services selected.

Prepaying

Millions of Americans have entered into contracts to prearrange their funerals and prepay some or all of the expenses involved, and that trend appears to be on the rise. As the result of a 1999 survey, the AARP estimates that amounts invested in pre-need agreements for funerals and burials exceed \$25 billion, up from \$18 billion in 1995. The FTC Funeral Rule did not address prepaid funerals. Laws of individual states govern the prepayment of funeral goods and services; various states have laws to help ensure that these advance payments are available to pay for the funeral products and services when they are needed. But protections vary widely from state to state, and some state laws offer little or no effective protection. Some state laws require the funeral home or cemetery to place a percentage of the prepayment in a state-regulated trust or to purchase a life insurance policy with the death benefits assigned to the funeral home or cemetery. According to AARP, as of 1999, only Alabama did not have a law governing the sale of pre-need funeral and burial contracts.

In general, state regulation has addressed:

- Licensure requirements for sellers of pre-need goods and services
- Requirements of funds in trust
- Contract provisions and cancellation requirements
- Consumer protection recovery funds

State laws vary regarding who can sell pre-need contracts and whether a separate license or permit is necessary. If the pre-need contract is funded with an insurance product, some states require that the seller be a licensed insurance agent. Only five states specify that their "unfair and deceptive practices" regulations apply to pre-need contracts.

Individuals who sell pre-need contracts on behalf of one or more funeral homes but do not, themselves, provide funeral goods and services must comply with the rule. In such a case, as an agent of a funeral provider, the individual is covered by the rule. These requirements only apply to the pricing, cost, and disclosure requirements for goods and services included in the contract, not the funding of the contracts.

The rule does not apply to pre-need contracts entered into before the rule went into effect in 1984. However, if a pre-need contract signed before 1984 is modified after 1984, the modification triggers all of the rule's requirements.

The percentage of funds from pre-need contracts required to be kept in trust by the funeral services provider varies from state to state. Most states require that 90 percent or more of the funds must be kept in trust for pre-need funeral services. The range is from 40 percent to 100 percent. In the majority of states, the amount of funds which must be kept in trust for pre-need cemetery contracts is less than 75 percent. The range is from 30 percent to 100 percent.

State regulation of pre-need contracts varies widely as well, with some states requiring only that the contract be in writing and include the terms and the names of the parties to the agreement, and other states requiring specific disclosures, easy-to-understand language, and large print. The regulation of cancellation procedures for these contracts also varies widely, with only a minority of states requiring a standard disclosure about the purchaser's right to cancel.

Recovery funds are established by states as a way to make funds available to consumers who have been defrauded or have experienced a breach of contract. Only a few states have a consumer protection recovery fund for pre-need funeral or burial agreements, or both.

There are several different ways to prefinance a funeral, including the following.

Individual Plans

In connection with a pre-need contract, the money to pay for a funeral is placed into a bank, credit union, or savings and loan association in the name(s) of the purchaser of the merchandise or services and the seller. The money is in the purchaser's control (100 percent) and before death can be withdrawn only by the purchaser. The money *and interest* are the purchaser's until such time that death occurs. The account can be payable on death (POD) or a Totten Trust in trust for (ITF) the seller. The proceeds are then available to the seller upon the death of the purchaser. If the purchaser chooses to withdraw any or all of the money (principal, interest, or both) before death, the contract is generally considered null and void. The purchaser is responsible for paying taxes on the interest earned on the amounts in the account.

A client could self-fund his or her funeral without a pre-need contract by investing funds in an account jointly with rights of survivorship (WROS) with a family member. It would be the family member's responsibility to use the funds to pay for the funeral and burial expenses. When setting up any type of individual account to pay for the cost of funeral, burial, or both, make sure that it is set up so it is not considered part of the probate estate so funds can be accessed on a timely basis.

No matter how pre-need contracts are funded, there are two important elements of these arrangements that you should review.

1. *Guaranteed or nonguaranteed.* If a contract is guaranteed, the funeral services provider promises to provide the goods and services specified in the contract regardless of his or her cost at the time of performance and accept the prefunded amount as payment in full. Nonguaranteed means that family members can be asked to bear additional expense despite the prefunding.
2. *Revocable/irrevocable.* Revocable contracts are refundable to the consumer anytime before death. Irrevocable contracts cannot be refunded, but that can work to your client's advantage if he or she needs to become eligible for an entitlement program to pay for the costs of long-term care or for supplemental income. Irrevocable contracts can be exempt up to a set limit as an asset. If certificates for merchandise (casket or outer container) are purchased, additional monies can also be sheltered to not count as assets.

Trusts

This prearranged funeral agreement generally requires a written prearrangement and then remitting funds to the seller to fund a trust. These trusts often pool the funds of many purchasers. As previously mentioned, state regulations vary regarding what percentage of the funds remitted by the purchaser need to be put into the trust and how much can be retained by the funeral services provider. Many states do require that 100 percent of the remittance be placed in trusts, but state regulations do vary. Interest remains in the trust and the costs of administering the trust may be imposed against individual accounts. Oftentimes pre-need trust accounts are irrevocable. One of the possible advantages with a trust is that your client may not have to pay tax on the interest earned by the trust. A disadvantage could be that less than the full amount could be refunded if the contract is cancelled.

In Kansas, for example, if your client has one of these contracts and should move to another state or more than 150 miles from the designated cemetery, he or she may cancel the contract. However, he or she may only receive 85 percent of his or her original investment and would lose all interest on the investment. Sometimes cancellations are not allowed under any circumstances or huge cancellation penalties are assessed.

Insurance

In some states, insurance products (general whole life policies, annuities) can be used as a means to finance funeral contracts. It is important to look these policies and contracts over carefully because there are many different kinds available. When using an insurance policy to prefinance a funeral, you should make sure that the price of the prearranged contract is guaranteed or the insurance policy is indexed for inflation to cover the increased costs. If your client purchases an insurance contract and signs an agreement with a funeral provider that does not guarantee costs, your client could end up paying two separate mark-ups. Any additional purchases or changes of merchandise or services previously not selected will obviously result in increased costs amending the guaranteed aspect of the agreement.

Annuities

This is similar to using an insurance policy to fund a pre-need agreement, but a tax-deferred annuity is instead purchased to fund the cost of the funeral, or a portion of an annuity is set aside to pay for funeral arrangements.

If your client is thinking about prepaying for funeral goods and services, it's important to consider these issues before putting down any money:

- What are they are paying for?
- Are they buying only merchandise, like a casket and vault, or are they purchasing funeral services as well?
- What happens to the money they have prepaid? States have different requirements for handling funds paid for prearranged funeral services.
- What happens to the interest income on money that is prepaid and put into a trust account?
- Who is responsible for the taxes on interest income on the funds invested?
- Are your clients protected if the firm they deal with goes out of business?
- Can the client cancel the contract and get a full refund if he or she changes his or her mind?
- What happens if the client moves to a different area or dies while away from home? Some prepaid funeral plans can be transferred, but often at an added cost.
- Is the client eligible for other benefits, such as veterans benefits, that would have an impact on the funeral plan?
- Would it be more advantageous for the client to set aside and invest funds on his or her own to fund funeral and burial costs? Oftentimes, it will be more beneficial to retain and invest those funds.
- Does the client or his or her family already have cemetery rights? How do they affect planning?
- Does the client need to worry about countable assets for eligibility for entitlement programs?

Be sure your client's family is made aware of the plans your client has made and where the documents are filed.

VETERANS BENEFITS

If your client is a veteran, you should be aware that he or she is eligible for burial benefits available from the U.S. Department of Veterans Affairs (VA) National Cemetery Administration. Benefits include a gravesite in any of the 117 national cemeteries with available space, opening and closing of the grave, perpetual care, a government headstone or marker, a grave liner for casketed remains, and a presidential memorial certificate, at no cost to the family.

Eligibility

Persons eligible for burial in a VA national cemetery include the individuals that follow. Be sure to consult with the VA or visit its Web site, <http://www.va.gov/>, for more specific limitations on the groups discussed here.

- Veterans and members of the Armed Forces
 - Army, Navy, Air Force, Marine Corps, Coast Guard
 - Any member of the Armed Forces of the United States who dies on active duty
 - Any citizen of the United States who, during any war in which the United States has been, or may hereafter, be engaged, served in the Armed Forces of any Government allied with the United States during that war, whose last active service terminated honorably by death or otherwise, and who was a citizen of the United States at the time of entry into such service and at the time of death
 - Any veteran who was discharged under conditions other than dishonorable. With certain exceptions, service beginning after September 7, 1980, as an enlisted person, and service after October 16, 1981, as an officer, must be for a minimum of 24 months or the full period for which the person was called to active duty. Undesirable, bad conduct, and any other type of discharge other than honorable may disqualify the individual for veterans benefits, depending upon a determination made by a VA Regional Office. Cases presenting multiple discharges of varying character are also referred for adjudication to a VA Regional Office.
- Members of reserve components and reserve officers' training corps.
- Commissioned officers, National Oceanic and Atmospheric Administration.
- Public health service.
- World War II Merchant Mariners.
- Spouses and dependents. The spouse or *unremarried* surviving spouse of an eligible person, even if that person is not buried or memorialized in a national cemetery, is eligible for interment in a national cemetery. In addition, the spouse of a member of the Armed Forces of the United States lost or buried at sea or officially determined to be permanently absent in a status of missing or missing in action or whose remains have been donated to science or cremated and the ashes scattered is eligible. The surviving spouse of an eligible decedent who remarries an ineligible individual and whose remarriage is void, terminated by the ineligible individual's death, or dissolved by annulment or divorce is eligible for burial in a national cemetery. The surviving spouse of an eligible decedent who remarries an eligible person retains his or her eligibility for burial in a national cemetery.
- Others. This includes such other persons or classes of persons as designated by the Secretary of Veterans Affairs (38 U.S.C. § 2402(6)) or the Secretary of the Air Force (Public Law 95-202, § 401).

Headstones and Markers

The VA furnishes upon request, at no charge to the applicant, a government headstone or marker to mark the unmarked grave of an eligible veteran in *any* cemetery around the world. Any deceased veteran eligible for burial in a VA national cemetery (see previous list) is also eligible for a government-provided headstone or marker. Headstones and markers are provided for eligible spouses and dependents of veterans only when buried in a national, military post/base, or state veterans cemetery. Spouses and dependents buried in a private cemetery are not eligible for a government-provided headstone or marker.

Military Funeral Honors

On January 1, 2000, the Department of Defense (DOD) began the implementation plan for providing military funeral honors for eligible veterans as enacted in Section 578 of Public Law 106-65 of the National Defense Authorization Act for 2000.

Upon the family's request, the law requires that every eligible veteran receive a military funeral honors ceremony to include folding and presenting the United States burial flag and the playing of "Taps." The law defines a military funeral honors detail as consisting of two or more uniformed military persons with at least one a member of the veteran's parent service of the Armed Forces. The DOD calls for funeral home directors to request military funeral honors on behalf of the veteran's family. Veterans organizations may assist in the provision of military funeral honors. When military funeral honors at a national cemetery are desired, they are arranged prior to the committal service by the funeral home.

Questions or comments concerning the DOD military funeral honors program may be sent to the address below. A military funeral honors Web site is located at www.militaryfuneralhonors.osd.mil.

Military Funeral Honors
10100 Reunion Place, Suite 260
San Antonio, TX 78216-4138

INDUSTRY TRENDS

It is not the usual case that an industry faced with oversupply and increased competition will increase prices as a response, but that is the case in the funeral services industry. It was estimated by the Government Accountability Office (previously the General Accounting Office) that the approximately 26,000 funeral homes in the United States were providing goods and services for an average of only six funerals a month. Death rates are not expected to increase significantly in the near term. Therefore, revenue growth needs to come from maximizing fees and increasing the number of services provided to the bereaved. The funeral industry is currently facing the following trends:

- Consolidation
- Increased calls for oversight from consumer groups

These trends have an effect on how the funeral industry does business and how the industry will change in the future. You should be aware of these trends because they can have an impact on your client's rights and also on how they choose to preplan their arrangements.

Consolidation

In the past, the local funeral home was most likely an independent, family-run business with strong ties to the community. Although supplied by huge corporations, the staff of the funeral home had oftentimes grown up in the community he or she served and often knew the clients for generations. This has been changing and will continue to change in the future.

The largest funeral services provider is Services Corporation International (SCI), a publicly traded company started in Houston in 1962. The founder observed that the underlying services needed to support a funeral business were often idle and believed that having centralized services for embalming, administration, and other support functions, such as a fleet of vehicles, would be more efficient. He started with three funeral homes in Houston and centralized services. By 1969, the company had acquired chains in Canada, and in 1970 the company went public. It became a NYSE traded company in 1974. Between 1970 and 1990, the company spread its operations, through acquisitions, to 40 states and four Canadian provinces. International expansion followed, with the purchase of over 100 funeral homes in Australia in 1993 and 1994. Also in 1994, SCI began acquisitions in the United Kingdom, leading to its current position as the leading provider of funeral and related services in the UK, controlling 15 percent of the market. The following year, it acquired the largest organization in Europe, Paris-based Pompes Funèbres Générales S.A. By the end of 1999, the company network included affiliates in 20 countries on five continents and employed over 40,000 worldwide.

SCI has successfully pursued a growth strategy fueled by acquisitions. Now, as the company's Web site states, it is pursuing a strategy of internal growth, by developing new products and services for the bereaved and introducing customs from one culture into another. One example cited is the introduction in the United States of memorial gardens where cremated remains can be buried or stored in vaults. These gardens were already successfully established in Australia and the United Kingdom. SCI, as the largest player in the industry, has been the most visible target for consumer and individual complaints.

Traditionally, the funeral services industry was divided along lines of business; the funeral homes provided funeral goods and services, cemeteries provided burial goods and services, and separate dealers sold monuments and memorials. Now, the lines between these segments are blurred as more funeral services providers attempt to sell goods and services out of their traditional business lines and cemeterians attempt to make greater inroads in providing services traditionally provided by funeral homes. All of these businesses, along with other third parties, are selling pre-need arrangements. This is leading to increasingly aggressive sales tactics.

One area of increased competition in the funeral services business that may benefit the consumer is the rise of companies that sell caskets directly to the consumer. There are two large Web-based resellers, Direct Casket (www.directcasket.com) and Web Caskets (www.webcaskets.com), from which you can order caskets for next-day delivery. These companies estimate that buying caskets from them can save you up to 50 percent on the price of this major purchase. The FTC Funeral Rule mandates that funeral homes have to accept caskets bought from other sources, although funeral services providers may try to discourage consumers from doing so.

Increased Calls for Oversight

Consumer groups and the AARP have been very vocal in their call for increased oversight of the funeral industry, particularly calls for stronger enforcement of the Funeral Rule and extension of the rule to pre-need funding. The FTC Funeral Rule is currently under review and in April 2000 the Senate Special Committee on Aging held a hearing called "Funerals and Burials: Protecting Consumers from Bad Practices." The purpose of the hearing was to educate consumers about the industry, expose bad practices, and explore the extent of consumer satisfaction with the industry. The special committee heard

testimony from individual consumers and consumer advocates and representatives of the industry and government bodies.

In 1999, the New York City Department of Consumer Affairs issued its report, *The High Cost of Dying*, which was highly critical of the funeral industry. Also in 1999, the AARP conducted a survey, "Survey of Older Funeral Burial Planners and Arrangers."

Witness testimony at the Senate Special Committee included the following representations by consumers and consumer advocates. (Note: These representations were made by individuals testifying before the special committee, but there is no indication of independent verification of these representations by the special committee as part of the official record of the hearings.)

Darryl J. Roberts, former funeral home director and author of *Profits of Death*, noted several areas of deception or misleading sales tactics in the industry, including misrepresenting the long-term benefits of embalming as a preservative and also the benefits of sealer caskets and sealed vaults as a method of long-term preservation. He noted that the industry has introduced anticompetitive legislation successfully in 12 states making it illegal for non-funeral service providers to sell funeral merchandise. He noted the following problems related to pre-need planning: There is currently no portability for these agreements, the majority of pre-need agreements are not guaranteed, funding requirements for pre-need trusts often give all the advantages to the sellers and none to the consumer, and pre-need insurance policies are overpriced and often offer no inflation protection. He presented a 15-point plan for increased legislative and regulatory oversight of the industry.

Father Henry Wasielewski, a Catholic priest in Phoenix and a funeral industry watchdog, presented information that he had gathered about pricing practices in the industry, showing the huge variance in prices in one community for similar services. The range in retail price for one casket that sold for less than \$300 wholesale was \$450 to \$5,900. The range in prices for direct cremations in that community ranged from \$450 to \$3,985. He also criticized the sales tactics employed by some salespersons of preplan funeral arrangements and some companies, including contracts that allow for cancellation of the contracts and retention of amounts paid due to late payments. He called for legislation to stop deceptive and anticompetitive trade practices of the industry.

Cheryl Lankford, a licensed funeral home operator from Florida, criticized the licensing requirements for pre-need salesmen, which in Florida do not require any special training or experience. She also criticized the practice of using commission-based incentives for these salespeople, which encouraged them to get consumers to add additional goods and services to these contracts to increase their commissions. She called for stricter licensure requirements for these salespeople.

The New York City Department of Consumer Affairs included the following findings in its report, *The High Cost of Dying*, which resulted from an investigation of the funeral industry in New York City:

- The funeral industry in New York City is becoming increasingly consolidated, with SCI owning at least 10 percent of funeral homes and conducting about 13 percent of the funerals in New York City. SCI funerals cost an average of 25 percent more than a funeral at an independent home.
- By using a strategy called clustering, SCI can in effect control an entire market. SCI owns five out of six Jewish funeral homes in Manhattan, and funerals at those homes

cost up to 50 percent more than funerals at independent homes. Because SCI maintains the original name of these homes, it is difficult to differentiate a funeral home that is part of a chain from an independently owned home.

- To fight competition from independent casket retailers, funeral homes are selectively discounting caskets when family members have obtained price information from an independent retailer. Also, although illegal, funeral homes will charge “handling fees” for caskets purchased from independent retailers.

The Department of Consumer Affairs called for the New York State Attorney General to investigate possible antitrust violations in connection with the consolidation of the industry. It also called for legislation calling for funeral homes to publicly disclose the ownership of every funeral home.

The AARP “Survey of Funeral and Burial Arrangers and Planners” (consumers who either arranged a funeral for a loved one or preplanned a funeral) found that there were varying levels of compliance with the FTC Funeral Rule. Among the Survey findings were the following:

- Funeral homes changed the services and prices that had been arranged ahead of time for 10 percent of those who preplanned or dealt with prearranged funerals.
- One-third of funeral arrangers or preplanners did not receive a price list when viewing casket lists. Also one-third did receive representations that protective features of certain caskets would preserve a body indefinitely.
- One-third of all arrangers and preplanners did not receive a general price list before discussing specific funeral goods and services.
- Almost one-third of those purchasing a burial plot were told that a grave liner or burial vault would help preserve the body indefinitely.
- One-third of those who purchased burial plots were not given a written price list.

The AARP called for increased oversight of pre-need arrangements, expansion of the Funeral Rule to include regulation of prepaid arrangements, and increased oversight of the consolidations in the industry.

Practice Issues

Despite the abundance of criticism of the industry, many funeral services providers continue to be ethical members of the local business community. In addition, the industry has issued some guidelines and initiated increased self-regulation to burnish its image.

You can be of assistance to your clients by:

- Gaining a general knowledge of the funeral services providers in your community, including ownership information.
- Understanding their rights as consumers and verifying that their rights have been respected by reviewing price lists, statements of goods and services, and any other written representations received.
- Whenever possible, accompanying clients to meetings with funeral services providers.
- Letting them know that all solicitations for prepaid funeral contracts should be discussed with you in advance and reviewed by you before they are signed.

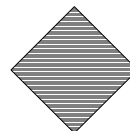
- Understanding all elements of these pre-need contracts, including guarantees, revocability, cancellation penalties, portability issues, and inflation indexes.
- Understanding how these contracts are funded and in what type of vehicle they are invested.
- Investigating the financial stability of any organization that is selling pre-need arrangements to your clients.
- Making sure that the funding requirements for any trusts meet, at a minimum, the funding requirements in the client's jurisdiction.
- Evaluating how this funding fits in with the client's current financial and estate plan.
- Evaluating how the funding method for the contract will affect the client's eligibility for any entitlement programs for which he or she needs to qualify.
- Making sure that the funds will be accessible when needed.
- Discussing with your client whether this is something he or she really wishes to do, or is doing for some other reason (question whether he or she has been unduly pressured by a salesperson).

SOURCES FOR FURTHER INFORMATION

There are numerous sources of information available about the funeral industry. The following list of sources is not all-inclusive, but it does include government, industry, and consumer resources.

AARP	www.aarp.org	Downloadable industry studies, articles and survey results on the funeral industry.
FAMSA-Funeral Consumers Alliance	www.funerals.org	This site provides information for consumers and provides information about Memorial Societies and their role in reducing the cost of funerals. Numerous links on the funeral industry as well as on death and dying.
Federal Trade Commission	www.ftc.gov	Includes the complete text of the Funeral Rule and documentation of the current review process, copies of all comments received and hearings held in connection with the review of the rule. (The most effective way to access this information is to do a search for "federal trade commission and funerals.")

International Order of the Golden Rule	www.ogr.org	This association of independently owned and operated funeral homes was founded in 1928 and its founding principle is “Service measured not by gold but by the Golden Rule.” Its mission is to help independent funeral homes remain independent. It has over 1200 members in North America and provides an online search capability for its member firms. It also has an online directory of all state and provincial boards.
National Funeral Directors Association	www.nfda.org	This is the largest trade group representing the funeral industry. It was founded in 1882. It issues voluntary guidelines for members to follow in the sale of pre-need contracts and publishes various consumer-oriented publications.
Senate Special Committee on Aging	www.senate.gov/~aging	Includes prepared text and video testimony from its hearings on matters pertaining to aging and the elderly.
Service Corporation International	www.sci-corp.com	This site includes an online directory of funeral services providers owned by SCI and a description of its goods and services, including information about its new branding campaign and new products.



CHAPTER 11:

Associations, Organizations, Agencies, and Other Resources

A tremendous amount of information related to aging and aging organizations is available to practitioners. Utilize the following groups and resources for additional information for your ElderCare/PrimePlus clients and families. This chapter is available on the accompanying CD-ROM and can be used as an in-house directory by practitioners and staff. The Web sites referenced in the chapter are accessible via the CD-ROM as well.



- **Chapter 11: Associations, Organizations, Agencies, and Other Resources** (*also see accompanying CD-ROM*)

ASSOCIATIONS AND ORGANIZATIONS*

Note: The resource materials in this section can be indexed as follows (referenced alphabetically and by subject area):

A

Adult Day Care

National Association of Activity Professionals (NAAP)
National Council on Aging (NCOA)

African-American Health

National Caucus and Center on Black Aged, Inc. (NCBA)
National Medical Association (NMA)
National Urban League

Aging Research

Administration on Aging (AoA)
Alliance for Aging Research
Alzheimer's Association
Alzheimer's Disease Education and Referral (ADEAR) Center

* Source: The material in the "Associations and Organizations" section is taken from *The Resource Directory for Older People*, a cooperative effort of the National Institute on Aging (NIA) and the Administration on Aging. It is available on NIA's Web site at <http://www.nia.nih.gov/health/resource/rd2001.htm> and on AoA's Web site at <http://www.aoa.gov>.

American Federation for Aging Research (AFAR)
American Geriatrics Society (AGS)
American Society on Aging (ASA)
Beverly Foundation
John Douglas French Alzheimer's Foundation
Gerontological Society of America (GSA)
National Institute on Aging (NIA)

AIDS

AIDS Clinical Trials Information Service (ACTIS)
HIV/AIDS Treatment Information Service (ATIS)
National Association on HIV Over Fifty (NAHOF)
National Institute of Allergy and Infectious Diseases (NIAID)
National Prevention Information Network (NPIN)
National STD and AIDS Hotlines

Alaska Native Health

Indian Health Service (IHS)
National Indian Council on Aging (NICOA)
National Resource Center on Native American Aging (NRCNAA)

Alcohol Abuse

National Council on Alcoholism and Drug Dependence (NCADD)
National Institute on Alcohol Abuse and Alcoholism (NIAAA)
Substance Abuse and Mental Health Services Administration (SAMHSA)

Alternative Medicine

National Center for Complementary and Alternative Medicine Clearinghouse (NCCAM)

Alzheimer's Disease

Alzheimer's Association
Alzheimer's Disease Education and Referral (ADEAR) Center
American Academy of Neurology (AAN)
American Health Assistance Foundation (AHAFA)
John Douglas French Alzheimer's Foundation
National Institute of Environmental Health Sciences
National Institute of Mental Health (NIMH)
National Institute of Neurological Disorders and Stroke (NINDS)
National Institute on Aging (NIA)

Arthritis

American Academy of Orthopaedic Surgeons (AAOS)
Arthritis Foundation (AF)
National Arthritis and Musculoskeletal and Skin Diseases Information Clearinghouse
National Psoriasis Foundation (NPF)

Asian Pacific American Health

Japanese American Citizens League (JACL)
National Asian Pacific Center on Aging (NAPCA)
Native Elder Health Care Resource Center (NEHRC)
Organization of Chinese Americans (OCA)

Assisted Living

American Association of Homes and Services for the Aging (AAHSA)
American Health Care Association (AHCA)
American Medical Directors Association (AMDA)
Assisted Living Foundation of America (ALFA)
National Council on Aging (NCOA)
National Resource Center on Supportive Housing & Home Modifications

Autoimmune Diseases

Lupus Foundation of America (LFA)
National Arthritis and Musculoskeletal and Skin Diseases Information Clearinghouse

B

Balance Disorders

American Academy of Otolaryngology-Head and Neck Surgery, Inc. (AAO)
National Institute on Deafness and Other Communication Disorders (NIDCD)
Vestibular Disorders Association (VEDA)

Blindness

American Academy of Ophthalmology (AAO)
American Council of the Blind (ACB)
American Foundation for the Blind (AFB)
American Optometric Association (AOA)
Better Vision Institute (BVI)
Glaucoma Research Foundation (GRF)
Lighthouse National Center for Vision and Aging (LNCVA)
National Eye Health Education Program (NEHEP)
National Library Service for the Blind and Physically Handicapped (NLSBPH)
Prevent Blindness America (PBA)

Brain Diseases

Alzheimer's Association
Alzheimer's Disease Education and Referral (ADEAR) Center
American Academy of Neurology (AAN)
American Brain Tumor Association (ABTA)
American Parkinson's Disease Association (APDA)
The Dana Alliance for Brain Initiatives
John Douglas French Alzheimer's Foundation
National Institute of Neurological Disorders and Stroke (NINDS)
Society for Neuroscience

C

Cancer

American Cancer Society (ACS)
American Health Foundation (AHF)
Leukemia and Lymphoma Society, Inc. (LLS)
National Cancer Institute (NCI)
The Skin Cancer Foundation

Caregiving

Administration on Aging (AoA)
Alzheimer's Association
Beverly Foundation
Brookdale Center on Aging (BCOA) of Hunter College
Catholic Charities USA (CCUSA)
Children of Aging Parents (CAPS)
Eldercare Locator
Elderweb
John Douglas French Alzheimer's Foundation
National Association of Professional Geriatric Care Managers (NAPGCM)
National Council on Aging (NCOA)
National Family Caregivers Association (NFCA)
National Osteoporosis Foundation (NOF)
National Resource Center: Diversity and Long-Term Care (NRCDLTC)
Well Spouse Foundation (WSF)

Chinese American Health

Organization of Chinese Americans (OCA)

Chiropractors

American Chiropractic Association (ACA)

Clinical Trials

AIDS Clinical Trials Information Service (ACTIS)
Alzheimer's Disease Education and Referral (ADEAR) Center
National Arthritis and Musculoskeletal and Skin Disease Information Clearinghouse
National Cancer Institute (NCI)
National Center for Complementary and Alternative Medicine Clearinghouse (NCCAM)
National Diabetes Information Clearinghouse (NDIC)
National Digestive Diseases Information Clearinghouse (NDDIC)
National Eye Health Education Program (NEHEP)
National Heart, Lung, and Blood Institute (NHLBI) Information Center
National Human Genome Research Institute (NHGRI)
National Institute of Allergy and Infectious Diseases (NIAID)
National Institute of Child Health and Human Development (NICHD) Information Clearinghouse
National Institute of Dental and Craniofacial Research (NIDCR)
National Institute of Environmental Health Sciences
National Institute of Mental Health (NIMH)
National Institute of Neurological Disorders and Stroke (NINDS)
National Institute of Nursing Research (NINR)
National Institute on Aging (NIA)
National Institute on Alcohol Abuse and Alcoholism (NIAAA)
National Institute on Deafness and Other Communication Disorders (NIDCD)
National Institute on Drug Abuse (NIDA)
National Kidney and Urological Diseases Information Clearinghouse (NKUDIC)
National Library of Medicine (NLM)

Communication Disorders

American Speech-Language-Hearing Association (ASHA)
American Tinnitus Association (ATA)
Better Hearing Institute
Captioned Media Program (CMP)
International Hearing Society (IHS)
National Association of the Deaf (NAD)
National Institute on Deafness and Other Communication Disorders (NIDCD)
Self Help for Hard of Hearing People, Inc. (SHHH)

Community-Based Care

Administration on Aging (AoA)
Beverly Foundation
Center for Advancement of State Community Services Program (CASCSP)
Eldercare Locator
Indian Health Service (IHS)
Kansas Geriatric Education Center (KS-GEC)
National Association of Area Agencies on Aging (N4A)
National Association of Community Health Centers (NACHC)
National Association of State Units on Aging (NASUA)
National Long-Term Care Resource Center (NLTCRC)
Project Aliento
Visiting Nurse Associations of America (VNAA)

Community Service

B'nai B'rith
Corporation for National Service (CNS)
Elder Craftsmen (EC)
Gray Panthers (GP)
Green Thumb, Inc. (GT)
National Council on Aging (NCOA)
National Urban League
United Way of America
Volunteers of America

Computer Literacy

Generations Online
SeniorNet (SN)

Consumer Information

Council of Better Business Bureaus (CBBB)
Federal Citizen Information Center (FCIC)
Federal Trade Commission (FTC)
National Consumer's League (NCL)
National Council Against Health Fraud (NCAHF)

Counseling

American Association for Geriatric Psychiatry (AAGP)
American Association for Marriage and Family Therapy
American Counseling Association (ACA)
American Psychiatric Association (APA)

American Psychological Association (APA)
Catholic Charities USA (CCUSA)
National Association of Social Workers (NASW)
National Mental Health Association (NMHA)
National Organization for Victim Assistance (NOVA)

Crime

Clearinghouse on Abuse and Neglect for the Elderly (CANE)
Department of Justice (DOJ)
National Center on Elder Abuse (NCEA)
National Organization for Victim Assistance (NOVA)
National Policy and Resource Center on Women and Aging (NPRCWA)

D

Databases

Alzheimer's Disease Education and Referral (ADEAR) Center
American Association of Retired Persons (AARP)
American Brain Tumor Association (ABTA)
Census Bureau
Clearinghouse on Abuse and Neglect for the Elderly (CANE)
Gerontological Society of America (GSA)
National Center for Health Statistics (NCHS)
National Diabetes Information Clearinghouse (NDIC)
National Digestive Diseases Information Clearinghouse (NDDIC)
National Health Information Center (NHIC)
National Library of Medicine (NLM)
National Rehabilitation Information Center (NARIC)
Office on Smoking and Health (OSH)

Death & Dying

National Hospice and Palliative Care Organization (NHPCO)
National Hospice Foundation (NHF)
Partnership for Caring, Inc. (PFC)

Diabetes

American Diabetes Association (ADA)
National Diabetes Information Clearinghouse (NDIC)

Digestive Disorders

National Digestive Diseases Information Clearinghouse (NDDIC)

Disabilities

American Academy of Physical Medicine and Rehabilitation (AAPMR)
American Occupational Therapy Association, Inc. (AOTA)
American Physical Therapy Association (APTA)
Disabled American Veterans (DAV)
National Legal Support for Elderly People with Mental Disabilities Project
National Library Service for the Blind and Physically Handicapped (NLSBPH)
National Rehabilitation Information Center (NARIC)
National Resource Center: Diversity and Long-Term Care (NRCDLTC)

Dizziness

American Academy of Otolaryngology-Head and Neck Surgery, Inc. (AAO)
Vestibular Disorders Association (VEDA)

Drug Abuse

National Council on Alcoholism and Drug Dependence (NCADD)
National Institute on Drug Abuse (NIDA)
Substance Abuse and Mental Health Services Administration (SAMHSA)

E

Education

Association for Gerontology in Higher Education (AGHE)
B'nai B'rith
Elderhostel
Green Thumb, Inc. (GT)
Legal Counsel for the Elderly (LCE)
National Association for Practical Nurse Education and Services (NAPNES)

Elder Abuse

Clearinghouse on Abuse and Neglect for the Elderly (CANE)
Department of Justice (DOJ)
National Center on Elder Abuse (NCEA)
National Organization for Victim Assistance (NOVA)

Emergency Assistance

American Red Cross
Catholic Charities USA (CCUSA)
MedicAlert Foundation

Employment

Department of Labor (DOL)
Disabled American Veterans (DAV)
Equal Employment Opportunity Commission (EEOC)
Green Thumb, Inc. (GT)
National Association for Hispanic Elderly (Asociación Nacional Por Personas Mayores)
National Caucus and Center on Black Aged, Inc. (NCBA)
National Council on Aging (NCOA)
National Resource and Information Center (NRIC)
National Senior Citizens Education and Research Center (NSCERC)
National Urban League

Environment

Environmental Protection Agency (EPA)
National Institute of Environmental Health Sciences

Epilepsy

Epilepsy Foundation
National Institute of Neurological Disorders and Stroke (NINDS)

Exercise

American College of Sports Medicine (ACSM)
American Heart Association (AHA)
Arthritis Foundation (AF)
Center for the Study of Aging/International Association of Physical Activity, Aging and Sports (IAPAAS)
Centers for Disease Control and Prevention (CDC)
National Association for Health & Fitness (NAHF)
National Association for Human Development (NAHD)
President's Council on Physical Fitness and Sports (PCPFS)
Robert Wood Johnson Foundation
Young Men's Christian Association (YMCA)
Young Women's Christian Association (YWCA)

Eyes

American Academy of Ophthalmology (AAO)
American Council of the Blind (ACB)
American Federation for the Blind (AFB)
American Health Assistance Foundation (AHAF)
American Optometric Association (AOA)
Better Vision Institute (BVI)
Glaucoma Research Foundation (GRF)
Lighthouse National Center for Vision and Aging (LNCVA)
National Eye Health Education Program (NEHEP)
National Library Service for the Blind and Physically Handicapped (NLSBPH)
Opticians Association of America (OAA)
Prevent Blindness America (PBA)

F

Financial Information & Assistance

American Academy of Ophthalmology (AAO)
American Bar Association
American Cancer Society (ACS)
American Health Assistance Foundation (AHAF)
American Optometric Association (AOA)
American Red Cross
Catholic Golden Age (CGA)
Department of Veterans Affairs (VA)
Disabled American Veterans (DAV)
Employee Benefits Security Administration (EBSA)
Health Care Financing Administration (HCFA)
Hill-Burton Free Medical Care Program
Leukemia and Lymphoma Society, Inc. (LLS)
Meals on Wheels Association of America (MOWAA)
Medicare Rights Center (MRC)
National Committee to Preserve Social Security and Medicare (NCPSSM)
Social Security Administration (SSA)
United Seniors Health Council (USHC)
United Way of America

Foot Care

American Podiatric Medical Association (APMA)

Fraud

Council of Better Business Bureaus (CBBB)
Department of Justice (DOJ)
Federal Trade Commission (FTC)
Food and Drug Administration (FDA)
National Bar Association (NBA)
National Consumer's League (NCL)
National Council Against Health Fraud (NCAHF)

G

Geriatrics

American Association for Geriatric Psychiatry (AAGP)
American Geriatrics Society (AGS)
National Association of Professional Geriatric Care Managers (NAPGCM)

Gerontology

Association for Gerontology in Higher Education (AGHE)
Gerontological Society of America (GSA)
National Gerontological Nursing Association (NGNA)

Guardianship

American Health Care Association (AHCA)
Brookdale Center on Aging (BCOA) of Hunter College
The Center for Social Gerontology (TCSG)

H

Health Care Policy

Administration on Aging (AoA)
Alliance for Aging Research
American College of Physicians-American Society of Internal Medicine (ACP-ASIM)
American Hospital Association (AHA)
American Medical Association (AMA)
American Medical Directors Association (AMDA)
American Osteopathic Association
American Pharmaceutical Association (APhA)
American Society on Aging (ASA)
Center for Advancement of State Community Services Program (CASCSP)
National Association for Home Care (NAHC)
National Association of Community Health Centers (NACHC)
National Association of State Units on Aging (NASUA)
National Committee to Preserve Social Security and Medicare (NCPSSM)
National Osteoporosis Foundation (NOF)
National Women's Health Network (NWHN)
Robert Wood Johnson Foundation (RWJF)
Substance Abuse and Mental Health Services Administration (SAMHSA)

Health Research

Agency for Healthcare Research & Quality (AHRQ)
American Dental Association (ADA)
American Foundation for Urologic Diseases (AFUD)
American Health Foundation (AHF)
American Heart Association (AHA)
American Medical Association (AMA)
American Nurses Association (ANA)
American Parkinson's Disease Association (APDA)
American Tinnitus Association (ATA)
Arthritis Foundation (AF)
Centers for Disease Control and Prevention (CDC)
Department of Transportation (DOT)
Epilepsy Foundation
Food and Drug Administration (FDA)
Foundation for Biomedical Research (FBR)
National Arthritis and Musculoskeletal and Skin Diseases Information Clearinghouse
National Cancer Institute (NCI)
National Center for Complementary and Alternative Medicine Clearinghouse (NCCAM)
National Diabetes Information Clearinghouse (NDIC)
National Digestive Diseases Information Clearinghouse (NDDIC)
National Eye Health Education Program (NEHEP)
National Gerontological Nursing Association (NGNA)
National Human Genome Research Institute (NHGRI)
National Heart, Lung, and Blood Institute (NHLBI) Information Center
National Institute of Allergy and Infectious Diseases (NIAID)
National Institute of Child Health and Human Development (NICHD) Information Clearinghouse
National Institute of Dental and Craniofacial Research (NIDCR)
National Institute of General Medical Sciences (NIGMS)
National Institute of Mental Health (NIMH)
National Institute of Neurological Disorders and Stroke (NINDS)
National Institute of Nursing Research (NINR)
National Institute on Aging (NIA)
National Institute on Alcohol Abuse and Alcoholism (NIAAA)
National Institute on Deafness and Other Communication Disorders (NIDCD)
National Institute on Drug Abuse (NIDA)
National Kidney and Urological Diseases Information Clearinghouse (NKUDIC)
National Kidney Foundation (NKF)
National Library of Medicine (NLM)
National Organization for Rare Disorders (NORD)
National Osteoporosis Foundation (NOF)

Hearing Loss

American Academy of Otolaryngology-Head and Neck Surgery, Inc. (AAO)
American Speech-Language-Hearing Association (ASHA)
Better Hearing Institute
Captioned Media Program (CMP)
International Hearing Society (IHS)
National Association of the Deaf (NAD)

National Institute on Deafness and Other Communication Disorders (NIDCD)
Self Help for Hard of Hearing People, Inc. (SHHH)

Heart Diseases

American Association of Cardiovascular and Pulmonary Rehabilitation (AACVPR)
American Health Assistance Foundation (AHAF)
American Health Foundation (AHF)
American Heart Association (AHA)
American Lung Association (ALA)
National Heart, Lung, and Blood Institute (NHLBI) Information Center

Hispanic Health

National Alliance for Hispanic Health
National Association for Hispanic Elderly (Asociación Nacional Por Personas Mayores)
National Council of La Raza (NCLR)
National Hispanic Council on Aging (NHCoA)
Project Aliento

Home Health Care

American Medical Directors Association (AMDA)
National Association for Home Care (NAHC)
National Association for Practical Nurse Education and Services (NAPNES)
National Association of Area Agencies on Aging (N4A)
National Resource and Information Center (NRIC)
Vestibular Disorders Association (VEDA)
Visiting Nurse Associations of America (VNAA)

Horticultural Therapy

American Horticultural Therapy Association (AHTA)

Hospice

American Medical Directors Association (AMDA)
National Association for Home Care (NAHC)
National Hospice and Palliative Care Organization (NHPCO)
National Hospice Foundation (NHF)
Partnership for Caring, Inc. (PFC)
Visiting Nurse Associations of America (VNAA)

Hospitals

American Hospital Association (AHA)
Department of Veterans Affairs (VA)
Health Care Financing Administration (HCFA)
Hill-Burton Free Medical Care Program

Housing

American Association of Homes and Services for the Aging (AAHSA)
American Health Care Association (AHCA)
American Medical Directors Association (AMDA)
Assisted Living Foundation of America (ALFA)
B'nai B'rith
Continuing Care Accreditation Commission (CCAC)

Elderweb

National Council on Aging (NCOA)

National Long-Term Care Ombudsmen Resource Center (NLTCORC)

National Long-Term Care Resource Center (NLTCRC)

National Resource Center on Supportive Housing & Home Modifications

Huntington's Disease

Huntington's Disease Society of America (HDSA)

National Institute of Neurological Disorders and Stroke (NINDS)

Hysterectomy

American College of Obstetricians and Gynecologists (ACOG)

Hysterectomy Educational Resources and Services Foundation (HERS)

I

Immunizations

National Coalition for Adult Immunization (NCAI)

National Institute of Allergy and Infectious Diseases (NIAID)

Incontinence

National Association for Continence (NAFC)

National Kidney and Urological Diseases Information Clearinghouse (NKUDIC)

Simon Foundation for Continence

Infectious Diseases

Centers for Disease Control and Prevention (CDC)

National Coalition for Adult Immunizations

National Institute of Allergy and Infectious Diseases (NIAID)

Insurance

Agency for Healthcare Research & Quality (AHRQ)

American Association of Retired Persons (AARP)

Health Care Financing Administration (HCFA)

Health Insurance Association of America (HIAA)

Medicare Rights Center (MRC)

Social Security Administration (SSA)

United Seniors Health Council (USHC)

Intergenerational Programs

Corporation for National Service (CNS)

Elder Craftsmen (EC)

Generations Online

Generations Together (GT)

Gray Panthers (GP)

National Council on Aging (NCOA)

National Urban League

Young Men's Christian Association (YMCA)

Young Women's Christian Association (YWCA)

J

Japanese American Health

Japanese American Citizens League (JACL)

Joint & Bone Diseases

American Academy of Orthopaedic Surgeons (AAOS)

National Arthritis and Musculoskeletal and Skin Diseases Information Clearinghouse

National Osteoporosis Foundation (NOF)

NIH Osteoporosis and Related Bone Diseases National Resource Center (NIH-ORBD-NRC)

Paget Foundation for Paget's Disease of Bone and Related Disorders (PF)

K

Kidney Diseases

American Foundation for Urologic Diseases (AFUD)

National Kidney and Urological Diseases Information Clearinghouse (NKUDIC)

National Kidney Foundation

L

Legal Issues

American Bar Association

Brookdale Center on Aging (BCOA) of Hunter College

The Center for Social Gerontology (TCSG)

Eldercare Initiative in Consumer Law (EICL)

Equal Employment Opportunity Commission (EEOC)

Legal Counsel for the Elderly (LCE)

Legal Services for the Elderly (LSE)

National Academy of Elder Law Attorneys, Inc. (NAELA)

National Association of State Units on Aging (NASUA)

National Bar Association (NBA)

National Center on Poverty Law, Inc. (NCPL)

National Legal Support for Elderly People with Mental Disabilities Project

National Long-Term Care Resource Center (NLTCCRC)

National Senior Citizens Law Center (NSCLC)

Pension Rights Center (PRC)

Leisure Activities

American Association of Retired Persons (AARP)

Catholic Golden Age (CGA)

Elder Craftsmen (EC)

Elderhostel

National Association of Area Agencies on Aging (N4A)

National Senior Games Association (NSGA)

President's Council on Physical Fitness and Sports (PCPFS)

Young Men's Christian Association (YMCA)

Young Women's Christian Association (YWCA)

Leukemia

Leukemia and Lymphoma Society, Inc. (LLS)
National Cancer Institute (NCI)

Long-Term Care

American Association of Homes and Services for the Aging (AAHSA)
American Geriatrics Society (AGS)
American Health Care Association (AHCA)
American Medical Directors Association (AMDA)
Assisted Living Foundation of America (ALFA)
Beverly Foundation
Center for Advancement of State Community Services Program (CASCSP)
Elderweb
Health Insurance Association of America (HIAA)
Kansas Geriatric Education Center (KS-GEC)
National Association for Practical Nurse Education and Services (NAPNES)
National Association of Activity Professionals (NAAP)
National Association of State Units on Aging (NASUA)
National Citizen's Coalition for Nursing Home Reform (NCCNHR)
National Committee to Preserve Social Security and Medicare (NCPSSM)
National Council on Aging (NCOA)
National Long-Term Care Ombudsmen Resource Center (NLTCORC)
National Long-Term Care Resource Center (NLTCRC)
National Resource Center: Diversity and Long-Term Care (NRCDLTC)

Low Vision

American Academy of Ophthalmology (AAO)
American Council of the Blind (ACB)
American Foundation for the Blind (AFB)
American Optometric Association (AOA)
Better Vision Institute (BVI)
Glaucoma Research Foundation (GRF)
Lighthouse National Center for Vision and Aging (LNCVA)
National Eye Health Education Program (NEHEP)
National Library Service for the Blind and Physically Handicapped (NLSBPH)
Opticians Association of America (OAA)
Prevent Blindness America (PBA)

Lung Diseases

American Association of Cardiovascular and Pulmonary Rehabilitation (AACVPR)
American Lung Association (ALA)
National Heart, Lung, and Blood Institute (NHLBI) Information Center
Pulmonary Fibrosis Foundation (PFF)

Lupus

Arthritis Foundation (AF)
Lupus Foundation of America (LFA)
National Arthritis and Musculoskeletal and Skin Diseases Information Clearinghouse

M

Medicaid

Health Care Financing Administration (HCFA)

Medical Care

American Academy of Dermatology

American Academy of Family Physicians (AAFP)

American Academy of Neurology (AAN)

American Academy of Ophthalmology (AAO)

American Academy of Orthopaedic Surgeons (AAOS)

American Academy of Otolaryngology-Head and Neck Surgery, Inc. (AAO)

American Academy of Physical Medicine and Rehabilitation (AAPMR)

American Association of Critical-Care Nurses (AACN)

American Chiropractic Association (ACA)

American College of Obstetricians and Gynecologists (ACOG)

American College of Physicians-American Society of Internal Medicine (ACP-ASIM)

American College of Surgeons (ACS)

American Dental Association (ADA)

American Geriatrics Society (AGS)

American Medical Association (AMA)

American Nurses Association (ANA)

American Osteopathic Association

American Podiatric Medical Association (APMA)

Department of Veterans Affairs (VA)

Hill-Burton Free Medical Care Program

National Medical Association (NMA)

Medicare

Health Care Financing Administration (HCFA)

Medicare Rights Center (MRC)

National Committee to Preserve Social Security and Medicare (NCPSSM)

Medicines

American Academy of Family Physicians (AAFP)

American Association of Retired Persons (AARP)

American Pharmaceutical Association (APhA)

Food and Drug Administration (FDA)

National Council on Patient Information and Education (NCPPIE)

Menopause

American College of Obstetricians and Gynecologists (ACOG)

American Menopause Foundation (AMF)

National Heart, Lung, and Blood Institute (NHLBI) Information Center

National Osteoporosis Foundation (NOF)

North American Menopause Society (NAMS)

Men's Health

American Cancer Society (ACS)

American Foundation for Urologic Diseases (AFUD)

Young Men's Christian Association (YMCA)

Mental Health

American Association for Geriatric Psychiatry (AAGP)
American Association for Marriage and Family Therapy
American Counseling Association (ACA)
American Psychiatric Association (APA)
American Psychological Association (APA)
National Alliance for the Mentally Ill (NAMI)
National Association for Human Development (NAHD)
National Association of Social Workers (NASW)
National Institute of Mental Health (NIMH)
National Mental Health Association (NMHA)
Substance Abuse and Mental Health Services Administration (SAMHSA)

Minority Health

Administration on Aging (AoA)
Indian Health Service (IHS)
Japanese American Citizens League (JACL)
National Alliance for Hispanic Health
National Asian Pacific Center on Aging (NAPCA)
National Association for Hispanic Elderly (Asociación Nacional Por Personas Mayores)
National Caucus and Center on Black Aged, Inc. (NCBA)
National Council of La Raza (NCLR)
National Hispanic Council on Aging (NHCoA)
National Indian Council on Aging (NICOA)
National Medical Association (NMA)
National Resource Center: Diversity and Long-Term Care (NRCDLTC)
National Resource Center on Native American Aging (NRCNAA)
National Urban League
Native Elder Health Care Resource Center (NEHRC)
Organization of Chinese Americans (OCA)
Project Aliento

Mouth Care

American Dental Association (ADA)
National Institute of Dental and Craniofacial Research (NIDCR)

Multiple Sclerosis

National Institute of Neurological Disorders and Stroke (NINDS)
National Multiple Sclerosis Society (NMSS)

Music Therapy

American Music Therapy Association (AMTA)

N

Native American Health

Indian Health Service (IHS)
National Association of Area Agencies on Aging (N4A)
National Indian Council on Aging (NICOA)
National Resource Center on Native American Aging (NRCNAA)
Native Elder Health Care Resource Center (NEHCRC)

Native Hawaiian Health

National Resource Center on Native American Aging (NRCNAA)
Native Elder Health Care Resource Center (NEHCRC)

Nurses

American Association of Critical-Care Nurses (AACN)
American Nurses Association (ANA)
National Association for Practical Nurse Education and Services (NAPNES)
National Gerontological Nursing Association (NGNA)
National Institute of Nursing Research (NINR)
Visiting Nurse Associations of America (VNAA)

Nursing Homes

American Association of Homes and Services for the Aging (AAHSA)
American Geriatrics Society (AGS)
American Health Care Association (AHCA)
American Medical Directors Association (AMDA)
Health Care Financing Administration (HCFA)
National Citizen's Coalition for Nursing Home Reform (NCCNHR)
National Long-Term Care Ombudsmen Resource Center (NLTCORC)
National Long-Term Care Resource Center (NLTCRC)

Nutrition

American Dietetic Association (ADA)
American Heart Association (AHA)
Food and Drug Administration (FDA)
Food and Nutrition Information Center (FNIC)
Meals on Wheels Association of America (MOWAA)
National Association of Area Agencies on Aging (N4A)
National Association of Nutrition and Aging Service Programs (NANASP)
National Association of State Units on Aging (NASUA)
National Policy and Resource Center on Nutrition and Aging

O

Occupational Therapy

American Occupational Therapy Association, Inc. (AOTA)
Visiting Nurse Associations of America (VNAA)

Osteopathy

American Osteopathic Association

Osteoporosis

American Academy of Orthopaedic Surgeons (AAOS)
American College of Obstetricians and Gynecologists (ACOG)
National Arthritis and Musculoskeletal and Skin Diseases Information Clearinghouse
National Osteoporosis Foundation (NOF)
NIH Osteoporosis and Related Bone Diseases National Resource Center (NIH-ORBD-NRC)

P

Paget's Disease

National Arthritis and Musculoskeletal and Skin Diseases Information Clearinghouse
NIH Osteoporosis and Related Bone Diseases National Resource Center (NIH-ORBD-NRC)

Paget Foundation for Paget's Disease of Bone and Related Disorders (PF)

Parkinson's Disease

American Parkinson's Disease Association (APDA)

National Institute of Neurological Disorders and Stroke (NINDS)

Parkinson's Disease Foundation (PDF)

Pensions

Department of Labor (DOL)

Department of Veterans Affairs (VA)

Disabled American Veterans (DAV)

Employee Benefits Security Administration

Older Women's League (OWL)

Pension Rights Center (PRC)

Social Security Administration (SSA)

Pet Therapy

Delta Society

Physical Fitness

American College of Sports Medicine (ACSM)

American Heart Association (AHA)

Arthritis Foundation (AF)

Center for the Study of Aging/International Association of Physical Activity, Aging and Sports (IAPAAS)

Centers for Disease Control and Prevention (CDC)

National Association for Health & Fitness (NAHF)

National Association for Human Development (NAHD)

President's Council on Physical Fitness and Sports (PCPFS)

Robert Wood Johnson Foundation

Young Men's Christian Association (YMCA)

Young Women's Christian Association (YWCA)

Physical Therapy

American Physical Therapy Association (APTA)

Visiting Nurse Associations of America (VNAA)

Prostate Diseases

American Foundation for Urologic Diseases (AFUD)

National Kidney and Urologic Diseases Information Clearinghouse (NKUDIC)

Psychiatry

American Association for Geriatric Psychiatry (AAGP)

American Psychiatric Association (APA)

R

Rehabilitation

American Academy of Physical Medicine and Rehabilitation (AAPMR)
American Association of Cardiovascular and Pulmonary Rehabilitation (AACVPR)
American Council of the Blind (ACB)
American Horticultural Therapy Association (AHTA)
American Music Therapy Association (AMTA)
American Occupational Therapy Association, Inc. (AOTA)
American Physical Therapy Association (APTA)
Better Hearing Institute
Delta Society
Department of Veterans Affairs (VA)
Lighthouse National Center for Vision and Aging (LNCVA)
National Association of Activity Professionals (NAAP)
National Institute of Child Health and Human Development (NICHD) Information Clearinghouse
National Rehabilitation Information Center (NARIC)
National Stroke Association (NSA)

Respite Care

Brookdale Center on Aging (BCOA) of Hunter College
Well Spouse Foundation (WSF)

Restless Legs

Restless Legs Syndrome Foundation

Retirement Planning

American Association of Retired Persons (AARP)
Continuing Care Accreditation Commission (CCAC)
Employee Benefits Security Administration
National Association for Human Development (NAHD)
SPRY (Setting Priorities for Retirement Years) Foundation
United Seniors Health Council (USHC)

Rural Health

Green Thumb, Inc. (GT)
Kansas Geriatric Education Center (KS-GEC)
National Council on Aging (NCOA)
National Resource Center on Native American Aging (NRCNAA)
National Rural Health Association (NRHA)

S

Safety

American Red Cross
Department of Labor (DOL)
Department of Transportation (DOT)
Environmental Protection Agency (EPA)
Food and Drug Administration (FDA)
Food and Nutrition Information Center (FNIC)
National Consumer's League
National Council on Patient Information and Education (NCPIE)

Skin Diseases

American Academy of Dermatology
American Cancer Society (ACS)
National Arthritis and Musculoskeletal and Skin Diseases Information Clearinghouse
National Cancer Institute (NCI)
National Psoriasis Foundation (NPF)
The Skin Cancer Foundation

Sleep Disorders

National Heart, Lung, and Blood Institute (NHLBI) Information Center
National Sleep Foundation (NSF)

Social Security

National Committee to Preserve Social Security and Medicare (NCPSSM)
Social Security Administration (SSA)

Spanish Language Resources

AIDS Clinical Trials Information Service (ACTIS)
Alzheimer's Association
Alzheimer's Disease Education and Referral (ADEAR) Center
American Cancer Society (ACS)
American Diabetes Association (ADA)
Brookdale Center on Aging (BCOA) of Hunter College
Centers for Disease Control and Prevention (CDC)
HIV/AIDS Treatment Information Service (ATIS)
National Alliance for Hispanic Health
National Asian Pacific Center on Aging (NAPCA)
National Association for Hispanic Elderly (Asociación Nacional Por Personas Mayores)
National Coalition for Adult Immunization (NCAI)
National Council of La Raza (NCLR)
National Diabetes Information Clearinghouse (NDIC)
National Institute of General Medical Sciences (NIGMS)
National Hispanic Council on Aging (NHCoA)
National Institute of Allergy and Infectious Diseases (NIAID)
National Institute of Child Health and Human Development (NICHD) Information Clearinghouse
National Institute on Aging (NIA)
National Institute on Drug Abuse (NIDA)
National Women's Health Information Center (NWHI)
North American Menopause Society (NAMS)
Pension Rights Center (PRC)
Project Aliento
Substance Abuse and Mental Health Services Administration (SAMHSA)

Speech Therapy

American Speech-Language-Hearing Association (ASHA)
Visiting Nurse Associations of America (VNAA)

Statistics

Administration on Aging (AoA)
Agency for Healthcare Research & Quality (AHRQ)
Census Bureau
Centers for Disease Control and Prevention (CDC)
Department of Justice (DOJ)
Department of Labor (DOL)
Health Care Financing Administration (HCFA)
National Center for Health Statistics (NCHS)
Social Security Administration (SSA)

Stroke

American Academy of Neurology (AAN)
American Health Assistance Foundation (AHA)
American Heart Association (AHA)
American Stroke Association (ASA)
National Heart, Lung, and Blood Institute (NHLBI) Information Center
National Institute of Neurological Disorders and Stroke (NINDS)
National Stroke Association (NSA)

Support Groups

Alzheimer's Association
American Brain Tumor Association (ABTA)
American Cancer Society (ACS)
American Diabetes Association (ADA)
American Menopause Foundation (AMF)
American Parkinson's Disease Association (APDA)
American Stroke Association (ASA)
American Tinnitus Association (ATA)
Arthritis Foundation (AF)
Children of Aging Parents (CAPS)
Epilepsy Foundation
Gray Panthers (GP)
Huntington's Disease Society of America (HDSA)
Hysterectomy Educational Resources and Services Foundation (HERS)
International Tremor Foundation (ITF)
Japanese American Citizens League (JACL)
Leukemia and Lymphoma Society, Inc. (LLS)
Lupus Foundation of America (LFA)
National Alliance for the Mentally Ill (NAMI)
National Association for Continence (NAFC)
National Association on HIV Over Fifty (NAHOF)
National Family Caregivers Association (NFCA)
National Hispanic Council on Aging (NHCaA)
National Hospice Foundation (NHF)
National Interfaith Coalition on Aging (NICA)
National Kidney Foundation
National Multiple Sclerosis Society (NMSS)
National Organization for Rare Disorders (NORD)
National Organization for Victim Assistance (NOVA)

National Psoriasis Foundation (NPF)
National Self-Help Clearinghouse (NSHC)
National Stroke Association (NSA)
Parkinson's Disease Foundation (PDF)
Partnership for Caring, Inc. (PFC)
Prevent Blindness America (PBA)
Restless Legs Syndrome Foundation
Self Help for Hard of Hearing People, Inc. (SHHH)
Simon Foundation for Continence
Well Spouse Foundation (WSF)
Young Women's Christian Association (YWCA)

Surgery

American College of Surgeons (ACS)
American Hospital Association (AHA)

T

Therapy

American Association for Geriatric Psychiatry (AAGP)
American Association for Marriage and Family Therapy
American Counseling Association (ACA)
American Horticultural Therapy Association (AHTA)
American Music Therapy Association (AMTA)
American Psychiatric Association (APA)
American Psychological Association (APA)
Delta Society
National Mental Health Association (NMHA)

Transportation

American Cancer Society (ACS)
Beverly Foundation
Community Transportation Association of America (CTAA)
Department of Transportation (DOT)
National Association of Area Agencies on Aging (N4A)

Travel

American Association of Retired Persons (AARP)
B'nai B'rith
Catholic Golden Age (CGA)
Elderhostel

Tremor

International Tremor Foundation (ITF)

U

Urologic Diseases

American Foundation for Urologic Diseases (AFUD)
National Kidney and Urological Diseases Information Clearinghouse (NKUDIC)

V

Veterans Health

Department of Veterans Affairs (VA)
Disabled American Veterans (DAV)

Volunteers

Corporation for National Service (CNS)
Delta Society
Legal Counsel for the Elderly (LCE)
National Council on Aging (NCOA)
United Way of America
Volunteers of America
Young Men's Christian Association (YMCA)

W

Women's Health

American College of Obstetricians and Gynecologists (ACOG)
American Menopause Foundation (AMF)
DES Action
Hysterectomy Educational Resources and Services Foundation (HERS)
National Osteoporosis Foundation (NOF)
National Resource and Information Center (NRIC)
National Women's Health Information Center (NWHI)
National Women's Health Network (NWHN)
North American Menopause Society (NAMS)
Older Women's League (OWL)
Young Women's Christian Association (YWCA)

Note: The list of Associations and Organizations (organized alphabetically) including their description and contact information follows:

Agency for Healthcare Research & Quality (AHRQ)

Publications Clearinghouse
PO Box 8547
Silver Spring, MD 20907-8547
Phone: (800) 358-9295 (toll-free)
Web site: <http://www.ahrq.gov>

AHRQ, part of the federal government, provides an information clearinghouse service that distributes *Evidence-Based Summaries and Reports*, *Clinical Practice Guidelines*, and other medical statistics and information. Call to order copies of guidelines on topics such as cardiac rehabilitation, treatment of pressure sores, or other publications on elder and long-term health care, health insurance, and minority health data. Visit the Web site to download *Clinical Practice Guidelines* on topics such as urinary incontinence, screening for Alzheimer's disease, and post-stroke rehabilitation.

AIDS Clinical Trials Information Service (ACTIS)

PO Box 6421

Rockville, MD 20849-6421

Phone: (800) TRIALS-A (874-2572) (toll-free) (English, Spanish, Portuguese)
(301) 519-0459

TTY: (888) 480-3739 (toll-free)

Fax: (301) 519-6616

E-mail: actis@actis.org

Web site: <http://www.actis.org>

ACTIS, funded by the federal government, is a central resource providing current information on federally and privately sponsored clinical trials for HIV/AIDS patients. Free, confidential information is available in English, Spanish, or Portuguese.

Alliance for Aging Research

2021 K Street, NW, Suite 305

Washington, DC 20006

Phone: (202) 293-2856

Fax: (202) 785-8574

Web site: <http://www.agingresearch.org>

The Alliance is a national, citizen advocacy organization offering free publications including *Investing in Older Women's Health*, *Meeting the Medical Needs of the Senior Boom*, *Delaying the Diseases of Aging*, and other aging-related subjects such as menopause, how to age with ease, and health care options under Medicare.

Alzheimer's Association

919 North Michigan Avenue, Suite 1100

Chicago, IL 60611

Phone: (800) 272-3900 (toll-free)

(312) 335-8700

TTY: (312) 335-8882

Fax: (312) 335-1110

E-mail: info@alz.org

Web site: <http://www.alz.org>

The Association is a nonprofit organization offering information and support services to people with Alzheimer's disease (AD) and their families. Contact the 24-hour, toll-free telephone line to link with local chapters and community resources. The Association funds research to find a cure for AD and provides information on caregiving. A free catalog of educational publications is available in English and Spanish.

Alzheimer's Disease Education and Referral (ADEAR) Center

PO Box 8250

Silver Spring, MD 20907-8250

Phone: (800) 438-4380 (toll-free) (English, Spanish)

(301) 495-3311

Fax: (301) 495-3334

E-mail: adear@alzheimers.org

Web site: <http://www.alzheimers.org>

The ADEAR Center, funded by the National Institute on Aging, distributes information about Alzheimer's disease (AD) to health professionals, patients and their families, and the public. Contact the Center for information about the symptoms, diagnosis, and

treatment of AD; recent research; and referrals to state and other national services. On its Web site, the Center offers searchable publications and databases, including the AD Clinical Trials Database of studies accepting volunteers.

American Academy of Dermatology (AAD)

930 North Meacham Road
Schaumburg, IL 60173-4965
Phone: (888) 462-3376 (toll-free) (automated ordering system)
(847) 330-0230
Fax: (847) 330-0050
Web site: <http://www.aad.org>

AAD, an association of doctors specializing in dermatology, provides pamphlets and general information about skin cancers, contact allergies (like poison ivy), shingles (herpes zoster), and other skin conditions. Audio-cassettes, news releases, and public service announcements on dermatology topics also are available. Contact AAD for referrals to certified dermatologists.

American Academy of Family Physicians (AAFP)

11400 Tomahawk Creek Parkway
Leawood, KS 66201
Phone: (800) 274-2237 (toll-free)
(913) 906-6000
Fax: (913) 906-6094
E-mail: fp@aafp.org
Web site: <http://familydoctor.org> (information for the public)

AAFP, a national association of doctors in family practice, offers education and information on health care and disease prevention. Contact the AAFP for referrals to certified doctors. Publications on topics such as sensible eating, preventive health services and family practice, and a health care guide are available free from AAFP-certified doctors or for a fee from AAFP. The Web site offers free fact sheets on specific diseases, questions and answers about common health issues, self-care flowcharts, and databases on drugs and drug reactions.

American Academy of Neurology (AAN)

1080 Montreal Avenue
St. Paul, MN 55116
Phone: (651) 695-1940
Fax: (651) 695-2791
Web site: <http://www.aan.com>

The Academy is an association of doctors specializing in disorders of the brain and central nervous system. Contact AAN for information about neurology. Visit the Academy's Web site for referrals to accredited neurologists. Publications include the AAN's *Patient Information Guide* on neurological disorders and treatment.

American Academy of Ophthalmology (AAO)

PO Box 7424
San Francisco, CA 94120-7424
Phone: (800) 222-3937 (toll-free)
(415) 561-8500
Fax: (415) 561-8567
Web site: <http://www.eyenet.org>

AAO is an association of doctors specializing in eye diseases. The Academy's Eye Care America helpline provides information and publications and connects eligible older people with ophthalmologists who provide free eye care in their community. U.S. citizens qualify for free care at age 65 if they have no health insurance and have not seen an eye doctor for at least three years.

American Academy of Orthopaedic Surgeons (AAOS)

6300 North River Road
Rosemont, IL 60018-4262
Phone: (847) 823-7186
Fax: (847) 823-8125
Web site: <http://www.aaos.org>

AAOS is a nonprofit organization of doctors specializing in bones, joints, muscles, ligaments, and tendons. Contact AAOS for information on orthopaedic medicine including arthritis, osteoporosis, artificial joints, and prevention of hip fractures. Publications on orthopedic medicine, many specifically for older people, are available.

American Academy of Otolaryngology—Head and Neck Surgery, Inc. (AAO)

1 Prince Street
Alexandria, VA 22314
Phone: (703) 836-4444
TTY: (703) 519-1585
Fax: (703) 683-5100
E-mail: webmaster@entnet.org
Web site: <http://www.entnet.org>

The Academy is an organization of doctors specializing in ear, nose, and throat problems and diseases of the head and neck. Contact AAO for referrals to specialists and publications on topics such as cosmetic facial surgery, head and neck tumors, treatments for certain types of hearing loss, and balance disorders.

American Academy of Physical Medicine and Rehabilitation (AAPMR)

One IBM Plaza, Suite 2500
Chicago, IL 60611-3604
Phone: (312) 464-9700
Fax: (312) 464-0227
E-mail: info@aapmr.org
Web site: <http://www.aapmr.org>

The Academy is an organization of physicians who treat people with disabilities. Contact AAPMR for referrals to physiatrists or for information and publications about rehabilitation medicine.

American Association for Geriatric Psychiatry (AAGP)

7910 Woodmont Avenue, Suite 1050
Bethesda, MD 20814-3004
Phone: (301) 654-7850
Fax: (301) 654-4137
E-mail: aagpgpa@aol.com
Web site: <http://www.aagpgpa.org>

The Association works to improve the mental health and well-being of older people. Contact AAGP for information on geriatric psychiatry and to receive referrals to specialists. Available publications include *Growing Older*, *Growing Wiser: Coping with*

Expectations, Challenges and Changes in Later Years, and brochures on topics such as Alzheimer's disease, depression, and the role of the geriatric psychiatrist. Some consumer publications are free.

American Association for Marriage and Family Therapy (AAMFT)

1133 15th Street, NW, Suite 300
Washington, DC 20005
Phone: (202) 452-0109
Fax: (202) 223-2329
E-mail: memberservices@aamft.org
Web site: <http://www.aamft.org>

AAMFT is a professional association of qualified marriage and family therapists. The Association provides referrals to marriage and family therapists and offers publications on topics including divorce, depression, and sexual problems.

American Association of Cardiovascular and Pulmonary Rehabilitation (AACVPR)

7600 Terrace Avenue, Suite 203
Middleton, WI 53562-3174
Phone: (608) 831-6989
Fax: (608) 831-5122
E-mail: aacvpr@tmahq.com
Web site: <http://www.aacvpr.org>

AACVPR is an organization of certified heart, lung, and blood specialists that provides information on diagnosis, treatment, and disease prevention. Information and publications are available on consumer guidelines for cardiac rehabilitation and purchasing fitness equipment. Visit the Web site for a free brochure.

American Association of Critical-Care Nurses (AACN)

101 Columbia
Aliso Viejo, CA 92656-4109
Phone: (800) 899-AACN (899-2226) (toll-free)
(949) 362-2050
Fax: (949) 362-2020
E-mail: info@aacn.org
Web site: <http://www.aacn.org>

AACN is a nonprofit professional association dedicated to meeting the needs of its members who care for acutely and critically ill patients and their families. The Association provides practice and educational resources as well as professional support for its members. Contact AACN for publications and audiovisual materials on critical care.

American Association of Homes and Services for the Aging (AAHSA)

2519 Connecticut Avenue, NW
Washington, DC 20008-1520
Phone: (202) 783-2242
Fax: (202) 783-2255
E-mail: inform@aahsa.org
Web site: <http://www.aahsa.org>

AAHSA is a national, nonprofit organization providing older people with services and information on housing, health care, and community involvement. Visit the AAHSA Web site for information for seniors and caregivers.

American Association of Retired Persons (AARP)

601 E Street, NW
Washington, DC 20049
Phone: (800) 424-3410 (toll-free)
(202) 434-2277
Fax: (202) 434-6973
Web site: <http://www.aarp.org>

AARP is a nonprofit organization that advocates for older Americans' health, rights, and life choices. Local chapters provide information and services on crime prevention, consumer protection, and income tax preparation. Members can join group health, auto, life, and home insurance programs, investment plans, or a discount mail-order pharmacy service. The AgeLine database, available on CD-ROM, contains extensive resources on issues of concern to older people. Publications are available on housing, health, exercise, retirement planning, money management, leisure, and travel.

American Bar Association

Commission on the Legal Problems of the Elderly
740 15th Street, NW
Washington, DC 20005-1022
Phone: (202) 662-8690
Fax: (202) 662-8698
E-mail: abaelderly@abanet.org
Web site: <http://www.abanet.org/elderly>

The Commission examines and responds to law-related needs of older people. It makes referrals and maintains a listing of legal aid offices where older people can get free or low-cost legal assistance. The Commission's Web site lists available publications and videos.

American Brain Tumor Association (ABTA)

2720 River Road, Suite 146
Des Plaines, IL 60018
Phone: (800) 886-2282 (toll-free) (Patient Line)
(847) 827-9910
Fax: (847) 827-9918
E-mail: info@abta.org
Web site: <http://www.abta.org>

ABTA is a nonprofit organization, offering free social work consultations, a nationwide database of established support groups, mentorship for people who want to start a support group, a resource listing of specialist physicians, and referrals to organizations providing services for brain tumor patients. Publications on brain tumors, treatment, and coping with disease are available.

American Cancer Society (ACS)

1599 Clifton Road, NE
Atlanta, GA 30329
Phone: (800) ACS-2345 (227-2345) (toll-free)
(404) 320-3333
Fax: (404) 329-5787
Web site: <http://www.cancer.org>

ACS is a national, community-based volunteer health organization, providing information on cancer and its prevention. The Society sponsors a variety of programs such as Man to Man (education and support for men with prostate cancer) and workshops such as Taking Charge of Money Matters, which addresses financial concerns arising from cancer treatment. Local ACS offices sponsor services for cancer patients and their families, including self-help groups, transportation programs, and limited financial aid. Contact the ACS for free publications. Spanish language resources are available.

American Chiropractic Association (ACA)

1701 Clarendon Boulevard
Arlington, VA 22209
Phone: (800) 986-4636 (toll-free)
(703) 276-8800
Fax: (703) 243-2593
E-mail: memberinfo@amerchiro.org
Web site: <http://www.amerchiro.org>

ACA is a professional organization of chiropractors. It offers educational programs on spinal problems, posture, physical fitness, and occupational safety. Contact the ACA to buy publications and materials on spinal health and safety. Visit the Web site to find a chiropractor.

American College of Obstetricians and Gynecologists (ACOG)

409 12th Street, SW
PO Box 96920
Washington, DC 20090-6920
Phone: (202) 863-2518 (resource center)
Web site: <http://www.acog.org>

ACOG is a professional society of doctors specializing in women's health care. Contact ACOG for referrals. For free pamphlets on osteoporosis, menopause, and hormone replacement therapy, send a self-addressed, stamped envelope.

American College of Physicians–American Society of Internal Medicine (ACP-ASIM)

190 North Independence Mall West
Philadelphia, PA 19106-1572
Phone: (800) 523-1546 (toll-free)
(215) 351-2400
Fax: (215) 351-2829
E-mail: interpub@mail.acponline.org
Web site: <http://www.acponline.org>

ACP-ASIM is the nation's largest medical specialty society. Members of ACP-ASIM specialize in a variety of areas, such as internal medicine, cardiology, infectious diseases, rheumatology, gastroenterology, and oncology. Contact the ACP-ASIM for referrals. ACP-ASIM produces *Healthscope*, a film series on public health.

American College of Sports Medicine (ACSM)

PO Box 1440
Indianapolis, IN 46206
Phone: (317) 637-9200
Fax: (317) 634-7817
Web site: <http://www.acsm.org>

ACSM is a scientific and medical association of health professionals interested in exercise. It offers training and certification. ACSM's Active Aging Partnership focuses on education, research, and improving practice for those committed to working with older adults. For free information on exercise for older people, send a self-addressed, stamped envelope.

American College of Surgeons (ACS)

633 North St. Clair Street
Chicago, IL 60611-3211
Phone: (312) 202-5000
Fax: (312) 202-5001
Web site: <http://www.facs.org>

ACS is a national organization offering educational materials and information about qualified surgeons and surgical treatments for many illnesses and injuries. Contact ACS to locate board-certified surgeons. Public education materials are available on frequently performed types of surgery.

American Council of the Blind (ACB)

1155 15th Street, NW, Suite 1004
Washington, DC 20005
Phone: (800) 424-8666 (toll-free)
(202) 467-5081
Fax: (202) 467-5085
E-mail: info@acb.org
Web site: <http://www.acb.org>

ACB is a national organization that advocates for blind and visually impaired people. It provides educational programs, health care services, information about Social Security benefits for visually impaired people, vocational training, and other health and social services. Toll-free information, referrals, and free educational materials are available.

American Counseling Association (ACA)

5999 Stevenson Avenue
Alexandria, VA 22304
Phone: (800) 347-6647, ext. 222 (toll-free)
(703) 823-9800
Fax: (703) 823-0252
Web site: <http://www.counseling.org>

ACA offers information to older people on adult psychological development and aging. A catalog of publications and videos is available.

American Dental Association (ADA)

211 East Chicago Avenue
Chicago, IL 60611
Phone: (312) 440-2593
(312) 440-2500
Fax: (312) 440-2800
Web site: <http://www.ada.org>

ADA is a professional organization that conducts dental research and evaluates findings from dental science for the public. State and local ADA chapters provide referrals to dentists. Publications are available on subjects such as tooth decay, dentures, smoking, diet, and mouth care. Online publications cover topics such as gum disease, finding a dentist, and resolving disputes over treatment.

American Diabetes Association (ADA)

1701 North Beauregard Street
Arlington, VA 22311
Phone: (800) DIABETES (342-2383) (toll-free)
(703) 549-1500
Web site: <http://www.diabetes.org>

ADA provides information and educational materials on preventing, treating, and living with diabetes. The Association has specific outreach programs for minority communities, including the Diabetes Assistance and Resources Program, providing information in English and Spanish to the Hispanic community, the African American Program, and Awakening the Spirit, which disseminates diabetes information to the Native American community. Local ADA chapters offer support and referrals to community agencies and services.

American Dietetic Association (ADA)

216 West Jackson Boulevard
Chicago, IL 60606-6995
Phone: (800) 366-1655 (toll-free) (Consumer Nutrition Hotline)
(312) 899-0040
Fax: (312) 899-4899
Website: <http://www.eatright.org>

ADA is a professional society of registered dietitians and other dietetic professionals who provide nutrition information, education, counseling, and care. One of ADA's professional practice groups focuses on the special needs of older people and offers nutrition counseling and indirect assistance through state and local meal programs. Call ADA to locate a registered dietitian.

American Federation for Aging Research (AFAR)

1414 Sixth Avenue, 18th Floor
New York, NY 10019
Phone: (212) 752-2327
Fax: (212) 832-2298
E-mail: amfedaging@aol.com
Web site: <http://www.afar.org> or
<http://www.infoaging.org>

AFAR is a nonprofit organization dedicated to supporting basic aging research. AFAR funds a wide variety of cutting-edge research on the aging process and age-related diseases. Visit the Web site for a list of free publications.

American Foundation for the Blind (AFB)

11 Penn Plaza, Suite 300
New York, NY 10001
Phone: (800) AFB-LINE (232-5463) (toll-free)
TTY: (212) 502-7662
Fax: (212) 502-7777
E-mail: afbinfo@afb.net
Web site: <http://www.afb.org>

A national, nonprofit organization, AFB provides services and support for people who are blind or visually impaired. AFB's Technology Information Bank supports the Talking Books program and provides information and mentoring on technology assistance for people who are blind. Books, pamphlets, videos, and periodicals about blindness are available.

American Foundation for Urologic Diseases (AFUD)

1128 North Charles Street
Baltimore, MD 21201
Phone: (410) 468-1800
Fax: (410) 468-1808
E-mail: admin@afud.org
Web site: <http://www.afud.org> or
<http://www.prostatehealth.com>

The Foundation works toward the prevention and cure of urologic disease in part by keeping patients, family members, and friends informed about these disorders, treatment options, and recent research findings. AFUD operates six national health education councils that distribute patient education materials on a variety of urologic topics. A specific Web site addresses prostate health. Online publications are free; publications are available by mail for a fee.

American Geriatrics Society (AGS)

350 Fifth Avenue
New York, NY 10118
Phone: (212) 308-1414
Fax: (212) 832-8646
E-mail: info.amger@americangeriatrics.org
Web site: <http://www.americangeriatrics.org>

AGS is a nonprofit organization of physicians and health care professionals supporting the study of geriatrics. Contact AGS for information on geriatrics, long-term care, acute and chronic illnesses, rehabilitation, and nursing home care. Publications include the *AGS Complete Guide to Aging and Health* and the *AGS Medical Reference Guide*.

American Health Assistance Foundation (AHAF)

15825 Shady Grove Road, Suite 140
Rockville, MD 20850
Phone: (800) 437-AHAF (437-2423) (toll-free)
(301) 948-3244
Fax: (301) 258-9454
Web site: <http://www.ahaf.org>

AHAF provides information and supports research on age-related illnesses. The Foundation supports three research programs: Alzheimer's Disease (AD) Research, which along with the Alzheimer's Family Relief Program, offers emergency grants of up to \$500 to AD patients in need and their caregivers; National Glaucoma Research; and the National Heart Foundation. Contact AHAF for free publications on AD, glaucoma, heart disease, and stroke.

American Health Care Association (AHCA)

1201 L Street, NW
Washington, DC 20005
Phone: (202) 842-4444
Fax: (202) 842-3860
Web site: <http://www.ahca.org>

AHCA is an organization representing the interests of nursing homes, assisted living centers, and subacute care facilities. Publications are available about nursing homes, guardianship, assisted living, financing, and long-term care services.

American Health Foundation (AHF)

1 Dana Road
Valhalla, NY 10595
Phone: (914) 592-2600
Fax: (914) 592-6317
Web site: <http://www.ahf.org>

AHF is a nonprofit organization conducting research on cancer; preventive medicine; and the effects of lifestyle, environment, and nutrition on health. Contact AHF for information and publications on healthy living, heart disease, cancer, and high cholesterol.

American Heart Association (AHA)

7272 Greenville Avenue
Dallas, TX 75231
Phone: (800) AHA-USA1 (242-8721) (toll-free)
(888) 4-STROKE (478-7653) (toll-free)
Fax: (214) 706-2139
Web site: <http://www.americanheart.org>

AHA is a nonprofit organization funding research and providing information on the diagnosis, treatment, and prevention of heart diseases and stroke. Contact AHA for its cookbooks, guide to heart attack treatment, and guide to fitness.

American Horticultural Therapy Association (AHTA)

National Office
909 York Street
Denver, CO 80206
Phone: (720) 865-3616
Fax: (720) 865-3728
E-mail: ahta@ahta.org
Web site: <http://www.ahta.org>

AHTA is a nonprofit, membership organization that promotes and advances horticultural therapy as a therapeutic intervention and rehabilitation option. The Association provides information related to the principles and practices of horticultural therapy.

American Hospital Association (AHA)

One North Franklin
Chicago, IL 60606
Phone: (312) 422-3000
Fax: (312) 422-4796
Web site: <http://www.aha.org>

AHA is a national nonprofit association representing all types of hospitals and health care networks, as well as patients and families. AHA provides education for health care leaders and information on health care issues and trends.

American Lung Association (ALA)

1740 Broadway
New York, NY 10019-4374
Phone: (800) LUNG-USA (586-4872) (toll-free)
(212) 315-8700
Fax: (212) 265-5642
E-mail: info@lungusa.org
Web site: <http://www.lungusa.org>

ALA is dedicated to the prevention, cure, and control of lung diseases such as asthma, emphysema, tuberculosis, and lung cancer. The Association offers community service, public health education, advocacy, and research.

American Medical Association (AMA)

515 North State Street
Chicago, IL 60610
Phone: (800) 621-8335 (toll-free)
(312) 464-5000
Fax: (312) 464-5600
Web site: <http://www.ama-assn.org>

AMA is an organization of licensed doctors that distributes scientific information on health and sets standards on medical law and practice. Local AMA associations can provide referrals to qualified doctors. AMA publishes the *Journal of the American Medical Association*, other subscription medical journals, and books for sale, including an encyclopedia of medicine.

American Medical Directors Association (AMDA)

10480 Little Patuxent Parkway, Suite 760
Columbia, MD 21044
Phone: (800) 876-2632
(410) 740-9743
Fax: (410) 740-4572
E-mail: webmaster@amda.com
Web site: <http://www.amda.com>

AMDA is a national professional association representing doctors who care for older people in a variety of long-term care settings, including nursing facilities, hospice, home care, continuing care retirement communities, and assisted living. The Association provides education, advocacy, information, and professional development for long-term care professionals. AMDA has information on health care policy, regulations, and clinical practice guidelines.

American Menopause Foundation (AMF)

350 Fifth Avenue, Suite 2822
New York, NY 10118
Phone: (212) 714-2398
Fax: (212) 714-1252
E-mail: menopause@earthlink.org
Web site: www.americanmenopause.org

The Foundation is a nonprofit health organization providing support and assistance on all issues concerning menopause. AMF has information on scientific research and coordinates a network of volunteer support groups for women.

American Music Therapy Association (AMTA)

8455 Colesville Road, Suite 1000
Silver Spring, MD 20910
Phone: (301) 589-3300
Fax: (301) 589-5175
E-mail: info@musictherapy.org
Web site: <http://www.musictherapy.org>

AMTA is a nonprofit organization that advocates, promotes, and provides resources and information on the uses and benefits of music therapy. Contact AMTA for referrals as well as for publications and audiovisual materials.

American Nurses Association (ANA)

600 Maryland Avenue, SW, Suite 100W

Washington, DC 20024-2571

Phone: (800) 274-4262 (toll-free)

(202) 554-4444

Fax: (202) 651-7001

E-mail: memberinfo@ana.org

Web site: <http://www.nursingworld.org>

ANA, a national association of registered nurses, serves as an advocate for nursing practitioners as well as sponsors research and continuing education. Contact the Association for *Facts About Nursing* and other publications. ANA sets standards for the practice of gerontological nursing.

American Occupational Therapy Association, Inc. (AOTA)

4720 Montgomery Lane

PO Box 31220

Bethesda, MD 20824-1220

Phone: (800) 729-2682 (toll-free) (Association members)

(301) 652-2682

TTY: (800) 377-8555 (toll-free)

Fax: (301) 652-7711

Web site: <http://www.aota.org>

AOTA offers information on the role of occupational therapy in promoting functional independence, preventing disability, and maintaining health. Contact AOTA for referrals to local practitioners and therapy programs. The Association publishes two periodicals, *OT Practice* and the *American Journal of Occupational Therapy*, as well as many books for educators.

American Optometric Association (AOA)

243 North Lindbergh Boulevard

St. Louis, MO 63141

Phone: (800) 365-2219 (toll-free)

(314) 991-4100

Fax: (314) 991-4101

Web site: <http://www.aoanet.org>

AOA, a national organization of optometrists, evaluates ophthalmic products and sponsors continuing education programs. It offers VISION USA, a free eye-care program for uninsured or low-income older people and their families. Contact AOA for referrals to certified optometrists and for publications such as *Driving Tips for Older Adults*, *Contact Lenses After 40*, and fact sheets on floaters, macular degeneration, and glaucoma.

American Osteopathic Association

142 East Ontario Street

Chicago, IL 60611

Phone: (800) 621-1773 (toll-free)

Fax: (312) 202-8200

E-mail: info@aoa-net.org

Web site: <http://www.aoa-net.org>

The American Osteopathic Association represents osteopathic physicians (DOs, or doctors of osteopathic medicine), promotes public health, encourages scientific research, and is the accrediting agency for all osteopathic medical schools and health care facilities.

American Parkinson's Disease Association (APDA)

1250 Hylan Boulevard, Suite 4B

Staten Island, NY 10305

Phone: (800) 223-2732 (toll-free)

Fax: (718) 981-4399

E-mail: info@apdaparkinson.org

Web site: <http://www.apdaparkinson.org>

A nonprofit organization, APDA funds research to find a cure for Parkinson's disease. APDA's toll-free line refers callers to local chapters for information on community services, specialists, and treatments. Publications and educational materials are available on Parkinson's disease, speech therapy, exercise, diet, and aids for daily living.

American Pharmaceutical Association (APhA)

2215 Constitution Avenue, NW

Washington, DC 20037-2985

Phone: (800) 237-2742 (toll-free)

(202) 628-4410

Fax: (202) 783-2351

E-mail: webmaster@mail.aphanet.org

Web site: <http://www.aphanet.org> or

<http://www.pharmacyandyou.org> (consumer information site)

APhA is the national society of licensed pharmacists providing public health information and referrals to resources on medicine and public policy. Available publications include *Managing Medicines as You Grow Older*, *National Medical Awareness Test*, and *Self-Medication Awareness Test*.

American Physical Therapy Association (APTA)

1111 North Fairfax Street

Alexandria, VA 22314

Phone: (800) 999-2782, ext. 3395 (toll-free)

(703) 684-2782

Fax: (703) 706-8578

Web site: <http://www.apta.org>

APTA is an organization of physical therapists providing referrals to APTA geriatric-certified therapists and information on debilitating ailments like arthritis, stroke, scoliosis, and sudden onset of illness. APTA's Section on Geriatrics offers publications on topics such as osteoporosis; incontinence; neck pain; carpal tunnel syndrome; hip, knee, or shoulder care; and what physical therapists can offer older adults.

American Podiatric Medical Association (APMA)

9312 Old Georgetown Road

Bethesda, MD 20814

Phone: (800) FOOT-CARE (366-8227) (toll-free)

(301) 571-9200

Fax: (301) 530-2752

E-mail: askapma@apma.org

Web site: <http://www.apma.org>

APMA is an association of podiatrists providing services and information on foot problems and foot health. Contact APMA for information on local chapters and referrals to certified podiatrists. Publications on proper foot care and the effects of arthritis and diabetes on feet are available.

American Psychiatric Association (APA)

1400 K Street, NW
Washington, DC 20005
Phone: (202) 682-6000
Fax: (202) 682-6850
E-mail: apa@psych.org
Web site: <http://www.psych.org>

APA is an association of psychiatrists, physicians specializing in diagnosing and treating people with mental and emotional disorders. Its Council on Aging establishes standards for psychiatric care of older people. Contact the APA for information on elder care issues, including medication use by older people, treatment of Alzheimer's disease, and nursing homes. Contact APA for referrals to local psychiatrists.

American Psychological Association (APA)

750 First Street, NE
Washington, DC 20002-4242
Phone: (800) 374-2721 (toll-free)
(202) 336-5500
E-mail: webmaster@apa.org
Web site: <http://www.apa.org>

APA is a professional society of psychologists that provides assistance and information on mental, emotional, and behavioral disorders. Contact the APA for a list of state chapters, information on the psychosocial aspects of aging, and referrals to APA-member psychologists. The APA's section on older people produces publications on topics such as dementia and dementia research. Publications include a quarterly subscription magazine, *Psychology and Aging*.

American Red Cross

430 17th Street, NW
Washington, DC 20006
Phone: (800) HELP-NOW (435-7669) (toll-free) (donations only)
(202) 639-3269
Fax: (202) 639-3520
E-mail: info@usa.redcross.org
Web site: <http://www.redcross.org>

The Red Cross offers health information programs, health services, blood donation services, disaster relief, and emergency services to the public and the Armed Forces. Local chapters provide programs for older people, including retirement planning, crime prevention instruction, safety courses, health screening clinics, and home nurse care instruction. Publications about programs, information, and services are available.

American Society on Aging (ASA)

833 Market Street, Suite 511
San Francisco, CA 94103
Phone: (800) 537-9728 (toll-free)
(415) 974-9600
Fax: (415) 974-0300
E-mail: info@asaging.org
Web site: <http://www.asaging.org>

ASA is a nonprofit organization providing information about medical and social practice, research, and policy pertinent to the health of older people. Membership and subscriptions to *Generations*, a quarterly journal, and *Aging Today*, the Society's bimonthly news magazine, are available to the public. A catalog of books for sale and other educational materials is available on the Web site.

American Speech-Language-Hearing Association (ASHA)

10801 Rockville Pike
Rockville, MD 20852
Phone: (800) 498-2071 (toll-free) (ASHA Action Center)
(800) 638-8255 (toll-free)
TTY: (800) 638-8255 (toll-free)
(301) 897-0157
Fax: (877) 541-5035
E-mail: actioncenter@asha.org
Web site: <http://www.asha.org>

ASHA represents the interests of medical specialists in speech, language, and hearing science and advocates for people with communication-related disorders. Contact ASHA's toll-free telephone line for information on speech-language legislation, communication disorders, or referrals to specialists. ASHA produces publications and fact sheets on topics such as communication disorders and hearing aids.

American Stroke Association (ASA)

c/o American Heart Association
7272 Greenville Avenue
Dallas, TX 75231
Phone: (888) 4STROKE (478-7653) (toll-free)
Fax: (214) 706-5231
E-mail: strokeassociation@heart.org
Web site: <http://www.strokeassociation.org>

ASA, a division of the American Heart Association, provides the Stroke Family Warmline, a toll-free information and referral service offering lists of certified doctors who are stroke specialists and volunteer stroke survivors or family members. Callers receive support and can request free information. ASA publishes *Stroke Connection*, a priced subscription magazine for survivors and families.

American Tinnitus Association (ATA)

PO Box 5
Portland, OR 97207
Phone: (800) 634-8978 (toll-free)
(503) 248-9985
Fax: (503) 248-0024
E-mail: tinnitus@ata.org
Web site: <http://www.ata.org>

ATA is a volunteer organization supporting research and providing information on tinnitus, a constant buzzing or ringing in the ears or head. ATA sponsors self-help groups nationwide, each offering information, assistance, and referrals to community services and tinnitus specialists.

Arthritis Foundation (AF)

National Office
1330 West Peachtree Street
Atlanta, GA 30309
Phone: (800) 283-7800 (toll-free)
(404) 965-7537
Fax: (404) 872-0457
E-mail: help@arthritis.org
Web site: <http://www.arthritis.org>

AF is a nonprofit, volunteer organization focusing on research and information to cure, prevent, or better treat arthritis and related diseases. Contact AF for information on arthritis, related diseases (such as lupus erythmatosus and rheumatism), and referrals to local chapters, specialists, or support groups. Publications and videos are available on topics such as self-help and exercise therapy.

Assisted Living Federation of America (ALFA)

11200 Waples Mill Road, Suite 150
Fairfax, VA 22030
Phone (703) 691-8100
Fax: (703) 691-8106
Web site: <http://www.alfa.org>

ALFA represents for-profit and nonprofit providers of assisted living, continuing care retirement communities, independent living, and other forms of housing and services. The Federation works to advance the assisted living industry and enhance the quality of life for consumers.

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
E-mail: aghetemp@aghe.org
Web site: <http://www.aghe.org>

AGHE's members are organizations and institutions of higher education. Through conferences, publications, technical assistance, research studies, and consultation with policymakers, AGHE, an educational unit of the Gerontological Society of America, seeks to advance gerontology as a field of study at institutions of higher education.

Better Hearing Institute

5021-B Backlick Road

Annandale, VA 22003

Phone: (800) EAR-WELL (327-9355) (toll-free) (Hearing Helpline)

(703) 684-3391

Fax: (703) 684-6048

E-mail: mail@betterhearing.org

Web site: <http://www.betterhearing.org>

The Institute is a nonprofit, educational organization providing information on medical, surgical, and rehabilitation options for improving hearing loss and on hearing aids.

Contact the Institute's Hearing Helpline for facts on hearing loss and a list of publications.

Better Vision Institute (BVI)

1655 North Fort Myer Drive

Arlington, VA 22209

Phone: (800) 424-8422 (toll-free)

(703) 243-1508

Fax: (703) 243-1537

Web site: <http://www.visionsite.org>

BVI provides news and information on vision health and care. Contact the Institute for facts on the detection, treatment, and prevention of eye diseases. Publications include fact sheets on cataracts, nutrition, care of eyeglasses, diabetes, and vision care.

Beverly Foundation

44 South Mentor Avenue

Pasadena, CA 91106

Phone: (626) 792-2292

Fax: (626) 792-6117

E-mail: bf3@ix.netcom.com

Web site: <http://www.beverlyfoundation.org>

The Foundation focuses on mobility and transportation for older people within the community, service delivery within home and institutional settings, and overall life enrichment. It engages in research and education projects and provides information for professionals and caregivers.

B'nai B'rith

1640 Rhode Island Avenue, NW

Washington, DC 20036

Phone: (800) 500-6533 (toll-free)

(202) 857-6600

Fax: (202) 857-1099

E-mail: seniors@bnaibrith.org

Web site: <http://www.bnaibrith.org>

B'nai B'rith is the world's oldest and largest Jewish service organization, providing community service, education, and advocacy. Its Center for Senior Housing and Services sponsors housing and travel for senior citizens. A list of publications is available.

Brookdale Center on Aging (BCOA) of Hunter College

1114 Avenue of the Americas, 40th Floor

New York, NY 10036

Phone: (646) 366-1000

Fax: (212) 481-5069

E-mail: info@brookdale.org

Web site: <http://www.brookdale.org>

BCOA sponsors a variety of programs, including the Institute on Law and Rights of Older Adults, which fights for grandparent rights. Other programs focus on elder care services, guardianship, caregiving, Medicare, intergenerational activities, and Alzheimer's disease. Contact BCOA about publications (some available in Spanish), including *Senior Rights Reporter*, *Benefits Checklist for Seniors*, *Help for Seniors*, and *Help for Grandparent Caregivers*, which are for sale.

Captioned Media Program (CMP)

National Association of the Deaf (NAD)

1447 East Main Street

Spartanburg, SC 29307

Phone: (800) 237-6213 (toll-free)

TTY: (800) 237-6819 (toll-free)

Fax: (800) 538-5636

E-mail: info@cfv.org

Web site: <http://www.cfv.org>

CMP is a free video lending program funded by the Department of Education and administered by NAD. CMP provides open-captioned videos (that is, they display English text with any TV/VCR). Videos are available for deaf or hard of hearing Americans, their parents, families, teachers, counselors, interpreters, or others. CMP has a wide variety of videos ranging from travel to classic movies; from sign language to hobbies.

Catholic Charities USA (CCUSA)

1731 King Street, Suite 200

Alexandria, VA 22314

Phone: (703) 549-1390

Fax: (703) 549-1656

Web site: <http://www.catholiccharitiesusa.org>

CCUSA is a network of organizations offering nationwide services to older people, including counseling, homemaker and caregiver services, emergency assistance, group homes, and institutional care. CCUSA advocates for older people's Social Security benefits, employment opportunities, and housing. Publications describe Catholic Charities' programs for older people.

Catholic Golden Age (CGA)

National Headquarters

PO Box 249

Olyphant, PA 18447

Phone: (800) 836-5699 (toll-free)

Fax: (570) 586-7721

E-mail: info@catholicgoldenage.org

Web site: <http://www.catholicgoldenage.org>

CGA sponsors charitable work and helps older people meet their social, physical, economic, intellectual, and spiritual needs. Contact CGA for various group insurance plans, discounts on eyeglasses, prescription drugs, and travel. Local CGA chapters provide activities for members, including disease prevention and health promotion programs.

Census Bureau

Special Populations Branch
FB3 Room 2384
Washington, DC 20233
Phone: (301) 457-2378
Fax: (301) 457-6634
Web site: <http://www.census.gov>

The Census Bureau, part of the federal government, collects and provides timely, relevant, and quality data about the people and economy of the United States. Contact the Census Bureau for age-related data and statistics about the older populations in the United States.

The Center for Social Gerontology (TCSG)

2307 Shelby Avenue
Ann Arbor, MI 48103
Phone: (734) 665-1126
Fax: (734) 665-2071
E-mail: tcs@tcs.org
Web site: <http://www.tcs.org>

TCSG is a nonprofit research, training, and social policy organization. Particular attention is focused on law and aging, tobacco use and older people, guardianship service providers, and adult guardianship. Contact the Center for information on publications, videos, training, and technical assistance.

Center for the Advancement of State Community Services Programs (CASCSP)

National Association of State Units on Aging (NASUA)

1225 I Street, NW, Suite 725
Washington, DC 20005
Phone: (202) 898-2578
Fax: (202) 898-2583
E-mail: info@nasua.org
Web site: <http://www.nasua.org>

The Center, part of NASUA, provides information and support for community-based care for older people. The Center also helps state and area Agencies on Aging design, develop, and manage these care systems and develop state policies. A list of publications and materials on long-term and community-based care is available.

Center for the Study of Aging/International Association of Physical Activity, Aging and Sports (IAPAAS)

706 Madison Avenue
Albany, NY 12208-3604
Phone: (518) 465-6927
Fax: (518) 462-1339
E-mail: iapaas@acl.com

The Center is a free-standing, nonprofit organization promoting research, education, and training in the field of aging. IAPAAS is the Center's membership division. It organizes programs on health, fitness, prevention, and aging. Contact the Center for a list of publications and information about the quarterly newsletter, *Lifelong Health and Fitness*.

Centers for Disease Control and Prevention (CDC)

1600 Clifton Road
Atlanta, GA 30333
Phone: (800) 311-3435 (toll-free)
(404) 639-3311
TTY: (800) 255-0135 (toll-free)
Fax: (404) 639-7392
E-mail: netinfo@cdc.gov
Web site: <http://www.cdc.gov>

The CDC, part of the federal government, is the lead agency for protecting the health and safety of people at home or abroad. The CDC produces fact sheets that help people make informed decisions about their health and health care. Contact the CDC for public information, health statistics, funding opportunities, and prevention guidelines. Spanish language resources are available.

Children of Aging Parents (CAPS)

1609 Woodbourne Road, Suite 302A
Levittown, PA 19057
Phone: (800) 227-7294 (toll-free)
(215) 945-6900
Fax: (215) 945-8720
Web site: <http://www.caps4caregivers.org>

CAPS is a nonprofit organization that provides support services to caregivers of older people. It serves as a clearinghouse for information on elder care resources and issues, including Instant Aging workshops to help communities understand the needs of older people. Send a self-addressed, stamped envelope to receive publications on aging or information about support groups.

Clearinghouse on Abuse and Neglect of the Elderly (CANE)

University of Delaware
College of Human Services, Education and Public Policy
Department of Consumer Studies
Newark, DE 19716
Phone: (302) 831-3525
Fax: (302) 831-6081
Web site: <http://www.elderabusecenter.org/clearing/index.html>

CANE, funded by the Administration on Aging, is a database of elder abuse materials and resources operated by the University of Delaware's National Center on Elder Abuse (NCEA). CANE staff will conduct customized information searches and provide resources and referrals to elder abuse support groups. *NCEA Exchange*, CANE's newsletter, is available free.

Community Transportation Association of America (CTAA)

1341 G Street, NW, 10th Floor
Washington, DC 20005
Phone: (202) 628-1480
Fax: (202) 737-9197
Web site: <http://www.ctaa.org>

CTAA is a national association committed to removing barriers to isolation and improving mobility for all people. It offers educational programs and advocates making community transportation available, affordable, and accessible. CTAA provides information on transportation in medical emergencies and van conversions.

Continuing Care Accreditation Commission (CCAC)

2519 Connecticut Avenue, NW
Washington, DC 20008-1520
Phone: (202) 508-9459
Fax: (202) 220-0022
E-mail: afinnega@ccaonline.org
Web site: <http://www.ccaonline.org>

CCAC helps consumers identify quality retirement options. CCAC also accredits aging services that meet or exceed industry-generated standards of excellence in three areas: governance and administration; financial resources and disclosure; and resident life, health, and wellness.

Corporation for National Service (CNS)

1201 New York Avenue, NW
Washington, DC 20525
Phone: (800) 424-8867 (toll-free)
(202) 606-5000
TTY: (800) 833-3722 (toll-free)
Fax: (202) 565-2794
E-mail: acinfo@infosystec.com
Web site: <http://www.nationalservice.org>

CNS oversees volunteer community enhancement programs including: the National Senior Services Corps (a network of federally supported programs helping older people get involved in community service); the Foster Grandparent Program (encouraging older people to work with children with special needs); and the Senior Companion Program (volunteers assisting older people with special needs in hospitals, social service agencies, or home health care agencies). Contact CNS for pamphlets, brochures, fact sheets, and program handbooks.

Council of Better Business Bureaus (CBBB)

4200 Wilson Boulevard, Suite 800
Arlington, VA 22203
Phone: (703) 276-0100
Fax: (703) 525-8277
Web site: <http://www.bbb.org>

CBBB is a national organization promoting ethical practices between business and the public. Local BBBs can offer consumers help resolving complaints against companies. Publications include the *Tips On* series and booklets with advice on how to make wise buying decisions on a broad range of products and services.

The Dana Alliance for Brain Initiatives

745 Fifth Avenue, Suite 700
New York, NY 10151
Phone: (212) 223-4040
Fax: (212) 593-7623
E-mail: dabiinfo@danany.dana.org
Web site: <http://www.dana.org>

The Dana Alliance promotes public education about brain research. The Alliance links the public, press, and policymakers with experts and resources in the field of neuroscience. It also hosts conferences on the brain and brain diseases. Contact the Dana Alliance for publications on brain research and diagnosis and treatment of brain disorders.

Delta Society

289 Perimeter Road East
Renton, WA 98055-1329
Phone: (425) 226-7357
Fax: (425) 235-1076
E-mail: info@deltasociety.org
Web site: <http://www.deltasociety.org>

The Delta Society is a national, nonprofit organization whose mission is improving human health through service and therapy animals. Its program, Pet Partners, brings volunteers and their pets to nursing homes, hospitals, and schools. The Society Web site has information and resources about the human-animal-health connection.

Department of Justice (DOJ)

950 Pennsylvania Avenue, NW
Washington, DC 20530-0001
Phone: (202) 514-2000
TTY: (202) 514-0716
E-mail: ASKDOJ@usdoj.gov
Web site: <http://www.usdoj.gov/>

DOJ, part of the federal government, works to protect older Americans in a variety of ways, including the Nursing Home Initiative and elder justice efforts to prosecute institutions whose wrongdoing results in harm or death for residents. DOJ prosecutes health care and consumer fraud and enforces civil rights addressing discrimination against older people. Publications and statistics on victimization of older people are available.

Department of Labor (DOL)

Office of Public Affairs
Room S1032
200 Constitution Avenue, NW
Washington, DC 20210
Phone: (202) 693-4650
Fax: (202) 693-4674
Web site: <http://www.dol.gov>

DOL, part of the federal government, protects workers' rights. Contact DOL for information and assistance on pensions, employment, wages, discrimination, and occupational safety. The Senior Community Service Employment Program helps low-income older people through part-time employment and job training. The Web site includes links to information for employers, employees, and job seekers.

**Department of Transportation (DOT)
National Highway Traffic Safety Administration (NHTSA)**

Information

400 Seventh Street, SW

Washington, DC 20590

Phone: (888) 327-4236 (toll-free)

(202) 366-0123

TTY: (800) 424-9153 (toll-free)

(202) 366-7800

Web site: <http://www.nhtsa.dot.gov/>

The NHTSA is responsible for reducing deaths, injuries, and economic losses resulting from car accidents. It sets standards, investigates safety defects, and conducts research on driver behavior. Contact NHTSA for information on older drivers.

Department of Veterans Affairs (VA)

Office of Public Affairs

810 Vermont Avenue, NW

Washington, DC 20420

Phone: (800) 827-1000 (toll-free)

TTY: (800) 829-4833 (toll-free)

Web site: <http://www.va.gov>

The VA, part of the federal government, provides benefits for eligible veterans and their families in outpatient clinics, medical centers, and nursing homes across the United States. Contact the VA for information and publications on service locations and benefits, including comprehensive medical and dental care, other insurance benefits, vocational rehabilitation compensation, and pension.

DES Action

610 16th Street, Suite 301

Oakland, CA 94612

Phone: (800) DES-9288 (337-9288) (toll-free)

(510) 465-4011

Fax: (510) 465-4815

E-mail: desaction@earthlink.net

Web site: <http://www.desaction.org>

DES Action is a nonprofit organization providing information about the risks of exposure to diethylstilbestrol (DES), a hormone prescribed for pregnant women from the 1940s through 1971 that caused health problems in mothers and their children. Contact DES Action for referrals to specialists familiar with medical complications resulting from DES use. Free publications on the risks of DES are available.

Disabled American Veterans (DAV)

807 Maine Avenue, SW

Washington, DC 20024

Phone: (202) 554-3501

TTY: (202) 863-4414

Fax: (202) 554-3581

Web site: <http://www.dav.org>

DAV is a nonprofit organization representing disabled veterans and providing volunteer services and programs. DAV offers veterans job search training and help seeking their disability compensation and pension benefits. A list of free publications is available.

Elder Craftsmen (EC)

610 Lexington Avenue

New York, NY 10022

Phone: (212) 319-8128

Fax: (212) 319-8141

E-mail: eldercraftsmen@mindspring.com

Web site: <http://www.eldercraftsmen.org>

EC offers programs and services that promote the skills and creativity of older people. Training programs are available for many types of crafts. Intergenerational programs, community service programs, and artist-in-residence are also offered.

Eldercare Initiative in Consumer Law (EICL)

National Consumer Law Center, Inc. (NCLC)

18 Tremont Street, Suite 400

Boston, MA 02108

Phone: (617) 523-8010

Fax: (617) 523-7398

E-mail: aoa@nclc.org

Web site: <http://www.consumerlaw.org>

The Initiative provides assistance on legal issues of older people. The EICL conducts regional and national legal workshops focusing on aging issues, including threats to loss of shelter and financial exploitation. Contact the Initiative for publications and references.

Eldercare Locator

Phone: (800) 677-1116 (toll-free)

Fax: (202) 296-8134

Web site: <http://www.aoa.dhhs.gov>

The Eldercare Locator is a nationwide, directory assistance service helping older people and caregivers locate local support and resources for older Americans. It is funded by the Administration on Aging.

Elderhostel

11 Avenue de Lafayette

Boston, MA 02111-1746

Phone: (877) 426-8056 (toll-free)

(617) 426-7788

TTY: (877) 426-2167 (toll-free)

Fax: (877) 426-2166 (toll-free)

E-mail: registration@elderhostel.org

Web site: <http://www.elderhostel.org>

Elderhostel is a nonprofit organization providing educational travel programs to people over age 55. Their catalog, published 10 times a year, lists thousands of national and international programs.

Elderweb

1305 Chadwick Drive
Normal, IL 61761
Phone: (309) 451-3319
Fax: (866) 422-8995
E-mail: ksb@elderweb.com
Web site: <http://www.elderweb.com>

Elderweb is a research Web site for older people, professionals, and families seeking information on elder care and long-term care. Visit Elderweb for news and information on legal, financial, medical, housing issues for older people, and links to other Web sites.

Employee Benefits Security Administration

Department of Labor
200 Constitution Avenue
Washington, DC 20210
Phone: (202) 219-8776 (Technical Assistance and Inquiries)
(866) 444-3272 (publications)
Web site: <http://www.dol.gov/ebsa>

The Employee Benefits Security Administration (EBSA) (previously the Pension and Welfare Benefits Administration) assists and educates pension, health and other employee benefit plan participants and beneficiaries, as well as plan sponsors and members of the employee benefit community. EBSA's goal in providing direct assistance is to raise the knowledge level of plan participants and beneficiaries, service providers and other interested parties and to ensure that they have access to available plan documents filed with the Department of Labor. Contact EBSA for assistance with technical questions and for publications on such topics as cash balance pension plans, pension and health care coverage for dislocated workers, pension rights, filing a claim, and ERISA-related regulations, interpretations, and opinions. Most publications are also found on the Web site.

Environmental Protection Agency (EPA)

Public Information Center (PIC)

401 M Street, SW
Washington, DC 20460
Phone: (800) 490-9198 (toll-free) (publications)
(202) 260-5922
Fax: (202) 260-5153
E-mail: library-hq@epamail.epa.gov
Web site: <http://www.epa.gov>

EPA, part of the federal government, is responsible for controlling environmental pollution. The PIC provides nontechnical information about environmental issues such as clean air, clean water, pesticides, radon, and pollution. EPA's Web site has links to other health and environment-related Web sites. Printed and audiovisual information on environmental issues are available by calling the toll-free number.

Epilepsy Foundation

4351 Garden City Drive

Landover, MD 20785

Phone: (800) 332-1000 (toll-free)

(800) 332-4050 (toll-free) (National Epilepsy Library)

(301) 459-3700

Fax: (301) 577-2684

E-mail: postmaster@epilepsyfoundation.org

Web site: <http://www.epilepsyfoundation.org>

The Foundation is a national volunteer health organization supporting research, education, advocacy, and services for people with seizure disorders. Contact the Foundation for a list of local chapters, referrals to local specialists, support groups, camps, travel assistance, respite care, and employment assistance. Videos and a catalog of publications are available.

Equal Employment Opportunity Commission (EEOC)

1801 L Street, NW

Washington, DC 20507

Phone: (800) 669-3362 (toll-free) (publications)

(202) 663-4900 (headquarters)

TTY: (800) 800-3302 (toll-free) (publications)

(202) 663-4494 (headquarters)

Web site: <http://www.eeoc.gov>

The EEOC, part of the federal government, promotes equal opportunity in employment. It enforces the Age Discrimination in Employment Act (ADEA), conducts investigations, makes determinations, and effects reconciliations in age discrimination actions. Contact EEOC for information and referrals.

Federal Citizen Information Center (FCIC)

PO Box 100

Pueblo, CO 81009

Phone: (888) 878-3256 (toll-free)

(800) 688-9889 (toll-free) (National Contact Center)

TTY: (800) 326-2996 (toll-free) (National Contact Center)

Fax: (719) 948-9724

Web site: <http://www.pueblo.gsa.gov/>

FCIC, part of the federal government, distributes a wide range of consumer-oriented publications from many federal agencies. The Consumer Information Catalog lists more than 200 publications on topics ranging from health and housing to food and nutrition; from money management to employment. The National Contact Center answers questions and provides referral information on federal programs, benefits, and services.

Federal Trade Commission (FTC)

600 Pennsylvania Avenue, NW

Washington, DC 20580

Phone: (877) FTC-HELP (382-4357) (toll-free)

(202) 326-2222 (General Information Locator)

TTY: (202) 326-2502

E-mail: webmaster@ftc.gov

Web site: <http://www.ftc.gov>

FTC, part of the federal government, regulates trade and protects consumers from unfair and deceptive business practices. Its consumer protection programs include truth in advertising, packaging and labeling of products, product reliability, direct mail advertising, and nursing home business practices. Publications are available on refinancing a home, collecting a debt, buying a used car, and finding out credit history.

Food and Drug Administration (FDA)

HFE88

5600 Fishers Lane

Rockville, MD 20857

Phone: (888) INFO-FDA (463-6332) (toll-free)

(888) 723-3366 (toll-free) (Food Information Line)

(800) 822-7967 (toll-free) (Vaccine Adverse Event Reporting System)

(800) 838-7715 (toll-free) (Mammography Information Service)

Web site: <http://www.fda.gov>

FDA, part of the federal government, regulates the safety and effectiveness of food products, additives, drugs, medical devices, and cosmetics. Contact FDA for information on safe drug use and side effects, vitamins, and laws regulating medicines and foods. FDA has information for older people on topics including cancer, health fraud, nutrition, buying medicines online, and food safety.

Food and Nutrition Information Center (FNIC)

Department of Agriculture

Agricultural Research Service/National Agriculture Library

10301 Baltimore Avenue, Room 304

Beltsville, MD 20705-2351

Phone: (301) 504-5719

TTY: (301) 504-6856

Fax: (301) 504-6409

E-mail: fnic@nal.usda.gov

Web site: <http://www.nalusda.gov/fnic>

FNIC, part of the federal government, provides information, publications, and audiovisual materials on nutrition. Resource guides on nutrition and older people, heart disease, diabetes, vegetarianism, food safety, and food labeling are available.

Foundation for Biomedical Research (FBR)

818 Connecticut Avenue, NW, Suite 200

Washington, DC 20006

Phone: (202) 457-0654

Fax: (202) 457-0659

E-mail: info@fbresearch.org

Web site: <http://www.fbresearch.org>

FBR is a national organization advocating the ethical use of animals in scientific and medical research. Contact the Foundation for information and publications on how animal research helps scientists understand human health and aging.

Generations Online

108 Ralston House

3615 Chestnut Street

Philadelphia, PA 19104

Phone: (215) 222-6400

Fax: (215) 222-6401

Web site: <http://www.generationsonline.com>

Generations Online is a nonprofit Web site offering resources for older people unfamiliar with computers or the Internet. Generations Online provides self-training software for senior centers, libraries, retirement homes, and other locations for a one-time fee. The program is free for seniors. Its feature, Memories, links older people with school children for cultural, experiential, and personal exchanges on aging.

Generations Together (GT)

University Center for Social and Urban Research

University of Pittsburgh

121 University Place, Suite 300

Pittsburgh, PA 15260-5907

Phone: (412) 648-7150

Fax: (412) 648-7446

E-mail: sharris@pitt.edu

Web site: <http://www.pitt.edu/~gti/>

GT promotes mutually beneficial interaction between young and old through community outreach, education, research, and dissemination of knowledge. GT develops, supports, and studies intergenerational programs and related issues. GT sponsors the annual International Intergenerational Training Institute, which furthers collaboration between generations in workshops and resource development. Contact GT for a catalog of publications.

Gerontological Society of America (GSA)

1030 15th Street, NW, Suite 250

Washington, DC 20005-1503

Phone: (202) 842-1275

Fax: (202) 842-1150

E-mail: geron@geron.org

Web site: <http://www.geron.org>

GSA is a professional organization providing information, advocacy, and support for research into the study of aging. GSA has a database of information on biological and social aspects of aging, links to aging information resources, and referrals to researchers and specialists in gerontology. GSA distributes publications on a variety of aging-related topics.

Glaucoma Research Foundation (GRF)

200 Pine Street, Suite 200

San Francisco, CA 94104

Phone: (800) 826-6693 (toll-free)

(415) 986-3162

Fax: (415) 986-3763

E-mail: info@glaucoma.org

Web site: <http://www.glaucoma.org>

GRF is a national, nonprofit organization providing information and advocacy for people with glaucoma. Contact GRF for information on the causes, diagnosis, treatment, and prevention of glaucoma, referrals to specialists, and coping strategies for patients. Publications include the quarterly newsletter, *Gleams*, and a glaucoma patient guide.

Gray Panthers (GP)

733 15th Street, NW, Suite 437
Washington, DC 20005
Phone: (800) 280-5362 (toll-free)
(202) 737-6637
Fax: (202) 737-1160
E-mail: info@graypanthers.org
Web site: <http://www.graypanthers.org>

Gray Panthers is a national advocacy organization of activists concentrating on social and economic issues. Local chapters organize intergenerational groups to address issues including universal health care, Medicare, preserving Social Security, affordable housing, and discrimination. Contact the national office for referrals to chapters, information on issues, links to resources for older people, and a list of publications.

Green Thumb, Inc. (GT)

2000 North 14th Street, Suite 800
Arlington, VA 22201
Phone: (703) 522-7272
Fax: (703) 522-0141
Web site: <http://www.greenthumb.org>

GT is a national, nonprofit organization helping older, low-income workers train for and find work, particularly in rural areas. GT's Senior Community Service Employment Program, funded by the Department of Labor, provides training, work experience, educational opportunities, and placement in community service jobs. The Geezer.com Web site has information to help seniors supplement their income, launch new businesses, and market their handcrafted goods. Contact GT for a fact sheet and list of publications.

Health Care Financing Administration (HCFA)/The Centers for Medicare and Medicaid Services (CMS)

7500 Security Boulevard
Baltimore, MD 21244
Phone: (800) MEDICARE (633-4227) (toll-free) (Medicare hotline)
(410) 786-3000
Fax: (202) 690-7675
Web site: <http://www.cms.hhs.gov/> or
<http://www.medicare.gov> (Medicare information)

HCFA (CMS), part of the federal government, administers health insurance through Medicare and Medicaid. HCFA (CMS) regulates hospitals, nursing homes, and home health agencies. Contact HCFA (CMS) for *The Medicare Handbook* and other publications on related topics.

Note: This federal agency changed its name in July 2001 to The Centers for Medicare and Medicaid Services.

Health Insurance Association of America (HIAA)

1201 F Street, NW, 5th Floor
Washington, DC 20004
Phone: (202) 824-1600
(202) 824-1849 (publications information)
Fax: (202) 824-1722
Web site: <http://www.hiaa.org>

HIAA is a trade association representing the interests of the privately insured health care system. Contact HIAA for insurance information on health, long-term care, dental, disability, and supplemental coverage. HIAA also provides information and publications on health care issues, including continuation of group health benefits, major medical, and Medicare supplements.

**Hill-Burton Free Medical Care Program
Health Resources and Services Administration (HRSA)**

Department of Health and Human Services
Division of Facilities Compliance and Recovery
5600 Fishers Lane, Room 10C-16
Rockville, MD 20857
Phone: (800) 638-0742 (toll-free)
(800) 492-0359 (toll-free) (Maryland residents)
(301) 443-5656
Fax: (301) 443-0619
E-mail: webmaster@hrsa.gov
Web site: <http://www.hrsa.gov/osp/dfcr>

Hospitals and other health care facilities receive federal funds for construction or modernization under the Hill-Burton Program. In return, these facilities provide a specific amount of free or below cost health care services to eligible people. Contact the program for a list of participating facilities as well as information on eligibility.

HIV/AIDS Treatment Information Service (ATIS)

PO Box 6303
Rockville, MD 20849-6303
Phone: (800) HIV-0440 (448-0440) (toll-free) (English, Spanish, Portuguese)
(301) 519-0459
TTY: (888) 480-3739 (toll-free)
Fax: (301) 519-6616
E-mail: atis@hivatis.org
Web site: <http://www.hivatis.org>

ATIS, sponsored by the federal government, provides current treatment information on HIV and AIDS as well as answering HIV/AIDS-related questions. Referrals to national, state, and local organizations are provided. All information is free and confidential.

Huntington's Disease Society of America (HDSA)

158 West 29th Street, 7th Floor
New York, NY 10001-5300
Phone: (800) 345-HDSA (4372) (toll-free)
(212) 242-1968, Ext.10
Fax: (212) 239-3430
E-mail: hdsainfo@hdsa.org
Web site: <http://www.hdsa.org>

The Society is a nonprofit organization providing information, services, and advocacy for people with Huntington's disease (HD) and their families. Contact HDSA for research information on causes, diagnosis, and treatment of HD as well as referrals to testing centers, specialists, self-help groups, and social services. Publications and audiovisual materials on HD are available.

Hysterectomy Educational Resources and Services Foundation (HERS)

422 Bryn Mawr Avenue
Bala Cynwyd, PA 19004
Phone: (610) 667-7757
Fax: (610) 667-8096
E-mail: HERSFdn@aol.com
Web site: <http://www.hersfoundation.com>

HERS Foundation is a nonprofit organization providing information on hysterectomy (surgical removal of the uterus) and oophorectomy (removal of the ovaries). Contact HERS for telephone counseling and support services. A lending library contains medical literature on topics such as fibroids, hyperplasia, and ovarian conditions. A list of publications is available on request.

Indian Health Service (IHS)

Parklawn Bldg., Room 6-35
5600 Fishers Lane
Rockville, MD 20857
Phone: (301) 443-3593
Fax: (301) 443-0507
Web site: <http://www.ihs.gov>

The IHS, part of the federal government, operates a comprehensive health service program for American Indians and Alaska Natives. Services include hospital and community-based medical care, rehabilitation, and disease prevention. The IHS strives for maximum tribal involvement in all aspects of its services.

International Hearing Society (IHS)

16880 Middlebelt Road, Suite 4
Livonia, MI 48154
Phone: (800) 521-5247 (toll-free) (Hearing Aid Helpline)
(734) 522-7200 (outside the US and Canada)
Fax: (734) 522-0200
Web site: <http://www.hearingihs.org>

IHS is a professional organization providing assistance to consumers in locating a hearing aid specialist, support, and repair services. The Hearing Aid Helpline offers information and publications on how hearing works, types of hearing loss, and design and use of hearing instruments.

International Tremor Foundation (ITF)

7046 West 105th Street
Overland Park, KS 66212-1803
Phone: (913) 341-3880
Fax: (913) 341-1296
E-mail: UPF_ITF@msn.com
Web site: <http://www.essentialtremor.org>

ITF is an international, nonprofit organization providing support, information on medication use and surgical treatment, research, and other resources for people diagnosed with essential tremor. Contact ITF for referrals to medical specialists, a list of support groups by state, and information on more than 20 tremor disorders. Members may write or call for background literature and answers to specific questions.

Japanese American Citizens League (JACL)

National Headquarters
1765 Sutter Street
San Francisco, CA 94115
Phone: (415) 921-5225
Fax: (415) 931-4671
E-mail: jacl@jacl.org
Web site: <http://www.jacl.org>

JACL is a nonprofit educational organization fighting discrimination against Japanese Americans and their families by providing information, education, and advocacy. Contact JACL for assistance to retired people and information on programs on equal rights, racial violence, immigration, and fair employment. *Pacific Citizen*, a weekly newspaper, and other publications are available.

John Douglas French Alzheimer's Foundation

11620 Wilshire Boulevard, Suite 270
Los Angeles, CA 90025
Phone: (800) 477-2243 (toll-free)
(310) 445-4650
Fax: (310) 479-0516
Web site: <http://www.jdfaf.org>

The Foundation funds scientific research into the causes and cure for Alzheimer's disease. Contact the Foundation for the free publication *Caring for a Person with Memory Loss and Confusion*.

Kansas Geriatric Education Center (KS-GEC)

Center on Aging
University of Kansas Medical Center
3901 Rainbow Boulevard
Kansas City, KS 66160-7177
Phone: (913) 588-1636
Fax: (913) 588-3179
E-mail: hcallowa@kumc.edu
Web site: <http://coa.kumc.edu/gec>

KS-GEC provides information and support for developing community-based, long-term care for rural older people. The Center works closely with state and area Agencies on Aging. Contact the Center for a list of publications.

Legal Counsel for the Elderly (LCE)

American Association of Retired Persons (AARP)

601 E Street, NW
Washington, DC 20049
Phone: (202) 434-2120
TTY: (202) 434-6562
Fax: (202) 434-6464
Web site: <http://www.aarp.org>

LCE, part of AARP, works to expand the availability of legal services to older people and to enhance the quality of those services. The National Volunteer Lawyers Project matches legal cases affecting large numbers of older people with volunteer law firms. The Senior Lawyers Project tests ways retired lawyers can provide free legal services to older people in need. The National Elderlaw Studies Program provides individual home study courses as well as a paralegal certificate from the Department of Agriculture Graduate School. Publications are available.

Legal Services for the Elderly (LSE)

130 West 42nd Street, 17th Floor
New York, NY 10036
Phone: (212) 391-0120
Fax: (212) 719-1939
E-mail: hn4923@handsnet.org

LSE is an advisory center for lawyers specializing in legal problems of older people. While LSE does not provide direct services to clients, staff lawyers offer advice and write memoranda and briefs to lawyers who serve older clients on issues including Medicaid, Medicare, Social Security, disability, voluntary and involuntary commitment, age discrimination, pensions, rent-increase exemptions for older people, and nursing home care. A list of publications is available.

Leukemia and Lymphoma Society, Inc. (LLS)

1311 Mamaroneck Avenue
White Plains, NY 10605
Phone: (800) 955-4572 (toll-free)
(914) 949-5213
Fax: (914) 949-6691
E-mail: infocenter@leukemia-lymphoma.org
Web site: <http://www.leukemia.org>

LLS provides information, advocacy, and assistance for patients with leukemia and related cancers such as lymphoma, multiple myeloma, and Hodgkin's disease. Contact LLS for information, referrals to specialists and local chapters offering financial assistance to patients with leukemia, and support groups. Publications on leukemia and related cancers are available.

Lighthouse National Center for Vision and Aging (LNCVA)

111 East 59th Street
New York, NY 10022
Phone: (800) 829-0500 (toll-free)
(212) 821-9495
TTY: (212) 821-9713
Fax: (212) 821-9705
E-mail: info@lighthouse.org
Web site: <http://www.lighthouse.org>

LNCVA provides advocacy, support, information, and resources on vision impairment and blindness. Contact the Lighthouse for referrals to specialists and resources on visual disability, vision rehabilitation, links to related services, as well as information on eye diseases such as macular degeneration, glaucoma, cataracts, and diabetic retinopathy. Publications and audiovisual materials are available on topics including vision, vision disorders, treatment options, and rehabilitation strategies.

Lupus Foundation of America (LFA)

1300 Piccard Drive, Suite 200
Rockville, MD 20850-4303
Phone: (800) 558-0121 (toll-free) (information line)
(301) 670-9292
Fax: (301) 670-9486
E-mail: lupusinfo@aol.com
Web site: <http://www.lupus.org>

LFA is a nonprofit organization supporting research and distributing information about diagnosis and treatment of lupus erythematosus, a chronic autoimmune disease. Contact the LFA for referrals to specialists, information about treatment and research, a listing of local chapters and support groups, other resource organizations, and a list of publications.

Meals On Wheels Association of America (MOWAA)

1414 Prince Street, Suite 302
Alexandria, VA 22314
Phone: (703) 548-5558
Fax: (703) 548-8024
Web site: <http://www.mowaa.org>

MOWAA is a national, nonprofit organization providing training and grants to programs that provide food to older people, and those who are frail, disabled, at-risk, or homebound.

MedicAlert Foundation

2323 Colorado Avenue
Turlock, CA 95382
Phone: (800) 432-5378 (toll-free)
(209) 668-3333
Fax: (209) 669-2495
Web site: <http://www.medicalert.org>

MedicAlert is a nonprofit, membership organization providing identification and medical information in emergencies. Contact MedicAlert for information about its membership services and costs.

Medicare Rights Center (MRC)

1460 Broadway, 11th Floor
New York, NY 10036
Phone: (212) 869-3850
Fax: (212) 869-3532
E-mail: info@medicarerights.org
Web site: <http://www.medicarerights.org>

MRC is a national, nonprofit service helping older adults and people with disabilities get good, affordable health care. Available educational materials include a train-the-trainer manual, booklets on Medicare basics, and Medicare home health.

National Academy of Elder Law Attorneys, Inc. (NAELA)

1604 North Country Club Road
Tucson, AZ 85716
Phone: (520) 881-4005
Fax: (520) 325-7925
Web site: <http://www.naela.org>

NAELA is a nonprofit association assisting lawyers, bar associations, and others who work with older people and their families. Contact NAELA for information on lawyers specializing in issues pertinent to older people, resources to legal information, assistance, and education. A list of publications is available.

National Alliance for Hispanic Health

1501 16th Street, NW
Washington, DC 20036
Phone: (202) 387-5000
E-mail: alliance@hispanichealth.org
Web site: <http://www.hispanichealth.org/>

The Alliance is a network of health and human service providers fostering the health, well-being, and prosperity of Hispanics. Network members provide consumer information, help formulate culturally competent standards of care, support research into specific health concerns facing Hispanics, and promote appropriate use of technology. Spanish language resources are available.

National Alliance for the Mentally Ill (NAMI)

Colonial Place Three
2107 Wilson Boulevard, Suite 300
Arlington, VA 22201
Phone: (800) 950-NAMI (950-6264) (toll-free) (NAMI Helpline)
(703) 524-7600
TTY: (703) 516-7227
Fax: (703) 524-9094
Web site: <http://www.nami.org>

NAMI offers support groups, education, advocacy, and research to help people with mental illness. The Alliance seeks to educate all people about severe and persistent mental illnesses to eliminate stigma and promote access to services. Search the Web site for lists of local affiliates and state organizations.

**National Arthritis and Musculoskeletal and Skin Diseases Information Clearinghouse
National Institute of Arthritis and Musculoskeletal and Skin Diseases (NIAMS)
National Institutes of Health**

1 AMS Circle
Bethesda, MD 20892-3675
Phone: (877) 22-NIAMS (226-4267) (toll-free)
(301) 495-4484
TTY: (301) 565-2966
Fax: (301) 881-2731 (faxback service)
E-mail: NIAMSInfo@mail.nih.gov
Web site: <http://www.nih.gov/niams>

NIAMS Information Clearinghouse is funded by NIAMS, part of NIH. The Clearinghouse provides information and resources on all forms of arthritis, musculoskeletal diseases such as fibromyalgia, as well as skin diseases. Contact the Clearinghouse for information on research and referrals to research programs and community resources. Publications are available on the causes, treatments, and prevention of arthritis, lupus, musculoskeletal disorders, and diseases of bones, joints, and skin.

National Asian Pacific Center on Aging (NAPCA)

1511 3rd Avenue, Suite 914

Seattle, WA 98101-1626

Phone: (206) 624-1221

Fax: (206) 624-1023

E-mail: info@napca.org

Web site: <http://www.napca.org>

NAPCA is a nonprofit agency dedicated to serving aging Asian and Pacific Islanders. It offers employment programs, multilingual community forums and health care education. The Center works with elders, policy makers, program administrators, and community leaders. Publications include a newsletter and translated health care materials.

National Association for Continence (NAFC)

PO Box 8310

Spartanburg, SC 29305-8310

Phone: (800) 252-3337 (toll-free) (ordering line)

Fax: (864) 579-7902

E-mail: memberservices@nafc.org

Web site: <http://www.nafc.org>

NAFC, formerly Help for Incontinent People, is a nonprofit organization providing advocacy, education, and support to people with incontinence and their families. Contact NAFC for referrals to specialists, resources, and information about the causes, prevention, diagnosis, treatments, and management alternatives for incontinence. Publications are available.

National Association for Health & Fitness (NAHF)

201 South Capitol Avenue, Suite 560

Indianapolis, IN 46225

Phone: (317) 237-5630

Fax: (317) 237-5632

Web site: <http://www.physicalfitness.org/>

NAHF is a nonprofit organization promoting physical fitness, sports, and healthy lifestyles. The Association supports State Governor's Councils on Physical Fitness and Sports. NAHF supports employee health and fitness programs including Let's Get Physical, an interactive educational program based on the Surgeon General's 1996 report recommending moderate physical activity most days of the week.

National Association for Hispanic Elderly (Asociación Nacional Por Personas Mayores)

234 East Colorado Boulevard, Suite 300

Pasadena, CA 91101

Phone: (626) 564-1988

Fax: (626) 564-2659

The Association is a national, private, nonprofit organization providing a variety of services for older Hispanic people. Resources include a national Hispanic research center, research and consultation for organizations seeking to reach older Spanish-speaking people, and dissemination of written and audiovisual materials in English and Spanish. The Association administers Project AYUDA, a program providing employment counseling and placement services.

National Association for Home Care (NAHC)

228 7th Street, SE
Washington, DC 20003
Phone: (202) 547-7424
Fax: (202) 547-3540
E-mail: webmaster@nahc.org
Web site: <http://www.nahc.org>

NAHC promotes hospice and home care, sets standards of care, and conducts research on aging, health, and health care policy. Association publications include *How to Choose a Home Care Provider* and other free consumer guides on home care and hospice care.

National Association for Human Development (NAHD)

1424 16th Street, NW, Suite 102
Washington, DC 20036
Phone: (202) 328-2191
Fax: (202) 265-6682
E-mail: nahdcasa@worldnet.att.net

NAHD is a nonprofit organization providing information and materials for national, state, and local groups helping people maintain their physical, mental, and social well-being. Contact NAHD program specialists for slides, videos, booklets, posters, and training manuals on health and physical fitness. Program materials focusing on older people include topics such as wellness, physical fitness, preventive medicine, self-care, and retirement planning.

National Association for Practical Nurse Education and Services (NAPNES)

1400 Spring Street, Suite 330
Silver Spring, MD 20910
Phone: (301) 588-2491
Fax: (301) 588-2839
E-mail: napnes@bellatlantic.net

NAPNES is a professional organization of licensed practical nurses, other nurses, physicians, nursing home administrators, and the general public specializing in direct long-term care of older people. NAPNES offers long-term care certification to practical/vocational nurses. Contact NAPNES for information on practical nursing and referrals to member nurses and resource organizations.

National Association of Activity Professionals (NAAP)

PO Box 5530
Sevierville, TN 37864
Phone: (865) 429-0717
Fax: (865) 453-9914
E-mail: THENAAP@aol.com
Web site: <http://www.thenaap.com>

NAAP is a professional organization providing activity education, advocacy, industry standards, and programming for long-term-care facilities, retirement living communities, and adult day care centers. Contact NAAP for referrals to specialists and information on therapeutic and restorative activities, regulation and policy updates, and program models. Publications are available.

National Association of Area Agencies on Aging (N4A)

927 15th Street, NW, 6th Floor
Washington, DC 20005
Phone: (800) 677-1116 (toll-free) (Eldercare Locator)
(202) 296-8130
Fax: (202) 296-8134
Web site: <http://www.n4a.org>

N4A is the umbrella organization for the AoA-funded Area Agencies on Aging. It also represents the interests of Title VI Native American aging programs. The Association administers the AoA-sponsored Eldercare Locator, a toll-free number linking older adults and their family members with local resources on aging. N4A publishes the *National Directory for Eldercare Information and Referral*.

National Association of Community Health Centers (NACHC)

1330 New Hampshire Avenue, NW, Suite 122
Washington, DC 20036
Phone: (202) 659-8008
Fax: (202) 659-8519
E-mail: dhawkins@nachc.com
Web site: <http://www.nachc.com>

NACHC is a national association representing community health centers nationwide. Contact NACHC for referrals to local health centers and information on the Association's programs as well as health care regulation and policy updates.

National Association of Nutrition and Aging Service Programs (NANASP)

1101 Vermont Avenue, NW, Suite 1001
Washington, DC 20005
Phone: (202) 682-6899
Fax: (202) 682-3984
Web site: <http://www.nanasp.org>

NANASP, a membership organization, supports a broad range of nutrition and related services for community-dwelling older people by training nutrition providers and advocating for older people. Publications include a *Legislative Action Manual* and *The Washington Bulletin*.

National Association of Professional Geriatric Care Managers (NAPGCM)

1604 North Country Club Road
Tucson, AZ 85716-3102
Phone: (520) 881-8008
Fax: (520) 325-7925
E-mail: info@caremanager.org
Web site: <http://www.caremanager.org>

NAPGCM is a nonprofit organization representing the interests of elder care practitioners and advocating for older peoples' independence, autonomy, and quality of health care. Contact NAPGCM for resources, referrals to local Association chapters, and information on counseling and treatment programs. Publications and referrals to professional care managers are available through the Web site.

National Association of Social Workers (NASW)

750 First Street, NE, Suite 700
Washington, DC 20002-4241
Phone: (800) 638-8799 (toll-free)
(202) 408-8600
Fax: (202) 336-8310
E-mail: info@naswdc.org
Web site: <http://www.naswdc.org>

NASW is a membership organization promoting, advocating, developing, and protecting social workers and the practice of social work. Contact NASW for referrals to counseling resources and specialists, information about social work, and information from the members section focusing on aging issues and health care.

National Association of State Units on Aging (NASUA)

1225 I Street, NW, Suite 725
Washington, DC 20005
Phone: (202) 898-2578
Fax: (202) 898-2583
E-mail: info@nasua.org
Web site: <http://www.nasua.org>

NASUA is a public-interest organization providing information, assistance, and advocacy on behalf of older people. Contact NASUA for information on rights of older people, health care and social services regulations, and referrals to lawyers specializing in elder law and aging issues. Publications are available on topics such as the Older Americans Act, long-term care, older worker issues, elder abuse, and nutrition programs. The Association cooperates in administering the Eldercare Locator, AoA's toll-free information service.

National Association of the Deaf (NAD)

814 Thayer Avenue
Silver Spring, MD 20910-4500
Phone: (301) 587-1788
TTY: (301) 587-1789
Fax: (301) 587-1791
E-mail: NADinfo@nad.org
Web site: <http://www.nad.org>

NAD is a private, nonprofit organization representing the interests and rights of people who are deaf or hearing impaired. It advocates for greater access to education, employment, health care, and social services. Contact NAD for information on legal assistance, public policy on deafness and disabilities, and referrals to products that assist deaf and hearing-impaired people. Publications are available.

National Association on HIV Over Fifty (NAHOF)

Southwest Boulevard Family Health Care Services, Inc.
340 Southwest Boulevard
Kansas City, KS 66103
Phone: (816) 421-5263
Fax: (913) 722-2542
E-mail: janepfowler@mindspring.com
Web site: <http://www.hivoverfifty.org>

NAHOF is a membership organization promoting the availability of a full range of educational, prevention, service, and health care programs for people over age 50 and affected by HIV. NAHOF provides a forum to exchange information and share concerns about HIV and older adults.

National Bar Association (NBA)

1225 11th Street, NW
Washington, DC 20001
Phone: (202) 842-3900
Fax: (202) 289-6170
Web site: <http://www.nationalbar.org>

NBA uses its national membership, statewide minority bar programs, minority law students, minority bar group alliances, and private attorneys, to form links with community groups providing legal assistance to low-income, minority older people. Publications include *Saving The Home* and *Defending Against Fraud and Scams*, a resource book on second mortgages.

National Cancer Institute (NCI)

National Institutes of Health
Public Inquiries Office
Building 31, Room 10A03
31 Center Drive MSC 2580
Bethesda, MD 20892-2580
Phone: (800) 4-CANCER (422-6237) (toll-free) (Cancer Information Service-CIS)
TTY: (800) 332-8615 (toll-free)
(301) 435-3848
E-mail: webmaster@cancer.gov
Web site: <http://www.nci.nih.gov>

NCI, part of NIH, is the lead agency for cancer research and statistics, treatments, clinical trials, patient education, and public information on all types of cancer, risk factors, and prevention. NCI's toll-free CIS provides immediate, science-based answers to the public's specific questions about cancer. The CIS provides referrals to cancer specialists and other related resources, including where to find survivor groups. Many free publications are available.

National Caucus and Center on Black Aged, Inc. (NCBA)

1424 K Street, NW, Suite 500
Washington, DC 20005
Phone: (202) 637-8400
Fax: (202) 347-0895
E-mail: ncba@aol.com
Web site: <http://www.ncba-blackaged.org>

NCBA is a national, nonprofit organization providing health and social service information, advocacy, and assistance to African-Americans and low-income older people. Contact NCBA for information on its local chapters and programs including senior employment and training, housing, health promotion, and advocacy. Publications include a support-service reference guide, job placement guides, and a *Profile of Black Elderly*.

**National Center for Complementary and Alternative Medicine Clearinghouse (NCCAM)
National Institutes of Health (NIH)**

PO Box 8218
Silver Spring, MD 20907-8218
Phone: (888) 644-6226 (toll-free)
(301) 231-7357
TTY: (866) 464-3615 (toll-free)
Fax: (866) 464-3616
E-mail: nccam-info@nccam.nih.gov
Web site: <http://www.nccam.nih.gov>

The Clearinghouse, funded by NCCAM, provides information on alternative medical therapies not commonly used or previously accepted in conventional Western medicine. Contact the Clearinghouse for information on holistic healing traditions, including acupuncture, herbs, homeopathy, therapeutic massage, and traditional oriental medicine. NCCAM does not recommend specific therapies. Publications are available by fax-on-demand and on the Web site.

**National Center for Health Statistics (NCHS)
Centers for Disease Control and Prevention (CDC)**

6525 Belcrest Road
Hyattsville, MD 20782-2003
Phone: (301) 458-4636
Web site: <http://www.cdc.gov/nchs/>

NCHS, part of the federal government, is the agency that monitors and compiles information on the Nation's health. NCHS statistical programs on aging collect information on the health of older people, their lifestyles, exposure to unhealthy influences, diagnosis and age of onset for illnesses or disabilities, and patterns of health care service use. Contact NCHS for reports on trends in health and aging.

National Center on Elder Abuse (NCEA)

1225 I Street, NW, Suite 725
Washington, DC 20005
Phone: (202) 898-2586
Fax: (202) 898-2583
E-mail: NCEA@nasua.org
Web site: <http://www.elderabusecenter.org/>

NCEA is operated jointly by the National Association of State Units on Aging, the National Committee for the Prevention of Elder Abuse, and the University of Delaware to disseminate information about abuse and neglect of older people. NCEA operates the Clearinghouse on Abuse and Neglect of the Elderly and can provide referrals to agencies and specialists. Publications are available on prevention of abuse, neglect, and state regulations.

National Center on Minority Health and Health Disparities (NCMHD)

National Institutes of Health (NIH)

6707 Democracy Boulevard

MSC 5465

Bethesda, MD 20892-5465

Phone: (301) 402-1366

Fax: (301) 496-4035

NCMHD, part of NIH, conducts and supports research, training, dissemination of information, and other programs with respect to minority health conditions and other populations with health disparities.

National Center on Poverty Law, Inc. (NCPL)

205 West Monroe Street

Chicago, IL 60606

Phone: (312) 263-3830

Fax: (312) 263-3846

Web site: <http://www.povertylaw.org>

NCPL is a professional organization advocating for low-income people and providing assistance, resources, and information on poverty law. Contact NCPL for referrals to poverty law specialists, program information on welfare, work force, housing, and community development. Publications are available on topics such as grandparents' visitation, access to home health care for older people, protecting older homeowners from refinancing scams, and the needs of multigenerational low-income families.

National Citizen's Coalition for Nursing Home Reform (NCCNHR)

1424 16th Street, NW, Suite 202

Washington, DC 20036-2211

Phone: (202) 332-2275

Fax: (202) 332-2949

E-mail: nccnhr@nccnhr.org

Web site: <http://www.nccnhr.org>

NCCNHR provides information on nursing home reform, promotes quality standards, and works to empower residents. Contact NCCNHR for information on community-based, consumer/citizen action, and long-term care ombudsmen groups. Publications on nursing homes and long-term care are available.

National Coalition for Adult Immunization (NCAI)

4733 Bethesda Avenue, Suite 750

Bethesda, MD 20814

Phone: (301) 656-0003

Fax: (301) 907-0878

E-mail: ncai@nfid.org

Web site: <http://www.nfid.org/ncai>

NCAI is a network of organizations formed to achieve better health through immunizations and support for science-based recommendations. NCAI helps coordinate National Adult Immunization Awareness Week, an annual observance in the fall. Check the Web site for a chart outlining the NCAI-recommended adult immunization schedule. Spanish language resources are available.

National Committee to Preserve Social Security and Medicare (NCPSSM)

10 G Street, NE, Suite 600
Washington, DC 20004-4215
Phone: (800) 966-1935 (toll-free)
(202) 216-0420
Fax: (202) 216-0451
Web site: <http://www.ncpssm.org>

NCPSSM, an advocacy and education membership organization, works to protect and enhance federal programs vital to seniors' health and economic well-being. Contact NCPSSM for details on membership as well as information on seniors' rights, Medicare, Social Security, long-term care, and disability issues. Free informational brochures are available.

National Consumer's League (NCL)

1701 K Street, NW, Suite 1200
Washington, DC 20006
Phone: (800) 876-7060 (toll-free) (National Fraud Information Center)
(202) 835-3323
Fax: (202) 835-0747
E-mail: info@nclnet.org
Web site: <http://www.natlconsumersleague.org> (National Consumer's League) or
<http://www.fraud.org> (National Fraud Information Center)

NCL is a private, nonprofit advocacy group representing consumers on marketplace and workplace issues, providing government, businesses, and other organizations with consumers' perspectives on social issues. Contact the NCL for information on topics such as privacy, consumer credit, food safety, and drug safety. NFIC supports victims of telemarketing and Internet fraud, and informs law enforcement of fraud cases. Publications are available.

National Council Against Health Fraud (NCAHF)

PO Box 1276
Loma Linda, CA 92354
Phone: (201) 723-2955 (consumer health information)
Web site: <http://www.ncahf.org>

NCAHF is a nonprofit agency that provides a Web site listing reliable sources of health information on the Internet. Contact the Council for information on health fraud, misinformation, and quackery, or to report fraud and investigate health claims by companies or organizations. NCAHF provides information on legitimate health groups, sponsors discussion groups that evaluate new health organizations, and suggests alternative medical techniques. A free weekly e-mail newsletter is available online.

National Council of La Raza (NCLR)

1111 19th Street, NW, Suite 1000
Washington, DC 20036
Phone: (202) 785-1670
Fax: (202) 776-1794
Web site: <http://www.nclr.org>

NCLR is a private, nonprofit organization established to reduce poverty and discrimination, and improve opportunities for Hispanics. NCLR health programs develop culturally relevant, bilingual health education and promotional materials. The Hispanic Health Project works to lower the incidence of a variety of preventable conditions.

National Council on Aging (NCOA)

409 3rd Street, SW, Suite 200

Washington, DC 20024

Phone: (202) 479-1200

Fax: (202) 479-0735

E-mail: info@ncoa.org

Web site: <http://www.ncoa.org>

NCOA is a private, nonprofit organization providing information, training, technical assistance, advocacy, and leadership in all aspects of aging services and issues. Contact NCOA for information on training programs and in-home services for older people. NCOA publications are available on topics such as lifelong learning, senior center services, adult day care, long-term care, financial issues, senior housing, rural issues, intergenerational programs, and volunteers in aging.

National Council on Alcoholism and Drug Dependence (NCADD)

20 Exchange Place, Suite 2902

New York, NY 10005

Phone: (800) NCA-CALL (622-2255) (toll-free)

(212) 269-7797

Fax: (212) 269-7510

E-mail: national@ncadd.org

Web site: <http://www.ncadd.org>

NCADD is a nonprofit organization providing advocacy, assistance, and information on alcoholism and drug addiction. Contact NCADD for information on causes, diagnosis, and treatments; referrals to specialists; lists of community resource centers; and NCADD-affiliated organizations nationwide. Fact sheets, brochures, and videotapes also are available.

National Council on Patient Information and Education (NCPIE)

4915 Saint Elmo Avenue, Suite 505

Bethesda, MD 20814-6053

Phone: (301) 656-8565

Fax: (301) 656-4464

E-mail: ncpie@erols.com

Web site: <http://www.talkaboutrx.org>

NCPIE is a nonprofit coalition providing advocacy, information, and services to educate and empower consumers to make sound decisions about use of prescription and over-the-counter medicines. Contact NCPIE to discuss drug safety or facts about specific drugs. NCPIE's Web site and publications provide information on medications, side effects, and manufacturers' recalls.

National Diabetes Information Clearinghouse (NDIC)

National Institute of Diabetes and Digestive and Kidney Diseases (NIDDK)

National Institutes of Health (NIH)

1 Information Way

Bethesda, MD 20892-3560

Phone: (800) 860-8747 (toll-free)

(301) 654-3327

Fax: (301) 907-8906

E-mail: ndic@info.niddk.nih.gov

Web site: <http://www.niddk.nih.gov>

NDIC, funded by NIDDK, part of NIH, provides referrals to diabetes specialists and organizations, and searches from its database of patient and professional education materials. Call for publications on topics such as alternative therapies, controlling diabetes, complications of diabetes, and diabetes in Asian, Hispanic, and other ethnic groups. Spanish-language publications are available.

National Digestive Diseases Information Clearinghouse (NDDIC)

National Institute of Diabetes and Digestive and Kidney Diseases (NIDDK)

National Institutes of Health (NIH)

2 Information Way

Bethesda, MD 20892-3570

Phone: (800) 891-5389 (toll-free)

(301) 654-3810

Fax: (301) 907-8906

E-mail: nddic@info.niddk.nih.gov

Web site: <http://www.niddk.nih.gov>

NDDIC, funded by NIDDK, part of NIH, provides referrals to digestive diseases organizations and support groups, as well as searches from its database of patient and professional education materials. Fact sheets are available on gastroesophageal reflux disease, hemorrhoids, constipation, ulcers, and irritable bowel syndrome.

National Eye Health Education Program (NEHEP)

National Eye Institute (NEI)

National Institutes of Health (NIH)

2020 Vision Place

Bethesda, MD 20892-3655

Phone: (301) 496-5248

Fax: (301) 402-1065

E-mail: 2020@nei.nih.gov

Web site: <http://www.nei.nih.gov>

NEHEP, funded by the NEI, part of NIH, is a partnership of professional, civic, and voluntary organizations and federal agencies. NEHEP provides referrals to vision professionals and other health resources. The Program offers free materials to educate the public about how to protect eye health and prevent vision loss, and distributes information on such topics as preventing diabetic eye disease, glaucoma, and low vision.

National Family Caregivers Association (NFCA)

10400 Connecticut Avenue, #500

Kensington, MD 20895-3944

Phone: (800) 896-3650 (toll-free)

Fax: (301) 942-2302

E-mail: info@nfcacares.org

Web site: <http://www.nfcacares.org>

NFCA is a grass roots organization providing advocacy, support, and information for family members who care for chronically ill, older, or disabled relatives. There is no charge for family members to be on the mailing list and to receive the newsletter, *Take Care!* Contact NFCA for help finding resources.

National Gerontological Nursing Association (NGNA)

7794 Grow Drive
Pensacola, FL 32514
Phone: (800) 723-0560 (toll-free)
Fax: (850) 484-8762
E-mail: ngna@puetzamc.com
Web site: <http://www.ngna.org>

NGNA, an organization of nurses specializing in the care of older adults, informs the public on health issues affecting older people, supports education for nurses and other health care practitioners, and provides a forum to discuss topics such as nutrition in long-term care facilities and elder law for nurses. NGNA offers information on gerontological nursing and conducts nursing research related to older people.

**National Health Information Center (NHIC)
Office of Disease Prevention and Health Promotion (ODPHP)**

Department of Health and Human Services
PO Box 1133
Washington, DC 20013-1133
Phone: (800) 336-4797 (toll-free)
(301) 565-4167
Fax: (301) 984-4256
Faxback: (301) 468-1204
E-mail: nhicinfo@health.org
Web site: <http://www.health.gov/NHIC>

NHIC, a service of the federal government, links consumers and health professionals with resources and information. The Center provides health information, contacts for federally supported health information centers, lists of national health observances, and toll-free numbers sponsored by the federal government.

National Heart, Lung, and Blood Institute (NHLBI) Information Center

PO Box 30105
Bethesda, MD 20824-0105
Phone: (800) 575-WELL (9355) (toll-free) (recorded information)
(301) 592-8573
Fax: (301) 592-8563
E-mail: NHLBIinfo@rover.nhlbi.nih.gov
Web site: <http://www.nhlbi.nih.gov>

The Information Center, funded by NHLBI, part of NIH, provides referrals to resource organizations and information on elevated cholesterol, high blood pressure, heart disease, exercise, risk of and recovery from stroke, chronic cough, asthma, cystic fibrosis, and sleep disorders. Publications include two newsletters, *HeartMemo* and *AsthmaMemo*.

National Hispanic Council on Aging (NHCoA)

2713 Ontario Road, NW
Washington, DC 20009
Phone: (202) 265-1288
Fax: (202) 745-2522
E-mail: nhcoa@worldnet.att.net
Web site: <http://www.nhcoa.org>

NHCoA is a national organization providing advocacy, education, and information for older Hispanic people. Contact the Council for facts and resources on health, employment, housing, strengthening families, and building communities, as well as referrals to local Council chapters. Publications in English and Spanish are available.

National Hospice and Palliative Care Organization (NHPCO)

1700 Diagonal Road, Suite 300

Alexandria, VA 22314

Phone: (800) 658-8898 (toll-free) (Hospice Helpline and Locator)
(703) 837-1500

E-mail: info@nhpco.org

Web site: <http://www.nhpco.org>

NHPCO is a nonprofit, membership organization working to enhance the quality of life for individuals who are terminally ill and advocating for people in the final stage of life. Contact NHPCO for information, resources, and referrals to local hospice services. Publications, fact sheets, and Web site resources are available on topics including how to find and evaluate hospice services.

National Hospice Foundation (NHF)

1700 Diagonal Road, Suite 300

Alexandria, VA 22314

Phone: (800) 338-8619 (toll-free)
(703) 516-4928

Fax: (703) 525-5762

E-mail: info@nhpco.org

Web site: <http://www.hospiceinfo.org>

NHF, a nonprofit, charitable organization affiliated with the National Hospice and Palliative Care Organization, provides support and information about hospice care options. NHF publications include *Hospice Care: A Consumer's Guide to Selecting a Hospice Program*, *Communicating Your End-of-Life Wishes*, and *Hospice Care and the Medicare Hospice Benefit*.

National Human Genome Research Institute (NHGRI)

National Institutes of Health (NIH)

Office of Policy and Public Affairs

Building 31; Room 4B09

Bethesda, MD 20892

Phone: (301) 402-0911

Website: <http://www.nhgri.nih.gov>

NHGRI, part of NIH, coordinates the Human Genome Project, an international research effort to characterize the genomes of human and selected model organisms through complete mapping and sequencing of their DNA.

National Indian Council on Aging (NICOA)

10501 Montgomery Boulevard, NE, Suite 210

Albuquerque, NM 87111-3846

Phone: (505) 292-2001

Fax: (505) 292-1922

E-mail: dave@nicoa.org

Web site: <http://www.nicoa.org>

NICOA provides services, advocacy, and information on aging issues for older American Indian and Alaska Native people. Contact NICOA for information about its resources and support groups serving the national Indian community, and NICOA's clearinghouse for issues affecting older Indian people. Publications are available, including the newsletter *Elder Voices*.

National Information and Referral Support Center (NIRSC)

1225 I Street, NW, Suite 725

Washington, DC 20005-3914

Phone: (202) 898-2578

Fax: (202) 898-2583

E-mail: staff@nasua.org

Web site: <http://www.nasua.org>

NIRSC provides technical assistance, consultation, and training to state and area Agencies on Aging and to local information and referral providers funded under the Older Americans Act. Contact the Center for referrals, resources, and information on how to locate services for older people. A list of Center publications is available.

National Institute of Allergy and Infectious Diseases (NIAID)

National Institutes of Health (NIH)

Bethesda, MD 20892-2520

Phone: (301) 496-5717

Fax: (301) 402-0120

E-mail: niaidoc@nih.gov

Web site: <http://www.niaid.nih.gov>

NIAID, part of NIH, conducts and supports research on the prevention, diagnosis, and treatment of HIV/AIDS and other infectious and allergic diseases. Contact NIAID for information on allergies, as well as viral and bacterial illnesses. The Institute provides referrals to specialists, support groups, and other resources; publications and fact sheets are available, some in Spanish.

National Institute of Child Health and Human Development (NICHD) Information Clearinghouse

PO Box 3006

Rockville, MD 20847

Phone: (800) 370-2943

Fax: (301) 984-1473

E-mail: NICHDClearinghouse@mail.nih.gov

Web site: <http://www.nichd.nih.gov>

The Clearinghouse, funded by NICHD, part of NIH, is a resource for publications and health issues related to NICHD research. The Institute conducts and supports research on neurobiologic, developmental, and behavioral processes that determine and maintain the health of children, adults, families, and populations. Spanish language resources are available.

National Institute of Dental and Craniofacial Research (NIDCR)

National Institutes of Health (NIH)

Bethesda, MD 20892-2290

Phone: (301) 496-4261

(301) 402-7364 (National Oral Health Information Clearinghouse—NOHIC)

TTY: (301) 656-7581

Fax: (301) 469-9988

E-mail: nidcrinfo@mail.nih.gov

nohic@nidcr.nih.gov

Web site: <http://www.nidcr.nih.gov/>

<http://www.nohic.nidcr.nih.gov>

NIDCR, part of NIH, conducts and supports research on the causes, treatment, and prevention of diseases of the teeth, gums, and facial bones. Contact NOHIC for facts about oral health in people with disabling conditions and referrals to additional resources. Contact NIDCR for information on available publications, audiovisual materials, and fact sheets.

National Institute of Environmental Health Sciences (NIEHS)

National Institutes of Health (NIH)

PO Box 12233

Research Triangle Park, NC 27709

Phone: (919) 541-3345

Web site: <http://www.niehs.nih.gov/home.htm>

NIEHS, part of NIH, conducts and supports research on potential environmental contributors to human illnesses and dysfunction, including asthma, Alzheimer's, bronchitis, cancer, lead poisoning, Parkinson's, and other chronic diseases. NIEHS also studies variable human susceptibilities to these environmental factors. The National Toxicology Program, headquartered at NIEHS, tests natural and man-made chemicals for safety.

National Institute of General Medical Sciences (NIGMS)

National Institutes of Health (NIH)

Office of Communications and Public Liaison

Bethesda, MD 20892-6200

Phone: (301) 496-7301

Fax: (301) 402-0224

E-mail: pub_info@nigms.nih.gov

Web site: <http://www.nigms.nih.gov>

NIGMS, part of NIH, conducts and supports research in medical fields such as genetics, cellular and molecular biology, and pharmacology. Publications include *Medicines for You* (also available in Spanish), and *Inside the Cell*.

National Institute of Mental Health (NIMH)

National Institutes of Health (NIH)

Bethesda, MD 20892-9663

Phone: (800) 421-4211 (toll-free)

(301) 443-4513

TTY: (301) 443-8431

Fax: (301) 443-4279

E-mail: nimhinfo@nih.gov

Web site: <http://www.nimh.nih.gov>

NIMH, part of NIH, conducts and supports mental health research, including mental disorders of aging. Contact NIMH for information on mental health and aging, Alzheimer's disease, anxiety disorders, depression, and suicide.

National Institute of Neurological Disorders and Stroke (NINDS)

National Institutes of Health (NIH)

Office of Communications and Public Liaison

Bethesda, MD 20892-2540

Phone: (800) 352-9424 (toll-free) (information service)

(301) 496-5751

Fax: (301) 402-2186

Web site: <http://www.ninds.nih.gov>

NINDS, part of NIH, conducts and supports research on stroke and neurological disorders. NINDS provides information on its research targets, including stroke, head and spinal injuries, tumors of the central nervous system, epilepsy, multiple sclerosis, Huntington's disease, Parkinson's disease, and Alzheimer's disease. A directory of voluntary health agencies is available.

National Institute of Nursing Research (NINR)

Office of Science Policy and Public Liaison

National Institutes of Health (NIH)

31 Center Drive

Building 31, Room 5B10

Bethesda, MD 20892-2178

Phone: (301) 496-0207

Fax: (301) 480-8845

Web site: <http://www.nih.gov/ninr>

NINR, part of NIH, conducts and supports basic and clinical research to establish a scientific basis for the care of individuals across the life span. Studies addressed by nurse researchers include the management of chronic diseases, health disparities, improving palliative end-of-life care, and telehealth technology.

National Institute on Aging (NIA)

National Institutes of Health (NIH)

Office of Communications and Public Liaison

Bethesda, MD 20892-2292

Phone: (800) 222-2225 (toll-free) (NIA Information Center—NIAIC)

(800) 438-4380 (toll-free) (Alzheimer's Disease Education and Referral Center-ADEAR)

(301) 496-1752

TTY: (800) 222-4225 (toll-free) (NIAIC)

Fax: (301) 589-3014 (NIAIC)

(301) 495-3334 (ADEAR)

E-mail: niainfo@jbs1.com (NIAIC)

adear@alzheimers.org (ADEAR)

Web site: <http://www.nih.gov/nia>

<http://www.alzheimers.org>

NIA, part of NIH, conducts and supports biomedical, social, and behavioral research on aging processes, disease, and the special problems and needs of older people. NIA develops and disseminates publications on topics such as the biology of aging, exercise, doctor/patient communication, and menopause. The Institute produces the Age Pages—a series of fact sheets for consumers on a wide range of subjects including nutrition, medications, forgetfulness, sleep, driving, and long-term care. Information, publications, referrals, resource lists, and database searches on Alzheimer's disease are available through the Institute-funded ADEAR Center.

National Institute on Alcohol Abuse and Alcoholism (NIAAA)

National Institutes of Health (NIH)

Bethesda, MD 20892-7003

Phone: (301) 443-3860

Fax: (301) 443-6077

E-mail: niaaaweb-r@exchange.nih.gov

Web site: <http://www.niaaa.nih.gov>

NIAAA, part of NIH, conducts and supports research on alcoholism and alcohol abuse. Contact the NIAAA for information on genetic and behavioral aspects of alcoholism; physiologic effects of alcohol abuse; and diagnosis, treatment, and prevention of alcohol-related problems.

National Institute on Deafness and Other Communication Disorders (NIDCD)

National Institutes of Health (NIH)

Office of Communication and Public Liaison

Bethesda, MD 20892-2320

Phone: (800) 241-1044 (toll-free) (NIDCD Information Clearinghouse)
(301) 496-7243

TTY: (800) 241-1055 (toll-free) (NIDCD Information Clearinghouse)
(301) 402-0252

Fax: (301) 402-0018

E-mail: nidcd@nidcd.nih.gov

Web site: <http://www.nidcd.nih.gov>

NIDCD, part of NIH, conducts and supports research on normal mechanisms as well as diseases and disorders of hearing, balance, smell, taste, voice, speech, and language. NIDCD develops and disseminates health information to the public based on scientific discovery.

National Institute on Drug Abuse (NIDA)

National Institutes of Health (NIH)

Public Information and Liaison Branch

Bethesda, MD 20892-9561

Phone: (800) 729-6686 (toll-free) (National Clearinghouse for Alcohol and Drug Information—NCADI)

(301) 443-1124

TTY: (800) 487-4889 (toll-free)

Fax: (888) 644-6432 (toll-free) (NIDA Infobox)

(888) 889-6432 (toll-free) (TTY NIDA Infobox)

(301) 443-7397

E-mail: info@nida.nih.gov

Web site: <http://www.nida.nih.gov>

NIDA, part of NIH, conducts and supports research on the physiology of specific drug addictions, effects of abused substances, and current and potential treatments. Contact NIDA for scientific information, and patient and public education materials on drug abuse, its causes, consequences, prevention, and treatment. Spanish language resources are available.

National Interfaith Coalition on Aging (NICA)

National Council on Aging (NCOA)

409 3rd Street, SW, Suite 200

Washington, DC 20024

Phone: (800) 424-9046 (toll-free)

(202) 479-1200

Fax: (202) 479-0735

Web site: <http://www.ncoa.org>

The Coalition, a constituent unit of NCOA, consists of individuals and organizations of various faiths concerned with issues of religion, spirituality, and aging. NICA provides networking opportunities and educational programs.

National Kidney and Urological Diseases Information Clearinghouse (NKUDIC)

National Institute of Diabetes and Digestive and Kidney Diseases (NIDDK)

3 Information Way

Bethesda, MD 20892-3580

Phone: (800) 891-5390 (toll-free)

(301) 654-4415

Fax: (301) 907-8906

E-mail: nkudic@info.niddk.nih.gov

Web site: <http://www.niddk.nih.gov>

NKUDIC, funded by NIDDK, provides referrals to specialists, resource organizations, and support groups. Publications and information on subjects such as kidney stones, prostate gland problems, urinary incontinence, and urinary tract infections are available.

National Kidney Foundation (NKF)

30 East 33rd Street

New York, NY 10016

Phone: (800) 622-9010 (toll-free)

(212) 889-2210

Fax: (212) 779-0068

Web site: <http://www.kidney.org>

NKF is a nonprofit organization providing information on the diagnosis, treatment, and prevention of kidney and urinary tract diseases. The Foundation supports research and organ donation programs. Contact the NKF for a list of local chapters that provide services, including blood and drug banks, screening programs, transportation assistance, publications, and referrals to specialists.

National Legal Support for Elderly People with Mental Disabilities Project

Judge David L. Bazelon Center for Mental Health Law

1101 15th Street, NW, Suite 1212

Washington, DC 20005-5002

Phone: (202) 467-5730

TTY: (202) 467-4232

Fax: (202) 223-0409

E-mail: hn1660@handsnet.org

Web site: <http://www.bazelon.org>

The Project focuses on legal issues of older people, training legal aid lawyers, organizing workshops, and providing information on legal issues facing older people with mental disabilities. Contact the Project for publications on disability rights for older people.

National Library of Medicine (NLM)

National Institutes of Health (NIH)

Bethesda, MD 20894

Phone: (888) FIND-NLM (346-3656) (toll-free)
(301) 496-6308

Fax: (301) 496-4450

E-mail: custserv@nlm.nih.gov

Web site: <http://www.nlm.nih.gov> (MEDLINE) or
<http://www.nlm.nih.gov/medlineplus> (MEDLINEplus) or
<http://www.clinicaltrials.gov> (Clinical Trials database)

NLM, part of NIH, is the world's largest medical library. The collection can be consulted in the reading room or requested on interlibrary loan. NLM offers nationwide access to information through a National Network of Libraries of Medicine. The database, MEDLINE, is available via the Web. MEDLINEplus links the public to many sources of consumer health information.

National Library Service for the Blind and Physically Handicapped (NLSBPH)

Library of Congress

Reference Section

1291 Taylor Street, NW

Washington, DC 20542

Phone: (800) 424-8567 (toll-free)
(202) 707-5100

Fax: (202) 707-0712

E-mail: nls@loc.gov

Web site: <http://www.lcweb.loc.gov/nls/>

NLSBPH, funded by the Library of Congress, is a network of regional and local libraries that provide free library services to blind and physically disabled people. Contact NLSBPH about programs such as postage-free delivery and return-mailing of audio-books and books and magazines in Braille. Specially designed Talking Books and cassette players also are lent to the public free. NLSBPH provides information on blindness and physical disabilities.

National Long-Term Care Ombudsman Resource Center (NLTCORC)

National Citizens' Coalition for Nursing Home Reform (NCCNHR)

1424 16th Street, NW, Suite 202

Washington, DC 20036

Phone: (202) 332-2275

Fax: (202) 332-2949

E-mail: ombudcenter@nccnhr.org

NLTCORC is operated by the NCCNHR in collaboration with the National Association of State Units on Aging. The Center supports groups under federal mandate to identify and resolve residents' problems at long-term care facilities. Contact the Center for information and publications on nursing home reform and adult care.

National Long-Term Care Resource Center (NLTCRC)

Division of Health Services, Research and Policy
University of Minnesota School of Public Health
Mayo Mailcode 197, Room D527
420 Delaware Street, SE
Minneapolis, MN 55455
Phone: (612) 624-5171
Fax: (612) 624-5434
Web site: <http://www.hsr.umn.edu>

The Center assists state and area Agencies on Aging and other community-based service agencies to monitor, develop, and refine community long-term care systems through legal reform. NLTCRC provides information on long-term health care, rehabilitation and acute care reform, ethics, and quality of life issues in nursing homes. A list of publications is available.

National Medical Association (NMA)

1012 10th Street, NW
Washington, DC 2001
Phone: (888) 662-7497 (toll-free) (Automated Physician Referral)
(202) 347-1895
Fax: (202) 842-3293
E-mail: rwilliams@nmanet.org
Web site: <http://www.nmanet.org>

NMA promotes the interests of doctors and patients of African descent. NMA offers a physician referral service and the brochure *Looking for Dr. Right: Guide to Choosing a Physician Using 1-888-NMAPHYSicians*.

National Mental Health Association (NMHA)

1021 Prince Street
Alexandria, VA 22314-2971
Phone: (800) 969-NMHA (6642) (toll-free) (National Mental Health Information Center)
(703) 684-7722
Fax: (703) 684-5968
E-mail: infoctr@nmha.org
Web site: <http://www.nmha.org>

The NMHA Information Center provides referrals to mental health specialists, as well as publications such as *Coping with Growing Older*, and *Answers to Your Questions About Clinical Depression*.

National Multiple Sclerosis Society (NMSS)

733 3rd Avenue, 6th Floor
New York, NY 10017-3288
Phone: (800) FIGHT-MS (344-4867) (toll-free)
(212) 986-3240
Fax: (212) 986-7981
E-mail: nat@nmss.org
Web site: <http://www.nmss.org>

The Society is a nonprofit organization providing support and information on the diagnosis and treatment of multiple sclerosis (MS). Contact NMSS for referrals to specialists and local chapter offices. A list of free publications and films on MS is available from local chapters.

National Organization for Rare Disorders (NORD)

PO Box 8923
New Fairfield, CT 06812-8923
Phone: (800) 999-6673 (toll-free)
(203) 746-6518
TTY: (203) 746-6927
Fax: (203) 746-6481
E-mail: orphan@rarediseases.org
Web site: <http://www.rarediseases.org>

NORD is a federation of voluntary health organizations and individuals, dedicated to helping people with rare diseases and assisting the organizations that serve them. NORD is committed to the identification, treatment, and cure of rare disorders through education, advocacy, research, and service.

National Organization for Victim Assistance (NOVA)

1757 Park Road, NW
Washington, DC 20010
Phone: (202) 232-6682 (includes crisis hotline service)
Fax: (202) 462-2255
E-mail: nova@try-nova.org
Web site: <http://www.try-nova.org>

NOVA is a nonprofit organization dedicated to improving services to survivors of violent crimes or disasters. NOVA offers a toll-free, 24-hour crisis counseling hotline that refers victims to support services throughout the country. NOVA provides a list of publications on subjects, including older crime victims, victim assistance, and victim rights.

National Osteoporosis Foundation (NOF)

1232 22nd Street, NW
Washington, DC 20037-1292
Phone: (202) 223-2226
Fax: (202) 223-2237
Web site: <http://www.nof.org>

NOF is a nonprofit, voluntary health organization dedicated to promoting lifelong bone health to reduce the widespread prevalence of osteoporosis and related fractures. NOF works to find a cure for osteoporosis through research, education, and advocacy. The Foundation provides general information on osteoporosis; its quarterly newsletter and booklets are available through membership.

National Policy and Resource Center on Nutrition and Aging

Department of Dietetics and Nutrition
Florida International University (FIU)
University Park, OE200
Miami, FL 33199
Phone: (305) 348-1517
Fax: (305) 348-1518
E-mail: nutreldr@fiu.edu
Web site: <http://www.fiu.edu/~nutreldr>

The FIU Center, funded primarily by the Administration on Aging, works to reduce malnutrition and promotes good nutritional practices among older adults nationwide. The Center provides information dissemination, training and technical assistance, and policy analysis.

National Policy and Resource Center on Women and Aging (NPRCWA)

Heller Graduate School
Brandeis University, Mail Stop 035
PO Box 9110
Waltham, MA 02254-9110
Phone: (800) 929-1995 (toll-free)
(781) 736-3866
Fax: (781) 736-3865
E-mail: natwomctr@binah.cc.brandeis.edu
Web site: <http://www.brandeis.edu/heller/national/>

NPRCWA focuses on older women's issues and provides policy analysis, research, and assistance to the network of Administration on Aging-funded state and area Agencies on Aging. The Center provides information and publications on women's health, caregiving, income security, and housing as well as prevention of crime and violence toward older women.

**National Prevention Information Network (NPIN)
Centers for Disease Control and Prevention (CDC)**

Public Health Service
PO Box 6003
Rockville, MD 20849-6003
Phone: (800) 458-5231 (toll-free)
(301) 562-1098
TTY: (800) 243-7012 (toll-free)
Fax: (888) 282-7681 (toll-free)
(301) 562-1050
E-mail: info@cdcnpin.org
Web site: <http://www.cdcnpin.org>

NPIN, sponsored by the CDC, is a national reference, referral, and distribution service for information on HIV/AIDS, other sexually transmitted diseases, and tuberculosis. NPIN's services are designed to facilitate information sharing about prevention, treatment, and support services. NPIN does not provide medical advice.

National Psoriasis Foundation (NPF)

6600 SW 92nd Avenue, Suite 300
Portland, OR 97223-7195
Phone: (800) 723-9166 (toll-free)
(503) 244-7404
Fax: (503) 245-0626
E-mail: getinfo@npfusa.org
Web site: <http://www.psoriasis.org>

NPF is a nonprofit organization providing free information on psoriasis and psoriatic arthritis research and treatment. NPF provides directories of specialists and products, opportunities to volunteer for research projects, links to support groups, and educational newsletters and booklets.

National Rehabilitation Information Center (NARIC)

1010 Wayne Avenue, Suite 800
Silver Spring, MD 20910-5633
Phone: (800) 346-2742 (toll-free)
(301) 562-2400
Fax: (301) 562-2401
E-mail: naricinfo@kra.com
Web site: <http://www.naric.com>

NARIC, funded by the Department of Education, provides information on rehabilitation of people with physical or mental disabilities. Contact NARIC for database searches on all types of physical and mental disabilities, as well as referrals to local and national facilities and organizations. All of NARIC's database information is available online, free.

National Resource and Information Center (NRIC)

Women's Bureau (WB)

Department of Labor
200 Constitution Avenue, NW, Room S-3111
Washington, DC 20210
Phone: (800) 827-5335 (toll-free)
(800) 347-3741 (toll-free)
TTY: (800) 326-2577 (toll-free)

NRIC, funded by the WB, provides information on issues of concern to working women, their families, and employers. Contact NRIC for facts on programs such as the Fair Pay Clearinghouse, which provides updates on efforts to identify and eliminate sexism, ageism, racism, and other forms of workplace discrimination. Single copies of publications, including *Work and Elder Care* and *Hiring Someone to Work in Your Home*, are available free.

National Resource Center: Diversity and Long-Term Care (NRCDLTC)

The Heller School Schneider Institute for Health Policy
Brandeis University
PO Box 9110
Waltham, MA 02454-9110
Phone: (800) 456-9966 (toll-free)
(781) 736-3930
Fax: (781) 736-3965
Web site: <http://www.sihp.brandeis.edu>

NRCDLTC, a partnership between Brandeis University and San Diego State University, provides information on methods, resources, systems, and services for caring for older people. The Center provides referrals to health policy resources and information on issues of diversity in aging, including disabilities, race, ethnicity, gender, generations, and chronic diseases. A list of publications is available on request.

National Resource Center on Native American Aging (NRCNAA)

PO Box 9037
Grand Forks, ND 58202-9037
Phone: (800) 896-7628 (toll-free)
(701) 777-3437
Fax: (701) 777-2389
Web site: <http://www.und.edu/dept/nrcnaa>

The Resource Center, funded by the Administration on Aging, provides support, advocacy, and information for older Native Americans, including American Indians, Alaska Natives, and Native Hawaiians. Contact the Center for legal information and references, geriatric leadership training, cultural awareness, and a variety of publications.

National Resource Center on Supportive Housing & Home Modifications

USC Andrus Gerontology Center
3715 McClintock Avenue
Los Angeles, CA 90089-0191
Phone: (213) 740-1364
Fax: (213) 740-7069
Web site: <http://www.homemods.org>

The Center is funded in association with the Archstone Foundation and the California Endowment. Contact the Center for information on government-assisted housing, assisted living policies, home modifications for older people, training and education courses, and technical assistance. Publications and fact sheets are available.

National Rural Health Association (NRHA)

One West Armour Boulevard, Suite 203
Kansas City, MO 64111
Phone: (816) 756-3140
Fax: (816) 756-3144
Web site: <http://www.nrharural.org>

NRHA is a nonprofit, professional organization targeting health care problems unique to rural areas and serving as a liaison between rural health care providers and older people. Contact NRHA for information on health care delivery to rural providers and for its quarterly *Journal of Rural Health*.

National Self-Help Clearinghouse (NSHC)

365 Fifth Avenue, Suite 3300
New York, NY 10016-4309
Phone: (212) 817-1822
Fax: (212) 817-2990
E-mail: info@selfhelpweb.org
Web site: <http://www.selfhelpweb.org>

NSHC collects and distributes information about support and self-help groups nationwide. Contact NSHC for publications or referrals to self-help groups, helping networks, and support systems.

National Senior Citizens Education and Research Center (NSCERC)

8403 Colesville Road, Suite 1200
Silver Spring, MD 20910
Phone: (301) 578-8900
Fax: (301) 578-8947
Web site: <http://www.nscerc.org>

NSCERC is a nonprofit organization providing employment opportunities, conducting research programs and workshops, and publishing its research findings.

National Senior Citizens Law Center (NSCLC)

1101 14th Street, NW, Suite 400

Washington, DC 20005

Phone: (202) 289-6976

Fax: (202) 289-7224

E-mail: nsclc@nsclc.org

Web site: <http://www.nsclc.org>

NSCLC offers assistance to Legal Aid Offices and private lawyers working on behalf of low-income older and disabled people. The Center does not accept individual clients but acts as a clearinghouse of information on legal problems such as age discrimination, Social Security, pension plans, Medicaid, Medicare, nursing homes, and protective services.

National Senior Games Association (NSGA)

3032 Old Forge Drive

Baton Rouge, LA 70808

Phone: (225) 925-5678

Fax: (225) 216-7552

Web site: <http://www.nsga.com>

NSGA is a nonprofit organization promoting healthy lifestyles for older people through education, fitness, and sports. Its Web site announces Association events and activities and offers videotapes of group activities.

National Sleep Foundation (NSF)

1522 K Street, NW, Suite 500

Washington, DC 20005

Phone: (202) 347-3471

Fax: (202) 347-3472

E-mail: nsf@sleepfoundation.org

Web site: <http://www.sleepfoundation.org>

NSF is a nonprofit organization providing services and information about sleep disorders. Contact the Foundation for a list of accredited sleep centers and local specialists. A variety of NSF publications on sleep, sleep disorders, and related topics are available.

National STD and AIDS Hotlines

Centers for Disease Control and Prevention (CDC)

Public Health Service

1600 Clifton Road

Atlanta, GA 30333

Phone: (800) 342-AIDS (2437) (toll-free) (English)

(800) 227-8922 (toll-free) (English)

(800) 344-SIDA (7432) (toll-free) (Spanish)

TTY: (880) 243-7889 (toll-free)

E-mail: hivnet@ashastd.org

Web site: <http://www.ashastd.org>

The Hotlines offer information, referrals, and free publications about prevention, risks, and treatment of sexually transmitted diseases.

National Stroke Association (NSA)

9707 East Easter Lane
Englewood, CO 80112-3747
Phone: (800) STROKES (787-6537) (toll-free)
(303) 754-0930
Fax: (303) 649-1328
Web site: <http://www.stroke.org>

The Association provides information about stroke prevention, acute treatment, recovery, and rehabilitation to the public. NSA offers referrals to support groups, care centers, and local resources for stroke survivors, caregivers, and family members.

National Urban League

120 Wall Street, 8th Floor
New York, NY 10005
Phone: (212) 558-5300
Fax: (212) 344-5332
Web site: <http://www.nul.org>

The Urban League is a nonprofit, community service organization helping older African Americans through advocacy and service programs, which include health awareness, nutrition, housing, and intergenerational activities. Contact the League for information about its Seniors in Community Service Program, which provides training and part-time employment to low-income, older people. The Health Promotion Project helps local groups plan and carry out disease prevention activities in communities nationwide. Newsletters and bulletins are available.

National Women's Health Information Center (NWHIC)

Phone: (800) 994-WOMAN (96626) (toll-free)
TTY: (888) 220-5446 (toll-free)
E-mail: 4woman@soza.com
Web site: <http://www.4woman.gov>

NWHIC, part of the federal government, is a health and referral center for women. Spanish language resources are available.

National Women's Health Network (NWHN)

514 10th Street, NW, Suite 400
Washington, DC 20004
Phone: (202) 347-1140
Fax: (202) 347-1168
Web site: <http://www.womenshealthnetwork.org>

NWHN works to ensure that women have access to quality, affordable health care, serving as a clearinghouse of information on women's health issues. The Network also lobbies for increased governmental support for women's health care. Contact NWHN for information and publications on women's health issues.

Native Elder Health Care Resource Center (NEHCRC)

University of Colorado Health Sciences Center
Campus Box A011-13
4455 East 12 Avenue
Denver, CO 80220
Phone: (303) 315-9228
Fax: (303) 315-9579
E-mail: dawn.wright@uchsc.edu
Web site: <http://www.uchsc.edu/sm/nehcrc>

NEHCRC promotes the health of older Native people, including Alaska Natives and Native Hawaiians by increasing cultural competence among health care professionals. The Center focuses on four target areas: determining health status, improving medical standards, increasing access to care, and mobilizing community resources. Contact NEHCRC for information on its programs and publications.

**NIH Osteoporosis and Related Bone Diseases National Resource Center
(NIH-ORBD-NRC)**

1232 22nd Street, NW
Washington, DC 20037-1292
Phone: (800) 624-BONE (2663) (toll-free)
(202) 223-0344
TTY: (202) 466-4315
Fax: (202) 293-2356
E-mail: orbdnrc@nof.org
Web site: <http://www.osteoporosis.gov>

The Resource Center provides patients, health professionals, and the public with resources and information on osteoporosis, Paget's disease of the bone, osteogenesis imperfecta, and other metabolic bone diseases. The Center is supported by the National Institute of Arthritis and Musculoskeletal and Skin Diseases and six other Institutes and Offices.

North American Menopause Society (NAMS)

PO Box 94527
Cleveland, OH 44101
Phone: (440) 442-7550
Fax: (440) 442-2660
E-mail: info@menopause.org
Web site: <http://www.menopause.org>

NAMS is a nonprofit multidisciplinary organization promoting women's health during midlife and beyond through an understanding of menopause. The Society supports research and serves as a resource for women and health care professionals. Spanish language resources are available.

Office on Smoking and Health (OSH)

Centers for Disease Control and Prevention
Mail Stop K-50
4770 Buford Highway, NE
Atlanta, GA 30341-3741
Phone: (800) CDC-1311 (232-1311) (toll-free)
(770) 488-5705
Fax: (770) 488-5939
E-mail: tobaccoinfo@cdc.gov
Web site: <http://www.cdc.gov/tobacco>

OSH, part of the federal government, develops and distributes the annual *Surgeon General's Report on Smoking and Health*. Contact OSH for information on tobacco and details about the smoking and health database which is available on CD-ROM. Print publications on smoking also are available.

Older Women's League (OWL)

666 11th Street, NW, Suite 700
Washington, DC 20001
Phone: (800) TAKE-OWL (825-3695) (toll-free)
(800) 863-1539 (toll-free) (PowerLine)
(202) 783-6686
(202) 783-6689 (PowerLine)
Fax: (202) 638-2356
E-mail: owlinfo@owl-national.org
Web site: <http://www.owl-national.org>

OWL is a national organization advocating for the special concerns of older women. OWL helped develop the Campaign for Women's Health and the Women's Pension Policy Consortium. Contact OWL's 24-hour PowerLine for information about legal and political activity related to health care, access to housing, economic security, individual rights, and violence against women and older people. OWL newsletters are available.

Opticians Association of America (OAA)

7023 Little River Turnpike
Annandale, VA 22003
Phone: (703) 916-8856
Fax: (703) 916-7966
E-mail: oaa@oaa.org
Web site: <http://www.oaa.org>

OAA represents the optometric industry and provides information on eye health and industry regulation. OAA sets industry standards for prescription eyeglasses, contact lenses, and low-vision aids and can give referrals to qualified opticians. Contact the OAA for publications on optometry news and information.

Organization of Chinese Americans (OCA)

1001 Connecticut Avenue, NW, Suite 601
Washington, DC 20036
Phone: (202) 223-5500
Fax: (202) 296-0540
E-mail: oc@ocanatl.org
Web site: <http://www.ocanatl.org>

OCA advocates for the rights of Chinese Americans. Contact OCA for referrals to legal specialists and legislative information on age discrimination, education, and employment opportunities for Chinese Americans, as well as access to health care and Social Security. OCA also publishes a national directory of Asian and Pacific American organizations.

Paget Foundation for Paget's Disease of Bone and Related Disorders (PF)

120 Wall Street, Suite 1602
New York, NY 10005-4001
Phone: (212) 509-5335
Fax: (212) 509-8492
E-mail: PagetFdn@aol.com
Web site: <http://www.paget.org>

PF provides information and programs for consumers and medical professionals about Paget's disease of bone and other bone disorders including primary hyperparathyroidism, fibrous dysplasia, osteoporosis, breast cancer metastatic to bone, and prostate cancer metastatic to bone.

Parkinson's Disease Foundation (PDF)

833 West Washington Boulevard
Chicago, IL 60607
Phone: (800) 457-6676 (toll-free)
(312) 733-1893
Fax: (312) 664-2344

PDF is a nonprofit organization providing research funding, information, and supportive services to people with Parkinson's Disease. Contact the Foundation for referrals to specialists. Publications are available.

Partnership for Caring, Inc. (PFC)

America's Voices for the Dying
1620 Eye Street, NW, Suite 202
Washington, DC 20006
Phone: (800) 989-9455 (toll-free)
Fax: (202) 296-8352
Web site: <http://www.partnershipforcaring.org/>

PFC is a national, nonprofit organization providing advocacy, resources, and information on the reform and enhancement of care for the dying. Contact the Partnership for referrals to resources and support groups, legal assistance, information on end-of-life issues, and the Consumers' End-of-Life Bill of Rights. Links to member organizations, publications, and fact sheets are available.

Pension and Welfare Benefits Administration (PWBA)

See **Employee Benefits Security Administration**

Pension Rights Center (PRC)

1140 19th Street, NW, Suite 602
Washington, DC 20036
Phone: (202) 296-3776
Fax: (202) 833-2472
E-mail: pnsnrightrights@aol.com

PRC's Legal Outreach Program advocates for the pension rights of workers, retirees, and their families. Contact the PRC for referrals to pension attorneys or for publications on pension law, divorce, federal retirement plans, self-help guides on pension problems, or pension plan handbooks. Spanish language resources are also available.

President's Council on Physical Fitness and Sports (PCPFS)

Hubert H. Humphrey Building, Room 738-H
200 Independence Avenue, SW
Washington, DC 20201
Phone: (202) 690-9000
Fax: (202) 690-5211
Web site: <http://www.fitness.gov>

PCPFS is an advisory body to the President and Secretary of the Department of Health and Human Services. The Council promotes opportunities in physical activity, fitness, and sports for all Americans. Contact PCPFS for information on physical activity/fitness, nutrition, health, and Council programs. Publications on physical education and health are available on the Web site.

Prevent Blindness America (PBA)

500 East Remington Road
Schaumburg, IL 60173
Phone: (800) 331-2020 (toll-free)
(847) 843-2020
Fax: (847) 843-8458
E-mail: info@preventblindness.org
Web site: <http://www.preventblindness.org>

PBA sponsors community services and public education about eye care, safety, and the diagnosis, treatment, and prevention of eye diseases. Local chapters offer community services, including vision screenings and self-help groups for those with glaucoma. Contact PBA for information and a list of publications.

Project Aliento

National Association for Hispanic Elderly (Asociación Nacional Por Personas Mayores)
1452 West Temple Street, Suite 100
Los Angeles, CA 90026
Phone: (213) 487-1922
Fax: (213) 202-5905

Project Aliento works to make the Administration on Aging-funded network of state and area Agencies on Aging accessible to older Hispanic people and their families. Contact Project Aliento for information, publications, and videos about community care and in-home support issues, as well as links to the formal aging network. Publications are available in English and Spanish.

Pulmonary Fibrosis Foundation (PFF)

1075 Santa Fe Drive
Denver, CO 80204
Phone: (720) 932-7850
Fax: (303) 825-5078
E-mail: breathe@pulmonaryfibrosis.org
Web site: <http://www.pulmonaryfibrosis.org>

PFF is a private, nonprofit organization providing assistance, resources, and information on pulmonary fibrosis and its related illnesses. Contact PFF for information on the diagnosis and treatment of PF and idiopathic pulmonary fibrosis, as well as referrals to specialists, resources, and support groups. Publications are available.

Restless Legs Syndrome Foundation

819 Second Street, SW
Rochester, MN 55902
Phone: (507) 287-6465
Fax: (507) 287-6312
E-mail: RLSFoundation@rls.org
Web site: <http://www.rls.org/foundation>

The Foundation is a nonprofit agency that provides information about restless legs syndrome. It develops support groups and seeks to find better treatments and a definitive cure.

Robert Wood Johnson Foundation (RWJF)

Route 1 College Road
Princeton, NJ 08543
Phone: (609) 452-8701
Fax: (609) 987-8845
E-mail: mail@rwjf.org
Web site: <http://www.rwjf.org>

The RWJ Foundation is a private, philanthropic organization that supports basic health services and pursues improved services for people with chronic illnesses, prevention of substance abuse, and control of health care costs. Publications about the Foundation's programs on health care issues are available.

Self Help for Hard of Hearing People, Inc. (SHHH)

7910 Woodmont Avenue, Suite 1200
Bethesda, MD 20814
Phone: (301) 657-2248
Fax: (301) 913-9413
E-mail: national@shhh.org
Web site: <http://www.shhh.org>

SHHH provides information and services for people who are hard of hearing, including assistance on education, legal issues, and self-help. Local SHHH chapters can provide information on community references and referrals to specialists. Contact SHHH for information on coping with hearing problems, hearing aids, and educational workshops for older people with hearing loss. A list of publications and materials is available.

Senior Job Bank

PO Box 30064
Savannah, GA 31410
E-mail: info@seniorjobbank.org
Web site: <http://www.seniorjobbank.org>

Senior Job Bank is an online resource that provides free job information and resources for members. Contact the Job Bank to find listings for occasional, part-time, flexible, temporary, or full-time jobs for older people.

SeniorNet (SN)

121 Second Street, 7th Floor
San Francisco, CA 94105
Phone: (800) 747-6848 (toll-free)
(415) 495-4990
Fax: (415) 495-3999
E-mail: press@seniornet.org
Web site: <http://www.seniornet.org>

SeniorNet is a nonprofit, educational organization that provides information and services to help older people become computer literate. Locally funded SN teaching sites offer introductory computer classes on various topics, providing older people with discounts on computer hardware, software, and publications. Members can access SN from any online computer and order publications on buying and using computers.

Simon Foundation for Continence

PO Box 835
Wilmette, IL 60091
Phone: (800) 237-4666 (toll-free)
(847) 864-3913
Fax: (847) 864-9758
Web site: <http://www.simonfoundation.org>

The Simon Foundation is a nonprofit, educational organization providing information on urinary and bowel incontinence. It offers support to people with incontinence and publications on its diagnosis and treatment. A guide booklet and videotapes are available.

The Skin Cancer Foundation

245 Fifth Avenue
New York, NY 10016
Phone: (800) SKIN-490 (754-6490) (toll-free)
(212) 725-5176
Fax: (212) 725-5751
Web site: <http://www.skincancer.org>

The Skin Cancer Foundation is a nonprofit organization providing information on the detection and treatment of skin cancer. The Foundation's brochures, newsletters, posters, and a new membership program give medical information and practical guidance on skin cancer. Send a self-addressed, stamped envelope for a list of publications.

Social Security Administration (SSA)

Office of Public Inquiries
6401 Security Boulevard
Baltimore, MD 21235
Phone: (800) 772-1213 (toll-free)
Fax: (410) 965-0695
Web site: <http://www.ssa.gov>

SSA, part of the federal government, is the agency responsible for Social Security retirement programs, survivor benefits, disability insurance, and Supplemental Security Income. Contact SSA for information and assistance with Social Security benefits as well as eligibility and disability issues. A directory is available listing the SSA offices in each state.

Society for Neuroscience

11 Dupont Circle, NW, Suite 500
Washington, DC 20036
Phone: (202) 462-6688
Fax: (202) 462-1547
E-mail: info@sfn.org
Web site: <http://www.sfn.org>

The Society is an organization of scientists and physicians interested in the brain, spinal cord, and peripheral nervous system. Contact the Society for the fact sheet series called *Brain Briefings*, short newsletters explaining how basic neuroscience research leads to clinical applications.

SPRY (Setting Priorities for Retirement Years) Foundation

10 G Street, NE, Suite 600
Washington, DC 20002
Phone: (202) 216-0401
Fax: (202) 216-0779
E-mail: spryfoundation@nepssm.org
Web site: <http://www.spry.org>

SPRY is a nonprofit foundation that develops research and education programs to help older adults plan for a healthy and financially secure future. The Web site links consumers to national health resources.

Substance Abuse and Mental Health Services Administration (SAMHSA)

Department of Health and Human Services
5600 Fishers Lane
Rockville, MD 20857
Phone: (800) 729-6686 (toll-free) (National Clearinghouse for Alcohol and Drug Information [NCADI])
TTY: (800) 487-4889 (toll-free)
Fax: (301) 468-7394
E-mail: info@samhsa.gov
Web site: <http://www.samhsa.gov>

SAMHSA, part of the federal government, is responsible for improving the quality and availability of prevention, treatment, and rehabilitation services in order to reduce the illness, death, disability, and cost resulting from substance abuse and mental illness. Spanish language resources are available from NCADI.

United Seniors Health Council (USHC)

409 3rd Street, NW, Suite 200
Washington, DC 20024
Phone: (800) 637-2604 (toll-free) (orders only)
(202) 479-6973
Fax: (202) 479-6660
E-mail: info@unitedseniorshealth.org
Web site: www.unitedseniorshealth.org/

USHC is a nonprofit organization dedicated to helping older consumers, caregivers, and professionals. The Council produces publications on topics such as financial planning, managed care, and long-term care insurance. The Council pioneered a Health Insurance Counseling Program, which helps consumers understand their many insurance options. Its Eldergames program is a comprehensive series of materials designed to stimulate the imagination and memories of older people.

United Way of America

701 North Fairfax Street
Alexandria, VA 22314-2045
Phone: (800) 892-2757 (toll-free)
(703) 836-7100
Fax: (703) 683-7813
Web site: <http://www.unitedway.org>

United Way is a philanthropic organization providing support for community programs. Contact the United Way to find local chapters linking people with resources such as dental and health services for low-income people or to volunteer for service programs in the community.

Vestibular Disorders Association (VEDA)

PO Box 4467
Portland, OR 97208-4467
Phone: (800) 837-8428 (toll-free)
(503) 229-7705
Fax: (503) 229-8064
E-mail: veda@vestibular.org
Web site: <http://www.vestibular.org>

VEDA is a nonprofit organization providing information and support for people with disorders such as Meniere's disease, BPPV, and labyrinthitis. The Association provides lists of clinics and vestibular specialists and offers information on disorders of the inner ear and management and diagnosis of dizzy spells. Publications are available on recent advances, rehabilitation, and support therapy.

Visiting Nurse Associations of America (VNAA)

11 Beacon Street, Suite 910
Boston, MA 02108
Phone: (888) 866-8773 (toll-free)
(617) 523-4042
Fax: (617) 227-4843
E-mail: vnaa@vnaa.org
Web site: <http://www.vnaa.org>

VNAA is an association of nonprofit, community-based home health care providers. Visiting nurses offer quality in-home medical care including physical, speech, and occupational therapy; social services; and nutritional counseling. Local agencies operate adult day-care centers, wellness clinics, hospices, and meals-on-wheels programs. A fact sheet and caregiver's handbook are available.

Volunteers of America

1660 Duke Street
Alexandria, VA 22314
Phone: (800) 899-0089 (toll-free)
(703) 341-5000
Fax: (703) 341-7000
Web site: <http://www.VolunteersofAmerica.org>

Volunteers of America is a national, nonprofit, spiritually based organization providing local human service programs and opportunities for individual community involvement. Specific programs include housing, assisted living, meals-on-wheels, transportation, and health care services.

Well Spouse Foundation (WSF)

30 East 40th Street
New York, NY 10016
Phone: (800) 838-0879 (toll-free)
(212) 685-8815
Fax: (212) 685-8676
E-mail: wellspouse@aol.com
Web site: <http://www.wellspouse.org>

WSF is a not-for-profit association of spousal caregivers. It offers support to the wives, husbands, and partners of chronically ill or disabled people. The Foundation has lists of support groups nationwide and sponsors recreational respite opportunities.

Young Men's Christian Association (YMCA)

101 North Wacker Drive, 14th Floor
Chicago, IL 60606
Phone: (800) USA-YMCA (872-9622) (toll-free)
(312) 977-0031
Fax: (312) 977-9063
Web site: <http://www.ymca.net>

YMCA is a membership organization providing physical fitness and health programs. Local YMCAs nationwide design Active Older Adult programs to meet the needs of older members, provide volunteer opportunities for senior citizens, and offer intergenerational programs.

Young Women's Christian Association (YWCA)

350 Fifth Avenue, Suite 301
New York, NY 10118
Phone: (212) 273-7800
Fax: (212) 465-2281
Web site: <http://www.ywca.org>

YWCA is a membership organization providing health, fitness, and community services for women. Educational workshops, recreational activities, and counseling services are available. ENCORE programs for women after breast cancer surgery combine group discussion with exercise to promote recovery. Informational brochures are available.

Note: There is no single correct way to search for information on the Internet. The only meaningful measure of success is if you get the results you desire. It's a good idea to try to use multiple search services and a combination of terms to increase the likelihood of your results being complete. Popular search engines include google.com, yahoo.com, askjeeves.com, dogpile.com, and many others.

FEDERAL AGENCIES

The 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

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

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 and provide information on services, programs, and opportunities for consumers and professionals.

State	Phone Number	Fax Number	Web site
Alabama	(334) 242-5743	(334) 242-5594	http://www.ageline.net
Alaska	(907) 465-3250	(907) 465-4716	http://www.alaskaaging.org
Arizona	(602) 542-4446	(602) 542-6575	http://www.de.state.az.us
Arkansas	(501) 682-2441	(501) 682-8155	http://www.state.ar.us/dhs/aging
California	(916) 322-5290	(916) 324-1903	http://www.cda.ca.gov
Colorado	(303) 866-2800	(303) 866-2696	http://www.cdhs.state.co.us/adrs/aas/index1
Connecticut	(860) 424-5277	(860) 424-4966	http://www.ctelderlyservices.state.ct.us
Delaware	(302) 255-9390	(302) 577-4793	http://www.DSAAPD.com
District of Columbia	(202) 724-5622	(202) 724-4979	http://www.dcoa.dc.gov
Florida	(850) 414-2000	(850) 414-2004	http://elderaffairs.state.fl.us/
Georgia	(404) 657-5258	(404) 657-5285	http://www2.state.ga.us/Departments/DHR/aging.html
Hawaii	(808) 586-0100	(808) 586-0185	http://www2.hawaii.gov/eoa
Idaho	(208) 334-3833	(208) 334-3033	http://www.idahoaging.com
Illinois	(217) 785-2870, (217) 524-6911	(217) 785-4477	http://www.state.il.us/aging

State	Phone Number	Fax Number	Web site
Indiana	(317) 232-7123	(317) 232-7867	http://www.ai.org/fssa/HTML/ PROGRAMS/2bAging.html
Iowa	(515) 242-3333	(515) 242-3300	http://www.state.ia.us/elderaffairs
Kansas	(785) 296-5222	(785) 296-0256	http://www.k4s.org/kdoa
Kentucky	(502) 564-6930	(502) 564-4595	http://www.chs.ky.gov/aging/
Louisiana	(225) 342-7100	(225) 342-7133	http://www.louisiana.gov/gov-office.asp
Maine	(207) 287-9200	(207) 287-9229	http://www.state.me.us/dhs/beas
Maryland	(410) 767-1100	(410) 333-7943	http://www.mdoa.state.md.us
Massachusetts	(617) 727-7750	(617) 727-9368	http://www.mass.gov/elder or http://www.800ageinfo.com
Michigan	(517) 373-7876	(517) 373-4092	http://www.miseniors.net
Minnesota	(651) 296-2770	(651) 297-7855	http://www.mnaging.org or http://www.MinnesotaHelp.info
Mississippi	(601) 359-4925	(601) 359-4370	http://www.mdhs.state.ms.us/aas.html
Missouri	(573) 751-3082	(573) 751-8687	http://www.dss.state.mo.us/da
Montana	(406) 444-5622	(406) 444-7743	http://www.dphhs.state.mt.us/sltc
Nebraska	(402) 471-2307	(402) 471-4619	http://www.hhs.state.ne.us/ags/agsindex.htm
Nevada	(702) 486-3545	(702) 486-3572	http://www.nvaging.net/
New Hampshire	(603) 271-4680	(603) 271-4643	http://www.dhhs.state.nh.us or http://www.state.nh.us/service/link/
New Jersey	(609) 943-3345	(609) 943-3343	http://www.state.nj.us/health
New Mexico	(505) 476-4799	(505) 827-7649	http://www.nmaging.state.nm.us/
New York	(518) 474-5731	(518) 474-0608	http://aging.state.ny.us
North Carolina	(919) 733-3983	(919) 733-0443	http://www.dhhs.state.nc.us/aging/home.htm

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State	Phone Number	Fax Number	Web site
North Dakota	(701) 328-8910	(701) 328-8989	http://www.state.nd.us/human_services/services/adultsaging
Ohio	(614) 466-5500	(614) 466-5741	http://www.state.oh.us/age
Oklahoma	(405) 521-2327	(405) 521-2086	http://www.okdhs.org/aging/index.html
Oregon	(503) 945-5811	(503) 373-7823	http://www.sdsd.hr.state.or.us
Pennsylvania	(717) 783-1550	(717) 772-3382	http://www.aging.state.pa.us
Puerto Rico	(787) 721-5710	(787) 721-6510	N/A
Rhode Island	(401) 462-0500	(401) 462-0503	http://www.DEA.state.ri.us
South Carolina	(803) 898-2501	(803) 898-4515	http://www.dhhs.state.sc.us
South Dakota	(605) 773-3656	(605) 773-6834	http://www.state.sd.us/asa
Tennessee	(615) 741-2056	(615) 741-3309	http://www.state.tn.us/comaging
Texas	(512) 424-6840	(512) 424-6890	http://www.tdoa.state.tx.us/
Utah	(801) 538-3910	(801) 538-4395	http://www.hsdaas.state.ut.us/
Vermont	(802) 241-2400	(802) 241-2325	http://www.dad.state.vt.us
Virginia	(804) 662-9333	(804) 662-9354	http://www.vda.virginia.gov
Virgin Islands	(340) 774-0930	(340) 774-3466	http://www.usvi.org/human_services/index.html
Washington	(360) 725-2310	(360) 438-8633	http://www.aasa.dshs.wa.gov/
West Virginia	(304) 558-3317	(304) 558-5699	http://www.state.wv.us/senior_services/
Wisconsin	(608) 266-2536	(608) 267-3203	http://www.dhfs.state.wi.us/aging
Wyoming	(307) 777-7986	(307) 777-5340	http://wdhfs.state.wy.us/aging/

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	Web site
Alabama	(334) 281-8780	http://www.rehab.state.al.us
Alaska	(907) 465-2814	http://www.labor.state.ak.us/dvr/home.htm
American Samoa	(684) 699-1371	N/A
Arizona	(800) 352-8168	http://www.de.state.az.us/rsa/vr.asp
Arkansas	(800) 330-0632	http://www.arsinfo.org/
California	(800) 952-5544	http://www.rehab.cahwnet.gov/default.htm
Colorado	(303) 866-4150	http://www.cdhs.state.co.us/ods/dvr/ods_dvr1.html
Connecticut	(800) 842-4510	http://www.dss.state.ct.us/svcs/rehab.htm
Delaware	(800) 273-9500	http://www.delawareworks.com/dvr/welcome.shtml
District of Columbia	(202) 442-8400	http://dhs.dc.gov/dhs
Florida	(800) 451-4327	http://www.rehabworks.org/
Georgia	(404) 232-3910	http://www.vocrehabga.org
Guam	(671) 475-2000	N/A
Hawaii	(808) 586-4996	http://www.state.hi.us/dhs/
Idaho	(208) 334-3390	http://www.state.id.us/idvr/idvrhome.htm
Illinois	(800) 843-6154	http://www.dhs.state.il.us/ors/vr/
Indiana	(574) 232-4861	http://www.ai.org/fssa/servicedisabl/vr/index.html
Iowa	(515) 281-4211	http://www.dvrs.state.ia.us
Kansas	(785) 267-5301	http://www.srskansas.org/rehab/index.htm
Kentucky	(800) 372-7172	http://kydvr.state.ky.us/
Louisiana	(504) 483-4777	http://www.dss.state.la.us/departments/lrs/vocational_rehabilitation.html
Maine	(207) 624-5950	http://www.state.me.us/rehab/
Maryland	(410) 554-9361	http://www.dors.state.md.us
Massachusetts	(800) 245-6543	http://www.state.ma.us/mrc/
Michigan	(800) 605-6722	http://www.michigan.gov/mdcd/0,1607,7-122-25392-,00.html
Minnesota	(651) 296-9981	http://www.mnworkforcecenter.org/rehab/
Mississippi	(662) 234-3171	http://www.mdrs.state.ms.us/

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State	Phone Number	Web site
Missouri	(573) 751-3251	http://www.vr.dese.state.mo.us/vr/co/VRWebsite.nsf/web/VROffices?open document
Montana	(877) 296-1197	http://www.dphhs.state.mt.us/dsd/govt_programs/vrp/index.htm
Nebraska	(402) 471-3644	http://www.vocrehab.state.ne.us
Nevada	(775) 684-4070	http://detr.state.nv.us/rehab/reh_vorh.htm
New Hampshire	(603) 271-3471	http://www.ed.state.nh.us/VR/index.htm
New Jersey	(609) 292-5987	http://www.state.nj.us/labor/dvrs/vrsindex.html
New Mexico	(505) 841-5723	www.dvrgetsjobs.com/Public/SpecialPrograms/DVRServicesSpecialProgramsCAREERS.asp
New York	(800) 222-JOBS (5627)	http://www.vesid.nysed.gov/
North Carolina	(919) 733-7807	http://dvr.dhhs.state.nc.us/
North Dakota	(701) 328-8950	http://www.crisnd.com/cris/program.html?program=1046
Ohio	(614) 438-1250	http://www.state.oh.us/rsc/index2.asp
Oklahoma	(405) 951-3400	http://www.okrehab.org/
Oregon	(503) 945-5880	http://www.dhs.state.or.us/vr/
Pennsylvania	(215) 560-1900	http://www.dli.state.pa.us/landi/cwp/browse.asp?a=128&bc=0&c=27855
Puerto Rico	(787) 728-6550	N/A
Rhode Island	(401) 421-7005	http://www.ors.state.ri.us
South Carolina	(803) 896-6500	http://www.scvrd.net/
South Dakota	(605) 773-3195	http://www.state.sd.us/dhs/drs/index.htm
Tennessee	(800) 669-1851	http://www.state.tn.us/humanserv/DRS.html
Texas	(800) 628-5115	http://www.rehab.state.tx.us/index.html
Utah	(801) 538-7530	http://www.usor.utah.gov/
Vermont	(866) 879-6757	http://www.vocrehabvermont.org/
Virginia	(800) 552-5019	http://www.vadrs.org/
Washington	(800) 637-5627	http://www1.dshs.wa.gov/dvr/
West Virginia	(304) 256-6900	http://www.wvdrs.org/

State	Phone Number	Web site
Wisconsin	(608) 261-0050	http://www.dwd.state.wi.us/dvr
Wyoming	(307) 777-7389	http://wydoe.state.wy.us/doe.asp?ID=5

THE BETTER BUSINESS BUREAU

The Better Business Bureau (BBB) system in the United States extends across the nation—coast-to-coast, and in Hawaii, Alaska, and Puerto Rico.

Since the founding of the first BBB in 1912, the BBB system has proven that the majority of marketplace problems can be solved fairly through the use of voluntary self-regulation and consumer education.

The BBB's core services include:

1. Business Reliability Reports
2. Dispute Resolution
3. Truth-in-Advertising
4. Consumer and Business Education
5. Charity Review

The following list provides contact information by state for local BBBs. Also see <http://www.bbb.org> for additional information.

Alabama

The Better Business Bureau
 Web site: <http://www.birmingham-al.bbb.org>
 E-mail: info@birmingham-al.bbb.org
 Phone: (205) 558-2222
 Fax: (205) 558-2239
 PO Box 55268
 Birmingham, AL 35255-5268

BBB of West Georgia-East Alabama
 Web site: <http://www.columbus-ga.bbb.org>
 E-mail: info@columbus-ga.bbb.org
 Phone: (706) 324-0712
 Fax: (706) 324-2181
 PO Box 2587
 Columbus, GA 31902-2587

BBB of North Alabama
 Web site: <http://www.northalabama.bbb.org>
 E-mail: info@northalabama.bbb.org
 Phone: (256) 533-1640
 Fax: (256) 533-1177
 PO Box 383
 Huntsville, AL 35804

BBB of South Alabama
 Web site: <http://www.bbbsouthal.org>
 E-mail: info@mobile.bbb.org
 Phone: (251) 433-5494
 Fax: (251) 438-3191
 PO Box 2008
 Mobile, AL 36652-2008

Alaska

Better Business Bureau, Inc.
 Web site: <http://www.alaska.bbb.org>
 E-mail: info@anchorage.bbb.org
 Phone: (907) 562-0704
 Fax: (907) 562-4061
 2805 Bering Street, Suite 5
 Anchorage, AK 99503-3819

Arizona

The Better Business Bureau
 Web site: <http://www.phoenix.bbb.org>
 E-mail: info@phoenix.bbb.org
 Phone: (602) 264-1721
 Fax: (602) 263-0997
 4428 N. 12th Street
 Phoenix, AZ 85014-4585

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BBB of Tucson
Web site: <http://www.tucson.bbb.org>
E-mail: info@tucson.bbb.org
Phone: (520) 888-5353
Fax: (520) 888-6262
434 S. Williams Blvd., Suite 102
Tucson, AZ 85711

AR (Arkansas) BBB of the
Mid-South, Inc.
Web site: <http://www.midsouth.bbb.org>
E-mail: info@bbbmidsouth.org
Phone: (901) 759-1300
Fax: (901) 757-2997
3693 Tyndale Drive
Memphis, TN 38125-0036

BBB of Arkansas
Web site: <http://www.arkansas.bbb.org>
E-mail: info@bbbarkansas.org
Phone: (501) 664-7274
Fax: (501) 664-0024
12521 Kanis Road
Little Rock, AR 72211-2605

California

BBB of the San Joaquin Valley, Inc.
Web site: <http://www.cencal.bbb.org>
E-mail: info@bbbcencal.org
Phone: (559) 222-8111
Fax: (559) 228-6518
2519 W. Shaw, #106
Fresno, CA 93711

Better Business Bureau
Web site: <http://www.oakland.bbb.org>
E-mail: info@oakland.bbb.org
Phone: (510) 238-1000
Fax: (510) 238-1018
510 16th Street, Suite 550
Oakland, CA 94612-1584

BBB of Northern Nevada, Inc.
Web site: <http://www.renobbb.org>
E-mail: information@renobbb.org
Phone: (775) 322-0657
Fax: (775) 322-8163
991 Bible Way
Reno, NV 89502-2122

Sacramento Valley BBB
Web site: <http://www.northeastcalifornia.bbb.org>
E-mail: info@northeastcalifornia.bbb.org
Phone: (916) 443-6843
Fax: (916) 441-3356
400 S. Street
Sacramento, CA 95814-6997

BBB of the Southland
Web site: <http://www.labbb.org>
E-mail: info@labbb.org
Phone: (909) 825-7280
Fax: (909) 825-6246
PO Box 970
Colton, CA 92324-3052

BBB of San Diego
Web site: <http://www.sandiego.bbb.org>
E-mail: info@sandiego.bbb.org
Phone: (858) 496-2131
Fax: (858) 496-2141
5050 Murphy Canyon, Suite 110
San Diego, CA 92123

BBB of Santa Clara Valley, Ltd.
Web site: <http://www.bbbsilicon.org>
E-mail: info@bbbsilicon.org
Phone: (408) 278-7400
Fax: (408) 278-7444
2100 Forest Ave., Suite 110
San Jose, CA 95128

BBB of San Mateo County
Web site: <http://www.sanmateo.bbb.org>
E-mail: info@sanmateo.bbb.org
Phone: (650) 552-9222
Fax: (650) 652-1748
510 Broadway, Suite 200
Millbrae, CA 94030

BBB of the Tri-Counties
Web site: <http://www.santabarbara.bbb.org>
E-mail: info@santabarbara.bbb.org
Phone: (805) 963-8657
Fax: (805) 962-8557
PO Box 129
Santa Barbara, CA 93102

Better Business Bureau, Inc.
Web site: <http://www.midcalbbb.org>
E-mail: info@midcalbbb.org
Phone: (209) 948-4880
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Stockton, CA 95202-3202

Colorado

Better Business Bureau of Southern
Colorado

Web site: <http://www.bbbsc.org>
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Phone: (719) 636-1155
Fax: (719) 636-5078
25 North Wahsatch
Colorado Springs, CO 80903

BBB of the Mountain States
Web site: <http://www.fortcollins.bbb.org>
E-mail: info@rockymtn.bbb.org
Phone: (970) 484-1348
Fax: (970) 221-1239
1730 S. College Ave., #303
Fort Collins, CO 80525

BBB Four Corners
Web site: <http://www.farmington.bbb.org>
E-mail: info@farmington.bbb.org
Phone: (505) 326-6501
Fax: (505) 327-7731
308 North Locke
Farmington, NM 87401-5855

Denver Area BBB
Web site: <http://www.denver.bbb.org>
E-mail: info@denver.bbb.org
Phone: (303) 758-2100
Fax: (303) 758-8321
1020 Cherokee Street
Denver, CO 80204-4039

BBB of Southern Colorado
Web site: <http://www.pueblo.bbb.org>
E-mail: info@pueblo.bbb.org
Phone: (719) 542-6464
Fax: (719) 542-5229
119 W. 6th Street, Suite 203
Pueblo, CO 81003-3119

Connecticut

The Better Business Bureau
Web site: <http://www.connecticut.bbb.org>
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Fax: (203) 269-3124
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Wallingford, CT 06492-2420

BBB of Central New England
Web site: <http://www.worcester.bbb.org>
E-mail: info@worcester.bbb.org
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32 Franklin Street, Suite 404
Worcester, MA 01608-1900

Delaware

BBB of Delaware
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Foulkstone Plaza
Wilmington, DE 19803

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BBB of Metro Washington, DC and
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Fax: (202) 393-1198
1411 K Street, NW, 10th Floor
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Florida

BBB of Northeast Florida
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E-mail: info@bbbsnefla.org
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Fax: (904) 721-7373
4417 Beach BV., Suite 202
Jacksonville, FL 32207

BBB Serving Miami, Ft. Lauderdale, and
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Web site: <http://www.bbbsoutheastflorida.org>
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2924 N Australian Ave.
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BBB of West Florida
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PO Box 7950
Clearwater, FL 33758-7950

BBB of Northwest Florida
Web site: <http://www.nwfl.bbb.org>
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PO Box 1511
Pensacola, FL 32591-1511

BBB of Central Florida, Inc.
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Altamonte Springs, FL 32714

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Better Business Bureau
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Chattanooga, TN 37402-2614

BBB of West Georgia-East Alabama
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Fax: (706) 324-2181
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Better Business Bureau of the
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Savannah, GA 31405-5817

BBB of Central Georgia
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Macon, GA 31201-3495

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4355 Emerald Street, Suite 290
Boise, ID 83706

BBB of Eastern Idaho &
Western Wyoming
Web site: <http://www.idahofalls.bbb.org>
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Fax: (208) 227-1630
320 Memorial Dr., Suite 2
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BBB of Central Illinois
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BBB of E. Missouri & S. Illinois
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BBB of Central & Eastern Kentucky, Inc.
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748 Main Street
Baton Rouge, LA 70802

BBB of Southwest Louisiana
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BBB of Northeast Louisiana
Web site: <http://www.monroe.bbb.org>
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141 Desiard Street, Suite 808
Monroe, LA 71201-7345

BBB/Greater New Orleans Area
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1539 Jackson Ave., Suite 400
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Shreveport, LA 71166-1812

BBB of Acadiana
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Maine

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Portland, ME 04103-2648

Maryland

BBB of Greater Maryland
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1414 Key Highway, Suite 100
Baltimore, MD 21230-5189

BBB of Metro Washington, DC and
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Web site: <http://www.dc.bbb.org>
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30555 Southfield Road, Suite 200
Southfield, MI 48076-7751

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Web site: <http://www.grandrapids.bbb.org>
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BBB Serving NW Ohio & SE Michigan
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BBB of the Mid-South, Inc.
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Better Business Bureau
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BBB Four Corners
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New York

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North Carolina

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BBB of the Southern Piedmont
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BBB of Coastal Carolina
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Fax: (419) 229-2029
PO Box 269
Lima, OH 45802-0269

Oklahoma

BBB of Central Oklahoma
Web site: <http://www.oklahomacity.bbb.org>
E-mail: info@oklahomacity.bbb.org
Phone: (405) 239-6081
Fax: (405) 235-5891
17 S. Dewey
Oklahoma City, OK 73102-2400

BBB of Tulsa
Web site: <http://www.tulsabbb.org>
E-mail: info@tulsabbb.org
Phone: (918) 492-1266
Fax: (918) 492-1276
University Club Tower
1722 South Carson Ave, Suite 3200
Tulsa, OK 74119

Oregon

BBB of Southwest Idaho
Web site: <http://www.boise.bbb.org>
E-mail: info@boise.bbb.org
Phone: (208) 342-4649
Fax: (208) 342-5116
4355 Emerald Street, Suite 290
Boise, ID 83706

Better Business Bureau of Oregon and
Western Washington
Web site: <http://www.thebbb.org>
E-mail: info@thebbb.org
Phone: (206) 431-2222
Fax: (206) 431-2211
PO Box 1000
DuPont, WA 98327

Pennsylvania

BBB of Western Pennsylvania
Web site: <http://www.pittsburgh.bbb.org>
E-mail: info@pittsburgh.bbb.org
Phone: (412) 456-2700
Fax: (412) 456-2739
300 Sixth Avenue, Suite 100-UL
Pittsburgh, PA 15222-2511

BBB/Northeastern PA
Web site: <http://www.nepa.bbb.org>
E-mail: info@nepa.bbb.org
Phone: (570) 614-4222
Fax: (570) 342-1282
4099 Birney Avenue
Moosic, PA 18507

BBB of Metro Washington, DC and
Eastern Pennsylvania
Web site: <http://www.dc.bbb.org>
E-mail: info@dc.bbb.org
Phone: (202) 393-8000
Fax: (202) 393-1198
1411 K Street, NW, 10th Floor
Washington, DC 20005-3404

Puerto Rico

BBB of Puerto Rico
E-mail: info@sanjuan.bbb.org
Phone: (787) 756-5400
Fax: (787) 758-0095
PO Box 363488
San Juan, PR 00936-3488

Rhode Island

BBB of Rhode Island, Inc.
Website: <http://www.rhodeisland.bbb.org>
E-mail: info@rhodeisland.bbb.org
Phone: (401) 785-1212
Fax: (401) 785-3061
120 Lavan Street
Warwick, RI 02888-1071

(continued)

South Carolina

The Better Business Bureau
Web site: <http://www.augusta-ga.bbb.org>
E-mail: info@augusta-ga.bbb.org
Phone: (706) 722-1574
Fax: (706) 724-0969
PO Box 2085
Augusta, GA 30903-2085

BBB of the Southern Piedmont
Web site: <http://www.charlotte.bbb.org>
E-mail: info@charlotte.bbb.org
Phone: (704) 527-0012
Fax: (704) 525-7624
5200 Park Road, Suite 202
Charlotte, NC 28209-3650

Better Business Bureau of the
Southeast Atlantic
Web site: <http://www.bbbsoutheastatlantic.org>
E-mail: email@bbbsoutheastatlantic.org
Phone: (912) 354-7521
Fax: (912) 354-5068
6606 Abercorn Street, Suite 108C
Savannah, GA 31405-5817

Better Business Bureau, Inc.
Web site: <http://www.columbia.bbb.org>
E-mail: info@columbia.bbb.org
Phone: (803) 254-2525
Fax: (803) 779-3117
PO Box 8326
Columbia, SC 29202

Better Business Bureau
Web site: <http://www.greenville.bbb.org>
E-mail: info@greenville.bbb.org
Phone: (864) 242-5052
Fax: (864) 271-9802
408 North Church Street
Suite C
Greenville, SC 29601-2164

BBB of Coastal Carolina
Web site: <http://www.carolina.bbb.org>
E-mail: cseft@sc.rr.com
Phone: (843) 626-6881
Fax: (843) 626-7455
2501 N. Kings Hwy, Unit 76
Myrtle Beach, SC 29577-3054

South Dakota

Better Business Bureau
Web site: <http://www.siouxlandbbb.org>
E-mail: info@siouxlandbbb.org
Phone: (712) 252-4501
Fax: (712) 252-0285
600 Fourth Street, Suite 900
Sioux City, IA 51101-1750

Tennessee

Better Business Bureau
Web site: <http://www.chattanooga.bbb.org>
E-mail: tngabbb@bellsouth.net
Phone: (423) 266-6144
Fax: (423) 267-1924
1010 Market Street, Suite 200
Chattanooga, TN 37402-2614

BBB of Greater East Tennessee
Web site: <http://www.knoxville.bbb.org>
E-mail: info@knoxville.bbb.org
Phone: (865) 692-1600
Fax: (865) 692-1590
PO Box 31377
Knoxville, TN 37930

BBB of the Mid-South, Inc.
Web site: <http://www.midsouth.bbb.org>
E-mail: info@bbbmidsouth.org
Phone: (901) 759-1300
Fax: (901) 757-2997
3693 Tyndale Drive
Memphis, TN 38125-0036

BBB of Nashville/Middle Tennessee
Web site: <http://www.middletennessee.bbb.org>
E-mail: bbbnash@aol.com
Phone: (615) 242-4222
Fax: (615) 250-4245
PO Box 198436
Nashville, TN 37219-8436

Texas

Abilene BBB
Web site: <http://www.abilene.bbb.org>
E-mail: info@abilene.bbb.org
Phone: (325) 691-1533
Fax: (325) 691-0309
3300 S. 14th Street, Suite 307
Abilene, TX 79605-5052

BBB of Amarillo Inc.
Web site: <http://www.amarillobbb.org>
E-mail: info@amarillobbb.org
Phone: (806) 379-6222
Fax: (806) 379-8206
PO Box 1905
Amarillo, TX 79105-1905

The Better Business Bureau
Web site: <http://www.centraltx.bbb.org>
E-mail: info@austin.bbb.org
Phone: (512) 445-2911
Fax: (512) 445-2096
2101 S. Ih 35, Suite 302
Austin, TX 78741-3854

BBB of Southeast Texas
Web site: <http://www.bbbsetexas.org>
E-mail: bureau@bbbsetexas.org
Phone: (409) 835-5348
Fax: (409) 838-6858
PO Box 2988
Beaumont, TX 77704-2988

BBB of Brazos Valley
Web site: <http://www.bbbbryan.org>
E-mail: info@bbbryan.org
Phone: (979) 260-2222
Fax: (979) 846-0276
PO Box 3868
Bryan, TX 77805-3868

BBB of the Coastal Bend
Web site: <http://www.caller.com/bbb>
Phone: (361) 852-4949
Fax: (361) 852-4990
4301 Ocean Drive
Corpus Christi, TX 78412

BBB of Metropolitan Dallas
Web site: <http://www.dallas.bbb.org>
E-mail: info@dallas.bbb.org
Phone: (214) 220-2000
Fax: (214) 740-0321
1600 Pacific
Suite 2800
Dallas, TX 75201

BBB of El Paso
Web site: <http://www.bbbelpaso.com>
Phone: (915) 577-0191
Fax: (915) 577-0209
221 N. Kansas, Suite 1101
El Paso, TX 79901

BBB/Ft. Worth
Web site: <http://www.fortworth.bbb.org>
E-mail: info@fwbbb.org
Phone: (817) 332-7585
Fax: (817) 882-0566
101 Summit Ave., Suite 707
Fort Worth, TX 76102-5978

BBB of Metropolitan Houston
Web site: <http://www.bbbhou.org>
E-mail: bbbinfo@bbbhou.org
Phone: (713) 341-6167
Fax: (713) 867-4947
1333 West Loop South, Suite 1200
Houston, TX 77027

BBB of the South Plains
Web site: <http://www.bbbsouthplains.org>
E-mail: info@bbbsouthplains.org
Phone: (806) 763-0459
Fax: (806) 744-9748
3333 66th Street
Lubbock, TX 79413-5711

BBB of the Permian Basin
Web site: <http://www.permianbasinbbb.org>
E-mail: info@bbbpb.org
Phone: (432) 563-1880
Fax: (432) 561-9435
PO Box 60206
Midland, TX 79706

The Better Business Bureau
Web site: <http://www.sanantonio.bbb.org>
E-mail: info@sanantonio.bbb.org
Phone: (210) 828-9441
Fax: (210) 828-3101
1800 Northeast Loop 410, Suite 400
San Antonio, TX 78217-5296

Better Business Bureau
Web site: <http://www.waco.bbb.org>
E-mail: info@waco.bbb.org
Phone: (254) 755-7772
Fax: (254) 755-7774
2210 Washington Avenue
Waco, TX 76701-1019

(continued)

BBB of San Angelo
Web site: <http://www.sanangelo.bbb.org>
E-mail: cekert@wcc.net
Phone: (325) 949-2989
Fax: (325) 949-3514
PO Box 3366
San Angelo, TX 76902-3366

BBB of North Central Texas
Web site: <http://www.bbbnorcentx.org>
E-mail: info@bbbnorcentx.org
Phone: (940) 691-1172
Fax: (940) 691-1175
4245 Kemp Blvd., Suite 900
Wichita Falls, TX 76308-2830

BBB of Central East Texas
Web site: <http://www.tyler.bbb.org>
E-mail: info@tyler.bbb.org
Phone: (903) 581-5704
Fax: (903) 534-8644
PO Box 6652
Tyler, TX 75711-6652

The BBB of South Texas, Inc.
Web site: <http://www.weslaco.bbb.org>
E-mail: info@weslaco.bbb.org
Phone: (956) 968-3678
Fax: (956) 968-7638
PO Box 69
Weslaco, TX 78599-0069

Utah

Better Business Bureau of Utah
Web site: <http://www.utah.bbb.org>
E-mail: info@utah.bbb.org
Phone: (801) 892-6009
Fax: (801) 892-6002
5673 S. Redwood Rd., #22
Salt Lake City, UT 84123-5322

Vermont

BBB Serving Eastern Massachusetts,
Maine & Vermont
Web site: <http://www.bosbbb.org>
E-mail: info@bosbbb.org
Phone: (508) 652-4800
Fax: (508) 652-4820
235 West Central Street, Suite 1
Natick, MA 01760-3767

Virginia

BBB of Metro Washington, DC and
Eastern Pennsylvania
Web site: <http://www.dc.bbb.org>
E-mail: info@dc.bbb.org
Phone: (202) 393-8000
Fax: (202) 393-1198
1411 K Street, NW, 10th Floor
Washington, DC 20005-3404

BBB of Greater Hampton Roads
Website: <http://www.norfolk.bbb.org>
E-mail: info@hamptonroadsbbb.org
Phone: (757) 531-1300
Fax: (757) 531-1388
586 Virginian Drive
Norfolk, VA 23505

BBB of Central Virginia
Web site: <http://www.richmond.bbb.org>
E-mail: info@richmond.bbb.org
Phone: (804) 648-0016
Fax: (804) 648-3115
701 E. Franklin, Suite 712
Richmond, VA 23219-2332

BBB of Western Virginia
Web site: <http://www.vabbb.org>
E-mail: info@roanoke.bbb.org
Phone: (540) 342-3455
Fax: (540) 345-2289
31 West Campbell Avenue
Roanoke, VA 24011-1301

Washington

The Better Business Bureau serving
Eastern Washington, North Idaho
and Montana
Web site: <http://www.thelocalbbb.com>
E-mail: info@thelocalbbb.com
Phone: (509) 455-4200
Fax: (509) 838-1079
508 West Sixth Avenue, Suite 401
Spokane, WA 99204-2356

Better Business Bureau of Oregon and
Western Washington
Web site: <http://www.thebbb.org>
E-mail: info@thebbb.org
Phone: (206) 431-2222
Fax: (206) 431-2211
PO Box 1000
DuPont, WA 98327

West Virginia

BBB of Metro Washington, DC and
Eastern Pennsylvania
Web site: <http://www.dc.bbb.org>
E-mail: info@dc.bbb.org
Phone: (202) 393-8000
Fax: (202) 393-1198
1411 K Street, NW, 10th Floor
Washington, DC 20005-3404

BBB/Canton Regional
Website: <http://www.cantonbbb.org>
E-mail: info@cantonbbb.org
Phone: (800) 362-0494
Fax: (330) 456-8957
PO Box 8017
Canton, OH 44711-8017

Wisconsin

BBB of Wisconsin
Website: <http://www.wisconsin.bbb.org>
E-mail: info@wisconsin.bbb.org
Phone: (414) 847-6000
Fax: (414) 302-0355
10101 W. Greenfield Avenue, Suite 125
West Allis, WI 53214

Wyoming

BBB of the Mountain States
Web site: <http://www.fortcollins.bbb.org>
E-mail: info@rockymtn.bbb.org
Phone: (970) 484-1348
Fax: (970) 221-1239
1730 S. College Ave., #303
Fort Collins, CO 80525

BBB of Eastern Idaho & Western
Wyoming
Web site: <http://www.idahofalls.bbb.org>
E-mail: inquiries-bbb@nsicomm.net
Phone: (208) 523-9754
Fax: (208) 227-1630
320 Memorial Dr., Suite 2
Idaho Falls, ID 83402-3615

TELECOMMUNICATIONS SERVICES FOR DEAF AND SPEECH-IMPAIRED PEOPLE

You may notice that some of your elderly clients are having difficulty hearing you. Perhaps you think they no longer understand you when, in fact, they are experiencing age-related hearing loss. This section can help you help them identify resources for enhanced communication devices. Telecommunications Relay Services (TRS) enable standard voice telephone users to talk to people who have difficulty hearing or speaking on the telephone. Under Title IV of the Americans with Disabilities Act, all telephone companies must provide free relay services either directly or through state programs throughout the 50 states, the District of Columbia, Puerto Rico, and all of the U.S. territories. Businesses, government agencies, family, friends, and employers of persons with hearing and speech disabilities make and receive relay calls everyday.

How Does TRS Work?

TRS uses operators, called “communications assistants” (CAs), to facilitate telephone calls for people who have difficulty hearing or speaking, and other individuals. Federal Communications Commission (FCC) rules require telephone companies to provide TRS nationwide on a 24 hour-a-day, 7 day a week basis, at no extra cost to callers. Conversations are relayed in real-time and CAs are not permitted to disclose the content of any conversation. Relay callers are not limited in the type, length, or nature of their calls.

What Is a TTY

Also called text telephones, TTYs have a typewriter keyboard and allow persons to type their telephone conversations via two-way text. The conversation is read on a lighted display screen and/or a paper printout on the TTY.

What Types of TRS Are Available?

There are several types of TRS available. Any of these may be initiated by an individual with a hearing or speech disability, or by a conventional telephone user.

Text-to-voice TRS. This type of TRS uses a CA who speaks what a TTY user types, and types what a voice telephone user replies. The first step of this type of TRS is the TTY user's call to the TRS center. This is functionally equivalent to receiving a "dial tone." The caller then gives the number of the party that he or she wants to call to the CA. The CA in turn places an outbound voice call to the called party. The CA serves as the "link" in the conversation, converting all TTY messages from the caller into voice messages, and all voice messages from the called party into typed messages for the TTY user. The process is performed in reverse when a voice telephone user initiates the call.

Voice carry over. Voice carry over (VCO) TRS enables a person who is hard of hearing, but who wants to use his/her own voice, to speak directly to the receiving party and to receive responses in text form through the CA. No typing is required by either the calling or the called party. This service is particularly useful to senior citizens who have lost their hearing, but who can still speak.

Hearing carry over. Hearing carry over (HCO) TRS enables a person with a speech disability to type his part of the conversation on a TTY. The CA reads these words to the called party, and the caller hears responses directly from the other party.

Speech-to-speech relay. With this option, a person with a speech disability uses a CA specially trained in understanding a variety of speech disorders. The CA repeats what the caller says in a manner that makes the caller's words clear and understandable. No special telephone is needed for this option.

Video relay services. This type of TRS enables individuals who use sign language to make relay calls through CAs who can interpret their calls. The caller signs to the CA with the use of video equipment and the CA voices what is signed to the called party and signs back to the caller. This type of relay service is not required by the FCC, but is offered on a voluntary basis by certain TRS programs. This option is helpful for people who use American Sign Language (ASL), and for people who cannot type on a TTY easily, such as children who are ASL users.

Spanish relay services. Telephone companies must provide interstate (between states) relay services in Spanish. While Spanish language relay is not required for calls within (intrastate) states, many states with large Spanish-speaking populations already offer this service on a voluntary basis.

7-1-1 Access to TRS

Just as you can call 4-1-1 for information, you can dial 7-1-1 to connect to relay service anywhere in the United States. 7-1-1 will make it easier for travelers to use relay because they will not have to remember relay numbers in every state.

Don't Hang Up!

Some people hang up on relay calls because they think the CA is a telemarketer. If you answer the phone and hear, "Hello, this is the relay service. Have you received a relay call before?" don't hang up. You are about to talk to a person who is deaf or hard-of-hearing or who has a speech disability, on your phone.

More Information on TRS and Equipment

To learn more about TRS, visit the Federal Communications Commission's (FCC) Web site at www.fcc.gov/cgb/dro/trs.html. If you have questions, need assistance on other disability issues, or if you would like to receive free information about disability issues on a regular basis via e-mail, contact the FCC's Consumer and Governmental Affairs Bureau at fccinfo@fcc.gov.

In addition, the FCC has established two special telephone numbers to help serve the public in an effective and efficient manner:

- (888) CALL FCC (voice)
- (888) TELL FCC (TTY)

Source: Federal Communications Commission, 2004; also see: http://www.fcc.gov/cgb/consumer_facts/trs.html

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

University of Alabama, Birmingham
University of North Alabama, Florence
University of South Alabama, Mobile

Alaska

University of Alaska, Anchorage

Arizona

Arizona State University, Tempe
Arizona State University–West, Phoenix
Northern Arizona University, Flagstaff
Phoenix College, Phoenix
University of Arizona, Tucson
Yavapai College, Prescott

(continued)

Arkansas

University of Arkansas, Fayetteville
University of Central Arkansas, Conway

California

American River College, Sacramento
California Council on Gerontology and Geriatrics, Aptos
California State University, Fullerton
California State University, Sacramento
Chaffey College, Rancho Cucamonga
Charles R. Drew University, Los Angeles
College of the Canyons, Santa Clarita
Los Angeles Pierce College, Woodland Hills
Rio Hondo College, Whittier
San Diego State University, San Diego
San Francisco State University, San Francisco
San Jose State University, San Jose
Stanford University, Stanford
University of California–Los Angeles
University of California–San Francisco
University of LaVerne, LaVerne
University of the Pacific, San Francisco
University of Southern California, Los Angeles
VA of Greater Los Angeles Healthcare System, Los Angeles

Colorado

Colorado State University, Ft. Collins
Metropolitan State College of Denver, Denver
University of Colorado–Colorado Springs
University of Denver, Denver
University of Northern Colorado, Greeley
University Seniors Association, Denver

Connecticut

Quinnipiac College, Hamden
Southern Connecticut State University, New Haven
St. Joseph College, West Hartford
University of Connecticut, Storrs

Florida

Barry University, Miami Shores
Florida Atlantic University, Boca Raton
Florida Gulf Coast University, Fort Meyers
Florida International University, North Miami

Florida State University, Tallahassee
New York Life Insurance AARP Operations, Tampa
University of Central Florida, Orlando
University of Florida, Gainesville
University of South Florida, Tampa

Georgia

Columbus State University, Columbus
Georgia Southern University, Statesboro
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

College of Southern Idaho, Twin Falls

Illinois

Concordia University, River Forest
Eastern Illinois University, Charleston
Illinois State University, Normal
Midwestern University, Downers Grove
National Louis University, Evanston
Northeastern Illinois University, Chicago
Northwestern University, Chicago
Rush University, Chicago
Southern Illinois University, Edwardsville/Carbondale
University of Illinois at Springfield, Springfield
Wilbur Wright College, Chicago

Indiana

Ball State University, Muncie
Bethel College, Mishawaka
Indiana University, Bloomington
Manchester College, North Manchester
Purdue University, Ft. Wayne
Purdue University, West Lafayette

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University of Evansville, Evansville
University of Indianapolis, Indianapolis
University of St. Francis, Ft. Wayne

Iowa

Des Moines University Osteopathic Medical Center, Des Moines
Iowa State University, Ames
University of Iowa, Iowa City
University of Northern Iowa, Cedar Falls

Kansas

Avilia University, Kansas City
Kansas State University, Manhattan
University of Kansas, Lawrence

Kentucky

Campbellsville University, Campbellsville
University of Kentucky, Lexington
Western Kentucky University, Bowling Green

Louisiana

University of Louisiana, Monroe
University of New Orleans, New Orleans

Maine

University of New England, Biddeford

Maryland

Maryland Consortium for Gerontology in Higher Education (ten affiliates), Anne Arundel
Community College, University of Baltimore, Community Colleges of Baltimore County, UMD–
Baltimore, Baltimore County, College Park, University College, College of Notre Dame, Salisbury
University, Towson University
Montgomery College, Rockville
University of Maryland, Baltimore
University of Maryland, College Park

Massachusetts

American International College, Springfield
Assumption College, Worcester
Boston University, Boston
Brandeis University, Waltham
Holyoke Community College, Holyoke
University of Massachusetts, Boston
University of Massachusetts, Lowell
University of Massachusetts, North Dartmouth

Michigan

Central Michigan University, Mt. Pleasant
Eastern Michigan University, Ypsilanti
Grand Rapids Community College, Grand Rapids
Michigan State University, East Lansing
Northern Michigan University, Marquette
Wayne State University, Detroit
Western Michigan University, Kalamazoo

Minnesota

Bethel College, St. Paul
College of St. Scholastica, Duluth
Luther Theological Seminary, St. Paul
Minnesota State University, Mankato
St. Cloud State University, St. Cloud
St. Mary's University of Minnesota, Minneapolis
University of Minnesota, Minneapolis
White Earth Tribal and Community College, Mahnomon

Mississippi

East Central Community College, Decatur
Mississippi Valley State University, Itta Bena
University of Mississippi, University

Missouri

Avila College, Kansas City
Central Missouri State University, Warrensburg
Madonna University, Livonia
University of Missouri and Lincoln University Consortium, Columbia
Missouri Southern State College, Joplin
Missouri Western State College, St. Joseph
Southwest Missouri State University, Springfield
St. Louis University, St. Louis
University of Missouri, Columbia, Kansas City, Rolla, St. Louis
Webster University, St. Louis

Montana

University of Montana, Missoula

Nebraska

University of Nebraska, Omaha

(continued)

Nevada

The Fielding Institute, Reno
Peru State College, Peru
University of Nevada, Las Vegas
University of Nevada, Reno

New Jersey

Felician College, Lodi
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
William Paterson College, Wayne

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
Hofstra University, Hempstead
Ithaca College, Ithaca
Keuka College, Keuka Park
Maria College, Albany
Marist College, Poughkeepsie
Molloy College, Rockville Centre
Mount Sinai Medical Center, New York City
Nazareth College, Rochester
Oswego State University, Oswego
Rockland Community College, Suffern
State University of New York, Albany, Buffalo, Cortland
Syracuse University, Syracuse
Touro College, Dix Hills
Utica College of Syracuse University, Utica
Yeshiva University, New York City

North Carolina

Appalachian State University, Boone
Bowman Gray School of Medicine, Winston-Salem
Central Piedmont Community College, Charlotte
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

Ohio

Bowling Green State University, Bowling Green
Case Western Reserve University, Cleveland
Cleveland State University, Cleveland
College of Mount St. Joseph, Cincinnati
Cuyahoga Community College, Cleveland
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
Sinclair Community College, Dayton
University of Akron
University of Findlay, Findlay
Wright State University, Dayton
Youngstown State University, Youngstown

Oklahoma

Langston University, Langston
Oklahoma State University, Stillwater
Southeastern 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 State University, Corvallis

Pennsylvania

California University of Pennsylvania–California
Cedar Crest College, Allentown
Chatham College, Pittsburgh

(continued)

East Stroudsburg University, East Stroudsburg
Immaculata College, Immaculata
Indiana University of Pennsylvania, Indiana
Kendal Corporation, West Chester
King's College, Wilkes Barre
Lancaster Institute for Health Education, Lancaster
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
Widener University, Chester

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
North Greenville College, Tigerville
University of South Carolina, Columbia
Winthrop University, Rock Hill

South Dakota

Augustana College, Sioux Falls
South Dakota State University, Brookings

Tennessee

Austin Peay State University, Clarkville
Middle Tennessee State University, Murfreesboro
University of Tennessee, Knoxville

Texas

Abilene Christian Academy, Abilene
Baylor University, Waco
Del Mar College, Corpus Christi
Eastfield College, Mesquite
Lee College, Baytown
Texas A&M, Kingsville

University of Houston, Houston
University of North Texas Health Science Center, Ft. Worth
University of North Texas, Denton
University of Texas–Austin, El Paso
University of Texas Health Science Center, Houston
University of Texas Medical Branch, Galveston
University of Texas Southwestern Medical Center, Dallas

Utah

Brigham Young University, Provo
University of Utah, Salt Lake City
Utah State University, Logan

Vermont

University of Vermont, Burlington

Virginia

George Mason University, Fairfax
James Madison University, Harrisonburg
Lynchburg College, Lynchburg
Radford University, Radford
Virginia Commonwealth University, Richmond
Virginia Polytechnic Institute and State University, Blacksburg

Washington, DC

AARP Foundation
Howard University
National Committee to Preserve Social Security and Medicare
University of the District of Columbia

Washington State

Gonzaga University, Spokane
Spokane Falls Community College, Spokane
University of Washington, Seattle

West Virginia

Mountain State University, Beckley
West Virginia State College, Institute
West Virginia University, Morgantown
Wheeling Jesuit University, Wheeling

(continued)

Wisconsin

Concordia University of Wisconsin, Mequon

Mount Mary College, Milwaukee

University of Wisconsin, LaCrosse; Madison; Menomonie, Milwaukee

Alberta, Canada

Education Resource Center for Continuing Care, Calgary

Mount Royal College, Calgary

Manitoba, Canada

University of Manitoba, Winnipeg

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/PrimePlus services.

AICPA Training Courses

The AICPA ElderCare/PrimePlus 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/PrimePlus Services practitioner. Five seminar courses (also available in self-study) are currently available to meet your training needs.

- *Developing and Managing an ElderCare/PrimePlus Practice* (product number 730073). 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/PrimePlus services.
- *ElderCare/PrimePlus: The Medical and Psychosocial Effects of Aging* (product number 731461). 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.
- *ElderCare/PrimePlus: The Financial Issues of Aging* (product number 731781). This course addresses the planning needs and financial concerns of aging, including planning for the costs of long-term care.
- *ElderCare/PrimePlus: 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/PrimePlus practitioner.

In addition, you can gain valuable training from the following highly recommended courses:

- *Professional Ethics: The AICPA's Comprehensive Course* (product number 732305). 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.

- *Tax, Health Care and Asset Protection Planning for Aging Clients* (product number 732077). 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/PrimePlus Marketing Toolkit

The AICPA contracted with the advertising firm of Hill, Holiday, Connors & Cosmopoulos to develop an ElderCare/PrimePlus Marketing Toolkit for practitioners offering CPA ElderCare/PrimePlus services or for those who wish to develop a practice in this area. The AICPA ElderCare/PrimePlus Services Task Force oversaw the development of this kit. The advertising kit contains two direct mail letters, four brochures, and 16 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/PrimePlus Services—2002 (product number 006634)

Serving as both an update on new developments as well as an introduction to those unfamiliar with CPA ElderCare/PrimePlus services, this Alert contains an abundant amount of information, a list of helpful Web sites and a listing of ElderCare/PrimePlus 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/PrimePlus 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 order through their Web site.

National Association of Professional Geriatric Care Managers
1604 North Country Club Road
Tucson, AZ 85716-3102
Phone: (520) 881-8008
Fax: (520) 325-7925
E-mail: info@caremanager.org
Web site: <http://www.caremanager.org/>

How to Protect Your Life Savings from Catastrophic Illness(4th ed., 1997)

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
Phone: (520) 881-4005
Fax (520) 325-7925
Web site: <http://www.naela.org/>

AICPA ELDERCARE/PRIMEPLUS SERVICES TASK FORCE MEMBERS

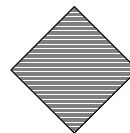
The ElderCare/PrimePlus Services Task Force welcomes your comments and questions about the emerging practice area of CPA ElderCare/PrimePlus services. The following table provides contact information.

Name	Address	Phone/Fax/E-mail
George A. Lewis Chair	Broussard Poche Lewis & Breaux 4112 West Congress Street Lafayette, LA 70506	Phone: (337) 988-4930 Fax: (337) 984-4574 E-mail: galewis@bplb.com or galbplb@aol.com
Michael Epp	Hawkings Epp Dumont Chartered Accountants Suite 101, 17107-107 Avenue Edmonton, Alberta Canada T5S 1G3	Phone: (780) 489-9606 Fax: (780) 484-9689 E-mail: mepp@hed-edm.com
Mitchell Freedman (PFP Liaison)	Mitchell Freedman Accountancy Corporation 15260 Ventura Boulevard, #940 Sherman Oaks, CA 91403	Phone: (818) 905-0321 Fax: (818) 789-0484 E-mail: mitchpfs@mfac-bizmgt.com
W. (Bill) A. M. Hyde	Millard, Rouse & Roseburgh 96 Nelson Street P.O. Box 367 Brantford, ON Canada N3T 5N3	Phone: (519) 759-3511 Fax: (519) 759-7961 E-mail: bhyde@millards.com

Name	Address	Phone/Fax/E-mail
Kelly G. Lohn	Lohn Caulder 200-837 Homer Street Vancouver, BC V6B 2W2 Canada	Phone: (604) 687-5444 Fax: (604) 688-7228 E-mail: klohn@lohncaulder.com
Jay H. Kaplan	Jay H. Kaplan, CPA 145 N. Church Street Spartanburg, SC 29306	Phone: (864) 489-4343 Fax: (864) 489-1164 E-mail: PWKaplan@aol.com
Paul Pethick	Soberman, Isenbaum & Colomby, LLP 2 St. Clair Avenue East, Suite 1100 Toronto, ON Canada M4T 2T5	Phone: (416) 964-7633 Fax: (416) 964-6454 E-mail: ppethick@soberman.com
Ted Sarenski (PFP Liaison)	DB&B Financial Services, LLC 443 North Franklin Street Syracuse, NY 13204	Phone: (315) 234-8100, ext. 117 Fax: (315) 234-8111 E-mail: tjs@dbandb.com
Michael David Schulman	Schulman Company, CPA, PC 70 West 36th Street, Suite 1402 New York, NY 10018	Phone: (212) 736-9353, ext. 201 Fax: (212) 736-9346 E-mail: michael@schulmancpa.com
Mike Seefeld	KBA Group 14241 Dallas Parkway, Suite 200 Dallas, TX 75254	Phone: (972) 702-7463 Fax: (972) 702-0673 E-mail: mseefeld@KBAGroup LLP.com
Debra Wright	Hereford, Lynch, Sellers, & Kirkham 1110 North Loop 336 W. 4th Floor Conroe, TX 77305	Phone: (936) 756-8127 Fax: (936) 756-8132 E-mail: dwright@hlsk.com
Staff Aides		
Beth Kaestner PFP Program Development Manager	American Institute of CPAs Harborside Financial Center 201 Plaza Three Jersey City, NJ 07311-3881	Phone: (201) 938-3378 Fax: (201) 521-5430 E-mail: bkaestner@aicpa.org
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Karen Duggan Principal, PrimePlus Services	The Canadian Institute of Chartered Accountants 277 Wellington Street West Toronto, Ontario M5V 3HZ Canada	Phone: (416) 204-3238 Fax: (416) 977-8585 E-mail: karen.duggan@cica.ca

(continued)

Name	Address	Phone/Fax/E-mail
Anat Kendal Director Financial Planning	American Institute of CPAs Harborside Financial Center 201 Plaza Three Jersey City, NJ 07311-3881	Phone: (201) 938-3555 E-mail: akendal@aicpa.org
Kimberly Smith Australian Liaison	Kimberly Smith & Associates P.O. Box 106 104 Auburn Road Hawthorn, Victoria, 3122 Australia	Phone: (613) 9818-8166 Fax: (613) 9818-8144 E-mail: advice@kimberly smith. com.au Domain: www.kimberlysmith.com.au



CHAPTER 12:

Sample Documents and Checklists

This chapter contains sample documents and checklists to assist you in engaging in ElderCare/PrimePlus 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 each engagement. The documents and checklists in this chapter also appear on the CD-ROM.



- **Sample Documents and Checklists** (*also see accompanying CD-ROM*)

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/PrimePlus 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.

We do more – so you can do it all

You've got a great life – and you've worked hard to make it and keep it that way. Putting in the hours – saving – investing – planning: making the tough choices, the right choices ... the best choices.

Yet some of your most important choices still lie ahead. Where will you live? How will you live? Will you be able to have the lifestyle you want? Preserve your freedom? Provide for your family?

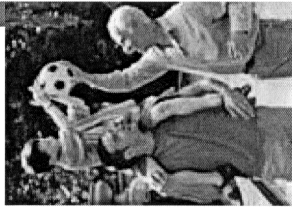
That's what our new CPA PrimePlus

Services is all about: helping you make the right choices, so you can live your life the way you like it.

CPA PrimePlus

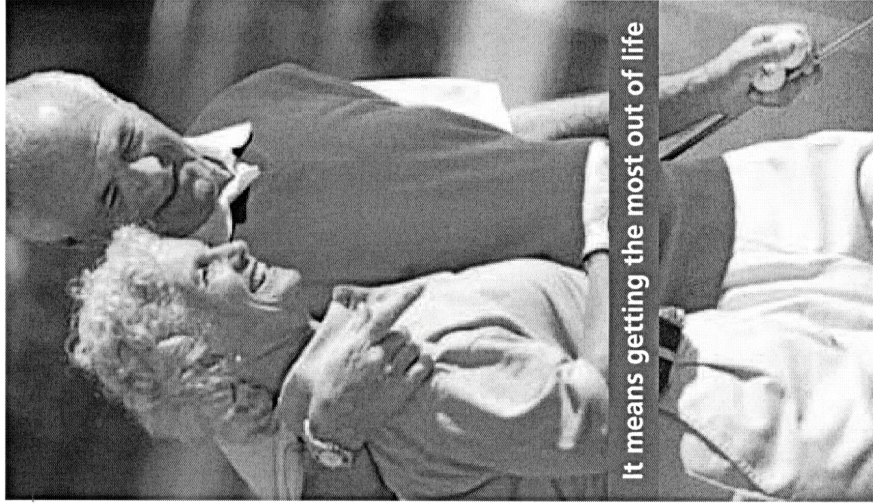
Services is a unique, customized package of services designed to help you maintain your lifestyle and financial independence.

Whether you're looking to manage your own affairs more easily and efficiently, or help someone you love make the most of their resources and choices, you'll find that CPA PrimePlus Services offers you a better way to handle the business of life.



INSERT LOGO HERE

Introducing our CPA PrimePlus ServicesSM ...



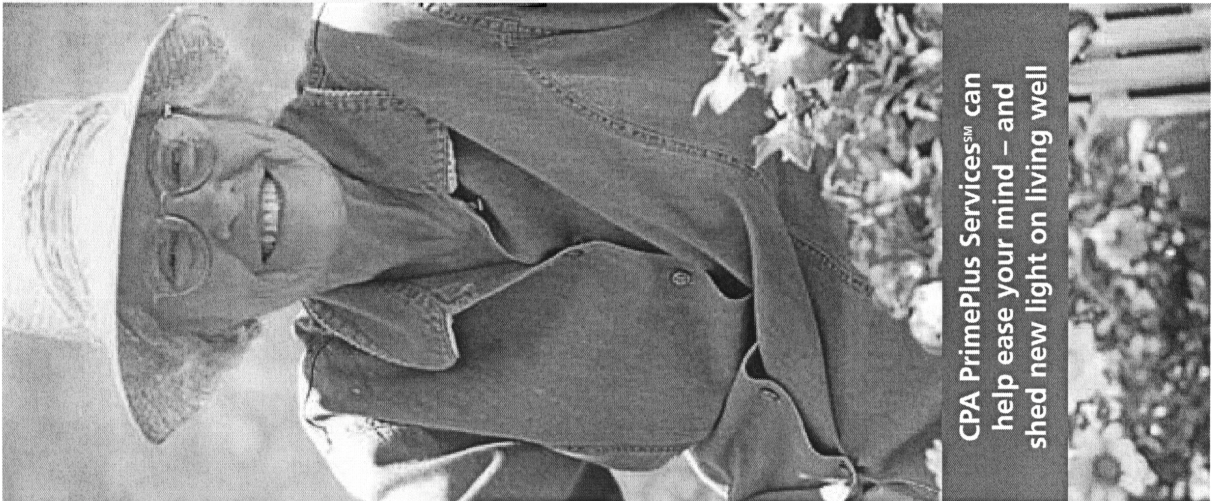
It means getting the most out of life



Resources • Strategies • Solutions

123-000-0000

Accounting Firm
1234 Any Street in the World
City, ST XXXXX



CPA PrimePlus ServicesSM can help ease your mind – and shed new light on living well!

Q Why should I use a CPA PrimePlus professional?

A Integrity, expertise, accountability, confidentiality – they're all good reasons to count on us as your trusted advisor. You can depend on us for accurate evaluations and impartial advice. When it comes to balancing your financial and lifestyle goals, CPA PrimePlus Services offers a comprehensive, tailored approach to meeting your changing needs.

Q Now that she's on her own, Mom has had a difficult time managing her accounts and assessing her long-term needs. I want to help her ... can CPA PrimePlus Services help us both?

A Definitely! CPA PrimePlus Services can be of special benefit to time-pressed families who want to help a loved one maximize and maintain their independence. CPA PrimePlus Services is especially valuable in helping families come together to make sound, caring decisions.

Q Will I be expected to pay for services I don't need?

A Absolutely not. One of the strengths of CPA PrimePlus Services is flexibility – we can tailor our services specifically to meet your individual needs.

Special services to help you make your best choices – while easing your workload and worry

As we mature, the relationship between financial needs and lifestyle choices can become increasingly complex. As your CPA PrimePlus Services professional, we can help you better see and understand “the big picture,” so you can make your best decisions in your retirement years.

Our training and expertise makes us uniquely qualified to offer objective, accurate assessments of our client's resources and how they're managed. So, we're a logical source for mature adults to turn to for expert, confidential

assistance in meeting challenges and making choices.

Wide-ranging, informed, impartial advice from someone you can trust: that's exactly what we offer with CPA PrimePlus Services.

Expert, impartial advice for the prime of your life

More time to call your own – and more peace of mind. Find out how our CPA PrimePlus Services can make a difference for you. Call us today for more details.



123-000-0000

Accounting Firm
1234 Any Street in the World
City, ST XXXXX

SAMPLE DIRECT MAIL LETTER TO ELDER PERSON

Mrs. Mary Jones
523 Circle Court
Hapsburg, MD

Dear Mrs. Jones:

I am looking forward to seeing you next week when you have an appointment for preparation of your federal and state tax returns. While you are in the office, I would like to discuss with you ways in which we can be of additional assistance to you and how we can relieve you of some of the duties that you are now handling.

Our firm offers CPA PrimePlus services to make life easier for those of our clients who want to enjoy their retirement and not have to be “tied down” with daily or weekly chores that could easily be handled by someone else. A brochure that explains PrimePlus services is enclosed. As you can see, these services range from ordinary, routine financial services to services that are not normally associated with a CPA firm.

Among the traditional services that you might be interested in are:

- Check preparation and bill paying. (You would still sign all checks.)
- Reconciliation of bank statements.
- Accounting for revenues and expenditures and accumulating the information needed for your annual tax returns.
- Banking services, including making deposits of income you receive and making sure that you have received all items due you in a timely fashion.
- Review and accounting for your brokerage accounts to make sure that the broker is following your instructions concerning investments.
- Preparation of payroll tax returns for your household help.

Among the nontraditional services we offer are:

- Assistance in planning for long-term care, if necessary.
- Advice in financing long-term care.
- Assistance in supervision of household repairs and inspection of your property to make sure it is being properly maintained.
- Assistance in selection of care providers, if required.

These are just a few of the services offered as a part of PrimePlus services. You can select as few or as many services as you need.

So before you come to your appointment next week, think about the things that “keep you awake at night” and the things that you don’t like to do or no longer feel comfortable doing. We will be happy to discuss these with you and help you make arrangements to solve these problems so you can enjoy your retirement years.

I look forward to seeing you next week.

John H. Brown, CPA

Encl.

SAMPLE DIRECT MAIL LETTER TO CHILD OF ELDER PERSON

Mr. Harold Jones
1800 Palm Boulevard
San Francisco, CA

Dear Mr. Jones:

I visited in the office with your mother last week when she came in for her tax return preparation appointment. Since you are her only child, I know you may be concerned that you are across the country from your mother and not able to assist her in various matters. Many of us today are in the same situation: our jobs and careers make it impossible to be around to check on our parents and to see if their needs are being met and if they are being protected from all of the scam artists who prey on the elderly.

Our firm is offering CPA ElderCare services to relieve some of the worries of children such as yourself and to help elderly persons live in their own homes as long as possible with dignity and protection from would-be predators. I am enclosing a brochure that describes the range of the services offered.

As you can see, these services range from financial and accounting services typically offered by CPA firms, such as check preparation, banking, and accounting, to services that are needed by some elderly persons but that are not traditionally handled by CPAs, including such things as arranging transportation and supervising care and maintenance of their homes. Each of our clients can select only those services they need or desire.

If at any time you feel that your mother needs assistance in performing various tasks, either financial or nonfinancial, discuss this service with her and give me a call. I will set up an appointment with her to discuss ways in which we can help her enjoy her retirement years. And if at any time you have concerns about your mother, please feel free to give me a call.

Sincerely,

John H. Brown, CPA

Encl.

POTENTIAL ELDERCARE/PRIMEPLUS CLIENTS WORKSHEET

Services Presently Being Provided

NAME AND ADDRESS	AGE	TAX RETURN	TAX PLANNING	PERSONAL FINANCIAL PLANNING	ESTATE PLANNING	OTHER (DESCRIBE)

CASH FLOW WORKSHEET FOR POTENTIAL OFFERING OF CPA ELDERCARE/PRIMEPLUS SERVICES

-
1. Potential clients identified in firm's client base:
 - a. Tax clients age 65 and older _____
 - b. Personal financial planning clients _____
 - c. Total number of potential clients _____
 - d. Estimated percent of clients who would purchase the services _____%
 - e. Estimated number of clients _____
 - f. Estimated average billing per client, per month _____
 - g. Estimated monthly revenue from ElderCare/PrimePlus clients _____

 2. Costs to get started:
 - a. Brochures (____ @ \$____ each) \$____
 - b. Direct mail letters (____ @ \$____ each) \$____
 - c. Literature:
 - Development and Management of an ElderCare Practice* (self-study) \$____
 - CPA PrimePlus Marketing Toolkit* \$59.00
 - CPA ElderCare/PrimePlus Services: A Practitioner's Resource Guide* \$129.00
 - _____ \$_____
 - d. Personnel costs:
 - Partner (____ hours @ \$____) \$____
 - Manager (____ hours @ \$____) \$____
 - Paraprofessional/secretarial (____ hours @ \$____) \$____ \$____
 - e. Office supplies for ____ clients @ \$____ each \$____
 - f. Total start-up costs \$_____

 3. Ongoing costs:
 - a. Personnel costs:
 - Partner (____ hours @ \$____) \$____
 - Manager (____ hours @ \$____) \$____
 - Paraprofessional/secretarial (____ hours @ \$____) \$____ \$____
 - b. Attendance for one person annually at ElderCare/PrimePlus conference \$_____
 - c. One seminar per year on elder issues \$_____
 - d. Increase in liability insurance cost to include bodily injury coverage \$_____
 - e. Other \$_____
 - f. Total ongoing costs \$_____

4. Profitability projection:

	Year 1	Year 2	Year 3
Annual billings for ElderCare/PrimePlus Services			
Start-up costs			
Ongoing costs			
Gross profit			

DETAILED INFORMATION ON POTENTIAL ELDERCARE/PRIMEPLUS CLIENT

Name _____

Location of residence _____

Mailing address _____

Telephone No. _____

Married ____ Widowed ____ Single ____ Divorced ____

1. Closest relatives/children

Name _____

Address _____

City/state _____

Telephone no. _____

Name _____

Address _____

City/state _____

Telephone no. _____

Name _____

Address _____

City/state _____

Telephone no. _____

Name _____

Address _____

City/state _____

Telephone no. _____

Name _____

Address _____

City/state _____

Telephone no. _____

Name _____

Address _____

City/state _____

Telephone no. _____

2. Why is this person considered a potential ElderCare client?

3. Caregivers presently employed by client

- In-house sitters/nurses
- Social worker/geriatric care manager
- Home health services
- Meal preparers/housekeepers
- Other (describe)

4. Services presently provided by our firm and [*date of last appointment*]:

- Tax return preparation (_____)
- Tax planning (_____)
- Personal financial planning (_____)
- Estate tax planning (_____)

5. Date and purpose of next appointment: _____

6. Partner responsible for client _____

7. Does the responsible partner agree that the client is a potential ElderCare client?

- yes no

8. Why or why not? _____

9. Services that might be provided to client:

- Banking
- Payroll preparation
- Payroll returns
- Check preparation/payment of bills
- Preparation and payment of estimated taxes
- Assistance in housing options
- Other (describe)

10. What is best way to contact client?

- Brochure
- Direct mail
- Personal visit
- Other

-
11. Person assigned to contact client _____
 12. Date or time of contact¹ _____
 13. Does information on ElderCare/PrimePlus services need to be furnished to client prior to meeting?
___ yes ___ no
 14. Information to be furnished/mailed and [date]:
___ Brochure (_____)
___ Letter (_____)
___ Other (describe) (_____)
 15. Are there any special family relationships or personal likes or dislikes of client that need to be considered? _____

-

¹ This might be the date of the next scheduled appointment with client for other services being provided by firm.

SAMPLE RESPONSE LETTER FOR CPA ELDERCARE/PRIMEPLUS SERVICES INQUIRY

To promote your ElderCare/PrimePlus 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 provide. You should promptly and properly respond to inquiries about your ElderCare/PrimePlus 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/PrimePlus 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 help 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/PrimePlus services offer the correct mix of assistance and oversight protection to help our clients' later years 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/PrimePlus 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/PrimePlus 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/PrimePlus 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/PrimePlus services. CPA ElderCare/PrimePlus 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, 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/PrimePlus 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/PrimePlus 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/PrimePlus engagement letters see the following areas of this guide:

Chapter 5, "Quality Control, Best Practices, and Risk Management"

Chapter 14, "Frequently Asked Questions"

Elderly Person Contracting With the CPA Directly²

June 6, 20XX

Mrs. Rena Flint
31 Dogwood Road
Front Royal, Virginia

Dear Mrs. Flint,

In accordance with your late husband's stated wishes, we are pleased that you have selected our firm to provide you with CPA ElderCare/PrimePlus 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 adviser, 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.

² For correspondence directly with the older adult, use 14 point font or higher.

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 Advance 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.³ 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 from \$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. Any difference between the monthly retainer amounts for the year and the annual billing will be settled at that time, either by payment of additional amounts to our firm or by a refund to you.

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:

³ 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 CPA ElderCare/PrimePlus Services to your mother, Mrs. Farragut. It is our understanding that you are the agent for your mother, acting under a durable, unlimited power of attorney, dated January 1, 20XX.

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 basis. 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 believe 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, 20XX. 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 e-mail.

- 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.⁴ 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. Suchecki, 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 no less often than annually.

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 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. Farragut's attorney by registered mail as to our intentions to withdraw from the engagement.

⁴ 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 & Associates

Sample Engagement Letter With Agency Agreement

June 6, 20XX

Mr. Paul Bellarmine

as Attorney in Fact for Mrs. Margaret Bellarmine

Dear Mr. Bellarmine:

We are pleased that you have selected our firm to provide CPA ElderCare/PrimePlus 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 adviser, 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 Christopher Pike. We will notify you when minor repairs are needed and will contract out services that Mr. Pike 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, Mrs. Lincoln, but it is our understanding that such reports to Mrs. 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 Mrs. Lincoln concerning matters discussed in this agreement. If such disagreements arise and a compromise cannot be reached between you and Mrs. 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 Henry McIntock, 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 with you or your mother. 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 an annual 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

Sample Agency Agreement for Receipts and Disbursements

PRINCIPAL: Mr. Paul Bellarmine, as attorney in fact for Mrs. Margaret Bellarmine

AGENT: Audit, Accounting & Associates and Henry McIntok, 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 McIntok, CPA (called Agent) agree as follows:

1. *Background:* Principal has retained regularly the services of Henry McIntok, CPA (McIntok), of Audit, Accounting & Associates to perform for Principal various accounting functions and services. Principal wishes to retain McIntok 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 McIntok 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 McIntok 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 30 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 monthly, 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

Henry Mclintok, CPA

AGENT

**Estimated Revenues (Boxes indicate month in which a receipt is anticipated.)
Indicate Date Received**

	Jan.	Feb.	March	April	May	June	July	Aug.	Sept.	Oct.	Nov.	Dec.
Social Security XYZ Co. Pension												
<i>Interest:</i> CD-City Bank Savings account-FNB												
<i>Dividends:</i> ABC National Clean Corp.												
<i>Rents:</i> 123 Adams Ave. B&C Building												
<i>Mineral Royalties:</i> Gas & Oil Company Abita Trust												

SAMPLE CONTRACT WITH ELDERLY PERSON FOR BANKING AND ACCOUNTING ASSISTANCE ONLY

June 6, 20XX

Mrs. Henry Smith
1221 Hidden Lake Road
Smithville, Tennessee

Dear Mrs. Smith:

In accordance with the terms of our discussions, we are pleased to provide accounting services to you. This letter summarizes the terms of our engagement and your responsibilities in connection therewith.

You will accumulate all financial information received at your home (invoices for payment, checks received, and any other financial correspondence) and place them in a file which we will supply. Weekly, Miss Tracy Manning, a member of our staff, will visit your home and bring all the information back to our office for processing and accounting, as follows:

1. Checks will be prepared on your checking account for all invoices requiring payment. It is our understanding that you will make arrangements to have automatic checking account deductions made for bills for utilities, cable television service, and telephone service.
2. A deposit slip will be prepared for any revenue receipts and carried to your bank. Copies will be made of the checks deposited and attached to your copy of the deposit ticket.
3. The prepared checks, with invoices attached to each, will be returned to you on the following visit for your approval and signature.
4. All transactions on your account will be recorded on our computer system and a listing of those transactions will be provided to you at the end of each month.
5. Upon receipt of the bank statement, we will reconcile your checking account on a monthly basis.
6. Annually, we will provide you a detail listing of all transactions in your checking account so that you may use that information for preparation of the necessary income tax returns. Although our firm will prepare your income tax returns, such preparation shall be considered a separate engagement and not a part of this agreement.

Since you have indicated that you will be traveling from time to time, it is our understanding that you have given a durable, unlimited power of attorney to your sister, Mrs. Sam Kaplan. In the event you are going to be away from home for an extended period, you will notify us and we will make arrangements with Mrs. Kaplan to retrieve your mail and deliver it to Miss Manning on a weekly basis. Any checks prepared for payment will be signed by Mrs. Kaplan in your absence.

It will be your responsibility to insure that all invoices are furnished to us; and you will have the responsibility to determine whether all revenue due to you has been received. Our responsibility will be limited to processing the information you have furnished to us, as described above.

Our fees for this service will be at our normal hourly rates and will be billed to you monthly. Either party to this agreement may cancel this engagement at any time. [*Note:* Since this agreement does not involve the safety and well-being of Mrs. Smith, the normal grace period prior to termination is not considered necessary.]

If this letter correctly expresses your understanding, please sign the enclosed copy where indicated and return it to us.

Sincerely,

Jones, Smith and Connery

Certified Public Accountants

By _____

Accepted and agreed to:

Mrs. Henry Smith

Date

SAMPLE PRIVACY NOTICE REQUIREMENTS AND DISTRIBUTION FORM

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 that clients of an ElderCare/PrimePlus practitioner 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/PrimePlus 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/PrimePlus engagements?
- Has a lawyer been consulted on our policies of disclosing confidential client information in conjunction with the performance of an ElderCare/PrimePlus engagement?
- Has the firm's underwriter been contacted to make sure that our existing policy covers ElderCare/PrimePlus services?

Client Issues

- Do we know who the client is? Have we made that clear to all parties to the engagement?⁵
- 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/her 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?

⁵ The AICPA ElderCare/PrimePlus Task Force has recommended that the client should always be considered to be the elderly person. Please see the course, *Developing and Managing an ElderCare/PrimePlus 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?
-

CLIENT FORMS

Sample Client Intake Form

This brief information form may be used by the CPA during an initial phone contact or referral related to ElderCare/PrimePlus 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

Name	Living?		Maintain contact?	
	Yes	No	Yes	No

Siblings

Name	Living?		Maintain contact?	
	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, primary caregiver, 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 Supplement _____

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 many 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 "most of the time" 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 of time 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-\$19,999
- \$20,000-\$29,999
- \$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/PrimePlus 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/PrimePlus 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/PrimePlus 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/sitter	\$ _____
Health care aide	\$ _____
Gardener	\$ _____
Transportation	\$ _____
CPA ElderCare/PrimePlus 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)
- 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)
- Individual retirement accounts (IRAs) and registered retirement savings plans (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)
- Attorney (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 and superintendent (names, addresses, telephones, 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) order	_____	_____	_____
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 the client have any comments or complaints about the care or the sitters from _____ Agency?

Did the shopping service arrive to pick up the client and her sitter for their regular shopping trips?

Did the cleaning service come as agreed upon?

Did the client have any concerns?

____ 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 on which all rents were received _____.

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 being 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”)

- 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 the client?
- If other transportation services are 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 CHECKLISTS

Nursing Home Checklist—Quick Form

Name of Nursing Home: _____ Date of Visit: _____

Yes No Comments

Basic Information

The nursing home is Medicare-certified.

The nursing home is Medicaid-certified.

The nursing home has the level of care needed (e.g. skilled, custodial), and a bed is available.

The nursing home has special services if needed in a separate unit (e.g. dementia, ventilator, or rehabilitation), and a bed is available.

The nursing home is located close enough for friends and family to visit.

Resident Appearance

Residents are clean, appropriately dressed for the season or time of day, and well groomed.

Nursing Home Living Spaces

The nursing home is free from overwhelming unpleasant odors.

The nursing home appears clean and well-kept.

The temperature in the nursing home is comfortable for residents.

The nursing home has good lighting.

Noise levels in the dining room and other common areas are comfortable.

Smoking is not allowed or may be restricted to certain areas of the nursing home.

Furnishings are sturdy, yet comfortable and attractive.

Staff

The relationship between the staff and the residents appears to be warm, polite, and respectful.

All staff wear name tags.

Staff knock on the door before entering a resident's room and refer to residents by name.

The nursing home offers a training and continuing education program for all staff.

The nursing home does background checks on all staff.

The guide on your tour knows the residents by name and is recognized by them.



Yes No Comments

There is a full-time Registered Nurse (RN) in the nursing home at all times, other than the Administrator or Director of Nursing.

The same team of nurses and Certified Nursing Assistants (CNAs) work with the same resident 4 to 5 days per week.

CNAs work with a reasonable number of residents.

CNAs are involved in care planning meetings.

There is a full-time social worker on staff.

There is a licensed doctor on staff. Is he or she there daily? Can he or she be reached at all times?

The nursing home's management team has worked together for at least one year.

Residents' Rooms

Residents may have personal belongings and/or furniture in their rooms.

Each resident has storage space (closet and drawers) in his or her room.

Each resident has a window in his or her bedroom.

Residents have access to a personal telephone and television.

Residents have a choice of roommates.

Water pitchers can be reached by residents.

There are policies and procedures to protect resident's possessions.

Hallways, Stairs, Lounges, and Bathrooms

Exits are clearly marked.

There are quiet areas where residents can visit with friends and family.

The nursing home has smoke detectors and sprinklers.

All common areas, resident rooms, and doorways are designed for wheelchair use.

There are handrails in the hallways and grab bars in the bathrooms.

Menus and Food

Residents have a choice of food items at each meal. (Ask if your favorite foods are served.)

Nutritious snacks are available upon request.

Activities

Residents, including those who are unable to leave their rooms, may choose to take part in a variety of activities.

	Yes	No	Comments
The nursing home has outdoor areas for resident use and staff help residents go outside.			
The nursing home has an active volunteer program.			
Safety and Care			
The nursing home has an emergency evacuation plan and holds regular fire drills.			
Residents get preventive care, like a yearly flu shot, to help keep them healthy.			
Residents may still see their personal doctors.			
The nursing home has an arrangement with a nearby hospital for emergencies.			
Care plan meetings are held at times that are convenient for residents and family members to attend whenever possible.			
The nursing home has corrected all deficiencies (failure to meet one or more Federal or State requirements) on its last state inspection report.			

Source: Nursing Home Checklist, Centers for Medicare and Medicaid Services, 2003; also see <http://www.medicare.gov/Nursing/Checklist.pdf>

Nursing Home Checklist—Comprehensive

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 and 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 AND 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 e-mail
 - 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 do staff members supervise and assist a resident in taking

(continued)

NURSING HOME CHECKLIST (CONTINUED)

- 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 Agency 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 (net of applicable taxes)	_____	_____	_____
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)

Receipts	Husband	Wife	Total
Subtotal	=====	=====	=====
Expenditures—Transportation			
Automobile payments	_____	_____	_____
Automobile insurance	_____	_____	_____
Fuel	_____	_____	_____
Repairs	_____	_____	_____
Taxis and public transportation	_____	_____	_____
Other	_____	_____	_____
Subtotal	=====	=====	=====
Expenditures—Insurance Premiums			
Disability	_____	_____	_____
Liability	_____	_____	_____
Life	_____	_____	_____
Medicare Part B	_____	_____	_____
Medicare prescription discount card	_____	_____	_____
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)

Receipts	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/PrimePlus 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 elder law 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.

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 a 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

REVIEW CHECKLIST FOR WILLS (CONTINUED)

potential future adopted or stepchildren in the line of descent. The birthdates Review Checklist for Wills 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 for 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, 20XX

Mrs. Sarah Snyder
31 Dogwood Road
Front Royal, Virginia

In accordance with the engagement letter between our firm and you dated May 26, 20XX, the following report details our activities for the quarter ended March 31, 20XX.

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, 20XX.

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 Spatz & 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, 20XX, 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, 20XX:

- 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 20XX.

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, 20XX

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. 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.

SAMPLE 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, 20XX.

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

SAMPLE AGREED-UPON PROCEDURES REPORT (CONTINUED)

**Independent Accountant's Report
on Applying Agreed-Upon Procedures**

Mrs. Regina Crater
105 Union Road
Franklin, Tennessee

Dear Mrs Crater:

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, 20XX, 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, 20XX. Burdette Home Care Agency is responsible for complying with the terms and conditions of the December 30, 19XX, 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, 20XX, through March 31, 20XX, 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, 20XX, through March 31, 20XX, 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, 20XX, through March 31, 20XX, 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, 20XX, through March 31, 20XX, 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, 20XX, indicated the following information:

<u>Prescription</u>	<u>Last Filled</u>	<u>Remaining Refills</u>
Drug A	November 22, 20XX	None
Drug B	December 12, 20XX	Three
Drug C	December 12, 20XX	Two

(continued)

SAMPLE 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.⁶ 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, 20XX

⁶ 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

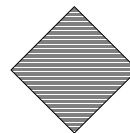
	<i>Yes</i>	<i>No</i>
1. Does the policy pay full benefits for:		
Skilled nursing care?	_____	_____
Intermediate care?	_____	_____
Custodial care?	_____	_____
Home health care?	_____	_____
Adult day health care?	_____	_____
Alternative care?	_____	_____
2. What are typical nursing home fees in the area?	_____	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 will judge when benefits can be received?	_____	
How will they judge?	_____	
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 nonforfeiture 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 nursing home 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 preexisting conditions?	_____	

(continued)

LONG-TERM CARE INSURANCE POLICY CHECKLIST (CONTINUED)

	<i>Yes</i>	<i>No</i>
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 rating?	_____	_____

Rating Agencies	Phone	Web Site
A.M. Best Worldwide Headquarters Ambest Road Oldwick, NJ USA	Customer service: (908) 439-2200, ext. 5742	http://www.ambest.com
Fitch Ratings Ltd. Corporate Headquarters (USA) One State Street Plaza New York, NY 10004	(212) 908-0500 or (800) 753-4824	http://www.fitchratings.com
Moody's Investors Service Moody's Corporation 99 Church Street New York, NY 10007	(212) 553-0377 (Ratings Desk) or (212) 553-1658 (Investor Services Group)	http://www.moody's.com
Standard & Poors (USA) (a division of The McGraw- Hill Companies, Inc.) 55 Water Street New York, NY 10041	(212) 438-1000 or (212) 438-2000 (Index Services)	http://www.standardandpoors.com
Weiss Ratings Inc. 15430 Endeavour Dr. Jupiter, FL 33478	(800) 289-9222 (Sales & Customer Service) or (561) 627-3300 (Corporate Offices)	http://www.weissratings.com



CHAPTER 13:

PowerPoint Presentation for Clients

POWERPOINT PRESENTATION FOR CLIENTS

The Microsoft® PowerPoint presentation included with *CPA Eldercare/PrimePlus Services: A Practitioner's Resource Guide*, second edition, titled *CPA ElderCare/PrimePlus Services: A Multidisciplinary Approach to the Needs of Older Adults and Families*, is to be used to present and explain ElderCare services to potential clients. Presented on the following pages are copies of those presentation slides. The CD-ROM containing the PowerPoint presentation is included with your guide.



- **CPA ElderCare/PrimePlus Services: A Multidisciplinary Approach to the Needs of Older Adults and Families (PowerPoint Presentation for Professionals)**—also see *accompanying CD-ROM*

Note: The PowerPoint presentation included with your copy of *CPA Eldercare/PrimePlus Services: A Practitioner's Resource Guide*, second edition, titled *CPA ElderCare/PrimePlus Services: A Multidisciplinary Approach to the Needs of Older Adults and Families*, requires PowerPoint 2002 to run properly. If you do not have PowerPoint 2002, please consult your software manual about converting the slides to another version of PowerPoint.

Personalizing Your Presentation

Follow these steps to personalize the ElderCare/PrimePlus 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/PrimePlus Services: A Multidisciplinary Approach to the Needs of Older Adults and Families" 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/PrimePlus services, 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 4, “Understanding With the Client, Engagement Letters, and Planning.”

**CPA
ElderCare/PrimePlus
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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eldercare
SERVICES
Accounting • Strategies • Solutions

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. Highlight the coming retirements by Baby Boomers starting in 2010. 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.

**CPA ElderCare/PrimePlus
Services: Why Now?**

- ♦ **America is aging—fast!**
 - By the year 2010, approximately 40 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**

NUMBER OF PERSONS 65 +: 1900 to 2030

Year (as of July 1)

Note: Increases in years on horizontal scale are uneven.

Source: U.S. Census Bureau, U.S. Bureau of the Census


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Slide 3

This slide assists the client in recognizing the need to consider CPA ElderCare/PrimePlus 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.



The Need for Our Services

- ◆ CPA ElderCare/PrimePlus 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

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Slide 4

This slide describes a variety of the elderly person's needs addressed by CPA ElderCare/PrimePlus 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.



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


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Slide 5

This slide describes some of the important components for successful aging.

Like other stages of life, the later years require consideration of needs, direct communication, and appropriate planning.



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.

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Slide 6

This slide describes the components of the multidisciplinary approach to care planning.

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.



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

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Slide 7

This slide depicts the types of services offered by CPA ElderCare/PrimePlus services: consulting, direct, and assurance.

You may wish to give examples of each here or when discussing slides 8, 9, and 10, and explain some of the different offerings in the financial and nonfinancial services area.

Types of Services Available

- ◆ Consulting Services
- ◆ Direct Services
- ◆ Assurance Services

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Slide 8

This slide depicts the wide range of consulting services offered by CPA ElderCare/PrimePlus services.

CPA ElderCare/PrimePlus 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.

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
 - Communication of expectations to care providers


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Slide 9



This slide shows the client the wide range of direct services available with CPA ElderCare/PrimePlus services.

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.



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



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.



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



Slide 11



This slide further describes the multidisciplinary team, an important and exciting component of CPA ElderCare/PrimePlus services.

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.



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.



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.



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**



Slide 13

This slide summarizes the benefits of using CPA ElderCare/PrimePlus 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 CPA ElderCare/PrimePlus services encourages client self-determination and may assist the elderly person to remain independent for a longer period. In addition, CPA ElderCare/PrimePlus 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 caregiving activities.



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, and provide time-saving considerations
- ♦ Provide assurance that specific goals are being met

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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 that you have "put them 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.



CPA ElderCare/PrimePlus Services

*YOUR PARTNER IN
SUCCESSFUL AGING*

Insert Firm Name Here

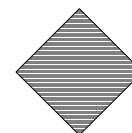
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CHAPTER 14:

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

What is ElderCare/PrimePlus?

ElderCare/PrimePlus is a unique, customizable package of services offered by certified public accountants to assist the elderly in maintaining, for as long as possible, their lifestyle and financial independence. Practitioners who provide ElderCare/PrimePlus services draw upon their strengths and competencies in a variety of areas, including accounting, cash flow planning and budgeting, pre- and post-retirement planning, insurance reviews, and tax planning.

What is the difference between PrimePlus services and ElderCare services?

In fall 2002, the AICPA and the Canadian Institute of Chartered Accountants (CICA) announced the decision to offer PrimePlus services as an alternative brand name to ElderCare services. The objective of the new branding is to make it easier for clients to see the connection between traditional services, such as tax return preparation and planning, and the new, more global approach to the services that older clients need.

When ElderCare was first introduced in 1998, the intent was to provide CPAs and CAs with an opportunity to grow their practices by offering a customizable package of lifestyle management services to their clients. While feedback on the service itself has generally been positive, a number of practitioners noted that the brand name ElderCare tends to limit the target market. Subsequent focus group studies supported this observation. Respondents between the ages of 66 and 80 felt that the term *elder* did not apply to them. They also felt the word *care* implied health care and did not readily associate the ElderCare branding with financial or lifestyle planning services.

The new focus on the brand PrimePlus services leverages existing strengths and competencies in cash flow planning and budgeting, pre- and post-retirement planning, insurance reviews, and tax planning. The new positioning also allows CPAs to broaden their focus for this service to include pre-retirement age clients and, as a result, benefit from the greater revenue potential of this expanded market. In other words, PrimePlus includes basically the same services as ElderCare but expands the potential market to much younger clients.

Practitioners may continue using the ElderCare brand label because it may more accurately describe their practice or they may have already established the ElderCare brand name in their market. The AICPA will continue to support both brand names. For instance, the CPA ElderCare Marketing Tool Kit includes marketing material for both brands.

Why would a potential client hire a CPA to perform ElderCare/PrimePlus services?

Although many other service providers are available, the CPA can bring a higher level of assurance or comfort to the elderly person (and family members). CPA ElderCare/PrimePlus services build on the CPA's reputation for independence, objectivity, and integrity to provide a service that is in the public interest.

Many of the services that a practitioner might be asked to perform would be within the traditional financial services area—accounting, banking, estate planning, financial planning, tax return preparation and planning, and cash flow management. 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 may be one of a number of skilled service providers, each servicing a different client need. For example, the CPA may perform banking, accounting, and investment monitoring services in addition to tax return preparation and tax planning. A licensed social worker or geriatric care manager might perform a needs assessment and supervise and coordinate medical matters. An attorney may be involved in drafting a will and various powers of attorney.

The CPA might be asked to conduct ongoing, continuous, and objective reviews of the performance of each of the service providers. Those providers not meeting goals, objectives, and criteria for performance will be 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 prior experience in ElderCare/PrimePlus, because CPA ElderCare/PrimePlus services are a relatively new market for CPAs. Many services may be within the normal arena of CPA duties, particularly in the traditional financial arena. You will already have the experience to perform those duties. Other services may be outside the normal arena of CPA duties. As these services develop, the AICPA will be updating the education and skill requirements.

The AICPA and the AICPA/CICA ElderCare/PrimePlus Task Force have developed a Competency Model to assist you in assessing your skills against the skills required of a CPA ElderCare/PrimePlus services provider. CPAs may access this Competency Model at www.cpa2.biz.com/cat.

You should have some knowledge of geriatric health issues and terminology, even though the CPA will rely 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 perhaps more important in this arena than in other client services.

What do I need to get started in ElderCare/PrimePlus?

As a minimum, a practitioner should study the AICPA/PDI course, *Developing and Managing an ElderCare/PrimePlus Practice*, but it is also recommended that he or she study all four CPE courses to obtain a comprehensive understanding of the medical/psychosocial, financial, and legal issues of aging that are involved in an ElderCare/PrimePlus practice. All four courses are available in self-study format through CPA2Biz at www.cpa2biz.com.

In addition, it is recommended that practitioners review the ElderCare/PrimePlus Competency Model (www.cpa2biz.com/cat) and associated learning resources to identify other applicable publications and practice tools.

The practitioner should also develop or obtain an inventory of services available for older clients in his or her community and should identify other professionals (for example, geriatric care managers, licensed social workers, doctors, and attorneys) who can assist the practitioner in providing services to the older client.

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 may be that of an observer, facilitator, and evaluator, depending upon the particular service. The whole concept of the practitioner acting as the eyes and ears of the absent family members in an ElderCare/PrimePlus 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 AICPA/CICA ElderCare/PrimePlus Task Force envisions the service will often begin as a traditional financial services engagement that might also include coordination and evaluation service. Typically, strategic partnerships and alliances would be 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 needs assessments or for inspection and reporting on care criteria that are outside of the practitioner's area of expertise, or with a care management company to provide services within the home.

How are CPA ElderCare/PrimePlus services engagements staffed?

Traditional financial services engagements would be staffed as you staff any similar engagement. Other 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/PrimePlus engagement. In such person-to-person contacts, continuity of the staff person or partner making the contact is extremely important.

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/PrimePlus 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, are to be involved in other aspects of the ElderCare/PrimePlus engagement, such as preparation of insurance claims, they would require additional training. A good source of additional information is the calendar at www.elderweb.com.

What material is available that I can use to develop the skills I need to commence developing an ElderCare/PrimePlus practice?

The practitioner should study the AICPA/PDI ElderCare/PrimePlus CPE courses for a basic understanding of the issues involved in an ElderCare/PrimePlus practice. In addition, courses in personal financial planning may provide additional information on some of the issues involved in ElderCare/PrimePlus. The practitioner can assess his or her proficiencies through the Competency Self-Assessment Tool (see previous discussion), which identifies learning opportunities for traditional (for example, group and self-study courses) and nontraditional (for example, resource guides, conferences, other publications) training. Other professional organizations, such as those for elder law attorneys, geriatric care managers, and long-term care insurers, offer continuing education and conferences that may be helpful.

Joining local networks of professionals who serve this market as well as volunteering in your community can also help you obtain the necessary skills. Additional information may be found on various Web sites on the Internet.

Should you have health care specialists or geriatric care specialists on your staff?

In general, unless the practitioner has developed an extended ElderCare/PrimePlus practice, such specialists would not be employed by the practitioner. 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 through a strategic alliance or partnering arrangement.

Will Medicare be involved in any way, and if so, how will it be handled?

The practitioner will probably have to deal with Medicare. 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/PrimePlus 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,” and at <http://cms.gov> and www.medicare.gov.

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/PrimePlus 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/PrimePlus often requires the practitioner to assume roles that have not traditionally been associated with CPAs. 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.

A significant risk associated with rendering ElderCare/PrimePlus services arises from being placed in a position of “monitoring” the health and health care for an older adult. This risk can be mitigated by requiring that a professional geriatric care manager or licensed social worker be engaged as part of an ElderCare/PrimePlus team when family members of the older adult are not available in person to monitor the adult’s condition and care.

The practitioner should clearly state that he or she will not be giving an opinion on the health of the elderly person. Also, the practitioner should not give his or her 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 that would leave the CPA open to potential litigation.

Fully document all ElderCare/PrimePlus 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/PrimePlus engagement. A checklist is located in Chapter 12, “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/PrimePlus 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/PrimePlus 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 Risk Management." For more information on the AICPA Insurance Programs, visit www.cpai.com.

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/PrimePlus 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/PrimePlus engagement?

Bonding is vital for those who work with cash or in another fiduciary capacity on CPA ElderCare/PrimePlus 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/PrimePlus services.

Are engagement letters really required for ElderCare/PrimePlus Services?

Engagement letters are critical for an ElderCare/PrimePlus engagement. They should be tailored to the circumstances in each case and should clearly identify the practitioner’s responsibilities and duties in the engagement.

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 has unique characteristics and services. See Chapter 12, “Sample Documents and Checklists,” for sample engagement letters and the section titled “Managing Professional Liability Risk,” in Chapter 5, “Quality Control, Best Practices, and Risk Management,” for additional information on engagement letter content and liability risk.

How should I bill for ElderCare/PrimePlus 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/PrimePlus 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/PrimePlus client. Such information assists the elderly client or the responsible family member in making choices concerning the type of care they can expect and information about where they 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/PrimePlus engagement?

In any ElderCare/PrimePlus 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 or she 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. These responsibilities should be clearly outlined in the engagement letter.

What if the elderly person involved in the ElderCare/PrimePlus engagement decides he or she no longer wants assistance?

The practitioner's response depends 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 or she 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, that party 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/PrimePlus 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 you have responsibility for paying your client's bills, how can the responsible party know this is being handled properly?

Various safeguards can be integrated into the engagement, such as having bank statements sent directly to the responsible party or having the practitioner prepare the checks and the responsible party sign them. In addition, the practitioner should implement appropriate internal controls within the firm to assure that funds are handled properly. The responsible party may also choose to receive monthly or quarterly financial reports. The practitioner should always maintain adequate internal controls over receipts and disbursements from client accounts and obtain adequate bonding.

Is the purpose of ElderCare/PrimePlus to minimize expenses being incurred by the elderly person or on behalf of the elderly person?

The object of ElderCare/PrimePlus is to allow the elderly person to live comfortably at a standard of living to which they are accustomed. Although the ElderCare/PrimePlus practitioner should monitor extraordinary 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/PrimePlus 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 about 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. Appropriate standards should be followed for each type of report issued.

What is my responsibility to the elderly person if for any reason I need to terminate or withdraw from an ElderCare/PrimePlus 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 believes 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

Because ElderCare/PrimePlus involves a range of services, from consulting to assurance (attestation) to direct provision of services, both financial and nonfinancial, the practitioner should make sure that the appropriate professional standards are followed for the type of service being rendered. Regardless of the level of service and the standards that may apply to a particular engagement, the practitioner is still bound by the AICPA Code of Professional Conduct and should consider Code rules in accepting, planning, and carrying out the engagement. The following comments from the AICPA/CICA ElderCare/PrimePlus Task Force should be considered, but these comments are not intended to supersede any rule.

Will CPA ElderCare/PrimePlus services be subject to peer review?

Those ElderCare/PrimePlus 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/PrimePlus 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. They should be considered as referrals, not recommendations.

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/PrimePlus 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/PrimePlus engagement letter should specify, as completely as possible, all situations in which the practitioner is authorized to release personal financial information on the ElderCare/PrimePlus 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/PrimePlus 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/PrimePlus 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 depends 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 *Resource Center for Investment Advisory Services* at www.cpa2biz.com.

May I be a trustee of a trust or an executor of an estate and also provide ElderCare/PrimePlus services to a beneficiary?

The practitioner should be cautious when acting as a trustee or an executor and also rendering ElderCare/PrimePlus services. The practitioner should carefully examine every situation to make sure that his or her objectivity and ethical standards are maintained at all times.

If I refer an ElderCare/PrimePlus 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/PrimePlus services to an elderly person. If a commission is involved, make sure that it is properly disclosed to the contracting parties.

Should I allow myself or staff to receive loans, gifts, or bequests from my ElderCare/PrimePlus 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 believed to be in the best interest to accept commissions and jeopardize the independence, integrity, and trust CPAs maintain. Further, the Code of Professional Conduct appears to apply in this situation and any practitioner accepting a commission in this case may be in breach of certain rules.

MARKETING

Who is my market?

The elderly population of the United States is the fastest growing segment of the population today.

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 practitioners 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. A third potential market consists of other professionals who provide services to older adults—lawyers, health care professionals, etc.

ElderCare/PrimePlus services are not for everybody. The most appropriate clients are those 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. Many of these will be healthy, active people who are looking for “home-office” support.

Should I try to develop a practice in ElderCare/PrimePlus even though I do not live in a retirement area?

ElderCare/PrimePlus services may add to the profitability of any practice. Although there may be some economy of scale in handling a large number of ElderCare/PrimePlus clients, it is possible to develop a profitable ElderCare/PrimePlus practice in areas where there are very few ElderCare/PrimePlus 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/PrimePlus services?

There are basically two markets for ElderCare/PrimePlus 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/PrimePlus. 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/PrimePlus clients.

Similar information about the availability of ElderCare/PrimePlus 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/PrimePlus 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/PrimePlus services.

Some organizations are already claiming to provide the services we propose. Will ElderCare/PrimePlus 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/PrimePlus 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/PrimePlus as a coordination and valuation service coupled with financial services.

Are ElderCare/PrimePlus services needed by persons who are in institutions?

Although ElderCare/PrimePlus 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/PrimePlus concepts can also apply to institutionalized persons. Typically, in those situations, the practitioner might handle the financial services part of ElderCare/PrimePlus. The practitioner might, however, be engaged by the responsible

family member to test for certain care criteria he or she 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.

Transfer of an ElderCare/PrimePlus 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, with an appropriate revision of the engagement letter.

CASE STUDIES FOR CPAS

The following case studies illustrate various situations that the CPA might encounter when offering CPA ElderCare/PrimePlus services. These situations involve the issues of aging that many ElderCare/PrimePlus clients experience, from loss of independence and medical and health issues, to greater susceptibility to fraud or financial improprieties by family members.

Case Study 1: Presenting Options to Clients

A practitioner's ElderCare/PrimePlus clients, Mr. and Mrs. Sales, lived in a large home. Mr. Sales began to develop signs of Alzheimer's. Mrs. Sales met with the practitioner to consider their options, for instance, whether they should sell their home and move into a retirement community where Mr. Sales would have care available when his condition deteriorated.

What can the practitioner do to help the Sales make a decision?

Analysis—Case Study 1

There are three options: both spouses moving to a retirement facility; Mr. Sales moving to a retirement facility when his condition worsened; staying at home and hiring the necessary caregivers.

First, the practitioner can review the retirement homes with Alzheimer's facilities available to meet the client's needs. This would include obtaining an estimate of the cost, Mr. Sales's expected life expectancy, and any information available from government inspections of the facilities.

The practitioner should prepare a projected cash flow statement assuming (1) that both Sales move into the facility and (2) that only Mr. Sales moves into the facility. The practitioner should also prepare a cash flow statement assuming that the decision is made to remain in their home and hire caregivers.

There are other matters the Sales should consider:

1. If he goes into a nursing facility, can she manage the home alone?
2. Will Mrs. Sales be able to visit Mr. Sales? (That is, are there transportation issues?)
3. Will the living standard of Mrs. Sales be adversely affected by any of the choices?
4. Can Mrs. Sales manage the couple's finances, or is she liable to overspend?

If the decision is made to move into a retirement facility, the practitioner may assist with the sale of the home and disposal of personal belongings. If the decision is made to stay

in the home, the practitioner should obtain information on caregivers available in the area, including social workers or care managers who can supervise the in-home care.

Case Study 2: Fraud Vulnerability and the Help

Mrs. Henry, an ElderCare/PrimePlus client, is legally blind. The practitioner does all of her banking activities except that Mrs. Henry insists on sending her housekeepers (who do not live in the home) on errands with blank checks that she has signed. When the practitioner advises Mrs. Henry that she should not be doing this, she assures the practitioner that she has done this for years and does not want her housekeepers to think that she doesn't trust them.

Since Mrs. Henry refuses to stop signing blank checks, the practitioner gets her to agree to have the housekeepers bring back receipts for all items purchased so the practitioner can review them.

What should the practitioner look for?

Analysis—Case Study 2

Since the housekeepers are obviously driving on errands for Mrs. Henry, either in her car or in their own cars, the practitioner should ascertain that there is proper insurance coverage to protect Mrs. Henry, in case the housekeeper has an accident.

The practitioner should develop a good budget to compare expenditures with anticipated needs. The practitioner could schedule a periodic meeting with Mrs. Henry to discuss unusual variances.

As for the receipts, themselves, the practitioner should consider:

- Do the amounts on the receipts agree with the check issued? Is there evidence of “cash back” when the check is written for a larger amount?
- Are the purchased items consistent with Mrs. Henry's life style? For instance, are groceries being purchased that are not on Mrs. Henry's prescribed diet or are in contradiction to her personal beliefs (liquor, for example)?
- Do quantities of items being purchased seem reasonable? Are meat purchases far in excess of quantities that Mrs. Henry would be expected to consume?
- Are any checks written to “cash”?
- Are there payments to unknown or suspicious people or businesses?

Finally, the practitioner should determine if charge accounts or direct billing can be done from the businesses where most of Mrs. Henry's purchases are made.

Case Study 3: Fraud Vulnerability and the Family

Part A

Mrs. Levy has two sons, Bob and Henry. Before the time she became incompetent, she gave Henry an unlimited, durable, power of attorney. She is now in a nursing home and is no longer competent to make decisions concerning her well-being or her estate.

Henry is the practitioner's client and he asked the practitioner to perform all accounting functions for his mother's estate, including the payment of bills and depositing of

income. After checks have been prepared, they are mailed to Henry for signature. Each month, he receives a full accounting of the financial transactions for the month.

Bob feels isolated from what is happening. Henry will not give him information on how his mother's money is being spent, how much money she has, and other situations. Bob asks the practitioner for the information.

What should the practitioner do?

Part B

Bob is furious and sues Henry and Henry's practitioner for financial abuse of his mother. It was proven in court that there has been no such abuse. However, in the interest of fairness, the judge revokes the power of attorney given to Henry and appoints Bob as guardian of his mother and her estate. Bob calls Henry's practitioner to say he knew he was doing a good job and that the only purpose of the suit was to find out what was going on. He asks the practitioner to continue in his current capacity, with the exception being that the checks will come to him for signature and he will be the sole recipient of the monthly financial statements. He also offers to pay for all legal costs the firm incurred in the litigation. (The account is a sizeable and prestigious account for the firm.)

What should the practitioner do?

Analysis—Case Study 3

Part A

The practitioner should review the engagement letter with Henry. If the letter says that Henry is the only one to receive the financial information, the practitioner will have to honor that agreement. But he should call Henry to see if Henry will amend the engagement letter to allow Bob to receive the monthly reports. The practitioner should explain to Henry the importance of communication with all family members so they don't feel they are being cheated or that their relative is being abused.

If Henry still refuses to release the information to Bob, the practitioner should document all conversations with him and notify Bob that the information cannot be provided. The practitioner should seriously consider whether he wants to continue the engagement.

Part B

The answer would depend on two things:

1. How responsible the practitioner feels toward Mrs. Levy. Is she a long-time client? Is there special knowledge needed to maintain her affairs?
2. How well the practitioner feels he can work with Bob. The inclination to refuse to continue the engagement is a valid one in this scenario. Knowing how Bob has acted in connection with the demands and the lawsuit, the practitioner would probably have some trust issues with Bob. And there is no indication that the animosity that has developed between the brothers will not continue. There is bound to be future, and perhaps continuing, family conflict.

Case Study 4: Family Conflicts and Communication

Part A

The practitioner renders ElderCare/PrimePlus services (primarily financial) to Mrs. Brown. Her adult son, Peter, lives out of state but visits his mother at least every other month. Peter decides that, although his mother is satisfied with the services she is receiving, he needs to be “in the loop” on her financial affairs. Peter has been given a durable power of attorney by his mother.

How should the practitioner deal with the situation?

Some items to be considered are:

- How often should the practitioner communicate with Peter?
- What matters should be discussed with Peter?
- Should Peter be included in a new engagement letter regarding his mother’s care?
- Should Peter be provided with written reports or is oral communication acceptable?
- Are there any matters that Mrs. Brown does not want to have the practitioner discuss with Peter?

Part B

Assume that, in addition to Peter, Mrs. Brown has a daughter, Sarah. Peter and Sarah have never been able to get along with each other. Sarah is aware that Peter has her mother’s power of attorney and is furious about it.

How should the practitioner handle the situation?

Part C

Mrs. Brown is agreeable to furnishing Peter with all of her financial information and discussing it with him in the quarterly meetings. But she refuses to let Sarah have this information because “she will just pester me for more money.” Conversely, she does not want to furnish Peter with any of her medical information but does not mind giving this information to Sarah.

What should the practitioner do?

Analysis—Case Study 4

Part A

The best place to start is to discuss the matter with Mrs. Brown. She may be fully agreeable to including Peter in all of her affairs, or there may be financial or health issues that she does not want to discuss with Peter. If the latter is the case, determine whether the “off limits” issues are so material that Peter would only get frustrated from a lack of information.

Assuming that Mrs. Brown does agree to involve Peter, draft a new engagement letter, signed by both Mrs. Brown and Peter, that clearly delineates what the relationship will be, what information is to be reported to Peter, and what, if any, decisions will be made by Peter.

The engagement letter also should set forth whether reports will be in writing or oral and when any meetings will be held. (Sarah said their solution was to have a family meeting

with Peter and his mother in person in the first and third quarters and a telephone conference meeting in the second and fourth quarters. The meetings last from 30 minutes to an hour depending on the matters which need to be discussed.)

Part B

Basically, the approach to the situation would be the same as in Part A. The practitioner should encourage Mrs. Brown to provide information to both children and to include both children in the quarterly meetings. There may have to be some consideration of whether the face-to-face meetings will work or whether the conference call meetings will be smoother.

Part C

Since Mrs. Brown is the client, regardless of who is paying the bill, her wishes will rule. However, the practitioner should explore with her the possibility that the limited information provided to the individual parties may not be in her best interests and may create additional friction. If she still doesn't budge, perhaps the better solution is to only communicate with Peter since he does have the power of attorney.

There is also the option of leaving matters the way they are now. However, that option has the risk of alienating Peter, who the practitioner may have to deal with at some time in the future.

Case Study 5: Questions of Financial and Physical Abuse

Part A

Mrs. Johnson is a long-time, very wealthy client. She is now 88 years old, but since she was 85 she has not been able to care for herself and has been diagnosed as having Alzheimer's disease. Rather than place her in a nursing home, her three children (Robert, Carolyn and Yvonne) have agreed to have 24-hour care in her home. A licensed clinical social worker supervises the in-home care. The firm handles all the financial affairs.

Robert, as the eldest child, has a durable power of attorney from his mother. Although the firm prepares checks for Mrs. Johnson's care and maintenance, Robert can, and does, occasionally write checks on his mother's account, individually. Although all financial reports go to Robert, the engagement letter specifically says the practitioner may discuss Mrs. Johnson's affairs with the two daughters.

In a one-month period, without the practitioner's knowledge, Robert purchases a new car for his mother and makes a substantial down payment on a beach-front condominium. The rest of the condominium purchase is financed by a loan which Robert signed for his mother as attorney-in-fact. When the firm receives the monthly bank statements and finds the checks that Robert has written, the practitioner calls him for an explanation. He says that the car was necessary so that the caregivers could go to the grocery store and perform other routine errands necessary to provide care for Mrs. Johnson. And the condominium purchase was done so that Mrs. Johnson could periodically visit to "breathe the fresh sea air." On the practitioner's next visit to Mrs. Johnson's home to pick up her mail, she notes there is no new car in the garage. She later finds out that the car in question is a very expensive sports car and has been registered at Robert's address in another city. Concerned, the practitioner calls the social worker to see if she feels that Mrs. Johnson

would benefit from the sea air. She tells the practitioner that Mrs. Johnson will never be able to leave her home again.

What should the practitioner do?

Part B

The manager assigned to Mrs. Johnson's engagement visits the home to retrieve mail. She reports on her return that it appeared that Mrs. Johnson had a bruise on her cheek and wondered if it might resemble a handprint. The caregiver explained that Mrs. Johnson had tried to get out of bed and had fallen against the night stand. The social worker's last visit was three days ago and she is not scheduled to visit again until five days from now.

What should the practitioner do?

Part C

The facts are the same as in Part B except that there is no licensed clinical social worker employed by Mrs. Johnson. Rather, her daughters take turns driving in every other weekend to check on their mother. In that way, one daughter only has to make the trip once a month.

How would this change the answer to Part B?

Analysis—Case Study 5

Part A

This is a clear case of financial abuse. There are several options. The practitioner should:

1. Consult her attorney regarding action to take. Depending on the laws in the practitioner's state concerning elder abuse, she may be required by law to notify the appropriate authorities of her suspicions. The attorney can also give the practitioner advice on when, or if, she should confront Robert with her concern and, if so, what she should tell him.
2. Call the sisters and inform them of her suspicions. They may be the ones who need to confront their brother and demand an explanation. Alternatively, they may feel that their mother needs two more sports cars registered in their names and in their cities and that the condominium sounds like a good time-share arrangement for the family.
3. Consider resigning from the engagement. Robert, as attorney-in-fact, is Mrs. Johnson in the eyes of the law. As long as he signs documents as attorney-in-fact, he cannot be prosecuted. Having already splurged, it is almost a certain fact that Robert will want something else "to make his mother's life easier." The practitioner would then be sitting idly by recording the plunder of Mrs. Johnson's estate. (*Note:* In Canada, the attorney-in-fact is considered to have a fiduciary responsibility and could be sued if inappropriate actions are taken.)

Part B

The manager's report may be an indication that some physical abuse is occurring. Even if the explanation given is reasonable, something needs to be done. The practitioner should immediately call the social worker, describe what the manager had said, and ask that the social worker make an immediate, unplanned visit to Mrs. Johnson. The telephone call should be documented in the files. Although some of the same options

might exist as did in Part A, physical abuse calls for a professional examination that is beyond the scope of a practitioner.

There will probably be some discussion of whether or not to call the children concerning the matter. One valid reaction would be to inform the social worker and let her handle the matter. A charge of elder abuse is very serious and should not even be implied unless there is clear and convincing proof.

Part C

In this case, the first telephone call would be to the two daughters, so the practitioner could carefully explain to them that there may not be a problem but that he believed they should be aware of the situation. The practitioner might suggest that they engage a properly trained medical person to go back to see Mrs. Johnson the next day on an unannounced visit. Remote cameras are available that can be hidden in a room to record what is happening or accessed real-time via the Internet.

Case Study 6: A House Call to a Tax Client

Part A

Mrs. Jones, age 90 and a long-time tax client, makes an appointment to have her tax return prepared. When she doesn't make the appointment, the practitioner calls her home, and she says she forgot but will be right there. After several hours, the practitioner again calls Mrs. Jones, and she says she couldn't find his office. So the practitioner tells her he will send a staff person to pick up the information from her.

When the staff person arrives at Mrs. Jones's house, she forgets that someone is coming and won't let the person in her home. A call from the practitioner convinces Mrs. Jones to let the person in. Although Mrs. Jones is very friendly, she has no idea of what information the practitioner needs. So she shows the staff person to a bedroom where there are stacks of unopened mail, unpaid bills, and checks that have not been deposited. She tells the staff person to take whatever they need. One document found is Mrs. Jones' tax return for the prior year, which has apparently not been mailed. There is also a letter from the government notifying her that she has not filed her tax return. Mrs. Jones' only relative is an 87-year-old brother who lives some 300 miles away.

What should the practitioner do?

Part B

What should the practitioner do if Mrs. Jones has no living relatives?

Analysis—Case Study 6

Part A

The first thing to do is to get help for Mrs. Jones. Her brother should be contacted immediately. If the practitioner knows her attorney, he should contact the attorney to see if Mrs. Jones has given a power of attorney to anyone. Other persons close to her, such as neighbors or her minister, should also be contacted.

As soon as possible, there should be some medical evaluation made of Mrs. Jones to determine if she is competent to live alone. Her dementia might be the result of over- or undermedication or it could be indicative of more serious problems. If the medical

evaluation shows that Mrs. Jones is no longer competent, action should be taken by the brother, with the practitioner's help, to have the courts appoint a guardian or trustee, and action should be taken to get Mrs. Jones into supervised care.

After the appointment of a guardian, the practitioner may be engaged by that person to sort out all the unpaid bills, deposit checks that have not been deposited, and, thereafter, collect Mrs. Jones' mail and process it accordingly. If Mrs. Jones is going to continue living at home, the practitioner may suggest the employment of a social worker to periodically visit and evaluate Mrs. Jones' condition.

Part B

In this case, the practitioner should enlist the aid of Mrs. Jones' neighbors, her attorney, and her minister to have Mrs. Jones properly cared for. This probably will entail having a court declare her incompetent and appoint a guardian.

Case Study 7: Office Meeting and Driving

Mrs. Morse, a wealthy tax client and widow, came to Martha King's office to deliver information for preparation of her tax return. Her large sedan jumped the sidewalk and crashed into one of the firm's conference rooms where, luckily, it came to a stop although the tires were still spinning and black smoke was pouring out. Staff members were able to turn the engine off and get Mrs. Morse out of the car, shaken but unhurt. Mrs. Morse said she didn't know what happened, but the gas pedal must have stuck.

Martha calmed Mrs. Morse, made a new appointment to get the information at Mrs. Morse's home, and made sure that she got home safely.

What should Martha do in the future?

Analysis—Case Study 7

After getting the car out of the conference room and helping Mrs. Morse to contact her insurance agent concerning repair of the car and building, Martha has already made the first step: Go to Mrs. Morse's home for future meetings rather than ask her to come to Martha's office.

One suggestion would be that Martha schedule the visit to Mrs. Morse's home within the week. The meeting is going to be somewhat difficult because Mrs. Morse will feel terribly guilty about the car accident. Martha should put her at ease, and emphasize that she is just glad that Mrs. Morse was not injured.

While at the home, Martha should do several things:

1. Determine if it appears that Mrs. Morse is still capable of living without assistance. Is the home neat or is it a wreck? Is there adequate food in the house and does it appear that Mrs. Morse is preparing adequate meals for herself?
2. Observe the grounds to see if they are well-kept or if they and the house show signs of neglect and deterioration.
3. Listen carefully to Mrs. Morse's comments to see if it appears that she is still quick witted and sharp or if there is increasing evidence of confusion and lack of memory.

If Mrs. Morse has children and Martha comes to the conclusion that Mrs. Morse is having difficulty managing her affairs, she should discreetly contact one of the children to

express her concerns. If the child does not live in the same town, Martha might suggest that he or she pay a visit to Mrs. Morse to see whether there has been a change in her condition or evidence that she might need additional assistance. Martha might also ask that the child stop by her office to discuss the situation.

Martha should not start selling ElderCare/PrimePlus services until the child has had an opportunity to visit Mrs. Morse. But at the meeting with the child after the visit, Martha could suggest several courses of action, including having a needs assessment performed by a trained professional. At that time, Martha could also tell the child the services that her firm could provide for Mrs. Morse.

If during the appointment at the home, Martha senses that Mrs. Morse is really all right and that the gas pedal probably did stick, she might take the opportunity to explain to Mrs. Morse the firm's ElderCare/PrimePlus services and how they might be of benefit to Mrs. Morse.

Case Study 8: Family Matters

Clarence Brown was having a normal tax preparation conference with his client, Melissa Jones, when she suddenly broke into tears. Clarence was somewhat startled since he had only, out of courtesy, asked how her mother, who lived in another city, was doing.

Once she could control her emotions, Melissa related the following to Clarence:

When Melissa's father had died three years previously, her only brother, George, had stepped in to help their mother with her finances. When George was sent overseas on a six-month assignment, her mother came to stay with her, and Melissa had to handle her finances. In reviewing the bank statements and cancelled checks, she found that George had spent over \$200,000 in just one year to buy a house, a car, and to pay for trips for himself and his girlfriend. When George returned early in the current year, she confronted him with this; he was furious and stormed out of her house.

In the middle of the year, Melissa's mother had to move into an assisted-living facility because she could no longer care for herself. George then sold the mother's home and put the money into a trust in his name. Although insurance and Social Security cover the mother's living arrangements, any other checks and dividends she receives are sent directly to George.

Melissa and her sister don't want to alienate George, but they are afraid that nothing will be left by the time their mother dies.

She asks the practitioner what she should do?

Analysis—Case Study 8

There are several issues involved in this case, some of which are beyond the expertise of a CPA:

1. Possible elderly abuse due to theft of funds.
2. Possible fraud.
3. Questions of future care of the mother.
4. Questions concerning what the sisters will ultimately inherit.

The practitioner should explain to Melissa that, even though she and her sister do not want to upset George, there is an overriding question concerning the well-being and financial stability of her mother's estate. George may be making plans to qualify the mother for Medicaid, which might not be in her best interests.

The practitioner should recommend that Melissa and her sister consult with an attorney knowledgeable about estates. If George has a valid, unlimited power of attorney, there may be little the sisters can do. However, in view of the mother's state of mind, there might be some question concerning whether she executed any such power of attorney while she was still competent. If there is no power of attorney, there is a much stronger case regarding possible fraud and theft.

The practitioner might also explain to Melissa what ElderCare/PrimePlus services involve and suggest that she and her sister explore having a practitioner in her mother's hometown handle the financial affairs.

Case Study 9: The Love Boat

About a year after his wife's sudden and unexpected death, Jim, a Canadian who was very wealthy, decided to go on his first cruise. When he returned, he announced to his family that he had met a woman named Helen and they have fallen in love.

Jim relied heavily on his chartered accountant (CA) for advice and guidance on many matters. With the help, of the CA, he had been able to remain in the family home, although he complained that he was lonesome after his care workers and domestic left for the day.

The CA was one of the first people Jim told of his pending marriage to Helen. Although the CA tried to share Jim's happiness, he was concerned about Jim's considerable financial resources and Helen's true intentions. Jim explained to his CA that Helen, an American 15 years his junior and a widow, owned her own large home and had a considerable stock portfolio. The happy couple had decided to build Helen's dream home in the United States. Helen would sell her current home and contribute the proceeds to the new home, but Jim would pay for the remainder of the construction costs. Jim had already placed \$100,000 as a deposit on the property where their dream home would be built. He and Helen had also agreed that Jim would contribute \$100,000 annually to their "lifestyle" budget. Although he did not want to spoil Jim's happiness, Jim's CA was aghast.

The CA suggested to Jim that he find out if Helen had a CPA and asked whether he could talk to him.

Part A

As it turned out, Jim put Helen's CPA in touch with his CA and the practitioners found out that both parties had similar concerns. Helen was indeed wealthy, although not as wealthy as Jim, and the representations she made to Jim were indeed true.

What suggestions should the CA make to Jim?

Part B

Helen said she did not have a CPA and handled all of her financial and tax affairs herself. In fact, she called Jim's CA and told him to stay out of their love life.

What suggestions should the CA make to Jim?

Analysis—Case Study 9

Part A

With this information, the CA advised Jim to consult an attorney to draw up a prenuptial agreement that would address the financial concerns and estate problems of both parties. He also assisted Jim in structuring his finances in such a manner that his and Helen's assets would not be co-mingled except to the extent that they were co-owners of the dream home and shared in the joint "lifestyle" budget account.

Part B

This is bad news. The CA should explain to Jim the dangers of such a marriage and the potential disaster for him and his estate. If Jim still wants to get married, the family should be enlisted and, perhaps, a social worker brought in to do a mental evaluation. If Jim still insists, the CA should strongly recommend that Jim execute a prenuptial agreement and help him to structure his estate in such a manner that Helen would be unable to benefit in the event Jim predeceases her. The CA might also enlist other community resources to see if Jim can be distracted with activities that would decrease his loneliness.

Case Study 10: Check Is in the Mail

Part A

An elderly client arrives at the practitioner's office to have her tax return prepared. She introduces the practitioner to her son, "who is helping me pay my bills." Needing additional information to complete the tax return, the practitioner asks to look at bank statements for the year. The client states that these are all mailed to the son, who says he has not retained any of them.

What should the practitioner do?

Part B

With the client's permission, the practitioner obtains copies of the bank statements from the local bank. He finds large, even-amount checks have been written each month and that the account has been depleted faster than it is being replaced.

What should the practitioner do?

Analysis—Case Study 10

Part A

Not retaining current bank statements and the associated canceled checks is extremely unusual. The practitioner should remind the son of the importance of record retention in the event of an IRS audit and the need to document important transactions.

The client stated that the statements are mailed to the son. The practitioner should ask whose idea that was and why a duplicate statement is not sent directly to the client. Was the mother pressured by the son?

To answer the posed question, the practitioner should have the mother sign a letter directing the bank to mail duplicate statements as well as copies of all paid checks directly to his office. In addition, the practitioner should also include a request that a duplicate statement be mailed to the mother every month.

It would be difficult for the son to object to this. If he did, the practitioner would have strong suspicions that the account was being tampered with. The practitioner should express his concerns to the mother privately and should contact her attorney to see if they should initiate a formal action with the authorities. Much of this depends on the mother's competency.

Part B

Clearly, the practitioner must investigate the payee of these checks and his relationship to his mother. While not a handwriting expert, the practitioner should attempt to identify the handwriting on the checks' endorsements to see if the handwriting is the son's. If so, he should speak to the firm's attorney and possibly notify authorities, as well as having the bank account frozen.

On the other hand, perhaps the mother's medical or other expenses have increased and all that is necessary is to work on a monthly budget with her, and possibly, her son. If there are medical expenses, are there reimbursement opportunities being overlooked?

Case Study 11: Mrs. Queen's Shoe-String Budget

Mrs. Queen, an ElderCare/PrimePlus client, is 89 years old and has recently moved into a retirement facility in the community following her husband's death. Mr. Queen had always handled their financial affairs, and now Mrs. Queen has hired the firm to fill that roll.

A problem quickly surfaces. Ann, the eldest child, who also lives in the community, has a durable, unlimited power of attorney from her mother. Ann has told the firm that any "excess" funds should be forwarded to Mrs. Queen's broker each month for investment.

When the practitioner visits Mrs. Queen, he realizes that one of her greatest concerns, which she says keeps her up at night in tears, is that she doesn't have enough "cash on hand" and is afraid that she will not have enough money to live on considering the additional costs associated with the move to the retirement facility.

A quick review of Mrs. Queen's bank statements, prior year income tax return, and investment portfolio shows that her fears are unwarranted; she is extremely wealthy. The practitioner does notice, however, that she is living on a "shoe-string budget" so that the majority of her monthly income can be invested with her broker.

What should the practitioner recommend in order to alleviate Mrs. Queen's worries?

Would Ann agree with the recommendation or would the practitioner run the risk of alienating someone that he may have to deal with on a more frequent basis in the future?

Does the practitioner think Mrs. Queen would feel torn between what he and what her daughter believe is best for her? If so, what could the practitioner do?

Analysis—Case Study 11

To alleviate Mrs. Queen's unnecessary fears of not having enough "cash on hand" to meet her cash flow needs, the practitioner may suggest preparing a simple prospective cash flow analysis. A prospective cash flow analysis will help ensure that the Mrs. Queen has enough cash and other liquid assets to live independently and adequate emergency funds on hand to meet any unforeseen contingencies. The analysis should also help identify whether Mrs. Queen or her family members have sufficient funds to meet her long-term care needs.

Additionally, the decision about how much cash should be kept “on hand” will need to be made by Mrs. Queen. Ideally, the account will be handled like an imprest fund. The practitioner can estimate the amount needed to pay Mrs. Queen’s bills for the month, quarter, and year, and request Mrs. Queen to replenish the fund periodically. The “dollar amount” issue may be resolved through an open discussion between Mrs. Queen, her daughter Ann, and the practitioner. (This is presuming that this is Mrs. Queen’s wishes.)

Case Study 12: Where Did I Put That Succession Plan?

Mr. Fair, 72 years old, has operated a successful store in the community for many years. The store is his life; he has no outside interests. His son, Paul, has worked in the business for 15 years. Paul is divorced and lives with his parents. Mr. Fair is very secretive about his financial affairs and has not shared any information with his wife, Paul, or any other members of the family.

Mr. Fair calls James, his CPA, for assistance when a tax audit of the store raises questions that he cannot answer. The auditor complains to James about the sloppy bookkeeping and a number of missing records. James finds that this is unusual since Mr. Fair has always been extremely meticulous in his recordkeeping. The matters raised by the auditor are eventually resolved, but questions from the auditor and James to Mr. Fair leave him confused and disoriented. In the process, James discovers \$300,000 in term deposits that Mr. Fair had forgotten and another bank account that had not been drawing interest in over a year. Mr. Fair also agreed, as a part of the audit settlement, to turn over the accounting duties to Paul.

James expressed his concerns about how the store’s finances were being handled to Paul and Mrs. Fair. They, with the assistance of other family members, were able to get Mr. Fair to a doctor for an evaluation. The doctor diagnosed early-stage Alzheimer’s and immediately suspended Mr. Fair’s drivers’ license.

With the assistance of the family and their attorney, James was able to correct some of the problems that had triggered the tax audit. However, Paul refused to attend any of these meetings. He instructed his father not to attend the meetings, not to sign anything, and was convinced that his father did not have Alzheimer’s.

How should James handle the situation?

Analysis—Case Study 12

James should advise the family to seek legal counsel. Assuming that Mr. Fair, being as secretive as he apparently is, has not made arrangements for his wife or another member of the family to have a durable power of attorney, the only solution may be to go to court to establish a guardianship or conservatorship and to appoint a member of the family to take charge of Mr. Fair’s affairs.

James could approach the problem with Mr. Fair from the perspective of the importance of succession planning for the long-term survival of his store. Since the store is Mr. Fair’s primary interest in life, James may be able to persuade him to establish some sort of succession plan to provide security for his family and continuity of service to store customers. Mr. Fair will probably be more receptive to accept recommendations coming from James with regard to succession planning rather than having his family question his competency.

The family will also have to make decisions concerning the future of the store. Is Mr. Fair still able to handle some of the nonfinancial matters? Is Paul competent to continue running the store? If Paul is running the store, should they engage someone independent to maintain the accounting records?

Everyone agrees that closing the store is not an option. The store is Mr. Fair's only interest in the world and his life revolves around it. If he didn't have the store to go to, it would kill him. In spite of the Alzheimer's, he does have some very lucid moments, and it does appear that he may still be able to participate in the decisions that need to be made going forward.

Case Study 13: Friendly Phone Voices

Louise, an only child, flew across the country to visit her mother at least once each six months. Her mother, 79 years old, lived in a secure condominium, and she and Louise talked on the telephone at least once each week.

When Louise arrived at her mother's condominium on her current visit, she noted a large stack of unopened mail in the entry hall. After they had greeted each other and sat down for a cup of tea, Louise asked her mother about the mail. It appeared that a lot of the mail consisted of magazines dealing with subjects her mother had no interest in. But before they could proceed further, the phone rang, her mother answered, and had a nice conversation. The mother was smiling when she returned and said it was nice young man offering her a free subscription to a magazine.

When the mother got ready for bed, Louise asked if she could stay up a while and sort out the unopened mail for her mother. In doing so, she found (in addition to the magazines) lottery tickets, show tickets, genealogical research papers, insurance policies, and unopened bank and credit card statements. The bank statements showed a large amount of automatic, continuing debits, and the credit card statements showed large charges—none of which had been paid in over three months.

When Louise confronted her mother with this information the next morning, her mother was embarrassed and surprised, stating that she thought "all that stuff was free."

When Louise called her husband, a medical doctor, he told her that he had just read some information about a service being provided by CPAs called ElderCare/PrimePlus services. With her mother's approval, Louise contacted the mother's CPA and asked for assistance.

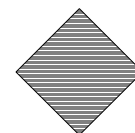
What should the practitioner do?

Analysis—Case Study 13

Here are some steps worth taking to address Louise's mother's vulnerability to possible telephone scam artists:

1. Immediately arrange for the mother's phone number to be changed to an unlisted number and consider contacting an answering service to screen calls before they could get to the condominium.
2. Contact Louise's mother's bank and either open a new bank account, close the existing account, or make arrangements to discontinue any future automatic debits and charges.

3. Contact the mother's credit card company to advise them of the discontinuance of monthly charges and to see if they could reverse some of the charges previously made.
4. Arrange for a new credit card and cancel the existing credit card.
5. Contact an attorney to have Louise's mother execute a durable power of attorney in favor of Louise.
6. Contact a qualified social worker to perform a needs assessment to see if the mother required additional assistance.
7. Make arrangements for the CPA to perform banking and accounting functions for the mother in the future, with a monthly report to the mother and to Louise.



ElderCare/PrimePlus Glossary

401(k) plans: A tax-deferred investment and savings plan that acts as a personal pension fund for employees. It allows employees of corporations and private companies to save and invest for their own retirement. In a 401(k) the employee authorizes pretax payroll deductions to be invested in mutual funds or other investment options offered by the employer's plan. Often, employers match the employee's contributions. The contributions, the investment earnings, and any employer match may grow tax-deferred until withdrawal (assumed to be retirement), at which time they are taxed as ordinary income. As with 403(b) plans, assets in 401(k)s can be withdrawn without penalty after age 59½, must start no later than April 1 of the year following the date that one turns age 70½, and must be taken annually subject to minimum distribution requirements.

403(b) plans: A tax-deferred investment and savings program for employees of certain tax-exempt employers. It allows employees of hospitals, educational institutions, and other nonprofit organizations to save and invest for their own retirement. Depending on the program, an employee authorizes pretax payroll deductions to be invested in a tax-sheltered annuity (TSA) or in a custodial account made up of mutual funds offered by the employer. Both contributions and the investment earnings may grow tax-deferred until withdrawal (assumed to be retirement), at which time they are taxed as ordinary income. As with IRAs, assets in 403(b) plans can be withdrawn without penalty after age 59½, must start no later than April 1 of the year following the date that one turns age 70½, and must be taken annually subject to minimum distribution requirements.

Abuse, physical and emotional: Neglect, abandonment, beating, restraint, deprivation of food or water, sexual abuse, humiliation, intimidation, insults, threats, and harassment. Abuse may be domestic, institutional, or self-neglect.

Activities of daily living, or ADLs: The basic tasks of everyday life, such as eating, bathing, dressing, toileting, and transferring. When people are unable to perform these activities, they need help to cope, either from other human beings or mechanical devices or both. Although persons of all ages may have problems performing the ADLs, prevalence rates are much higher for the elderly than for the nonelderly. Within the elderly population, ADL prevalence rates rise steeply with advancing age and are especially high for persons aged 85 and over. Measurement of the activities of daily living is critical because they have been found to be significant predictors of admission to a nursing home, use of paid home care, use of hospital services, use of physician services, insurance coverage, and mortality.

Alzheimer's disease, or AD: The most common cause of dementia in older people. AD affects the parts of the brain that control thought, memory, and language. It is a disease that progresses slowly, starting with mild memory problems and leading to severe brain damage. People with AD lose their abilities at different rates. AD can last from 3 to 20 years or more after the onset of symptoms. It is not yet clear what causes AD and there is

no known cure. The behavioral problems in AD are not something the person can control. They result from the brain damage that worsens over time.

AD begins slowly. At first, the only symptom may be memory problems. People with AD may have trouble remembering recent events, activities, or the names of familiar people or things. They may ask the same question repeatedly. Simple math problems may become hard to solve. Such difficulties begin to interfere with jobs or other activities. As the disease gets worse, people with AD may:

- Forget something that just happened even though they can remember events from many years ago.
- Become disoriented and get lost in once familiar places.
- Become passive and lose their initiative.
- Forget how to do simple tasks, like brushing their teeth or combing their hair.
- Not be able to think clearly.
- Have trouble talking, understanding, reading, and writing.
- Stop bathing regularly or eating regular meals.
- Have sudden, unpredictable mood changes.
- Become suspicious and paranoid about other people's intentions and behavior.
- Become confused, anxious, or aggressive. Some may become violent or angry, while others may be docile or helpless.
- Wander away from home.
- Need total care, eventually.

Assisted living facility: A combination of housing and health care services for individuals needing assistance with some of the activities of daily living (such as eating, walking, and bathing). Assisted living is a general term for living arrangements in which some services are available to residents (for example, meals, cleaning, and medication reminders), but residents still live independently within the assisted living complex.

Continuing care retirement community, or CCRC: A sprawling complex that, as the name implies, provides continuous care from one phase of life to the next. A CCRC contains three lifestyle options.

- The first is independent living in a small home on the grounds. The home might be a patio home, a condominium, a cottage, a ranch home, or even an apartment in a high-rise building. In many CCRCs there is a choice between renting an apartment or buying a home. Residents of these facilities are normally in fairly good health and lead quite independent lives, coming and going as they please.
- The second phase of a CCRC is an assisted living facility. Residents receive some help with daily living and dressing, for example. Depending on the facility, residents may just have a room and bath or an apartment with a small kitchen. In any event, there is always a dining room where the residents may take meals if they choose.
- The third phase of a CCRC is a nursing home, which offers 24-hour skilled care. Each CCRC is different, with its own appearance, rules and regulations, health care coverage, and cost. Some will allow an individual to move in only during the independent living phase.

Death, or survivor, benefits: Money and/or in-kind benefits paid to the survivors of the deceased (also called survivor benefits). These benefits are usually provided to eligible survivors of the deceased upon receipt of proof of death, such as a copy of the death certificates. Amounts may be paid in one lump sum, as in life insurance policies and the Social Security lump-sum burial expense payment, or they may be paid over time, as in Social Security survivor benefits.

Dementia: A group of symptoms caused by changes in brain function. Signs of dementia include changes in memory, personality, and behavior. Dementia makes it hard for a person to carry out normal daily activities. A person with dementia may ask the same questions repeatedly and get lost in familiar places. He or she may be unable to follow directions; be disoriented about time, people, and places; and neglect personal safety, hygiene, and nutrition. Older people with dementia were once called senile, and it was thought that becoming senile was just part of getting old. Dementia, however, is not a normal part of aging. It is important to find out the cause of a person's dementia, some of which can be treated and reversed. Other causes are due to irreversible changes in the brain and cannot be cured.

Funeral Rule: The Federal Trade Commission's (FTC) directive requiring funeral homes to give consumers accurate, itemized price information and various other disclosures about funeral goods and services. The FTC Funeral Rule applies to pre-need and at-need funeral arrangements.

The key to the FTC Funeral Rule is the general price list (GPL), which should be printed or typewritten, and must contain the following identifying information:

- The name, address, and telephone number of the funeral provider's place of business, including (where relevant) the address and telephone number for each branch
- The caption "General Price List"
- The effective date of the price list

The following three disclosures must appear on the statement. They should be set out, word-for-word, *exactly* as the rule prescribes. They are (1) legal requirements, (2) embalming, and (3) cash advance items.

The Funeral Rule prohibits specific misrepresentations in six areas: embalming, casket for direct cremation, outer burial container, legal and cemetery requirements, preservative and protective value claims, and cash advance items.

Geriatric care manager, or GCM: Someone who develops and implements a plan for all aspects of long-term care to assist an elderly person and, indirectly, the person's family members upon whose shoulders this task would otherwise fall.

Although graduate education is not required, a geriatric care manager usually has some form of graduate degree; social work and nursing seem to be the most common; and the GCM may be certified or licensed by a professional organization or by state statute or regulations, although this is not required.

Guardianship: The legal relationship between a ward and a guardian. Wards are usually persons the courts have declared incompetent to make particular decisions on their own behalf. Court-appointed guardians act as surrogate decision makers for the ward.

Home care: Services provided in the home to promote, maintain, and restore health or to minimize the effects of illness and disability. Home care can be for short-term purposes,

such as rehabilitative care after a hospital discharge or care for the terminally ill, or for long-term purposes, such as assistance with activities of daily living for persons with chronic disabilities.

Home health benefits: Medicare-covered services. If an individual is homebound and requires skilled services on an intermittent basis, Medicare will cover up to 35 hours per week of home health aide and skilled-nursing services. Skilled-nursing services include the administration of medication, IV therapy, tube feedings, catheter changes, and wound care. Intermittent usually means fewer than five days per week, but certain people may receive services seven days per week.

Hospice: A public agency or private organization that is primarily engaged in providing pain relief, symptom management, and supportive services to terminally ill individuals. Hospice care includes both home and inpatient care. Under the Medicare hospice benefit, Medicare covers costs of daily care and permits a hospice to provide appropriate custodial care, including homemaker services and counseling.

Individual retirement accounts, or IRAs: A tax-deferred investment and savings account that acts as a personal retirement fund for people with employment income. In a traditional IRA, contributions may be deductible or nondeductible, and the earnings may grow tax-deferred until withdrawal (assumed to be retirement), at which time they are taxed as ordinary income. IRAs are designed for individuals with earned income or married couples in which only one of the spouses has earned income and the couple files a joint return.

See also: *Roth IRA*.

Inter vivos or living trust: Generally established as a revocable trust; assets placed into the trust by the maker of the trust, who is the trustee of the trust. A successor trustee may manage those assets if the maker of the trust becomes incapacitated and will distribute the assets of the trust when the maker dies. The successor trustee is the fiduciary and has a legal duty to follow the terms of the trust as set out by the maker. This type of trust may allow the maker to avoid probate at death and conservatorship in the event of incapacity.

Keogh plans: A tax-deferred retirement plan designed to help self-employed workers or individuals who earn self-employed income establish a retirement savings program. There are two different types of Keoghs: profit-sharing and money purchase plans. Under Keogh regulations, the money purchase plan contribution is mandatory and the same percentage contribution is made each year, whether there are profits or not. The profit-sharing contribution may change each year, and individuals may contribute to both types of plans in the same year. The most attractive feature of Keogh plans is the high maximum contribution (currently up to \$40,000), which going forward will be indexed for inflation. The self-employed person makes contributions, and these along with investment earnings grow tax-deferred until withdrawal (assumed to be retirement), at which time they are taxed as ordinary income.

Last will and testament: Perhaps the most well-known means of disposing of property at death. Every state has its own rules for the making of a valid will, but at the very least, they involve a written document that is:

1. Signed by the person making it (called the testator or, if female, the testatrix), and
2. Witnessed by at least two disinterested witnesses (those who do not stand to inherit under the will).

The person nominated by the testator to wind down the affairs of the decedent is called the executor or, if female, the executrix. When a person with a will dies, he or she is said to die testate. This means, simply, that the will governs the disposition of that person's property. The alternative to dying testate is dying intestate. A person dying intestate has no last will and testament.

Living wills: A directive to physicians allowing an individual to express his or her desire not to be kept alive by extraordinary means in the event he or she is determined to be in a terminal condition. This document directs the physician to give or withhold life-sustaining medical care. The principal should state in the living will the conditions under which treatments should be continued or discontinued and what types of life sustaining efforts should be made.

Long-term care insurance: A contract between an individual and an insurance company. In exchange for the payment of premiums, the insurance company provides for the payment of a daily benefit to cover the costs of long-term care. Long-term care insurance covers an individual for many of the costs of home health care, the costs of community-based care (such as assisted living), and the costs of nursing home care. It rarely covers the costs of medical care (doctors or hospitals). This coverage works in conjunction with Medicare and/or private health insurance.

Lump-sum death benefit: A lump-sum death benefit for a Social Security recipient upon death, payable either to the surviving spouse or to a qualifying child [42 USC § 402(I)]. A qualifying child is one who was entitled to receive benefits as a result of the wage-earner's Social Security benefits.

Medicaid: A medical assistance program intended for those who have no other means to pay for necessary health care services. Entitlement is based on need alone and no premium payments are required. Medicaid is primarily administered by the states with a federal contribution that ranges between 50 percent and 80 percent of the funds paid out by the state for Medicaid services. Although specific regulations governing Medicaid vary from state to state, each state must comply with strict requirements in the Medicaid statute regarding eligible services, eligibility of participants, estate recovery, and other matters.

Medicaid for long-term care: A supplement to Medicare for what is sometimes referred to as community Medicaid benefits. Community benefits are traditional medical services delivered by physicians, hospitals, and other health care providers outside of nursing homes.

Medicare: A federal health insurance program for people aged 65 and older, those with certain disabilities, some under 65, and people of any age who suffer from permanent kidney failure (End-Stage Renal Disease). It is intended to provide basic insurance protection against health care costs, not to cover all medical expenses or long-term care. An eligible individual may choose to get benefits under Medicare through the traditional fee-for-service system (sometimes called Medicare) or through a managed care program, Medicare Advantage.

The traditional Medicare program has two parts. Part A is Hospital Insurance, and Part B is Supplementary Medical Insurance. Part A pays some of the costs of hospitalization, very limited nursing home care, and some home health services. Part B primarily covers doctors' fees and most outpatient and certain related services. Part A is free to qualifying

participants. A small monthly premium (\$66.60 per month in 2004) is charged for Medicare Part B coverage.

Medicare benefit period: Amount of time used to determine qualification for benefits. Deductible and co-payment amounts for Medicare Part A are determined per benefit period. A benefit period begins when a participant enters the hospital and continues until after the patient has been out of the hospital or skilled nursing care for 60 days. After that time, a new benefit period begins. Consequently, there may be several benefit periods in a year under Medicare Part A. Co-payments and deductibles under Medicare Part B are computed on an annual basis without regard to the benefit period provided in Medicare Part A.

Medicare Advantage: As a result of legislation passed in 1997, beneficiaries could (starting in 1999) opt out of the “traditional” Medicare program in favor of a private managed care plan or private fee-for-service plans. Medicare had been experimenting with managed care, specifically HMOs, for some time before the adoption of this legislation and a large number of Medicare beneficiaries have had coverage through HMOs for a number of years. To be eligible for Medicare managed care plans, an individual must:

- Have both Part A (Hospital Insurance) and Part B (Medical Insurance) coverage
- Not have End-Stage Renal Disease (unless he or she was already in a managed care plan before the enactment of the legislation), and
- Live in the service area of a Medicare managed care plan.

Medicare claims processors: Also known as “fiscal intermediaries” and “carriers.” Medicare intermediaries process Hospital Insurance (Part A) claims for institutional services, including inpatient hospital claims, skilled-nursing facilities, home health agencies, and hospice services. They also process hospital outpatient claims payable under Supplementary Medical Insurance (Part B). Examples of fiscal intermediaries are the Blue Cross and Blue Shield Association and commercial insurance companies.

Medicare supplemental insurance, or Medigap: Additional health insurance needed to fill the gaps in Medicare coverage. Traditional Medicare coverage does not pay all medical expenses. There are deductibles, coinsurance amounts, nonallowable charges, and noncovered services. Many retired persons and/or their spouses have protection that is provided by their former employer. Others purchase supplementary insurance policies, referred to as Medigap insurance.

Pension plans: A traditional retirement plan offered by some employers that pays a set amount each year during retirement. Also called a defined-benefit plan, company pensions guarantee a specific amount of benefits to employees, calculated using a formula that typically includes the employee's final salary, years of service, and a fixed percentage rate.

Powers of attorney: A document whereby one person (called the principal) authorizes someone else (called the agent, or the attorney-in-fact) to act on his or her behalf. A power of attorney may be general, granting broad authority to make decisions concerning investments, tax matters, and property transactions, or it may be specific, granting only limited authority to perform one of more specific duties. Every state has legislation authorizing the creation and use of powers of attorney. In all cases, the principal must be competent when the power of attorney is executed.

Note: There are different kinds of powers of attorney, also called advanced directives.

PrimePlus services: The newest phase of ElderCare. The ElderCare services brand is transitioning to PrimePlus services to make it easier for clients to see the connection between traditional services and the more global approach to the services that older clients need. The new focus on PrimePlus services leverages existing strengths and competencies in cash flow planning and budgeting, pre- and post-retirement planning, insurance reviews and tax planning. The new positioning allows CPAs to broaden their focus to include pre-retirement age clients, and to benefit from the greater revenue potential of this expanded market and from the longer term of the potential revenue stream.

Roth IRAs: A new option for IRAs introduced by the Taxpayer Relief Act of 1997. The Roth IRA offers higher income limits and more relaxed eligibility rules than available with a traditional IRA. In addition to these differences the Roth IRA turns the traditional IRA formula on its head. Retirement contributions are not deductible up front, but withdrawals can be made tax-free after age 59½.

See also: *Individual retirement accounts.*

Skilled-nursing facility benefits: Up to 100 days of Medicare-provided care in a Medicare-certified skilled-nursing facility (SNF) per benefit period if the individual was an inpatient in an acute care hospital for at least three days during the 30 days immediately before admission to the SNF and it has been determined they are in need of daily skilled services. Medicare defines *daily* as needing seven days per week of skilled-nursing care and at least five days per week of skilled therapy. Medicare pays for the first 20 days in a SNF. For days 21 through 100 a co-insurance amount is due.

Social Security: Benefits provided to qualified individuals. People qualify for Social Security retirement benefits as early as age 62 if they have held a job and paid Social Security taxes for at least 10 years in their lives. Social Security provides monthly cash benefits to retirees and their dependents, to disabled workers and their dependents, and to surviving dependents of deceased workers and retirees.

Statement of Funeral Goods and Services Selected: An itemized list of the goods and services that the consumer has selected during the arrangements conference. The statement allows consumers to evaluate their selections and to make any desired changes.

Target markets: Older adults and caregivers for older adults (usually their children). A typical older client for ElderCare/PrimePlus services is someone without an adequate local system of support. This may be because a spouse is deceased or incapacitated, or there are no children living in the area who are capable of, or willing to, assist the parent. Profiling the caregivers, usually adult children, is a more difficult matter. Individually, children may not have sufficient resources, but if they pool their resources, ElderCare services may be affordable.

The target markets described above apply to potential clients for the full range of ongoing ElderCare/PrimePlus services. The potential market for clients who would benefit from planning for the costs of long-term care and evaluation of care options is much greater. Clients at every income level can benefit from planning for these costs and the earlier a client plans, the greater choices they will have in the future.

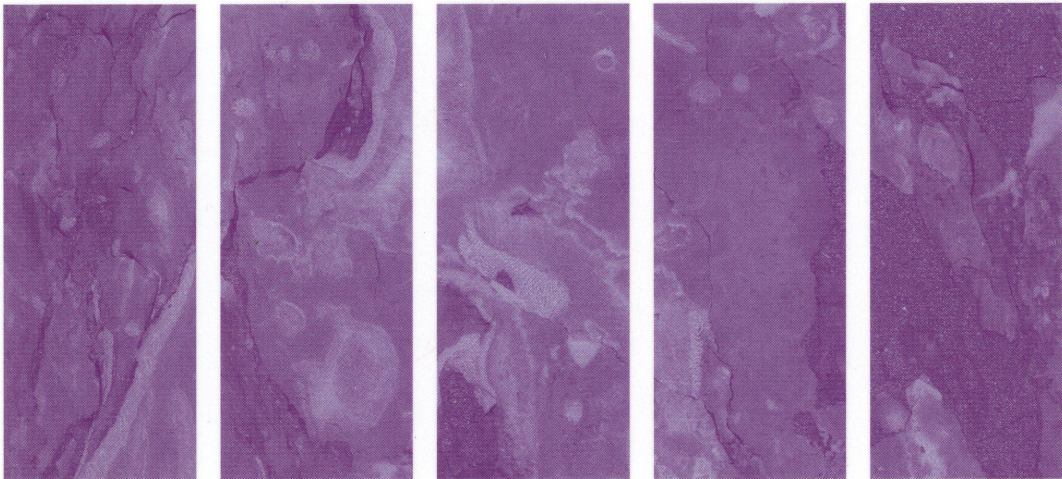
Testamentary trust: Created by the maker's will, funded by the estate, and administered by a trustee named in the will. Its primary goal is to appoint someone to manage the assets included in the trust. Incidental to this goal is saving on estate taxes.

There are several advantages to using a testamentary trust. One is that the maker can determine how the assets will be paid to the heirs. Sound financial management of the assets may also allow the assets to grow and produce additional income.

Also, a by-pass trust may be structured. In this arrangement the spouse can benefit from the trust during his or her lifetime, in which the principal is held in trust for other beneficiaries. Any remainder, even if it has doubled or tripled in value, produces no new estate taxes because the value of the trust was set for tax purposes at the time of death.

Trusts: An important element in the management of a client's estate, legal arrangements by which the legal ownership and the beneficial ownership of assets are separated. Trusts can be divided into two major categories, revocable or irrevocable. Irrevocable trusts cannot be changed (with very few exceptions) once they are put in place. They can be important in tax planning for larger estates, sometimes taking the form of insurance or a charitable trust. Each can take on many forms or variations. Revocable trusts are one of the most common estate planning tools for individuals. They can be amended or changed at any time before the person making the trust becomes incapacitated or dies. When working with an older client, it is important to continuously review and update any revocable trusts that may exist, in order to prevent conflicts and misunderstandings as well as to ensure the client's wishes will be carried out in the event of incapacitation or death.

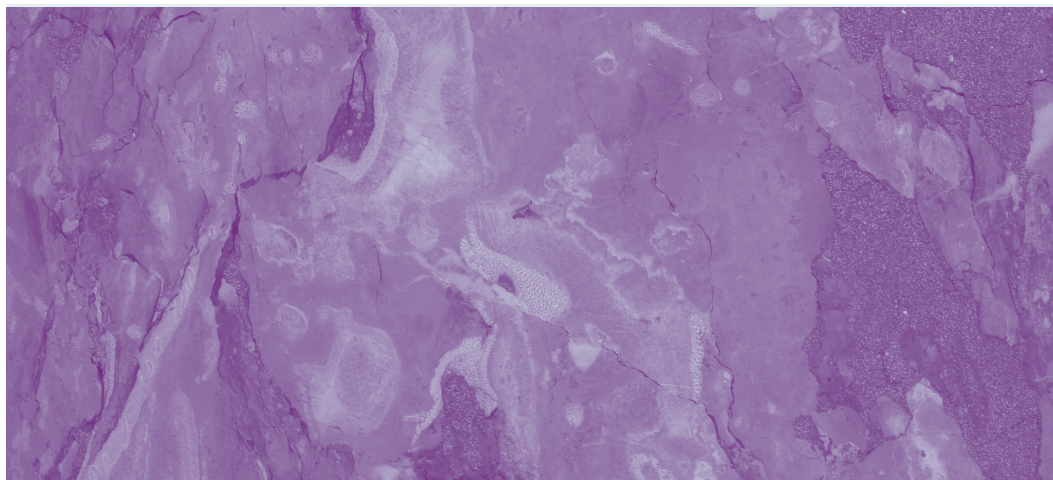
Viatical settlements: Situations in which an individual sells the benefits of his or her life insurance policy to a third party at a discount to get cash to pay for costly health care services. Viatical settlement companies may pay 60 percent of the face value of a policy to a person with a life expectancy of two years or less or as much as 80 percent to an individual with a life expectancy of six months or less. The industry generally uses the term *viatical settlement* to refer to a transaction involving a terminally or chronically ill insured and a *life settlement* to refer to a transaction involving an insured who is not terminally or chronically ill, generally over the age of 65.



CPA ElderCare/PrimePlus Services

A Practitioner's Resource Guide

Second Edition



AICPA

CPA ElderCare/PrimePlus Services: A Practitioner's Resource Guide
Toolkit CD-ROM

Introduction

The **Toolkit CD-ROM** provided with *CPA ElderCare/PrimePlus Services: A Practitioner's Resource Guide* provides forms, checklists, and other practical aids. Subject to the conditions in the License Agreement, which may be viewed on the READ-ME file on the CD-ROM, you may duplicate and modify the tools, and create your own customized forms.

The tools are accessible under the LIST OF TOOLS tab found on the opening screen of the *Toolkit*. The tools are referenced to their respective chapters in the Guide (for example, the file for “Monthly Price Comparison Worksheet” is listed under Chapter 12).

The forms and checklists on the *Toolkit CD-ROM* were produced in Microsoft Word 2000, except where noted.

The PowerPoint presentations from chapters 1 (for professionals) and 13 (for clients) require PowerPoint software; if you do not have PowerPoint, you will be unable to access this material.

In addition, one document (Chapter 12, “Sample Marketing Brochure”) is provided in portable document format or PDF. Adobe Acrobat Reader 5.0 is provided for viewing purposes. These documents may be viewed and printed but cannot be altered on screen.

[*Note:* Provided you have the appropriate software, you may open, copy, and save the files to your local drive. If you wish to convert a file to another software program, please consult the appropriate software manual to ascertain whether or not a conversion is possible.]

For the contents of the *CPA ElderCare/PrimePlus Services: A Practitioner's Resource Guide Toolkit CD-ROM*, see the LIST OF TOOLS tab.

CPA ElderCare/PrimePlus Services: A Practitioner's Resource Guide
Toolkit CD-ROM

Installation Instructions

The **Toolkit CD-ROM** provided with *CPA ElderCare/PrimePlus Services: A Practitioner's Resource Guide* provides forms, checklists, and other practical aids. Subject to the conditions in the License Agreement, which may be viewed on the READ-ME file on the CD-ROM, you may duplicate the tools, modify them as necessary, and create your own customized forms.

To Install and Use the Toolkit CD-ROM

1. The *Toolkit-CD ROM* is self loading. Insert the *Toolkit CD-ROM* (label side up) into your computer's CD-ROM drive and wait for the CD-ROM to load. If the CD-ROM should fail to load, you can load it from the "Run" menu accessible from the Start Tab on your screen.
2. The *Toolkit CD-ROM* will open to a title page screen containing 4 tabs: INSTRUCTIONS, INTRODUCTION, READ-ME, and LIST OF TOOLS.
3. To access the Tools, double click on the LIST OF TOOLS tab.
4. A linked table of contents for the tools contained on the CD-ROM will open. There are 38 tools and other materials on the CD-ROM (35 Word, 2 PowerPoint, and 1 PDF, see the LIST OF TOOLS Tab for a breakdown).
5. Click on the tool you wish to open. The tool file will open on screen in Word, PowerPoint (if you do not have PowerPoint software, you will be unable to access the PowerPoint presentations in chapters 1 and 13), or Adobe Acrobat. For example, Chapter 12, "Sample Privacy Notice" will open as a Word document. Chapter 12, "Sample Marketing Brochure," is a portable document format (PDF) file that will open in Adobe Acrobat for viewing and printing purposes but cannot be altered on screen.
6. Use the "Save As" method to save the Toolkit files to your hard drive and rename them as appropriate for your use.

Important. In order to reuse the original exhibits on your hard drive without modifications, you must save your work using the "Save As" command and give your work a different name. This will allow you to always have the unaltered files available on your hard drive and to continue to customize new documents as needed. Otherwise, you will need to pick up files from the CD-ROM each time you wish to make new documents.

Note to Users: As a general rule, remember to save your data frequently.

LIST OF TOOLS

- Chapter 1:** PowerPoint Presentation for Professionals (PowerPoint)
- Chapter 13:** PowerPoint Presentation for Clients (PowerPoint)
- Chapter 11:** Associations, Organizations, Agencies, and Other Resources (Word)
- Chapter 12:** Sample Documents and Checklists—
1. Sample Marketing Brochure (PDF)
 2. Sample Direct Mail Letter to Elder Person (Word)
 3. Sample Direct Mail Letter to Child of Elder Person (Word)
 4. Potential ElderCare/PrimePlus Clients Worksheet (Word)
 5. Cash Flow Worksheet for Potential Offering of CPA ElderCare/PrimePlus Services (Word)
 6. Detailed Information on Potential ElderCare/PrimePlus Client (Word)
 7. Sample Response Letter for CPA ElderCare/PrimePlus Services Inquiry (Word)
 8. Sample Press Release (Word)
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We do more – so you can do it all

You've got a great life – and you've worked hard to make it and keep it that way. Putting in the hours – saving – investing – planning; making the tough choices, the right choices ... the best choices.

Yet some of your most important choices still lie ahead. Where will you live? How will you live? Will you be able to have the lifestyle you want? Preserve your freedom? Provide for your family?

That's what our new **CPA PrimePlus Services** is all about: helping you make the right choices, so you can live your life the way you like it.

CPA PrimePlus Services is a unique, customized package of services designed to help you maintain your lifestyle and financial independence.



Whether you're looking to manage your own affairs more easily and efficiently, or help someone you love make the most of their resources and choices, you'll find that **CPA PrimePlus Services** offers you a better way to handle the business of life.



Introducing our CPA PrimePlus ServicesSM ...



It means getting the most out of life

CPA primeplusSM
SERVICES
Resources • Strategies • Solutions

123-000-0000

Accounting Firm
1234 Any Street in the World
City, ST XXXXX



CPA PrimePlus ServicesSM can help ease your mind – and shed new light on living well



Q Why should I use a CPA PrimePlus professional?

A Integrity, expertise, accountability, confidentiality – they’re all good reasons to count on us as your trusted advisor. You can depend on us for accurate evaluations and impartial advice. When it comes to balancing your financial and lifestyle goals, CPA PrimePlus Services offers a comprehensive, tailored approach to meeting your changing needs.

Q Now that she’s on her own, Mom has had a difficult time managing her accounts and assessing her long-term needs. I want to help her ... can CPA PrimePlus Services help us both?

A Definitely! CPA PrimePlus Services can be of special benefit to time-pressed families who want to help a loved one maximize and maintain their independence. CPA PrimePlus Services is especially valuable in helping families come together to make sound, caring decisions.

Q Will I be expected to pay for services I don’t need?

A Absolutely not. One of the strengths of CPA PrimePlus Services is flexibility – we can tailor our services specifically to meet your individual needs.

Special services to help you make your best choices – while easing your workload and worry

As we mature, the relationship between financial needs and lifestyle choices can become increasingly complex. As your CPA PrimePlus Services professional, we can help you better see and understand “the big picture,” so you can make your best decisions in your retirement years.

Our training and expertise makes us uniquely qualified to offer objective, accurate assessments of our client’s resources and how they’re managed. So, we’re a logical source for mature adults to turn to for expert, confidential

assistance in meeting challenges and making choices.

Wide-ranging, informed, impartial advice from someone you can trust: that’s exactly what we offer with CPA PrimePlus Services.

Expert, impartial advice for the prime of your life

More time to call your own – and more peace of mind. Find out how our CPA PrimePlus Services can make a difference for you. Call us today for more details.



123-000-0000

Accounting Firm
1234 Any Street in the World
City, ST XXXXX

Sample Direct Mail Letter to Elder Person

Mrs. Mary Jones
523 Circle Court
Hapsburg, MD

Dear Mrs. Jones:

I am looking forward to seeing you next week when you have an appointment for preparation of your Federal and state tax returns. While you are in the office, I would like to discuss with you ways in which we can be of additional assistance to you and how we can relieve you of some of the duties that you are now handling.

Our firm offers CPA PrimePlus Services to make life easier for those of our clients who want to enjoy their retirement and not have to be “tied down” with daily or weekly chores that could easily be handled by someone else. A brochure that explains PrimePlus Services is enclosed. As you can see, these services range from ordinary, routine financial services to services that are not normally associated with a CPA firm.

Among the traditional services that you might be interested in are:

- Check preparation and bill paying. (You would still sign all checks.)
- Reconciliation of bank statements.
- Accounting for revenues and expenditures and accumulating the information needed for you annual tax returns.
- Banking services, including making deposits of income you receive and making sure that you have received all items due you in a timely fashion.
- Review and accounting for your brokerage accounts to make sure that the broker is following your instructions concerning investments.
- Preparation of payroll tax returns for your household help.

Among the nontraditional services we offer are:

- Assistance in planning for long-term care, if necessary.
- Advice in financing long-term care.
- Assistance in supervision of household repairs and inspection of your property to make sure it is being properly maintained.
- Assistance in selection of care providers, if required.

These are just a few of the services offered as a part of PrimePlus Services. You can select as few or as many services as you need.

So before you come to your appointment next week, think about the things that “keep you awake at night” and the things that you don’t like to do or no longer feel comfortable doing. We will be happy to discuss these with you and help you make arrangements to solve these problems so that you can enjoy your retirement years.

I look forward to seeing you next week.

John H. Brown, CPA

Encl.

Sample Direct Mail Letter to Child of Elder Person

Mr. Harold Jones
1800 Palm Boulevard
San Francisco, CA

Dear Mr. Jones:

I visited in the office with your mother last week when she came in for her tax return preparation appointment. Since you are her only child, I know you may be concerned that you are across country from your mother and not able to assist her in various matters. Many of us today are in the same situation: our jobs and careers make it impossible to be around to check on our parents and to see if their needs are being met and if they are being protected from all of the scam artists who prey on the elderly.

Our firm is offering CPA ElderCare Services to relieve some of the worries of children such as yourself and to help elderly persons live in their own homes as long as possible with dignity and protection from would-be predators. I am enclosing a brochure which describes the range of the services offered.

As you can see, these services range from financial and accounting services typically offered by CPA firms, such as check preparation, banking and accounting, to services that are needed by some elderly persons but that are not traditionally handled by CPAs including such things as arranging transportation and supervising care and maintenance of their homes. Each of our clients can select only those services they need or desire.

If at any time you feel that your mother needs assistance in performing various tasks, either financial or nonfinancial, discuss this service with her and give me a call. I will set up an appointment with her to discuss ways in which we can help her enjoy her retirement years. And if at any time you have concerns about your mother, give me a call.

Sincerely,

John H. Brown, CPA

Encl.

Potential ElderCare/PrimePlus Clients Worksheet

(Services Presently Being Provided)

NAME AND ADDRESS	AGE	TAX RETURN	TAX PLANNING	PERSONAL FINANCIAL PLANNING	ESTATE PLANNING	OTHER (DESCRIBE)

Cash Flow Worksheet for Potential Offering of CPA ElderCare/PrimePlus Services

1. Potential clients identified in firm's client base:

- a. Tax clients with ages in excess of 65 _____
- b. Personal financial planning clients _____
- c. Total number of potential clients _____
- d. Estimated percent of clients who would purchase the services _____%
- e. Estimated number of clients _____
- f. Estimated average billing per client, per month _____
- g. Estimated monthly revenue from ElderCare/PrimePlus clients _____

2. Costs to get started:

- a. Brochures (_____ @ \$_____ each) \$_____
- b. Direct mail letters (_____ @ \$_____ each) \$_____
- c. Literature:

Development and Management of an ElderCare Practice (self-study) \$_____

CPA PrimePlus Marketing Toolkit \$59.00

CPA ElderCare/PrimePlus Services: A Practitioner's Resource Guide \$129.00

_____ \$_____

d. Personnel costs:

Partner (___ hours @ \$_____) \$_____

Manager (___ hours @ \$_____) \$_____

Paraprofessional/secretarial (___ hours @ \$_____) \$_____/ \$_____

e. Office supplies for ____ clients @ \$ _____ each\$ _____

f. Total start up costs _____

3. On-going costs:

a. Personnel costs:

Partner (____ hours @ \$ _____)\$ _____

Manager (____ hours @ \$ _____)\$ _____

Paraprofessional/secretarial (____ hours @ \$ _____)\$ _____/\$ _____

b. Attendance for one person annually at ElderCare Conference\$ _____

c. One seminar per year on elder issues \$ _____

d. Increase in liability insurance cost to include bodily injury coverage\$ _____

e. Other \$ _____

f. Total on-going costs \$ _____

4. Profitability projection:

	Year 1	Year 2	Year 3
Annual billings for ElderCare/PrimePlus Services			
Start-up costs			
On-going costs			
Gross profit			

Detailed Information on Potential ElderCare/PrimePlus Client

Name:

Location of residence:

Mailing address:

Telephone No. (____) _____ - _____

Married____ Widowed____ Single____ Divorced____

1. Closest relatives/children:

Name: _____

Address: _____

City/state: _____

Telephone No. (____) _____ - _____

Name: _____

Address: _____

City/state: _____

Telephone No. (____) _____ - _____

Name: _____

Address: _____

City/state: _____

Telephone No. (____) _____ - _____

Name: _____

Address: _____

City/state: _____

Telephone No. (____) _____ - _____

2. Why is this person considered a potential ElderCare client?

3. Caregivers presently employed by client

- In-house sitters/nurses
- Social worker/geriatric care manager
- Home health services
- Meal preparers/housekeepers
- Other (describe)

4. Services presently provided by our firm and [*date of last appointment*]:

- Tax return preparation (_____)
- Tax planning (_____)
- Personal financial planning (_____)
- Estate tax planning (_____)

5. Date and purpose of next appointment: _____

6. Partner responsible for client: _____

7. Does the responsible partner agree that the client is a potential ElderCare services client?

yes no

8. Why or why not?

9. Services that might be provided to client:

- Banking
- Payroll preparation
- Payroll returns
- Check preparation/payment of bills
- Preparation and payment of estimated taxes
- Assistance in housing options
- Other (describe)

10. What is best way to contact client?

- Brochure
- Direct mail
- Personal visit
- Other

11. Person assigned to contact client: _____

12. Date or time of contactⁱ : _____

13. Does information on ElderCare/PrimePlus services need to be furnished to client prior to meeting?

_____ yes _____ no

14. Information to be furnished/mailed and [*date*]:

ⁱ This might be the date of the next scheduled appointment with client for other services being provided by firm.

Sample Response Letter for CPA ElderCare/PrimePlus Services Inquiry

To promote your ElderCare/PrimePlus 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 provide. You should promptly and properly respond to inquiries about your ElderCare/PrimePlus 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/PrimePlus 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 help 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/PrimePlus services offer the correct mix of assistance and oversight protection to help our clients' later years 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/PrimePlus 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/PrimePlus 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/PrimePlus 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/PrimePlus services. CPA ElderCare/PrimePlus 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, 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/PrimePlus 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/PrimePlus Services offer the right mix of protection and assistance to help the golden years truly be happy ones."

Sample Engagement Letter—Elderly Person Contracting With the CPA Directly¹

June 6, 20XX

Mrs. Rena Flint
31 Dogwood Road
Front Royal, Virginia

Dear Mrs. Flint,

In accordance with your late husband's stated wishes, we are pleased that you have selected our firm to provide you with CPA ElderCare/PrimePlus 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 adviser, 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.

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.

¹ For corresponding directly with the older adult, use 14 point font or higher.

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 Advance 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 from \$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. Any difference between the monthly retainer amounts for the year and the annual billing will be settled at that time, either by payment of additional amounts to our firm or by a refund to you.

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:

Sample Engagement Letter—Attorney in Fact for Elderly Person Contracting With the CPA

Dear Mr. Farragut:

Thank you for choosing Audit, Accounting & Associates to provide CPA ElderCare/PrimePlus Services to your mother, Mrs. Farragut. It is our understanding that you are the agent for your mother, acting under a durable, unlimited power of attorney, dated January 1, 20XX.

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 basis. 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 believe 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, 20XX. 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 e-mail.
- 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.¹ 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. Suchecki, 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 no less often than annually.

¹ Specifically list all the tax returns you would contemplate preparing for the client. Avoid statements such as “all tax returns” or “all necessary returns.”

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 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. Farragut's attorney by registered mail as to our intentions to withdraw from the engagement.

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 & Associates

Sample Engagement Letter—With Agency Agreement

June 6, 20XX

Mr. Paul Bellarmine
as Attorney in Fact for Mrs. Margaret Bellarmine

Dear Mr. Bellarmine:

We are pleased that you have selected our firm to provide CPA ElderCare/PrimePlus 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 adviser, 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 Christopher Pike. We will notify you when minor repairs are needed and will contract out services that Mr. Pike 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, Mrs. Lincoln, but it is our understanding that such reports to Mrs. 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 Mrs. Lincoln concerning matters discussed in this agreement. If such disagreements arise and a compromise cannot be reached between you and Mrs. 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 Henry McIntock, 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 with you or your mother. 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 an annual 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

Sample Engagement Letter—Sample Agency Agreement for Receipts and Disbursements

PRINCIPAL: Mr. Paul Bellarmine, as attorney in fact for Mrs. Margaret Bellarmine

AGENT: Audit, Accounting & Associates and Henry McIntok, 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 McIntok, CPA (called Agent) agree as follows:

1. *Background:* Principal has retained regularly the services of Henry McIntok, CPA (McIntok), of Audit, Accounting & Associates to perform for Principal various accounting functions and services. Principal wishes to retain McIntok 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 McIntok 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 McIntok 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 30 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 monthly, 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 _____

Henry McIntok, CPA/AGENT _____

Estimated Revenues (*Boxes indicate month in which a receipt is anticipated.*)

Indicate Date Received

	Jan.	Feb.	March	April	May	June	July	Aug.	Sept.	Oct.	Nov.	Dec.
Social Security												
XYZ Co. Pension												
<i>Interest:</i>												
CD-City Bank												
Savings account-FNB												
<i>Dividends:</i>												
ABC National												
Cleon Corp.												
<i>Rents:</i>												
123 Adams Ave. B&C Building												
<i>Mineral Royalties:</i>												
Gas & Oil Company Abita Trust												

Sample Contract with Elderly Person for Banking and Accounting Assistance Only

June 6, 20XX

Mrs. Henry Smith
1221 Hidden Lake Road
Smithville, Tennessee

Dear Mrs. Smith:

In accordance with the terms of our discussions, we are pleased to provide accounting services to you. This letter summarizes the terms of our engagement and your responsibilities in connection therewith.

You will accumulate all financial information received at your home (invoices for payment, checks received, and any other financial correspondence) and place them in a file which we will supply. Weekly, Miss Tracy Manning, a member of our staff, will visit your home and bring all the information back to our office for processing and accounting, as follows:

1. Checks will be prepared on your checking account for all invoices requiring payment. It is our understanding that you will make arrangements to have automatic checking account deductions made for bills for utilities, cable television service, and telephone service.
2. A deposit slip will be prepared for any revenue receipts and carried to your bank. Copies will be made of the checks deposited and attached to your copy of the deposit ticket.
3. The prepared checks, with invoices attached to each, will be returned to you on the following visit for your approval and signature.
4. All transactions on your account will be recorded on our computer system and a listing of those transactions will be provided to you at the end of each month.
5. Upon receipt of the bank statement, we will reconcile your checking account on a monthly basis.

6. Annually, we will provide you a detail listing of all transactions in your checking account so that you may use that information for preparation of the necessary income tax returns. Although our firm will prepare your income tax returns, such preparation shall be considered a separate engagement and not a part of this agreement.

Since you have indicated that you will be traveling from time to time, it is our understanding that you have given a durable, unlimited power of attorney to your sister, Mrs. Sam Kaplan. In the event you are going to be away from home for an extended period, you will notify us and we will make arrangements with Mrs. Kaplan to retrieve your mail and deliver it to Miss Manning on a weekly basis. Any checks prepared for payment will be signed by Mrs. Kaplan in your absence.

It will be your responsibility to insure that all invoices are furnished to us; and you will have the responsibility to determine whether all revenue due to you has been received. Our responsibility will be limited to processing the information you have furnished to us, as described above.

Our fees for this service will be at our normal hourly rates and will be billed to you monthly. Either party to this agreement may cancel this engagement at any time. [*Note:* Since this agreement does not involve the safety and well-being of Mrs. Smith, the normal grace period prior to termination is not considered necessary.]

If this letter correctly expresses your understanding, please sign the enclosed copy where indicated and return it to us.

Sincerely,

Jones, Smith and Connery
Certified Public Accountants

By _____

Accepted and agreed to:

Mrs. Henry Smith

Date

Sample Privacy Notice Requirements and Distribution Form

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 that clients of an ElderCare/PrimePlus practitioner 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/PrimePlus 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/PrimePlus engagements?
- Has a lawyer been consulted on our policies of disclosing confidential client information in conjunction with the performance of an ElderCare/PrimePlus engagement?
- Has the firm's underwriter been contacted to make sure that our existing policy covers ElderCare/PrimePlus services?

Client Issues

- Do we know who the client is? Have we made that clear to all parties to the engagement? ¹
- 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/her 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?

¹The AICPA ElderCare/PrimePlus Task Force has recommended that the client should always be considered to be the elderly person. Please see the course, Developing and Managing an ElderCare/PrimePlus 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/PrimePlus 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

Sample Client Intake Form (Continued)

Level of education: College _____ High school _____ Elementary _____

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: _____

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: _____

Sample Client Information Form (continued)

Address: _____

Phone number: _____

Kennel: _____

Children

Name	Living?		Maintain contact?	
	Yes	No	Yes	No

Siblings

Name	Living?		Maintain contact?	
	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: _____

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: _____

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, primary caregiver, 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 _____

Sample Client Assessment Form (continued)

Ethnicity:

White ____ Hispanic ____ Black ____ Asian ____ Am. Indian ____ Other ____

Primary language: English _____ Spanish _____ Other _____

Interpreter needed: Yes _____ No _____

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 Supplement _____

Medigap: Policy name and number: _____

Medicaid: Yes _____ No _____ Medicaid number: _____

Comments: _____

Sample Client Assessment Form (continued)

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: _____

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 | Yes/No |
| b. Trouble seeing | Yes/No |
| c. Trouble sleeping | Yes/No |
| d. Trouble with teeth or dentures | Yes/No |
| e. Foot problems | Yes/No |
| f. Pain | Yes/No |
| g. Fatigue | Yes/No |
| h. Falling, losing balance | Yes/No |

Comments: _____

Sample Client Assessment Form *(continued)*

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 _____

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: _____

Sample Client Assessment Form *(continued)*

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: _____

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?

- 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

No difficulty	Some difficulty	Unable to do

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 _____

Sample Client Assessment Form (continued)

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—

- a. Shopping for personal items?
- b. Using the telephone?
- c. Doing light housework?
- d. Preparing meals?
- e. Using public transportation or riding in automobile?
- f. Taking medications?

Yes	No	Does not do it

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—

- a. Taking a bath or shower?
- b. Dressing?
- c. Using the toilet?
- d. Getting in or out of bed?
- e. Eating?
- f. Walking?

Yes	No	Does not do it

You mentioned that you receive help with daily living activities. Who provides the help?

Who gives you the most help? _____

Comments: _____

Sample Client Assessment Form *(continued)*

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

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

Sample Client Assessment Form *(continued)*

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 _____

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 many 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

Sample Client Assessment Form (*continued*)

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

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 “most of the time” or if bothered by emotional problems “quite a bit,” refer the client for professional evaluation.]

Sample Client Assessment Form *(continued)*

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
- 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

Sample Client Assessment Form *(continued)*

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 of time 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: _____

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: _____

Sample Client Assessment Form *(continued)*

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	_____		

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 _____

Sample Client Assessment Form (*continued*)

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–\$19,999

\$20,000–\$29,999

\$30,000 or more

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

Sample Client Assessment Form *(continued)*

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
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: _____

Sample Client Assessment Form *(continued)*

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: _____

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: _____

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: _____

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/PrimePlus 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/PrimePlus 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/PrimePlus 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	\$ _____

Monthly Price Comparison Worksheet *(continued)*

Repairs and maintenance	\$ _____
Doctor bills	\$ _____
Medicine	\$ _____
Transportation	\$ _____
Groceries or meal delivery	\$ _____
Homemaker/sitter	\$ _____
Health care aide	\$ _____
Gardener	\$ _____
Transportation	\$ _____
CPA ElderCare/PrimePlus 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)
- 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)

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)
- Individual retirement accounts (IRAs) and registered retirement savings plans (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)
- Attorney (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 and superintendent (names, addresses, telephones, access to keys or client's home)

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) order	_____	_____	_____
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	_____	_____	_____
Other: _____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Monthly Engagement Checklist

Client _____

For month of _____

Client was visited ___ times this month by _____.

During the visits inquiries were made about :

Did the client have any comments or complaints about the care or the sitters from _____ Agency?

Did the shopping service arrive to pick up the client and her sitter for their regular shopping trips?

Did the cleaning service come as agreed upon?

Did the client have any concerns?

_____ 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 on which all rents were received _____.

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 being 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”)

- 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?

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 the client?
- If other transportation services are 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?	_____	_____

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—Quick Form

Name of Nursing Home: _____ Date of Visit: _____

	Yes	No	Comments
Basic Information			
The nursing home is Medicare-certified.			
The nursing home is Medicaid-certified.			
The nursing home has the level of care needed (e.g. skilled, custodial), and a bed is available.			
The nursing home has special services if needed in a separate unit (e.g. dementia, ventilator, or rehabilitation), and a bed is available.			
The nursing home is located close enough for friends and family to visit.			
Resident Appearance			
Residents are clean, appropriately dressed for the season or time of day, and well groomed.			
Nursing Home Living Spaces			
The nursing home is free from overwhelming unpleasant odors.			
The nursing home appears clean and well-kept.			
The temperature in the nursing home is comfortable for residents.			
The nursing home has good lighting.			
Noise levels in the dining room and other common areas are comfortable.			
Smoking is not allowed or may be restricted to certain areas of the nursing home.			
Furnishings are sturdy, yet comfortable and attractive.			
Staff			
The relationship between the staff and the residents appears to be warm, polite, and respectful.			
All staff wear name tags.			
Staff knock on the door before entering a resident's room and refer to residents by name.			
The nursing home offers a training and continuing education program for all staff.			

Source: Nursing Home Checklist, Centers for Medicare and Medicaid Services, 2003; also see <http://www.medicare.gov/Nursing/Checklist.pdf>

Nursing Home Checklist—Quick Form *(continued)*

	Yes	No	Comments
Staff <i>(continued)</i>			
The nursing home does background checks on all staff.			
The guide on your tour knows the residents by name and is recognized by them.			
There is a full-time Registered Nurse (RN) in the nursing home at all times, other than the Administrator or Director of Nursing.			
The same team of nurses and Certified Nursing Assistants (CNAs) work with the same resident 4 to 5 days per week.			
CNAs work with a reasonable number of residents.			
CNAs are involved in care planning meetings.			
There is a full-time social worker on staff.			
There is a licensed doctor on staff. Is he or she there daily? Can he or she be reached at all times?			
The nursing home's management team has worked together for at least one year.			
Residents' Rooms			
Residents may have personal belongings and/or furniture in their rooms.			
Each resident has storage space (closet and drawers) in his or her room.			
Each resident has a window in his or her bedroom.			
Residents have access to a personal telephone and television.			
Residents have a choice of roommates.			
Water pitchers can be reached by residents.			
There are policies and procedures to protect resident's possessions.			
Hallways, Stairs, Lounges, and Bathrooms			
Exits are clearly marked.			
There are quiet areas where residents can visit with friends and family.			
The nursing home has smoke detectors and sprinklers.			
All common areas, resident rooms, and doorways are designed for wheelchair use.			
There are handrails in the hallways and grab bars in the bathrooms.			

Nursing Home Checklist—Quick Form *(continued)*

	Yes	No	Comments
Menus and Food			
Residents have a choice of food items at each meal. (Ask if your favorite foods are served.)			
Nutritious snacks are available upon request.			
Activities			
Residents, including those who are unable to leave their rooms, may choose to take part in a variety of activities.			
The nursing home has outdoor areas for resident use and staff help residents go outside.			
The nursing home has an active volunteer program.			
Safety and Care			
The nursing home has an emergency evacuation plan and holds regular fire drills.			
Residents get preventive care, like a yearly flu shot, to help keep them healthy.			
Residents may still see their personal doctors.			
The nursing home has an arrangement with a nearby hospital for emergencies.			
Care plan meetings are held at times that are convenient for residents and family members to attend whenever possible.			
The nursing home has corrected all deficiencies (failure to meet one or more Federal or State requirements) on its last state inspection report.			

Nursing Home Checklist—Comprehensive

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 and 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)?

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 AND 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 e-mail
 - 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 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?

Nursing Home Checklist *(continued)*

- 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?
- 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 ?

Nursing Home Checklist *(continued)*

- 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?
- 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?

Nursing Home Checklist *(continued)*

- 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 Agency 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 Expenitures 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 (net of applicable taxes)	_____	_____	_____
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	=====	=====	=====

Receipts and Expenditures Worksheet *(continued)*

	Husband	Wife	Total
Expenditures—Clothing			
Clothing purchases	_____	_____	_____
Cleaning and alteration	_____	_____	_____
Subtotal	=====	=====	=====
Expenditures—Transportation			
Automobile payments	_____	_____	_____
Automobile insurance	_____	_____	_____
Fuel	_____	_____	_____
Repairs	_____	_____	_____
Taxis and public transportation	_____	_____	_____
Other	_____	_____	_____
Subtotal	=====	=====	=====
Expenditures—Insurance Premiums			
Disability	_____	_____	_____
Liability	_____	_____	_____
Life	_____	_____	_____
Medicare Part B	_____	_____	_____
Medicare prescription discount card	_____	_____	_____
Medigap	_____	_____	_____
Employer group health	_____	_____	_____
Long-term care insurance	_____	_____	_____
Other	_____	_____	_____
Subtotal	=====	=====	=====

Receipts and Expenditures Worksheet *(continued)*

	Husband	Wife	Total
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	_____	_____	_____
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/PrimePlus 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 elder law 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.

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 a 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 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.

Review Checklist for Wills *(continued)*

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 for 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, 20XX

Mrs. Sarah Snyder
31 Dogwood Road
Front Royal, Virginia

In accordance with the engagement letter between our firm and you dated May 26, 20XX, the following report details our activities for the quarter ended March 31, 20XX.

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, 20XX.

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, 20XX, 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, 20XX:

- 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 20XX.

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.

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

Sample Oral Report Memo to the File

TO: Files
FROM: Bernadette Galland
SUBJECT: Mrs. Farragut
DATE: April 18, 20XX

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. 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.

Sample 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, 20XX.

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

Sample Agreed-Upon Procedures Report (continued)

**Independent Accountant's Report
on Applying Agreed-Upon Procedures**

Mrs. Regina Crater
105 Union Road
Franklin, Tennessee

Dear Mrs Crater:

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, 20XX, 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, 20XX. Burdette Home Care Agency is responsible for complying with the terms and conditions of the December 30, 19XX, 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, 20XX, through March 31, 20XX, 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, 20XX, through March 31, 20XX, 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, 20XX, through March 31, 20XX, 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, 20XX, through March 31, 20XX, 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, 20XX, indicated the following information:

<i>Prescription Refills</i>	<i>Last Filled</i>	<i>Remaining</i>
Drug A	November 22, 20XX	None
Drug B	December 12, 20XX	Three
Drug C	December 12, 20XX	Two

Sample 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.¹ 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, 20XX

¹ 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.

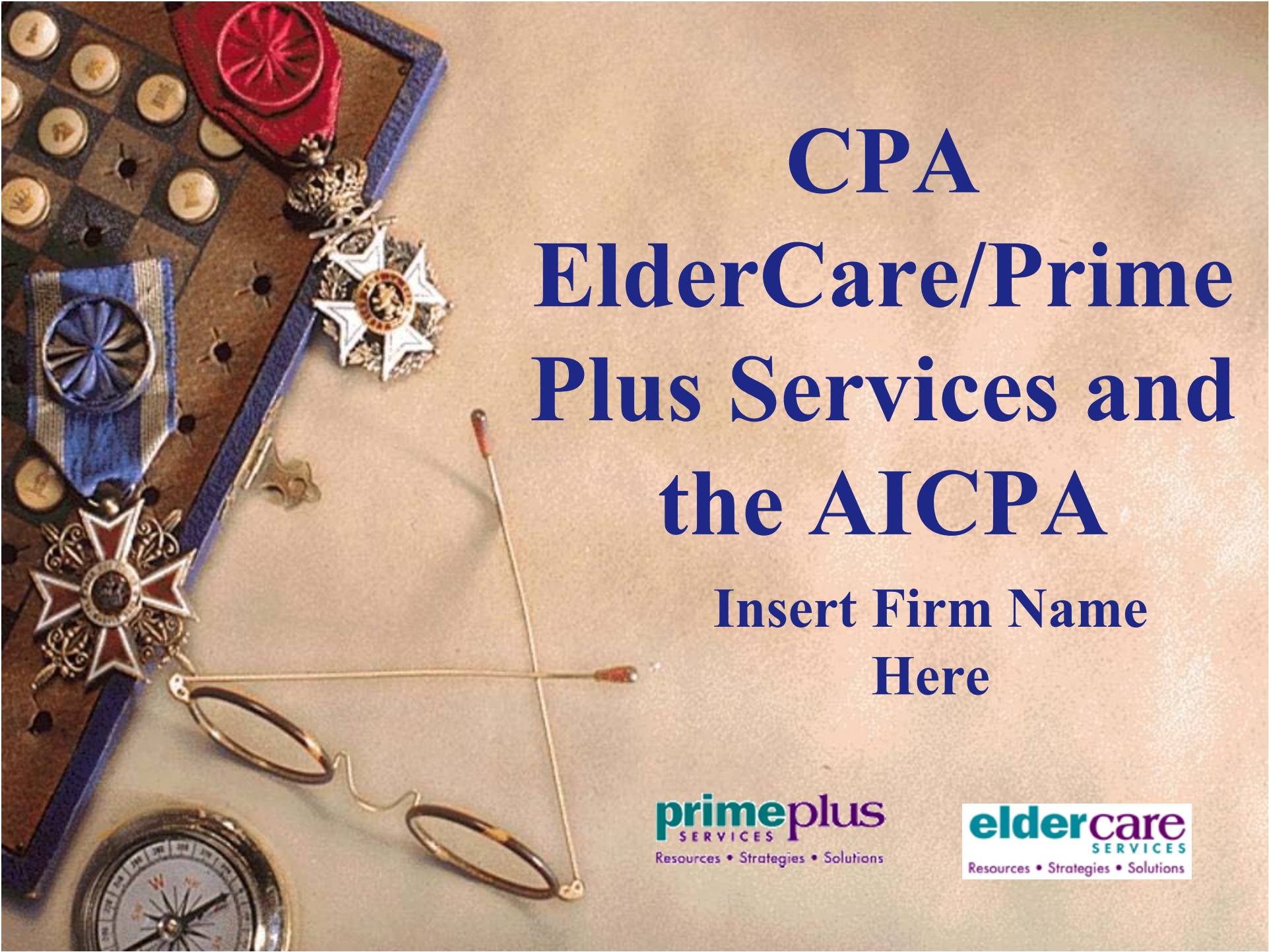
Long-Term Care Insurance Policy Checklist

	<i>Yes</i>	<i>No</i>
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 will judge when benefits can be received?	_____	
How will they judge?	_____	
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 nonforfeiture 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 nursing home 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 preexisting conditions?	_____	

Long-Term Care Insurance Policy Checklist (continued)

	<i>Yes</i>	<i>No</i>
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 rating?	_____	_____

Rating Agencies	Phone	Web site
A.M. Best Worldwide Headquarters Ambest Road Oldwick, NJ USA	Customer service: (908) 439-2200, ext. 5742	http://www.ambest.com
Fitch Ratings Ltd. Corporate Headquarters (USA) One State Street Plaza New York, NY 10004	(212) 908-0500 (800) 753-4824	http://www.fitchratings.com
Moody's Investors Service Moody's Corporation 99 Church Street New York, NY 10007	(212) 553-0377 (Ratings Desk) (212) 553-1658 (Investor Services Group)	http://www.moodys.com
Standard & Poors (USA) (a division of The McGraw-Hill Companies, Inc.) 55 Water Street New York NY 10041	(212) 438-1000 or (212) 438-2000 (Index Services)	http://www.standardandpoors.com
Weiss Ratings Inc. 15430 Endeavour Dr. Jupiter, FL 33478	(800) 289-9222 (Sales & Customer Service) or (561) 627-3300 (Corporate Offices)	http://www.weissratings.com

A collection of military medals and a pair of glasses on a wooden surface. The medals include a red ribbon with a circular emblem, a blue ribbon with a circular emblem, and two large star-shaped medals with intricate designs. A pair of gold-rimmed glasses with thin temples is positioned diagonally across the lower half of the image. A small compass is visible in the bottom left corner.

CPA ElderCare/Prime Plus Services and the AICPA

Insert Firm Name
Here

primeplus
SERVICES
Resources • Strategies • Solutions

eldercare
SERVICES
Resources • Strategies • Solutions



Overview of Session

- ◆ AICPA/CICA
ElderCare/PrimePlus
Services Task Force
- ◆ The Need for
ElderCare/PrimePlus
Services
- ◆ Definition
- ◆ Types of Services
- ◆ Reporting
- ◆ Program Evaluation
- ◆ Scope of Engagement
- ◆ CPA Requirements
- ◆ Considerations
- ◆ Resources
- ◆ The Future

AICPA/CICA ElderCare/PrimePlus Task Force



- ◆ Educational programs
- ◆ Practice development tools
- ◆ ElderCare/PrimePlus Competency Model
- ◆ Annual ElderCare/PrimePlus Conference
- ◆ Developing awareness of the service

primeplus
SERVICES
Resources • Strategies • Solutions

eldercare
SERVICES
Resources • Strategies • Solutions



The Need for ElderCare/PrimePlus Services

- ◆ America is aging—fast!
 - By the year 2010, approximately 40 million people will be 65 years and over; by 2030 this number will be 71.5 million people.
- ◆ 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 and “beanpole” families, and distance from older family members is often a consideration
- ◆ Older adults could benefit from protection from unscrupulous individuals and businesses.



What Is ElderCare?

- ◆ 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.”



- ◆ Assist clients in planning for the issues of aging.
- ◆ 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.



What Are CPA PrimePlus Services?

- ◆ “Elder” restricted market to persons over age 65.
- ◆ “Care” implied health care.
- ◆ “PrimePlus” removes negative connotations and allows promotion of the services to a younger group of clients.
- ◆ Both names will continue to be supported by the AICPA.

Types of CPA Eldercare/PrimePlus Services*



- ◆ Consulting Services
- ◆ Direct Services
- ◆ Assurance Services

*Any of these may include financial and nonfinancial services.



Examples of Consulting Services

- ◆ Assist clients and their families with the issues of aging.
- ◆ Establish standards of care with the client or family
- ◆ Develop an inventory of community resources and services
- ◆ Assist clients and families to develop and establish:
 - Goals of assistance
 - Customized delivery plan
 - Expected standards of performance
 - Communication of expectations to care providers



Examples of Direct Services

- ◆ Routine accounting and supervision of tasks
- ◆ Accounting for client's income and deposits
- ◆ Payment of bills
- ◆ Conducting routine financial transactions and monitoring revenue for timeliness and accuracy
- ◆ Supervision of investments
- ◆ Accounting for estates
- ◆ Arranging, paying for care providers
- ◆ Arranging transportation
- ◆ Supervising household expenditures



Examples of Assurance Services

- ◆ Review of routine financial transactions
- ◆ Investigate and provide information to responsible parties
- ◆ Inspect logs and diaries of care providers to ensure agreed-upon performance criteria are met
- ◆ Report findings to client, family members, or other responsible parties

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.

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



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



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



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



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

Resources for the Practitioner



- ◆ AICPA CPE courses on ElderCare/PrimePlus services
- ◆ AICPA Assurance Services Alert: CPA ElderCare Services
- ◆ Web site: www.aicpa.org/ecpp
- ◆ AICPA Annual ElderCare/PrimePlus Services Conference
- ◆ AICPA PrimePlus Marketing Tool Kit
- ◆ CPA ElderCare/PrimePlus Services: A Practitioner's Resource Guide

The Future

- ◆ AICPA Web site:
www.aicpa.org/ecpp
- ◆ AICPA/CICA
ElderCare/PrimePlus
Services Task Force



CHAPTER 11:

Associations, Organizations, Agencies, and Other Resources

A tremendous amount of information related to aging and aging organizations is available to practitioners. Utilize the following groups and resources for additional information for your ElderCare/PrimePlus clients and families.

Associations and Organizations*

Note: The list of Associations and Organizations (organized alphabetically) including their description and contact information follows:

Agency for Healthcare Research & Quality (AHRQ)

Publications Clearinghouse
PO Box 8547
Silver Spring, MD 20907-8547
Phone: (800) 358-9295 (toll-free)
Web site: <http://www.ahrq.gov>

AHRQ, part of the federal government, provides an information clearinghouse service that distributes *Evidence-Based Summaries and Reports*, *Clinical Practice Guidelines*, and other medical statistics and information. Call to order copies of guidelines on topics such as cardiac rehabilitation, treatment of pressure sores, or other publications on elder and long-term health care, health insurance, and minority health data. Visit the Web site to download *Clinical Practice Guidelines* on topics such as urinary incontinence, screening for Alzheimer's disease, and post-stroke rehabilitation.

AIDS Clinical Trials Information Service (ACTIS)

PO Box 6421
Rockville, MD 20849-6421
Phone: (800) TRIALS-A (874-2572) (toll-free) (English, Spanish, Portuguese)
(301) 519-0459
TTY: (888) 480-3739 (toll-free)
Fax: (301) 519-6616
E-mail: actis@actis.org
Web site: <http://www.actis.org>

* Source: The material in the "Associations and Organizations" section is taken from *The Resource Directory for Older People*, a cooperative effort of the National Institute on Aging (NIA) and the Administration on Aging. It is available on NIA's Web site at <http://www.nia.nih.gov/health/resource/rd2001.htm> and on AoA's Web site at <http://www.aoa.gov>.

ACTIS, funded by the federal government, is a central resource providing current information on federally and privately sponsored clinical trials for HIV/AIDS patients. Free, confidential information is available in English, Spanish, or Portuguese.

Alliance for Aging Research

2021 K Street, NW, Suite 305
Washington, DC 20006
Phone: (202) 293-2856
Fax: (202) 785-8574
Web site: <http://www.agingresearch.org>

The Alliance is a national, citizen advocacy organization offering free publications including *Investing in Older Women's Health*, *Meeting the Medical Needs of the Senior Boom*, *Delaying the Diseases of Aging*, and other aging-related subjects such as menopause, how to age with ease, and health care options under Medicare.

Alzheimer's Association

919 North Michigan Avenue, Suite 1100
Chicago, IL 60611
Phone: (800) 272-3900 (toll-free)
(312) 335-8700
TTY: (312) 335-8882
Fax: (312) 335-1110
E-mail: info@alz.org
Web site: <http://www.alz.org>

The Association is a nonprofit organization offering information and support services to people with Alzheimer's disease (AD) and their families. Contact the 24-hour, toll-free telephone line to link with local chapters and community resources. The Association funds research to find a cure for AD and provides information on caregiving. A free catalog of educational publications is available in English and Spanish.

Alzheimer's Disease Education and Referral (ADEAR) Center

PO Box 8250
Silver Spring, MD 20907-8250
Phone: (800) 438-4380 (toll-free) (English, Spanish)
(301) 495-3311
Fax: (301) 495-3334
E-mail: adear@alzheimers.org
Web site: <http://www.alzheimers.org>

The ADEAR Center, funded by the National Institute on Aging, distributes information about Alzheimer's disease (AD) to health professionals, patients and their families, and the public. Contact the Center for information about the symptoms, diagnosis, and treatment of AD; recent research; and referrals to state and other national services. On its Web site, the Center offers searchable publications and databases, including the AD Clinical Trials Database of studies accepting volunteers.

American Academy of Dermatology (AAD)

930 North Meacham Road
Schaumburg, IL 60173-4965
Phone: (888) 462-3376 (toll-free) (automated ordering system)
(847) 330-0230
Fax: (847) 330-0050
Web site: <http://www.aad.org>

AAD, an association of doctors specializing in dermatology, provides pamphlets and general information about skin cancers, contact allergies (like poison ivy), shingles (herpes zoster), and other skin conditions. Audio-cassettes, news releases, and public service announcements on dermatology topics also are available. Contact AAD for referrals to certified dermatologists.

American Academy of Family Physicians (AAFP)

11400 Tomahawk Creek Parkway
Leawood, KS 66201
Phone: (800) 274-2237 (toll-free)
(913) 906-6000
Fax: (913) 906-6094
E-mail: fp@aafp.org
Web site: <http://familydoctor.org> (information for the public)

AAFP, a national association of doctors in family practice, offers education and information on health care and disease prevention. Contact the AAFP for referrals to certified doctors. Publications on topics such as sensible eating, preventive health services and family practice, and a health care guide are available free from AAFP-certified doctors or for a fee from AAFP. The Web site offers free fact sheets on specific diseases, questions and answers about common health issues, self-care flowcharts, and databases on drugs and drug reactions.

American Academy of Neurology (AAN)

1080 Montreal Avenue
St. Paul, MN 55116
Phone: (651) 695-1940
Fax: (651) 695-2791
Web site: <http://www.aan.com>

The Academy is an association of doctors specializing in disorders of the brain and central nervous system. Contact AAN for information about neurology. Visit the Academy's Web site for referrals to accredited neurologists. Publications include the AAN's *Patient Information Guide* on neurological disorders and treatment.

American Academy of Ophthalmology (AAO)

PO Box 7424
San Francisco, CA 94120-7424
Phone: (800) 222-3937 (toll-free)
(415) 561-8500
Fax: (415) 561-8567
Web site: <http://www.eyenet.org>

AAO is an association of doctors specializing in eye diseases. The Academy's Eye Care America helpline provides information and publications and connects eligible older people with ophthalmologists who provide free eye care in their community. U.S. citizens qualify for free care at age 65 if they have no health insurance and have not seen an eye doctor for at least three years.

American Academy of Orthopaedic Surgeons (AAOS)

6300 North River Road
Rosemont, IL 60018-4262
Phone: (847) 823-7186
Fax: (847) 823-8125
Web site: <http://www.aaos.org>

AAOS is a nonprofit organization of doctors specializing in bones, joints, muscles, ligaments, and tendons. Contact AAOS for information on orthopaedic medicine including arthritis, osteoporosis, artificial joints, and prevention of hip fractures. Publications on orthopedic medicine, many specifically for older people, are available.

American Academy of Otolaryngology–Head and Neck Surgery, Inc. (AAO)

1 Prince Street
Alexandria, VA 22314
Phone: (703) 836-4444
TTY: (703) 519-1585
Fax: (703) 683-5100
E-mail: webmaster@entnet.org
Web site: <http://www.entnet.org>

The Academy is an organization of doctors specializing in ear, nose, and throat problems and diseases of the head and neck. Contact AAO for referrals to specialists and publications on topics such as cosmetic facial surgery, head and neck tumors, treatments for certain types of hearing loss, and balance disorders.

American Academy of Physical Medicine and Rehabilitation (AAPMR)

One IBM Plaza, Suite 2500
Chicago, IL 60611-3604
Phone: (312) 464-9700
Fax: (312) 464-0227
E-mail: info@aapmr.org
Web site: <http://www.aapmr.org>

The Academy is an organization of physicians who treat people with disabilities. Contact AAPMR for referrals to physiatrists or for information and publications about rehabilitation medicine.

American Association for Geriatric Psychiatry (AAGP)

7910 Woodmont Avenue, Suite 1050
Bethesda, MD 20814-3004
Phone: (301) 654-7850
Fax: (301) 654-4137
E-mail: aagpgpa@aol.com
Web site: <http://www.aagpgpa.org>

The Association works to improve the mental health and well-being of older people. Contact AAGP for information on geriatric psychiatry and to receive referrals to specialists. Available publications include *Growing Older*, *Growing Wiser: Coping with Expectations, Challenges and Changes in Later Years*, and brochures on topics such as Alzheimer's disease, depression, and the role of the geriatric psychiatrist. Some consumer publications are free.

American Association for Marriage and Family Therapy (AAMFT)

1133 15th Street, NW, Suite 300
Washington, DC 20005

Phone: (202) 452-0109

Fax: (202) 223-2329

E-mail: memberservices@aamft.org

Web site: <http://www.aamft.org>

AAMFT is a professional association of qualified marriage and family therapists. The Association provides referrals to marriage and family therapists and offers publications on topics including divorce, depression, and sexual problems.

American Association of Cardiovascular and Pulmonary Rehabilitation (AACVPR)

7600 Terrace Avenue, Suite 203

Middleton, WI 53562-3174

Phone: (608) 831-6989

Fax: (608) 831-5122

E-mail: aacvpr@sba.com

Web site: <http://www.aacvpr.org>

AACVPR is an organization of certified heart, lung, and blood specialists that provides information on diagnosis, treatment, and disease prevention. Information and publications are available on consumer guidelines for cardiac rehabilitation and purchasing fitness equipment. Visit the Web site for a free brochure.

American Association of Critical-Care Nurses (AACN)

101 Columbia

Aliso Viejo, CA 92656-4109

Phone: (800) 899-AACN (899-2226) (toll-free)

(949) 362-2050

Fax: (949) 362-2020

E-mail: info@aacn.org

Web site: <http://www.aacn.org>

AACN is a nonprofit professional association dedicated to meeting the needs of its members who care for acutely and critically ill patients and their families. The Association provides practice and educational resources as well as professional support for its members. Contact AACN for publications and audiovisual materials on critical care.

American Association of Homes and Services for the Aging (AAHSA)

2519 Connecticut Avenue, NW

Washington, DC 20008-1520

Phone: (202) 783-2242
Fax: (202) 783-2255
E-mail: inform@aahsa.org
Web site: <http://www.aahsa.org>

AAHSA is a national, nonprofit organization providing older people with services and information on housing, health care, and community involvement. Visit the AAHSA Web site for information for seniors and caregivers.

American Association of Retired Persons (AARP)

601 E Street, NW
Washington, DC 20049
Phone: (800) 424-3410 (toll-free)
(202) 434-2277
Fax: (202) 434-6973
Web site: <http://www.aarp.org>

AARP is a nonprofit organization that advocates for older Americans' health, rights, and life choices. Local chapters provide information and services on crime prevention, consumer protection, and income tax preparation. Members can join group health, auto, life, and home insurance programs, investment plans, or a discount mail-order pharmacy service. The AgeLine database, available on CD-ROM, contains extensive resources on issues of concern to older people. Publications are available on housing, health, exercise, retirement planning, money management, leisure, and travel.

American Bar Association

Commission on the Legal Problems of the Elderly
740 15th Street, NW
Washington, DC 20005-1022
Phone: (202) 662-8690
Fax: (202) 662-8698
E-mail: abaelderly@abanet.org
Web site: <http://www.abanet.org/elderly>

The Commission examines and responds to law-related needs of older people. It makes referrals and maintains a listing of legal aid offices where older people can get free or low-cost legal assistance. The Commission's Web site lists available publications and videos.

American Brain Tumor Association (ABTA)

2720 River Road, Suite 146
Des Plaines, IL 60018
Phone: (800) 886-2282 (toll-free) (Patient Line)
(847) 827-9910
Fax: (847) 827-9918
E-mail: info@abta.org
Web site: <http://www.abta.org>

ABTA is a nonprofit organization, offering free social work consultations, a nationwide database of established support groups, mentorship for people who want to start a support group, a

resource listing of specialist physicians, and referrals to organizations providing services for brain tumor patients. Publications on brain tumors, treatment, and coping with disease are available.

American Cancer Society (ACS)

1599 Clifton Road, NE
Atlanta, GA 30329
Phone: (800) ACS-2345 (227-2345) (toll-free)
(404) 320-3333
Fax: (404) 329-5787
Web site: <http://www.cancer.org>

ACS is a national, community-based volunteer health organization, providing information on cancer and its prevention. The Society sponsors a variety of programs such as Man to Man (education and support for men with prostate cancer) and workshops such as Taking Charge of Money Matters, which addresses financial concerns arising from cancer treatment. Local ACS offices sponsor services for cancer patients and their families, including self-help groups, transportation programs, and limited financial aid. Contact the ACS for free publications. Spanish language resources are available.

American Chiropractic Association (ACA)

1701 Clarendon Boulevard
Arlington, VA 22209
Phone: (800) 986-4636 (toll-free)
(703) 276-8800
Fax: (703) 243-2593
E-mail: memberinfo@amerchiro.org
Web site: <http://www.amerchiro.org>

ACA is a professional organization of chiropractors. It offers educational programs on spinal problems, posture, physical fitness, and occupational safety. Contact the ACA to buy publications and materials on spinal health and safety. Visit the Web site to find a chiropractor.

American College of Obstetricians and Gynecologists (ACOG)

409 12th Street, SW
PO Box 96920
Washington, DC 20090-6920
Phone: (202) 863-2518 (resource center)
Web site: <http://www.acog.org>

ACOG is a professional society of doctors specializing in women's health care. Contact ACOG for referrals. For free pamphlets on osteoporosis, menopause, and hormone replacement therapy, send a self-addressed, stamped envelope.

American College of Physicians–American Society of Internal Medicine (ACP-ASIM)

190 North Independence Mall West
Philadelphia, PA 19106-1572
Phone: (800) 523-1546 (toll-free)
(215) 351-2400
Fax: (215) 351-2829
E-mail: interpub@mail.acponline.org

Web site: <http://www.acponline.org>

ACP-ASIM is the nation's largest medical specialty society. Members of ACP-ASIM specialize in a variety of areas, such as internal medicine, cardiology, infectious diseases, rheumatology, gastroenterology, and oncology. Contact the ACP-ASIM for referrals. ACP-ASIM produces *Healthscope*, a film series on public health.

American College of Sports Medicine (ACSM)

PO Box 1440

Indianapolis, IN 46206

Phone: (317) 637-9200

Fax: (317) 634-7817

Web site: <http://www.acsm.org>

ACSM is a scientific and medical association of health professionals interested in exercise. It offers training and certification. ACSM's Active Aging Partnership focuses on education, research, and improving practice for those committed to working with older adults. For free information on exercise for older people, send a self-addressed, stamped envelope.

American College of Surgeons (ACS)

633 North St. Clair Street

Chicago, IL 60611-3211

Phone: (312) 202-5000

Fax: (312) 202-5001

Web site: <http://www.facs.org>

ACS is a national organization offering educational materials and information about qualified surgeons and surgical treatments for many illnesses and injuries. Contact ACS to locate board-certified surgeons. Public education materials are available on frequently performed types of surgery.

American Council of the Blind (ACB)

1155 15th Street, NW, Suite 1004

Washington, DC 20005

Phone: (800) 424-8666 (toll-free)

(202) 467-5081

Fax: (202) 467-5085

E-mail: info@acb.org

Web site: <http://www.acb.org>

ACB is a national organization that advocates for blind and visually impaired people. It provides educational programs, health care services, information about Social Security benefits for visually impaired people, vocational training, and other health and social services. Toll-free information, referrals, and free educational materials are available.

American Counseling Association (ACA)

5999 Stevenson Avenue

Alexandria, VA 22304

Phone: (800) 347-6647, ext. 222 (toll-free)

(703) 823-9800

Fax: (703) 823-0252

Web site: <http://www.counseling.org>

ACA offers information to older people on adult psychological development and aging. A catalog of publications and videos is available.

American Dental Association (ADA)

211 East Chicago Avenue

Chicago, IL 60611

Phone: (312) 440-2593

(312) 440-2500

Fax: (312) 440-2800

Web site: <http://www.ada.org>

ADA is a professional organization that conducts dental research and evaluates findings from dental science for the public. State and local ADA chapters provide referrals to dentists.

Publications are available on subjects such as tooth decay, dentures, smoking, diet, and mouth care. Online publications cover topics such as gum disease, finding a dentist, and resolving disputes over treatment.

American Diabetes Association (ADA)

1701 North Beauregard Street

Arlington, VA 22311

Phone: (800) DIABETES (342-2383) (toll-free)

(703) 549-1500

Web site: <http://www.diabetes.org>

ADA provides information and educational materials on preventing, treating, and living with diabetes. The Association has specific outreach programs for minority communities, including the Diabetes Assistance and Resources Program, providing information in English and Spanish to the Hispanic community, the African American Program, and Awakening the Spirit, which disseminates diabetes information to the Native American community. Local ADA chapters offer support and referrals to community agencies and services.

American Dietetic Association (ADA)

216 West Jackson Boulevard

Chicago, IL 60606-6995

Phone: (800) 366-1655 (toll-free) (Consumer Nutrition Hotline)

(312) 899-0040

Fax: (312) 899-4899

Website: <http://www.eatright.org>

ADA is a professional society of registered dietitians and other dietetic professionals who provide nutrition information, education, counseling, and care. One of ADA's professional practice groups focuses on the special needs of older people and offers nutrition counseling and indirect assistance through state and local meal programs. Call ADA to locate a registered dietitian.

American Federation for Aging Research (AFAR)

1414 Sixth Avenue, 18th Floor
New York, NY 10019
Phone: (212) 752-2327
Fax: (212) 832-2298
E- mail: amfedaging@aol.com
Web site: <http://www.afar.org> or
<http://www.infoaging.org>

AFAR is a nonprofit organization dedicated to supporting basic aging research. AFAR funds a wide variety of cutting-edge research on the aging process and age-related diseases. Visit the Web site for a list of free publications.

American Foundation for the Blind (AFB)

11 Penn Plaza, Suite 300
New York, NY 10001
Phone: (800) AFB-LINE (232-5463) (toll-free)
TTY: (212) 502-7662
Fax: (212) 502-7777
E-mail: afbinfo@afb.net
Web site: <http://www.afb.org>

A national, nonprofit organization, AFB provides services and support for people who are blind or visually impaired. AFB's Technology Information Bank supports the Talking Books program and provides information and mentoring on technology assistance for people who are blind. Books, pamphlets, videos, and periodicals about blindness are available.

American Foundation for Urologic Diseases (AFUD)

1128 North Charles Street
Baltimore, MD 21201
Phone: (410) 468-1800
Fax: (410) 468-1808
E-mail: admin@afud.org
Web site: <http://www.afud.org> or
<http://www.prostatehealth.com>

The Foundation works toward the prevention and cure of urologic disease in part by keeping patients, family members, and friends informed about these disorders, treatment options, and recent research findings. AFUD operates six national health education councils that distribute patient education materials on a variety of urologic topics. A specific Web site addresses prostate health. Online publications are free; publications are available by mail for a fee.

American Geriatrics Society (AGS)

350 Fifth Avenue
New York, NY 10118
Phone: (212) 308-1414
Fax: (212) 832-8646
E-mail: info.amger@americangeriatrics.org
Web site: <http://www.americangeriatrics.org>

AGS is a nonprofit organization of physicians and health care professionals supporting the study of geriatrics. Contact AGS for information on geriatrics, long-term care, acute and chronic illnesses, rehabilitation, and nursing home care. Publications include the *AGS Complete Guide to Aging and Health* and the *AGS Medical Reference Guide*.

American Health Assistance Foundation (AHAF)

15825 Shady Grove Road, Suite 140
Rockville, MD 20850
Phone: (800) 437-AHAF (437-2423) (toll-free)
(301) 948-3244
Fax: (301) 258-9454
Web site: <http://www.ahaf.org>

AHAF provides information and supports research on age-related illnesses. The Foundation supports three research programs: Alzheimer's Disease (AD) Research, which along with the Alzheimer's Family Relief Program, offers emergency grants of up to \$500 to AD patients in need and their caregivers; National Glaucoma Research; and the National Heart Foundation. Contact AHAF for free publications on AD, glaucoma, heart disease, and stroke.

American Health Care Association (AHCA)

1201 L Street, NW
Washington, DC 20005
Phone: (202) 842-4444
Fax: (202) 842-3860
Web site: <http://www.ahca.org>

AHCA is an organization representing the interests of nursing homes, assisted living centers, and subacute care facilities. Publications are available about nursing homes, guardianship, assisted living, financing, and long-term care services.

American Health Foundation (AHF)

1 Dana Road
Valhalla, NY 10595
Phone: (914) 592-2600
Fax: (914) 592-6317
Web site: <http://www.ahf.org>

AHF is a nonprofit organization conducting research on cancer; preventive medicine; and the effects of lifestyle, environment, and nutrition on health. Contact AHF for information and publications on healthy living, heart disease, cancer, and high cholesterol.

American Heart Association (AHA)

7272 Greenville Avenue
Dallas, TX 75231
Phone: (800) AHA-USA1 (242-8721) (toll-free)
(888) 4-STROKE (478-7653) (toll-free)
Fax: (214) 706-2139
Web site: <http://www.americanheart.org>

AHA is a nonprofit organization funding research and providing information on the diagnosis, treatment, and prevention of heart diseases and stroke. Contact AHA for its cookbooks, guide to heart attack treatment, and guide to fitness.

American Horticultural Therapy Association (AHTA)

National Office
909 York Street
Denver, CO 80206
Phone: (720) 865-3616
Fax: (720) 865-3728
E-mail: ahta@ahta.org
Web site: <http://www.ahta.org>

AHTA is a nonprofit, membership organization that promotes and advances horticultural therapy as a therapeutic intervention and rehabilitation option. The Association provides information related to the principles and practices of horticultural therapy.

American Hospital Association (AHA)

One North Franklin
Chicago, IL 60606
Phone: (312) 422-3000
Fax: (312) 422-4796
Web site: <http://www.aha.org>

AHA is a national nonprofit association representing all types of hospitals and health care networks, as well as patients and families. AHA provides education for health care leaders and information on health care issues and trends.

American Lung Association (ALA)

1740 Broadway
New York, NY 10019-4374
Phone: (800) LUNG-USA (586-4872) (toll-free)
(212) 315-8700
Fax: (212) 265-5642
E-mail: info@lungusa.org
Web site: <http://www.lungusa.org>

ALA is dedicated to the prevention, cure, and control of lung diseases such as asthma, emphysema, tuberculosis, and lung cancer. The Association offers community service, public health education, advocacy, and research.

American Medical Association (AMA)

515 North State Street
Chicago, IL 60610
Phone: (800) 621-8335 (toll-free)
(312) 464-5000
Fax: (312) 464-5600
Web site: <http://www.ama-assn.org>

AMA is an organization of licensed doctors that distributes scientific information on health and sets standards on medical law and practice. Local AMA associations can provide referrals to qualified doctors. AMA publishes the *Journal of the American Medical Association*, other subscription medical journals, and books for sale, including an encyclopedia of medicine.

American Medical Directors Association (AMDA)

10480 Little Patuxent Parkway, Suite 760

Columbia, MD 21044

Phone: (800) 876-2632

(410) 740-9743

Fax: (410) 740-4572

E-mail: webmaster@amda.com

Web site: <http://www.amda.com>

AMDA is a national professional association representing doctors who care for older people in a variety of long-term care settings, including nursing facilities, hospice, home care, continuing care retirement communities, and assisted living. The Association provides education, advocacy, information, and professional development for long-term care professionals. AMDA has information on health care policy, regulations, and clinical practice guidelines.

American Menopause Foundation (AMF)

350 Fifth Avenue, Suite 2822

New York, NY 10118

Phone: (212) 714-2398

Fax: (212) 714-1252

E-mail: menopause@earthlink.org

Web site: www.americanmenopause.org

The Foundation is a nonprofit health organization providing support and assistance on all issues concerning menopause. AMF has information on scientific research and coordinates a network of volunteer support groups for women.

American Music Therapy Association (AMTA)

8455 Colesville Road, Suite 1000

Silver Spring, MD 20910

Phone: (301) 589-3300

Fax: (301) 589-5175

E-mail: info@musictherapy.org

Web site: <http://www.musictherapy.org>

AMTA is a nonprofit organization that advocates, promotes, and provides resources and information on the uses and benefits of music therapy. Contact AMTA for referrals as well as for publications and audiovisual materials.

American Nurses Association (ANA)

600 Maryland Avenue, SW, Suite 100W

Washington, DC 20024-2571

Phone: (800) 274-4262 (toll-free)

(202) 554-4444

Fax: (202) 651-7001
E-mail: memberinfo@ana.org
Web site: <http://www.nursingworld.org>

ANA, a national association of registered nurses, serves as an advocate for nursing practitioners as well as sponsors research and continuing education. Contact the Association for *Facts About Nursing* and other publications. ANA sets standards for the practice of gerontological nursing.

American Occupational Therapy Association, Inc. (AOTA)

4720 Montgomery Lane
PO Box 31220
Bethesda, MD 20824-1220
Phone: (800) 729-2682 (toll-free) (Association members)
(301) 652-2682
TTY: (800) 377-8555 (toll-free)
Fax: (301) 652-7711
Web site: <http://www.aota.org>

AOTA offers information on the role of occupational therapy in promoting functional independence, preventing disability, and maintaining health. Contact AOTA for referrals to local practitioners and therapy programs. The Association publishes two periodicals, *OT Practice* and the *American Journal of Occupational Therapy*, as well as many books for educators.

American Optometric Association (AOA)

243 North Lindbergh Boulevard
St. Louis, MO 63141
Phone: (800) 365-2219 (toll-free)
(314) 991-4100
Fax: (314) 991-4101
Web site: <http://www.aoanet.org>

AOA, a national organization of optometrists, evaluates ophthalmic products and sponsors continuing education programs. It offers VISION USA, a free eye-care program for uninsured or low-income older people and their families. Contact AOA for referrals to certified optometrists and for publications such as *Driving Tips for Older Adults*, *Contact Lenses After 40*, and fact sheets on floaters, macular degeneration, and glaucoma.

American Osteopathic Association

142 East Ontario Street
Chicago, IL 60611
Phone: (800) 621-1773 (toll-free)
Fax: (312) 202-8200
E-mail: info@aoa-net.org
Web site: <http://www.aoa-net.org>

The American Osteopathic Association represents osteopathic physicians (DOs, or doctors of osteopathic medicine), promotes public health, encourages scientific research, and is the accrediting agency for all osteopathic medical schools and health care facilities.

American Parkinson's Disease Association (APDA)

1250 Hylan Boulevard, Suite 4B
Staten Island, NY 10305
Phone: (800) 223-2732 (toll-free)
Fax: (718) 981-4399
E-mail: info@apdaparkinson.org
Web site: <http://www.apdaparkinson.org>

A nonprofit organization, APDA funds research to find a cure for Parkinson's disease. APDA's toll-free line refers callers to local chapters for information on community services, specialists, and treatments. Publications and educational materials are available on Parkinson's disease, speech therapy, exercise, diet, and aids for daily living.

American Pharmaceutical Association (APhA)

2215 Constitution Avenue, NW
Washington, DC 20037-2985
Phone: (800) 237-2742 (toll-free)
(202) 628-4410
Fax: (202) 783-2351
E-mail: webmaster@mail.aphanet.org
Web site: <http://www.aphanet.org> or
<http://www.pharmacyandyou.org> (consumer information site)

APhA is the national society of licensed pharmacists providing public health information and referrals to resources on medicine and public policy. Available publications include *Managing Medicines as You Grow Older*, *National Medical Awareness Test*, and *Self-Medication Awareness Test*.

American Physical Therapy Association (APTA)

1111 North Fairfax Street
Alexandria, VA 22314
Phone: (800) 999-2782, ext. 3395 (toll-free)
(703) 684-2782
Fax: (703) 706-8578
Web site: <http://www.apta.org>

APTA is an organization of physical therapists providing referrals to APTA geriatric-certified therapists and information on debilitating ailments like arthritis, stroke, scoliosis, and sudden onset of illness. APTA's Section on Geriatrics offers publications on topics such as osteoporosis; incontinence; neck pain; carpal tunnel syndrome; hip, knee, or shoulder care; and what physical therapists can offer older adults.

American Podiatric Medical Association (APMA)

9312 Old Georgetown Road
Bethesda, MD 20814
Phone: (800) FOOT-CARE (366-8227) (toll-free)
(301) 571-9200
Fax: (301) 530-2752
E-mail: askapma@apma.org
Web site: <http://www.apma.org>

APMA is an association of podiatrists providing services and information on foot problems and foot health. Contact APMA for information on local chapters and referrals to certified podiatrists. Publications on proper foot care and the effects of arthritis and diabetes on feet are available.

American Psychiatric Association (APA)

1400 K Street, NW
Washington, DC 20005
Phone: (202) 682-6000
Fax: (202) 682-6850
E-mail: apa@psych.org
Web site: <http://www.psych.org>

APA is an association of psychiatrists, physicians specializing in diagnosing and treating people with mental and emotional disorders. Its Council on Aging establishes standards for psychiatric care of older people. Contact the APA for information on elder care issues, including medication use by older people, treatment of Alzheimer's disease, and nursing homes. Contact APA for referrals to local psychiatrists.

American Psychological Association (APA)

750 First Street, NE
Washington, DC 20002-4242
Phone: (800) 374-2721 (toll-free)
(202) 336-5500
E-mail: webmaster@apa.org
Web site: <http://www.apa.org>

APA is a professional society of psychologists that provides assistance and information on mental, emotional, and behavioral disorders. Contact the APA for a list of state chapters, information on the psychosocial aspects of aging, and referrals to APA-member psychologists. The APA's section on older people produces publications on topics such as dementia and dementia research. Publications include a quarterly subscription magazine, *Psychology and Aging*.

American Red Cross

430 17th Street, NW
Washington, DC 20006
Phone: (800) HELP-NOW (435-7669) (toll-free) (donations only)
(202) 639-3269
Fax: (202) 639-3520
E-mail: info@usa.redcross.org
Web site: <http://www.redcross.org>

The Red Cross offers health information programs, health services, blood donation services, disaster relief, and emergency services to the public and the Armed Forces. Local chapters provide programs for older people, including retirement planning, crime prevention instruction, safety courses, health screening clinics, and home nurse care instruction. Publications about programs, information, and services are available.

American Society on Aging (ASA)

833 Market Street, Suite 511
San Francisco, CA 94103
Phone: (800) 537-9728 (toll-free)
(415) 974-9600
Fax: (415) 974-0300
E-mail: info@asaging.org
Web site: <http://www.asaging.org>

ASA is a nonprofit organization providing information about medical and social practice, research, and policy pertinent to the health of older people. Membership and subscriptions to *Generations*, a quarterly journal, and *Aging Today*, the Society's bimonthly news magazine, are available to the public. A catalog of books for sale and other educational materials is available on the Web site.

American Speech-Language-Hearing Association (ASHA)

10801 Rockville Pike
Rockville, MD 20852
Phone: (800) 498-2071 (toll-free) (ASHA Action Center)
(800) 638-8255 (toll-free)
TTY: (800) 638-8255 (toll-free)
(301) 897-0157
Fax: (877) 541-5035
E-mail: actioncenter@asha.org
Web site: <http://www.asha.org>

ASHA represents the interests of medical specialists in speech, language, and hearing science and advocates for people with communication-related disorders. Contact ASHA's toll-free telephone line for information on speech-language legislation, communication disorders, or referrals to specialists. ASHA produces publications and fact sheets on topics such as communication disorders and hearing aids.

American Stroke Association (ASA)

c/o American Heart Association
7272 Greenville Avenue
Dallas, TX 75231
Phone: (888) 4STROKE (478-7653) (toll-free)
Fax: (214) 706-5231
E-mail: strokeassociation@heart.org
Web site: <http://www.strokeassociation.org>

ASA, a division of the American Heart Association, provides the Stroke Family Warmline, a toll-free information and referral service offering lists of certified doctors who are stroke specialists and volunteer stroke survivors or family members. Callers receive support and can request free information. ASA publishes *Stroke Connection*, a priced subscription magazine for survivors and families.

American Tinnitus Association (ATA)

PO Box 5
Portland, OR 97207
Phone: (800) 634-8978 (toll-free)
(503) 248-9985
Fax: (503) 248-0024
E-mail: tinnitus@ata.org
Web site: <http://www.ata.org>

ATA is a volunteer organization supporting research and providing information on tinnitus, a constant buzzing or ringing in the ears or head. ATA sponsors self-help groups nationwide, each offering information, assistance, and referrals to community services and tinnitus specialists.

Arthritis Foundation (AF)

National Office
1330 West Peachtree Street
Atlanta, GA 30309
Phone: (800) 283-7800 (toll-free)
(404) 965-7537
Fax: (404) 872-0457
E-mail: help@arthritis.org
Web site: <http://www.arthritis.org>

AF is a nonprofit, volunteer organization focusing on research and information to cure, prevent, or better treat arthritis and related diseases. Contact AF for information on arthritis, related diseases (such as lupus erythmatosus and rheumatism), and referrals to local chapters, specialists, or support groups. Publications and videos are available on topics such as self-help and exercise therapy.

Assisted Living Federation of America (ALFA)

11200 Waples Mill Road, Suite 150
Fairfax, VA 22030
Phone (703) 691-8100
Fax: (703) 691-8106
Web site: <http://www.alfa.org>

ALFA represents for-profit and nonprofit providers of assisted living, continuing care retirement communities, independent living, and other forms of housing and services. The Federation works to advance the assisted living industry and enhance the quality of life for consumers.

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
E-mail: aghetemp@aghe.org
Web site: <http://www.aghe.org>

AGHE's members are organizations and institutions of higher education. Through conferences, publications, technical assistance, research studies, and consultation with policymakers, AGHE,

an educational unit of the Gerontological Society of America, seeks to advance gerontology as a field of study at institutions of higher education.

Better Hearing Institute

5021-B Backlick Road
Annandale, VA 22003
Phone: (800) EAR-WELL (327-9355) (toll-free) (Hearing Helpline)
(703) 684-3391
Fax: (703) 684-6048
E-mail: mail@betterhearing.org
Web site: <http://www.betterhearing.org>

The Institute is a nonprofit, educational organization providing information on medical, surgical, and rehabilitation options for improving hearing loss and on hearing aids. Contact the Institute's Hearing Helpline for facts on hearing loss and a list of publications.

Better Vision Institute (BVI)

1655 North Fort Myer Drive
Arlington, VA 22209
Phone: (800) 424-8422 (toll-free)
(703) 243-1508
Fax: (703) 243-1537
Web site: <http://www.visionsite.org>

BVI provides news and information on vision health and care. Contact the Institute for facts on the detection, treatment, and prevention of eye diseases. Publications include fact sheets on cataracts, nutrition, care of eyeglasses, diabetes, and vision care.

Beverly Foundation

44 South Mentor Avenue
Pasadena, CA 91106
Phone: (626) 792-2292
Fax: (626) 792-6117
E-mail: bf3@ix.netcom.com
Web site: <http://www.beverlyfoundation.org>

The Foundation focuses on mobility and transportation for older people within the community, service delivery within home and institutional settings, and overall life enrichment. It engages in research and education projects and provides information for professionals and caregivers.

B'nai B'rith

1640 Rhode Island Avenue, NW
Washington, DC 20036
Phone: (800) 500-6533 (toll-free)
(202) 857-6600
Fax: (202) 857-1099
E-mail: seniors@bnaibrith.org
Web site: <http://www.bnaibrith.org>

B'nai B'rith is the world's oldest and largest Jewish service organization, providing community service, education, and advocacy. Its Center for Senior Housing and Services sponsors housing and travel for senior citizens. A list of publications is available.

Brookdale Center on Aging (BCOA) of Hunter College

1114 Avenue of the Americas, 40th Floor

New York, NY 10036

Phone: (646) 366-1000

Fax: (212) 481-5069

E-mail: info@brookdale.org

Web site: <http://www.brookdale.org>

BCOA sponsors a variety of programs, including the Institute on Law and Rights of Older Adults, which fights for grandparent rights. Other programs focus on elder care services, guardianship, caregiving, Medicare, intergenerational activities, and Alzheimer's disease. Contact BCOA about publications (some available in Spanish), including *Senior Rights Reporter*, *Benefits Checklist for Seniors*, *Help for Seniors*, and *Help for Grandparent Caregivers*, which are for sale.

Captioned Media Program (CMP)

National Association of the Deaf (NAD)

1447 East Main Street

Spartanburg, SC 29307

Phone: (800) 237-6213 (toll-free)

TTY: (800) 237-6819 (toll-free)

Fax: (800) 538-5636

E-mail: info@cfv.org

Web site: <http://www.cfv.org>

CMP is a free video lending program funded by the Department of Education and administered by NAD. CMP provides open-captioned videos (that is, they display English text with any TV/VCR). Videos are available for deaf or hard of hearing Americans, their parents, families, teachers, counselors, interpreters, or others. CMP has a wide variety of videos ranging from travel to classic movies; from sign language to hobbies.

Catholic Charities USA (CCUSA)

1731 King Street, Suite 200

Alexandria, VA 22314

Phone: (703) 549-1390

Fax: (703) 549-1656

Web site: <http://www.catholiccharitiesusa.org>

CCUSA is a network of organizations offering nationwide services to older people, including counseling, homemaker and caregiver services, emergency assistance, group homes, and institutional care. CCUSA advocates for older people's Social Security benefits, employment opportunities, and housing. Publications describe Catholic Charities' programs for older people.

Catholic Golden Age (CGA)

National Headquarters

PO Box 249

Olyphant, PA 18447

Phone: (800) 836-5699 (toll-free)
Fax: (570) 586-7721
E-mail: info@catholicgoldenage.org
Web site: <http://www.catholicgoldenage.org>

CGA sponsors charitable work and helps older people meet their social, physical, economic, intellectual, and spiritual needs. Contact CGA for various group insurance plans, discounts on eyeglasses, prescription drugs, and travel. Local CGA chapters provide activities for members, including disease prevention and health promotion programs.

Census Bureau

Special Populations Branch
FB3 Room 2384
Washington, DC 20233
Phone: (301) 457-2378
Fax: (301) 457-6634
Web site: <http://www.census.gov>

The Census Bureau, part of the federal government, collects and provides timely, relevant, and quality data about the people and economy of the United States. Contact the Census Bureau for age-related data and statistics about the older populations in the United States.

The Center for Social Gerontology (TCSG)

2307 Shelby Avenue
Ann Arbor, MI 48103
Phone: (734) 665-1126
Fax: (734) 665-2071
E-mail: tcs@tcs.org
Web site: <http://www.tcs.org>

TCSG is a nonprofit research, training, and social policy organization. Particular attention is focused on law and aging, tobacco use and older people, guardianship service providers, and adult guardianship. Contact the Center for information on publications, videos, training, and technical assistance.

Center for the Advancement of State Community Services Programs (CASCSP)

National Association of State Units on Aging (NASUA)
1225 I Street, NW, Suite 725
Washington, DC 20005
Phone: (202) 898-2578
Fax: (202) 898-2583
E-mail: info@nasua.org
Web site: <http://www.nasua.org>

The Center, part of NASUA, provides information and support for community-based care for older people. The Center also helps state and area Agencies on Aging design, develop, and manage these care systems and develop state policies. A list of publications and materials on long-term and community-based care is available.

Center for the Study of Aging/International Association of Physical Activity, Aging and Sports (IAPAAS)

706 Madison Avenue
Albany, NY 12208-3604
Phone: (518) 465-6927
Fax: (518) 462-1339
E-mail: iapaas@acl.com

The Center is a free-standing, nonprofit organization promoting research, education, and training in the field of aging. IAPAAS is the Center's membership division. It organizes programs on health, fitness, prevention, and aging. Contact the Center for a list of publications and information about the quarterly newsletter, *Lifelong Health and Fitness*.

Centers for Disease Control and Prevention (CDC)

1600 Clifton Road
Atlanta, GA 30333
Phone: (800) 311-3435 (toll-free)
(404) 639-3311
TTY: (800) 255-0135 (toll-free)
Fax: (404) 639-7392
E-mail: netinfo@cdc.gov
Web site: <http://www.cdc.gov>

The CDC, part of the federal government, is the lead agency for protecting the health and safety of people at home or abroad. The CDC produces fact sheets that help people make informed decisions about their health and health care. Contact the CDC for public information, health statistics, funding opportunities, and prevention guidelines. Spanish language resources are available.

Children of Aging Parents (CAPS)

1609 Woodbourne Road, Suite 302A
Levittown, PA 19057
Phone: (800) 227-7294 (toll-free)
(215) 945-6900
Fax: (215) 945-8720
Web site: <http://www.caps4caregivers.org>

CAPS is a nonprofit organization that provides support services to caregivers of older people. It serves as a clearinghouse for information on elder care resources and issues, including Instant Aging workshops to help communities understand the needs of older people. Send a self-addressed, stamped envelope to receive publications on aging or information about support groups.

Clearinghouse on Abuse and Neglect of the Elderly (CANE)

University of Delaware
College of Human Services, Education and Public Policy
Department of Consumer Studies
Newark, DE 19716

Phone: (302) 831-3525
Fax: (302) 831-6081
Web site: <http://www.elderabusecenter.org/clearing/index.html>

CANE, funded by the Administration on Aging, is a database of elder abuse materials and resources operated by the University of Delaware's National Center on Elder Abuse (NCEA). CANE staff will conduct customized information searches and provide resources and referrals to elder abuse support groups. *NCEA Exchange*, CANE's newsletter, is available free.

Community Transportation Association of America (CTAA)

1341 G Street, NW, 10th Floor
Washington, DC 20005
Phone: (202) 628-1480
Fax: (202) 737-9197
Web site: <http://www.ctaa.org>

CTAA is a national association committed to removing barriers to isolation and improving mobility for all people. It offers educational programs and advocates making community transportation available, affordable, and accessible. CTAA provides information on transportation in medical emergencies and van conversions.

Continuing Care Accreditation Commission (CCAC)

2519 Connecticut Avenue, NW
Washington, DC 20008-1520
Phone: (202) 508-9459
Fax: (202) 220-0022
E-mail: afinnega@ccaonline.org
Web site: <http://www.ccaonline.org>

CCAC helps consumers identify quality retirement options. CCAC also accredits aging services that meet or exceed industry-generated standards of excellence in three areas: governance and administration; financial resources and disclosure; and resident life, health, and wellness.

Corporation for National Service (CNS)

1201 New York Avenue, NW
Washington, DC 20525
Phone: (800) 424-8867 (toll-free)
(202) 606-5000
TTY: (800) 833-3722 (toll-free)
Fax: (202) 565-2794
E-mail: acinfo@infosystec.com
Web site: <http://www.nationalservice.org>

CNS oversees volunteer community enhancement programs including: the National Senior Services Corps (a network of federally supported programs helping older people get involved in community service); the Foster Grandparent Program (encouraging older people to work with children with special needs); and the Senior Companion Program (volunteers assisting older people with special needs in hospitals, social service agencies, or home health care agencies). Contact CNS for pamphlets, brochures, fact sheets, and program handbooks.

Council of Better Business Bureaus (CBBB)

4200 Wilson Boulevard, Suite 800
Arlington, VA 22203
Phone: (703) 276-0100
Fax: (703) 525-8277
Web site: <http://www.bbb.org>

CBBB is a national organization promoting ethical practices between business and the public. Local BBBs can offer consumers help resolving complaints against companies. Publications include the *Tips On* series and booklets with advice on how to make wise buying decisions on a broad range of products and services.

The Dana Alliance for Brain Initiatives

745 Fifth Avenue, Suite 700
New York, NY 10151
Phone: (212) 223-4040
Fax: (212) 593-7623
E-mail: dabiinfo@danany.dana.org
Web site: <http://www.dana.org>

The Dana Alliance promotes public education about brain research. The Alliance links the public, press, and policymakers with experts and resources in the field of neuroscience. It also hosts conferences on the brain and brain diseases. Contact the Dana Alliance for publications on brain research and diagnosis and treatment of brain disorders.

Delta Society

289 Perimeter Road East
Renton, WA 98055-1329
Phone: (425) 226-7357
Fax: (425) 235-1076
E-mail: info@deltasociety.org
Web site: <http://www.deltasociety.org>

The Delta Society is a national, nonprofit organization whose mission is improving human health through service and therapy animals. Its program, Pet Partners, brings volunteers and their pets to nursing homes, hospitals, and schools. The Society Web site has information and resources about the human-animal-health connection.

Department of Justice (DOJ)

950 Pennsylvania Avenue, NW
Washington, DC 20530-0001
Phone: (202) 514-2000
TTY: (202) 514-0716
E-mail: ASKDOJ@usdoj.gov
Web site: <http://www.usdoj.gov/>

DOJ, part of the federal government, works to protect older Americans in a variety of ways, including the Nursing Home Initiative and elder justice efforts to prosecute institutions whose wrongdoing results in harm or death for residents. DOJ prosecutes health care and consumer

fraud and enforces civil rights addressing discrimination against older people. Publications and statistics on victimization of older people are available.

Department of Labor (DOL)

Office of Public Affairs
Room S1032
200 Constitution Avenue, NW
Washington, DC 20210

Phone: (202) 693-4650

Fax: (202) 693-4674

Web site: <http://www.dol.gov>

DOL, part of the federal government, protects workers' rights. Contact DOL for information and assistance on pensions, employment, wages, discrimination, and occupational safety. The Senior Community Service Employment Program helps low-income older people through part-time employment and job training. The Web site includes links to information for employers, employees, and job seekers.

Department of Transportation (DOT)

National Highway Traffic Safety Administration (NHTSA)
Information
400 Seventh Street, SW
Washington, DC 20590

Phone: (888) 327-4236 (toll-free)

(202) 366-0123

TTY: (800) 424-9153 (toll-free)

(202) 366-7800

Web site: <http://www.nhtsa.dot.gov/>

The NHTSA is responsible for reducing deaths, injuries, and economic losses resulting from car accidents. It sets standards, investigates safety defects, and conducts research on driver behavior. Contact NHTSA for information on older drivers.

Department of Veterans Affairs (VA)

Office of Public Affairs
810 Vermont Avenue, NW
Washington, DC 20420

Phone: (800) 827-1000 (toll-free)

TTY: (800) 829-4833 (toll-free)

Web site: <http://www.va.gov>

The VA, part of the federal government, provides benefits for eligible veterans and their families in outpatient clinics, medical centers, and nursing homes across the United States. Contact the VA for information and publications on service locations and benefits, including comprehensive medical and dental care, other insurance benefits, vocational rehabilitation compensation, and pension.

DES Action

610 16th Street, Suite 301
Oakland, CA 94612

Phone: (800) DES-9288 (337-9288) (toll-free)
(510) 465-4011
Fax: (510) 465-4815
E-mail: desaction@earthlink.net
Web site: <http://www.desaction.org>

DES Action is a nonprofit organization providing information about the risks of exposure to diethylstilbestrol (DES), a hormone prescribed for pregnant women from the 1940s through 1971 that caused health problems in mothers and their children. Contact DES Action for referrals to specialists familiar with medical complications resulting from DES use. Free publications on the risks of DES are available.

Disabled American Veterans (DAV)

807 Maine Avenue, SW
Washington, DC 20024

Phone: (202) 554-3501
TTY: (202) 863-4414
Fax: (202) 554-3581
Web site: <http://www.dav.org>

DAV is a nonprofit organization representing disabled veterans and providing volunteer services and programs. DAV offers veterans job search training and help seeking their disability compensation and pension benefits. A list of free publications is available.

Elder Craftsmen (EC)

610 Lexington Avenue
New York, NY 10022

Phone: (212) 319-8128
Fax: (212) 319-8141
E-mail: eldercraftsmen@mindspring.com
Web site: <http://www.eldercraftsmen.org>

EC offers programs and services that promote the skills and creativity of older people. Training programs are available for many types of crafts. Intergenerational programs, community service programs, and artist-in-residence are also offered.

Eldercare Initiative in Consumer Law (EICL)

National Consumer Law Center, Inc. (NCLC)
18 Tremont Street, Suite 400
Boston, MA 02108

Phone: (617) 523-8010
Fax: (617) 523-7398
E-mail: aoa@nclc.org

Web site: <http://www.consumerlaw.org>

The Initiative provides assistance on legal issues of older people. The EICL conducts regional and national legal workshops focusing on aging issues, including threats to loss of shelter and financial exploitation. Contact the Initiative for publications and references.

Eldercare Locator

Phone: (800) 677-1116 (toll-free)

Fax: (202) 296-8134

Web site: <http://www.aoa.dhhs.gov>

The Eldercare Locator is a nationwide, directory assistance service helping older people and caregivers locate local support and resources for older Americans. It is funded by the Administration on Aging.

Elderhostel

11 Avenue de Lafayette
Boston, MA 02111-1746

Phone: (877) 426-8056 (toll-free)

(617) 426-7788

TTY: (877) 426-2167 (toll-free)

Fax: (877) 426-2166 (toll-free)

E-mail: registration@elderhostel.org

Web site: <http://www.elderhostel.org>

Elderhostel is a nonprofit organization providing educational travel programs to people over age 55. Their catalog, published 10 times a year, lists thousands of national and international programs.

Elderweb

1305 Chadwick Drive
Normal, IL 61761

Phone: (309) 451-3319

Fax: (866) 422-8995

E-mail: ksb@elderweb.com

Web site: <http://www.elderweb.com>

Elderweb is a research Web site for older people, professionals, and families seeking information on elder care and long-term care. Visit Elderweb for news and information on legal, financial, medical, housing issues for older people, and links to other Web sites.

Employee Benefits Security Administration (EBPSA)
[formerly Pension and Welfare Benefits Administration (PWBA)]
Department of Labor

200 Constitution Avenue
Washington, DC 20210

Phone: (202) 219-8776 (Technical Assistance and Inquiries)
(866) 444-3272 (publications)
Web site: <http://www.dol.gov/dol/ebsa>

The Employee Benefits Security Administration (EBSA) (previously the Pension and Welfare benefits administration) assists and educates pension, health, and other employee benefit plan participants and beneficiaries, as well as plan sponsors and members of the employee benefit community. EBSA's goal in providing direct assistance is to raise the knowledge level of plan participants and beneficiaries, service providers and other interested parties and to ensure that they have access to available plan documents filed with the Department of Labor. Contact EBSA for assistance with technical questions and publications on such topics as cash balance pension plans, pension and health care coverage for dislocated workers, pension rights, filing a claim, and ERISA-related regulations, interpretations, and opinions. Most publications are also found on the Web site.

Environmental Protection Agency (EPA)
Public Information Center (PIC)
401 M Street, SW
Washington, DC 20460

Phone: (800) 490-9198 (toll-free) (publications)
(202) 260-5922
Fax: (202) 260-5153
E-mail: library-hq@epamail.epa.gov
Web site: <http://www.epa.gov>

EPA, part of the federal government, is responsible for controlling environmental pollution. The PIC provides nontechnical information about environmental issues such as clean air, clean water, pesticides, radon, and pollution. EPA's Web site has links to other health and environment-related Web sites. Printed and audiovisual information on environmental issues are available by calling the toll-free number.

Epilepsy Foundation
4351 Garden City Drive
Landover, MD 20785

Phone: (800) 332-1000 (toll-free)
(800) 332-4050 (toll-free) (National Epilepsy Library)
(301) 459-3700
Fax: (301) 577-2684
E-mail: postmaster@epilepsyfoundation.org
Web site: <http://www.epilepsyfoundation.org>

The Foundation is a national volunteer health organization supporting research, education, advocacy, and services for people with seizure disorders. Contact the Foundation for a list of local chapters, referrals to local specialists, support groups, camps, travel assistance, respite care, and employment assistance. Videos and a catalog of publications are available.

Equal Employment Opportunity Commission (EEOC)

1801 L Street, NW
Washington, DC 20507

Phone: (800) 669-3362 (toll-free) (publications)
(202) 663-4900 (headquarters)
TTY: (800) 800-3302 (toll-free) (publications)
(202) 663-4494 (headquarters)
Web site: <http://www.eeoc.gov>

The EEOC, part of the federal government, promotes equal opportunity in employment. It enforces the Age Discrimination in Employment Act (ADEA), conducts investigations, makes determinations, and effects reconciliations in age discrimination actions. Contact EEOC for information and referrals.

Federal Citizen Information Center (FCIC)

PO Box 100
Pueblo, CO 81009

Phone: (888) 878-3256 (toll-free)
(800) 688-9889 (toll-free) (National Contact Center)
TTY: (800) 326-2996 (toll-free) (National Contact Center)
Fax: (719) 948-9724
Web site: <http://www.pueblo.gsa.gov/>

FCIC, part of the federal government, distributes a wide range of consumer-oriented publications from many federal agencies. The Consumer Information Catalog lists more than 200 publications on topics ranging from health and housing to food and nutrition; from money management to employment. The National Contact Center answers questions and provides referral information on federal programs, benefits, and services.

Federal Trade Commission (FTC)

600 Pennsylvania Avenue, NW
Washington, DC 20580

Phone: (877) FTC-HELP (382-4357) (toll-free)
(202) 326-2222 (General Information Locator)
TTY: (202) 326-2502
E-mail: webmaster@ftc.gov
Web site: <http://www.ftc.gov>

FTC, part of the federal government, regulates trade and protects consumers from unfair and deceptive business practices. Its consumer protection programs include truth in advertising, packaging and labeling of products, product reliability, direct mail advertising, and nursing home business practices. Publications are available on refinancing a home, collecting a debt, buying a used car, and finding out credit history.

Food and Drug Administration (FDA)

HFE88
5600 Fishers Lane
Rockville, MD 20857

Phone: (888) INFO-FDA (463-6332) (toll-free)
(888) 723-3366 (toll-free) (Food Information Line)
(800) 822-7967 (toll-free) (Vaccine Adverse Event Reporting System)
(800) 838-7715 (toll-free) (Mammography Information Service)
Web site: <http://www.fda.gov>

FDA, part of the federal government, regulates the safety and effectiveness of food products, additives, drugs, medical devices, and cosmetics. Contact FDA for information on safe drug use and side effects, vitamins, and laws regulating medicines and foods. FDA has information for older people on topics including cancer, health fraud, nutrition, buying medicines online, and food safety.

Food and Nutrition Information Center (FNIC)

Department of Agriculture
Agricultural Research Service/National Agriculture Library
10301 Baltimore Avenue, Room 304
Beltsville, MD 20705-2351

Phone: (301) 504-5719
TTY: (301) 504-6856
Fax: (301) 504-6409
E-mail: fnic@nal.usda.gov
Web site: <http://www.nalusda.gov/fnic>

FNIC, part of the federal government, provides information, publications, and audiovisual materials on nutrition. Resource guides on nutrition and older people, heart disease, diabetes, vegetarianism, food safety, and food labeling are available.

Foundation for Biomedical Research (FBR)

818 Connecticut Avenue, NW, Suite 200
Washington, DC 20006

Phone: (202) 457-0654
Fax: (202) 457-0659
E-mail: info@fbresearch.org
Web site: <http://www.fbresearch.org>

FBR is a national organization advocating the ethical use of animals in scientific and medical research. Contact the Foundation for information and publications on how animal research helps scientists understand human health and aging.

Generations Online

108 Ralston House
3615 Chestnut Street
Philadelphia, PA 19104

Phone: (215) 222-6400
Fax: (215) 222-6401
Web site: <http://www.generationsonline.com>

Generations Online is a nonprofit Web site offering resources for older people unfamiliar with computers or the Internet. Generations Online provides self-training software for senior centers, libraries, retirement homes, and other locations for a one-time fee. The program is free for seniors. Its feature, Memories, links older people with school children for cultural, experiential, and personal exchanges on aging.

Generations Together (GT)

University Center for Social and Urban Research
University of Pittsburgh
121 University Place, Suite 300
Pittsburgh, PA 15260-5907

Phone: (412) 648-7150
Fax: (412) 648-7446
E-mail: sharris@pitt.edu
Web site: <http://www.pitt.edu/~gti/>

GT promotes mutually beneficial interaction between young and old through community outreach, education, research, and dissemination of knowledge. GT develops, supports, and studies intergenerational programs and related issues. GT sponsors the annual International Intergenerational Training Institute, which furthers collaboration between generations in workshops and resource development. Contact GT for a catalog of publications.

Gerontological Society of America (GSA)

1030 15th Street, NW, Suite 250
Washington, DC 20005-1503

Phone: (202) 842-1275
Fax: (202) 842-1150
E-mail: geron@geron.org
Web site: <http://www.geron.org>

GSA is a professional organization providing information, advocacy, and support for research into the study of aging. GSA has a database of information on biological and social aspects of aging, links to aging information resources, and referrals to researchers and specialists in gerontology. GSA distributes publications on a variety of aging-related topics.

Glaucoma Research Foundation (GRF)

200 Pine Street, Suite 200
San Francisco, CA 94104

Phone: (800) 826-6693 (toll-free)
(415) 986-3162
Fax: (415) 986-3763
E-mail: info@glaucoma.org
Web site: <http://www.glaucoma.org>

GRF is a national, nonprofit organization providing information and advocacy for people with glaucoma. Contact GRF for information on the causes, diagnosis, treatment, and prevention of glaucoma, referrals to specialists, and coping strategies for patients. Publications include the quarterly newsletter, *Gleams*, and a glaucoma patient guide.

Gray Panthers (GP)

733 15th Street, NW, Suite 437
Washington, DC 20005

Phone: (800) 280-5362 (toll-free)
(202) 737-6637
Fax: (202) 737-1160
E-mail: info@graypanthers.org
Web site: <http://www.graypanthers.org>

Gray Panthers is a national advocacy organization of activists concentrating on social and economic issues. Local chapters organize intergenerational groups to address issues including universal health care, Medicare, preserving Social Security, affordable housing, and discrimination. Contact the national office for referrals to chapters, information on issues, links to resources for older people, and a list of publications.

Green Thumb, Inc. (GT)

2000 North 14th Street, Suite 800
Arlington, VA 22201

Phone: (703) 522-7272
Fax: (703) 522-0141
Web site: <http://www.greenthumb.org>

GT is a national, nonprofit organization helping older, low-income workers train for and find work, particularly in rural areas. GT's Senior Community Service Employment Program, funded by the Department of Labor, provides training, work experience, educational opportunities, and placement in community service jobs. The Geezer.com Web site has information to help seniors supplement their income, launch new businesses, and market their handcrafted goods. Contact GT for a fact sheet and list of publications.

Health Care Financing Administration (HCFA)/The Centers for Medicare and Medicaid Services (CMS)

7500 Security Boulevard
Baltimore, MD 21244

Phone: (800) MEDICARE (633-4227) (toll-free) (Medicare hotline)
(410) 786-3000
Fax: (202) 690-7675
Web site: <http://www.cms.hhs.gov/> or
<http://www.medicare.gov> (Medicare information)

HCFA (CMS), part of the federal government, administers health insurance through Medicare and Medicaid. HCFA (CMS) regulates hospitals, nursing homes, and home health agencies. Contact HCFA (CMS) for *The Medicare Handbook* and other publications on related topics.

Note: This federal agency changed its name in July 2001 to The Centers for Medicare and Medicaid Services.

Health Insurance Association of America (HIAA)

1201 F Street, NW, 5th Floor
Washington, DC 20004

Phone: (202) 824-1600
(202) 824-1849 (publications information)
Fax: (202) 824-1722
Web site: <http://www.hiaa.org>

HIAA is a trade association representing the interests of the privately insured health care system. Contact HIAA for insurance information on health, long-term care, dental, disability, and supplemental coverage. HIAA also provides information and publications on health care issues, including continuation of group health benefits, major medical, and Medicare supplements.

Hill-Burton Free Medical Care Program

Health Resources and Services Administration (HRSA)
Department of Health and Human Services
Division of Facilities Compliance and Recovery
5600 Fishers Lane, Room 10C-16
Rockville, MD 20857

Phone: (800) 638-0742 (toll-free)
(800) 492-0359 (toll-free) (Maryland residents)
(301) 443-5656
Fax: (301) 443-0619
E-mail: webmaster@hrsa.gov
Web site: <http://www.hrsa.gov/osp/dfcr>

Hospitals and other health care facilities receive federal funds for construction or modernization under the Hill-Burton Program. In return, these facilities provide a specific amount of free or below cost health care services to eligible people. Contact the program for a list of participating facilities as well as information on eligibility.

HIV/AIDS Treatment Information Service (ATIS)

PO Box 6303
Rockville, MD 20849-6303

Phone: (800) HIV-0440 (448-0440) (toll-free) (English, Spanish, Portuguese)
(301) 519-0459
TTY: (888) 480-3739 (toll-free)
Fax: (301) 519-6616
E-mail: atis@hivatis.org
Web site: <http://www.hivatis.org>

ATIS, sponsored by the federal government, provides current treatment information on HIV and AIDS as well as answering HIV/AIDS-related questions. Referrals to national, state, and local organizations are provided. All information is free and confidential.

Huntington's Disease Society of America (HDSA)

158 West 29th Street, 7th Floor
New York, NY 10001-5300

Phone: (800) 345-HDSA (4372) (toll-free)
(212) 242-1968, Ext.10
Fax: (212) 239-3430
E-mail: hdsainfo@hdsa.org
Web site: <http://www.hdsa.org>

The Society is a nonprofit organization providing information, services, and advocacy for people with Huntington's disease (HD) and their families. Contact HDSA for research information on causes, diagnosis, and treatment of HD as well as referrals to testing centers, specialists, self-help groups, and social services. Publications and audiovisual materials on HD are available.

Hysterectomy Educational Resources and Services Foundation (HERS)

422 Bryn Mawr Avenue
Bala Cynwyd, PA 19004

Phone: (610) 667-7757
Fax: (610) 667-8096
E-mail: HERSFdn@aol.com
Web site: <http://www.hersfoundation.com>

HERS Foundation is a nonprofit organization providing information on hysterectomy (surgical removal of the uterus) and oophorectomy (removal of the ovaries). Contact HERS for telephone counseling and support services. A lending library contains medical literature on topics such as fibroids, hyperplasia, and ovarian conditions. A list of publications is available on request.

Indian Health Service (IHS)

Parklawn Bldg., Room 6-35
5600 Fishers Lane
Rockville, MD 20857

Phone: (301) 443-3593
Fax: (301) 443-0507
Web site: <http://www.ihs.gov>

The IHS, part of the federal government, operates a comprehensive health service program for American Indians and Alaska Natives. Services include hospital and community-based medical care, rehabilitation, and disease prevention. The IHS strives for maximum tribal involvement in all aspects of its services.

International Hearing Society (IHS)

16880 Middlebelt Road, Suite 4
Livonia, MI 48154

Phone: (800) 521-5247 (toll-free) (Hearing Aid Helpline)
(734) 522-7200 (outside the US and Canada)

Fax: (734) 522-0200
Web site: <http://www.hearingihs.org>

IHS is a professional organization providing assistance to consumers in locating a hearing aid specialist, support, and repair services. The Hearing Aid Helpline offers information and publications on how hearing works, types of hearing loss, and design and use of hearing instruments.

International Tremor Foundation (ITF)

7046 West 105th Street
Overland Park, KS 66212-1803

Phone: (913) 341-3880
Fax: (913) 341-1296
E-mail: UPF_ITF@msn.com
Web site: <http://www.essentialtremor.org>

ITF is an international, nonprofit organization providing support, information on medication use and surgical treatment, research, and other resources for people diagnosed with essential tremor. Contact ITF for referrals to medical specialists, a list of support groups by state, and information on more than 20 tremor disorders. Members may write or call for background literature and answers to specific questions.

Japanese American Citizens League (JACL)

National Headquarters
1765 Sutter Street
San Francisco, CA 94115

Phone: (415) 921-5225
Fax: (415) 931-4671
E-mail: jacl@jacl.org
Web site: <http://www.jacl.org>

JACL is a nonprofit educational organization fighting discrimination against Japanese Americans and their families by providing information, education, and advocacy. Contact JACL for assistance to retired people and information on programs on equal rights, racial violence, immigration, and fair employment. *Pacific Citizen*, a weekly newspaper, and other publications are available.

John Douglas French Alzheimer's Foundation

11620 Wilshire Boulevard, Suite 270
Los Angeles, CA 90025

Phone: (800) 477-2243 (toll-free)
(310) 445-4650
Fax: (310) 479-0516
Web site: <http://www.jdfaf.org>

The Foundation funds scientific research into the causes and cure for Alzheimer's disease. Contact the Foundation for the free publication *Caring for a Person with Memory Loss and Confusion*.

Kansas Geriatric Education Center (KS-GEC)

Center on Aging
University of Kansas Medical Center
3901 Rainbow Boulevard
Kansas City, KS 66160-7177

Phone: (913) 588-1636
Fax: (913) 588-3179
E-mail: hcallowa@kumc.edu
Web site: <http://coa.kumc.edu/gcc>

KS-GEC provides information and support for developing community-based, long-term care for rural older people. The Center works closely with state and area Agencies on Aging. Contact the Center for a list of publications.

Legal Counsel for the Elderly (LCE)

American Association of Retired Persons (AARP)
601 E Street, NW
Washington, DC 20049

Phone: (202) 434-2120
TTY: (202) 434-6562
Fax: (202) 434-6464
Web site: <http://www.aarp.org>

LCE, part of AARP, works to expand the availability of legal services to older people and to enhance the quality of those services. The National Volunteer Lawyers Project matches legal cases affecting large numbers of older people with volunteer law firms. The Senior Lawyers Project tests ways retired lawyers can provide free legal services to older people in need. The National Elderlaw Studies Program provides individual home study courses as well as a paralegal certificate from the Department of Agriculture Graduate School. Publications are available.

Legal Services for the Elderly (LSE)

130 West 42nd Street, 17th Floor
New York, NY 10036

Phone: (212) 391-0120
Fax: (212) 719-1939
E-mail: hn4923@handsnet.org

LSE is an advisory center for lawyers specializing in legal problems of older people. While LSE does not provide direct services to clients, staff lawyers offer advice and write memoranda and briefs to lawyers who serve older clients on issues including Medicaid, Medicare, Social Security, disability, voluntary and involuntary commitment, age discrimination, pensions, rent-increase exemptions for older people, and nursing home care. A list of publications is available.

Leukemia and Lymphoma Society, Inc. (LLS)

1311 Mamaroneck Avenue
White Plains, NY 10605

Phone: (800) 955-4572 (toll-free)
(914) 949-5213
Fax: (914) 949-6691
E-mail: infocenter@leukemia-lymphoma.org
Web site: <http://www.leukemia.org>

LLS provides information, advocacy, and assistance for patients with leukemia and related cancers such as lymphoma, multiple myeloma, and Hodgkin's disease. Contact LLS for information, referrals to specialists and local chapters offering financial assistance to patients with leukemia, and support groups. Publications on leukemia and related cancers are available.

Lighthouse National Center for Vision and Aging (LNCVA)

111 East 59th Street
New York, NY 10022

Phone: (800) 829-0500 (toll-free)
(212) 821-9495
TTY: (212) 821-9713
Fax: (212) 821-9705
E-mail: info@lighthouse.org
Web site: <http://www.lighthouse.org>

LNCVA provides advocacy, support, information, and resources on vision impairment and blindness. Contact the Lighthouse for referrals to specialists and resources on visual disability, vision rehabilitation, links to related services, as well as information on eye diseases such as macular degeneration, glaucoma, cataracts, and diabetic retinopathy. Publications and audiovisual materials are available on topics including vision, vision disorders, treatment options, and rehabilitation strategies.

Lupus Foundation of America (LFA)

1300 Piccard Drive, Suite 200
Rockville, MD 20850-4303

Phone: (800) 558-0121 (toll-free) (information line)
(301) 670-9292
Fax: (301) 670-9486
E-mail: lupusinfo@aol.com
Web site: <http://www.lupus.org>

LFA is a nonprofit organization supporting research and distributing information about diagnosis and treatment of lupus erythematosus, a chronic autoimmune disease. Contact the LFA for referrals to specialists, information about treatment and research, a listing of local chapters and support groups, other resource organizations, and a list of publications.

Meals On Wheels Association of America (MOWAA)

1414 Prince Street, Suite 302
Alexandria, VA 22314

Phone: (703) 548-5558
Fax: (703) 548-8024
Web site: <http://www.mowaa.org>

MOWAA is a national, nonprofit organization providing training and grants to programs that provide food to older people, and those who are frail, disabled, at-risk, or homebound.

MedicAlert Foundation

2323 Colorado Avenue
Turlock, CA 95382

Phone: (800) 432-5378 (toll-free)
(209) 668-3333
Fax: (209) 669-2495
Web site: <http://www.medicalert.org>

MedicAlert is a nonprofit, membership organization providing identification and medical information in emergencies. Contact MedicAlert for information about its membership services and costs.

Medicare Rights Center (MRC)

1460 Broadway, 11th Floor
New York, NY 10036

Phone: (212) 869-3850
Fax: (212) 869-3532
E-mail: info@medicarerights.org
Web site: <http://www.medicarerights.org>

MRC is a national, nonprofit service helping older adults and people with disabilities get good, affordable health care. Available educational materials include a train-the-trainer manual, booklets on Medicare basics, and Medicare home health.

National Academy of Elder Law Attorneys, Inc. (NAELA)

1604 North Country Club Road
Tucson, AZ 85716

Phone: (520) 881-4005
Fax: (520) 325-7925
Web site: <http://www.naela.org>

NAELA is a nonprofit association assisting lawyers, bar associations, and others who work with older people and their families. Contact NAELA for information on lawyers specializing in issues pertinent to older people, resources to legal information, assistance, and education. A list of publications is available.

National Alliance for Hispanic Health

1501 16th Street, NW
Washington, DC 20036

Phone: (202) 387-5000

E-mail: alliance@hispanichealth.org

Web site: <http://www.hispanichealth.org/>

The Alliance is a network of health and human service providers fostering the health, well-being, and prosperity of Hispanics. Network members provide consumer information, help formulate culturally competent standards of care, support research into specific health concerns facing Hispanics, and promote appropriate use of technology. Spanish language resources are available.

National Alliance for the Mentally Ill (NAMI)

Colonial Place Three
2107 Wilson Boulevard, Suite 300
Arlington, VA 22201

Phone: (800) 950-NAMI (950-6264) (toll-free) (NAMI Helpline)
(703) 524-7600

TTY: (703) 516-7227

Fax: (703) 524-9094

Web site: <http://www.nami.org>

NAMI offers support groups, education, advocacy, and research to help people with mental illness. The Alliance seeks to educate all people about severe and persistent mental illnesses to eliminate stigma and promote access to services. Search the Web site for lists of local affiliates and state organizations.

National Arthritis and Musculoskeletal and Skin Diseases Information Clearinghouse

National Institute of Arthritis and Musculoskeletal and Skin Diseases (NIAMS)

National Institutes of Health

1 AMS Circle
Bethesda, MD 20892-3675

Phone: (877) 22-NIAMS (226-4267) (toll-free)

(301) 495-4484

TTY: (301) 565-2966

Fax: (301) 881-2731 (faxback service)

E-mail: NIAMSInfo@mail.nih.gov

Web site: <http://www.nih.gov/niams>

NIAMS Information Clearinghouse is funded by NIAMS, part of NIH. The Clearinghouse provides information and resources on all forms of arthritis, musculoskeletal diseases such as fibromyalgia, as well as skin diseases. Contact the Clearinghouse for information on research and referrals to research programs and community resources. Publications are available on the causes, treatments, and prevention of arthritis, lupus, musculoskeletal disorders, and diseases of bones, joints, and skin.

National Asian Pacific Center on Aging (NAPCA)

1511 3rd Avenue, Suite 914
Seattle, WA 98101-1626

Phone: (206) 624-1221

Fax: (206) 624-1023

E-mail: info@napca.org

Web site: <http://www.napca.org>

NAPCA is a nonprofit agency dedicated to serving aging Asian and Pacific Islanders. It offers employment programs, multilingual community forums and health care education. The Center works with older people, policy makers, program administrators, and community leaders. Publications include a newsletter and translated health care materials.

National Association for Continence (NAFC)

PO Box 8310
Spartanburg, SC 29305-8310

Phone: (800) 252-3337 (toll-free) (ordering line)

Fax: (864) 579-7902

E-mail: memberservices@nafc.org

Web site: <http://www.nafc.org>

NAFC, formerly Help for Incontinent People, is a nonprofit organization providing advocacy, education, and support to people with incontinence and their families. Contact NAFC for referrals to specialists, resources, and information about the causes, prevention, diagnosis, treatments, and management alternatives for incontinence. Publications are available.

National Association for Health & Fitness (NAHF)

201 South Capitol Avenue, Suite 560
Indianapolis, IN 46225

Phone: (317) 237-5630

Fax: (317) 237-5632

Web site: <http://www.physicalfitness.org/>

NAHF is a nonprofit organization promoting physical fitness, sports, and healthy lifestyles. The Association supports State Governor's Councils on Physical Fitness and Sports. NAHF supports employee health and fitness programs including Let's Get Physical, an interactive educational program based on the Surgeon General's 1996 report recommending moderate physical activity most days of the week.

National Association for Hispanic Elderly (Asociación Nacional Por Personas Mayores)

234 East Colorado Boulevard, Suite 300
Pasadena, CA 91101

Phone: (626) 564-1988

Fax: (626) 564-2659

The Association is a national, private, nonprofit organization providing a variety of services for older Hispanic people. Resources include a national Hispanic research center, research and consultation for organizations seeking to reach older Spanish-speaking people, and dissemination of written and audiovisual materials in English and Spanish. The Association administers Project AYUDA, a program providing employment counseling and placement services.

National Association for Home Care (NAHC)

228 7th Street, SE
Washington, DC 20003

Phone: (202) 547-7424

Fax: (202) 547-3540

E-mail: webmaster@nahc.org

Web site: <http://www.nahc.org>

NAHC promotes hospice and home care, sets standards of care, and conducts research on aging, health, and health care policy. Association publications include *How to Choose a Home Care Provider* and other free consumer guides on home care and hospice care.

National Association for Human Development (NAHD)

1424 16th Street, NW, Suite 102
Washington, DC 20036

Phone: (202) 328-2191

Fax: (202) 265-6682

E-mail: nahdcasa@worldnet.att.net

NAHD is a nonprofit organization providing information and materials for national, state, and local groups helping people maintain their physical, mental, and social well-being. Contact NAHD program specialists for slides, videos, booklets, posters, and training manuals on health and physical fitness. Program materials focusing on older people include topics such as wellness, physical fitness, preventive medicine, self-care, and retirement planning.

National Association for Practical Nurse Education and Services (NAPNES)

1400 Spring Street, Suite 330
Silver Spring, MD 20910

Phone: (301) 588-2491

Fax: (301) 588-2839

E-mail: napnes@bellatlantic.net

NAPNES is a professional organization of licensed practical nurses, other nurses, physicians, nursing home administrators, and the general public specializing in direct long-term care of older people. NAPNES offers long-term care certification to practical/vocational nurses. Contact NAPNES for information on practical nursing and referrals to member nurses and resource organizations.

National Association of Activity Professionals (NAAP)

PO Box 5530
Sevierville, TN 37864

Phone: (865) 429-0717
Fax: (865) 453-9914
E-mail: THENAAP@aol.com
Web site: <http://www.thenaap.com>

NAAP is a professional organization providing activity education, advocacy, industry standards, and programming for long-term-care facilities, retirement living communities, and adult day care centers. Contact NAAP for referrals to specialists and information on therapeutic and restorative activities, regulation and policy updates, and program models. Publications are available.

National Association of Area Agencies on Aging (N4A)

927 15th Street, NW, 6th Floor
Washington, DC 20005

Phone: (800) 677-1116 (toll-free) (Eldercare Locator)
(202) 296-8130
Fax: (202) 296-8134
Web site: <http://www.n4a.org>

N4A is the umbrella organization for the AoA-funded Area Agencies on Aging. It also represents the interests of Title VI Native American aging programs. The Association administers the AoA-sponsored Eldercare Locator, a toll-free number linking older adults and their family members with local resources on aging. N4A publishes the *National Directory for Eldercare Information and Referral*.

National Association of Community Health Centers (NACHC)

1330 New Hampshire Avenue, NW, Suite 122
Washington, DC 20036

Phone: (202) 659-8008
Fax: (202) 659-8519
E-mail: dhawkins@nachc.com
Web site: <http://www.nachc.com>

NACHC is a national association representing community health centers nationwide. Contact NACHC for referrals to local health centers and information on the Association's programs as well as health care regulation and policy updates.

National Association of Nutrition and Aging Service Programs (NANASP)

1101 Vermont Avenue, NW, Suite 1001
Washington, DC 20005

Phone: (202) 682-6899
Fax: (202) 682-3984
Web site: <http://www.nanasp.org>

NANASP, a membership organization, supports a broad range of nutrition and related services for community-dwelling older people by training nutrition providers and advocating for older people. Publications include a *Legislative Action Manual* and *The Washington Bulletin*.

National Association of Professional Geriatric Care Managers (NAPGCM)

1604 North Country Club Road
Tucson, AZ 85716-3102

Phone: (520) 881-8008

Fax: (520) 325-7925

E-mail: info@caremanager.org

Web site: <http://www.caremanager.org>

NAPGCM is a nonprofit organization representing the interests of elder care practitioners and advocating for older peoples' independence, autonomy, and quality of health care. Contact NAPGCM for resources, referrals to local Association chapters, and information on counseling and treatment programs. Publications and referrals to professional care managers are available through the Web site.

National Association of Social Workers (NASW)

750 First Street, NE, Suite 700
Washington, DC 20002-4241

Phone: (800) 638-8799 (toll-free)

(202) 408-8600

Fax: (202) 336-8310

E-mail: info@naswdc.org

Web site: <http://www.naswdc.org>

NASW is a membership organization promoting, advocating, developing, and protecting social workers and the practice of social work. Contact NASW for referrals to counseling resources and specialists, information about social work, and information from the members section focusing on aging issues and health care.

National Association of State Units on Aging (NASUA)

1225 I Street, NW, Suite 725
Washington, DC 20005

Phone: (202) 898-2578

Fax: (202) 898-2583

E-mail: info@nasua.org

Web site: <http://www.nasua.org>

NASUA is a public-interest organization providing information, assistance, and advocacy on behalf of older people. Contact NASUA for information on rights of older people, health care and social services regulations, and referrals to lawyers specializing in elder law and aging issues. Publications are available on topics such as the Older Americans Act, long-term care, older worker issues, elder abuse, and nutrition programs. The Association cooperates in administering the Eldercare Locator, AoA's toll-free information service.

National Association of the Deaf (NAD)

814 Thayer Avenue
Silver Spring, MD 20910-4500

Phone: (301) 587-1788
TTY: (301) 587-1789
Fax: (301) 587-1791
E-mail: NADinfo@nad.org
Web site: <http://www.nad.org>

NAD is a private, nonprofit organization representing the interests and rights of people who are deaf or hearing impaired. It advocates for greater access to education, employment, health care, and social services. Contact NAD for information on legal assistance, public policy on deafness and disabilities, and referrals to products that assist deaf and hearing-impaired people. Publications are available.

National Association on HIV Over Fifty (NAHOF)
Southwest Boulevard Family Health Care Services, Inc.
340 Southwest Boulevard
Kansas City, KS 66103

Phone: (816) 421-5263
Fax: (913) 722-2542
E-mail: janepfowler@mindspring.com
Web site: <http://www.hivoverfifty.org>

NAHOF is a membership organization promoting the availability of a full range of educational, prevention, service, and health care programs for people over age 50 and affected by HIV. NAHOF provides a forum to exchange information and share concerns about HIV and older adults.

National Bar Association (NBA)
1225 11th Street, NW
Washington, DC 20001

Phone: (202) 842-3900
Fax: (202) 289-6170
Web site: <http://www.nationalbar.org>

NBA uses its national membership, statewide minority bar programs, minority law students, minority bar group alliances, and private attorneys, to form links with community groups providing legal assistance to low-income, minority older people. Publications include *Saving The Home* and *Defending Against Fraud and Scams*, a resource book on second mortgages.

National Cancer Institute (NCI)
National Institutes of Health
Public Inquiries Office
Building 31, Room 10A03
31 Center Drive MSC 2580
Bethesda, MD 20892-2580

Phone: (800) 4-CANCER (422-6237) (toll-free) (Cancer Information Service-CIS)
TTY: (800) 332-8615 (toll-free)

(301) 435-3848

E-mail: webmaster@cancer.gov

Web site: <http://www.nci.nih.gov>

NCI, part of NIH, is the lead agency for cancer research and statistics, treatments, clinical trials, patient education, and public information on all types of cancer, risk factors, and prevention. NCI's toll-free CIS provides immediate, science-based answers to the public's specific questions about cancer. The CIS provides referrals to cancer specialists and other related resources, including where to find survivor groups. Many free publications are available.

National Caucus and Center on Black Aged, Inc. (NCBA)

1424 K Street, NW, Suite 500

Washington, DC 20005

Phone: (202) 637-8400

Fax: (202) 347-0895

E-mail: ncba@aol.com

Web site: <http://www.ncba-blackaged.org>

NCBA is a national, nonprofit organization providing health and social service information, advocacy, and assistance to African-Americans and low-income older people. Contact NCBA for information on its local chapters and programs including senior employment and training, housing, health promotion, and advocacy. Publications include a support-service reference guide, job placement guides, and a *Profile of Black Elderly*.

National Center for Complementary and Alternative Medicine Clearinghouse (NCCAM)

National Institutes of Health (NIH)

PO Box 8218

Silver Spring, MD 20907-8218

Phone: (888) 644-6226 (toll-free)

(301) 231-7357

TTY: (866) 464-3615 (toll-free)

Fax: (866) 464-3616

E-mail: nccam-info@nccam.nih.gov

Web site: <http://www.nccam.nih.gov>

The Clearinghouse, funded by NCCAM, provides information on alternative medical therapies not commonly used or previously accepted in conventional Western medicine. Contact the Clearinghouse for information on holistic healing traditions, including acupuncture, herbs, homeopathy, therapeutic massage, and traditional oriental medicine. NCCAM does not recommend specific therapies. Publications are available by fax-on-demand and on the Web site.

National Center for Health Statistics (NCHS)

Centers for Disease Control and Prevention (CDC)

6525 Belcrest Road

Hyattsville, MD 20782-2003

Phone: (301) 458-4636

Web site: <http://www.cdc.gov/nchs/>

NCHS, part of the federal government, is the agency that monitors and compiles information on the Nation's health. NCHS statistical programs on aging collect information on the health of older people, their lifestyles, exposure to unhealthy influences, diagnosis and age of onset for illnesses or disabilities, and patterns of health care service use. Contact NCHS for reports on trends in health and aging.

National Center on Elder Abuse (NCEA)

1225 I Street, NW, Suite 725
Washington, DC 20005

Phone: (202) 898-2586

Fax: (202) 898-2583

E-mail: NCEA@nasua.org

Web site: <http://www.elderabusecenter.org/>

NCEA is operated jointly by the National Association of State Units on Aging, the National Committee for the Prevention of Elder Abuse, and the University of Delaware to disseminate information about abuse and neglect of older people. NCEA operates the Clearinghouse on Abuse and Neglect of the Elderly and can provide referrals to agencies and specialists. Publications are available on prevention of abuse, neglect, and state regulations.

National Center on Minority Health and Health Disparities (NCMHD)

National Institutes of Health (NIH)
6707 Democracy Boulevard
MSC 5465
Bethesda, MD 20892-5465

Phone: (301) 402-1366

Fax: (301) 496-4035

NCMHD, part of NIH, conducts and supports research, training, dissemination of information, and other programs with respect to minority health conditions and other populations with health disparities.

National Center on Poverty Law, Inc. (NCPL)

205 West Monroe Street
Chicago, IL 60606

Phone: (312) 263-3830

Fax: (312) 263-3846

Web site: <http://www.povertylaw.org>

NCPL is a professional organization advocating for low-income people and providing assistance, resources, and information on poverty law. Contact NCPL for referrals to poverty law specialists, program information on welfare, work force, housing, and community development. Publications are available on topics such as grandparents' visitation, access to home health care for older people, protecting older homeowners from refinancing scams, and the needs of multigenerational low-income families.

National Citizen's Coalition for Nursing Home Reform (NCCNHR)

1424 16th Street, NW, Suite 202
Washington, DC 20036-2211

Phone: (202) 332-2275
Fax: (202) 332-2949
E-mail: nccnhr@nccnhr.org
Web site: <http://www.nccnhr.org>

NCCNHR provides information on nursing home reform, promotes quality standards, and works to empower residents. Contact NCCNHR for information on community-based, consumer/citizen action, and long-term care ombudsmen groups. Publications on nursing homes and long-term care are available.

National Coalition for Adult Immunization (NCAI)

4733 Bethesda Avenue, Suite 750
Bethesda, MD 20814

Phone: (301) 656-0003
Fax: (301) 907-0878
E-mail: ncai@nfid.org
Web site: <http://www.nfid.org/ncai>

NCAI is a network of organizations formed to achieve better health through immunizations and support for science-based recommendations. NCAI helps coordinate National Adult Immunization Awareness Week, an annual observance in the fall. Check the Web site for a chart outlining the NCAI-recommended adult immunization schedule. Spanish language resources are available.

National Committee to Preserve Social Security and Medicare (NCPSSM)

10 G Street, NE, Suite 600
Washington, DC 20004-4215

Phone: (800) 966-1935 (toll-free)
(202) 216-0420
Fax: (202) 216-0451
Web site: <http://www.ncpssm.org>

NCPSSM, an advocacy and education membership organization, works to protect and enhance federal programs vital to seniors' health and economic well-being. Contact NCPSSM for details on membership as well as information on seniors' rights, Medicare, Social Security, long-term care, and disability issues. Free informational brochures are available.

National Consumer's League (NCL)

1701 K Street, NW, Suite 1200
Washington, DC 20006

Phone: (800) 876-7060 (toll-free) (National Fraud Information Center)
(202) 835-3323

Fax: (202) 835-0747

E-mail: info@nclnet.org

Web site: <http://www.natlconsumersleague.org> (National Consumer's League) or
<http://www.fraud.org> (National Fraud Information Center)

NCL is a private, nonprofit advocacy group representing consumers on marketplace and workplace issues, providing government, businesses, and other organizations with consumers' perspectives on social issues. Contact the NCL for information on topics such as privacy, consumer credit, food safety, and drug safety. NFIC supports victims of telemarketing and Internet fraud, and informs law enforcement of fraud cases. Publications are available.

National Council Against Health Fraud (NCAHF)

PO Box 1276

Loma Linda, CA 92354

Phone: (201) 723-2955 (consumer health information)

Web site: <http://www.ncahf.org>

NCAHF is a nonprofit agency that provides a Web site listing reliable sources of health information on the Internet. Contact the Council for information on health fraud, misinformation, and quackery, or to report fraud and investigate health claims by companies or organizations. NCAHF provides information on legitimate health groups, sponsors discussion groups that evaluate new health organizations, and suggests alternative medical techniques. A free weekly e-mail newsletter is available online.

National Council of La Raza (NCLR)

1111 19th Street, NW, Suite 1000

Washington, DC 20036

Phone: (202) 785-1670

Fax: (202) 776-1794

Web site: <http://www.nclr.org>

NCLR is a private, nonprofit organization established to reduce poverty and discrimination, and improve opportunities for Hispanics. NCLR health programs develop culturally relevant, bilingual health education and promotional materials. The Hispanic Health Project works to lower the incidence of a variety of preventable conditions.

National Council on Aging (NCOA)

409 3rd Street, SW, Suite 200

Washington, DC 20024

Phone: (202) 479-1200

Fax: (202) 479-0735

E-mail: info@ncoa.org

Web site: <http://www.ncoa.org>

NCOA is a private, nonprofit organization providing information, training, technical assistance, advocacy, and leadership in all aspects of aging services and issues. Contact NCOA for information on training programs and in-home services for older people. NCOA publications are

available on topics such as lifelong learning, senior center services, adult day care, long-term care, financial issues, senior housing, rural issues, intergenerational programs, and volunteers in aging.

National Council on Alcoholism and Drug Dependence (NCADD)

20 Exchange Place, Suite 2902
New York, NY 10005

Phone: (800) NCA-CALL (622-2255) (toll-free)

(212) 269-7797

Fax: (212) 269-7510

E-mail: national@ncadd.org

Web site: <http://www.ncadd.org>

NCADD is a nonprofit organization providing advocacy, assistance, and information on alcoholism and drug addiction. Contact NCADD for information on causes, diagnosis, and treatments; referrals to specialists; lists of community resource centers; and NCADD-affiliated organizations nationwide. Fact sheets, brochures, and videotapes also are available.

National Council on Patient Information and Education (NCPPIE)

4915 Saint Elmo Avenue, Suite 505
Bethesda, MD 20814-6053

Phone: (301) 656-8565

Fax: (301) 656-4464

E-mail: ncpie@erols.com

Web site: <http://www.talkaboutrx.org>

NCPPIE is a nonprofit coalition providing advocacy, information, and services to educate and empower consumers to make sound decisions about use of prescription and over-the-counter medicines. Contact NCPPIE to discuss drug safety or facts about specific drugs. NCPPIE's Web site and publications provide information on medications, side effects, and manufacturers' recalls.

National Diabetes Information Clearinghouse (NDIC)

National Institute of Diabetes and Digestive and Kidney Diseases (NIDDK)

National Institutes of Health (NIH)

1 Information Way

Bethesda, MD 20892-3560

Phone: (800) 860-8747 (toll-free)

(301) 654-3327

Fax: (301) 907-8906

E-mail: ndic@info.niddk.nih.gov

Web site: <http://www.niddk.nih.gov>

NDIC, funded by NIDDK, part of NIH, provides referrals to diabetes specialists and organizations, and searches from its database of patient and professional education materials. Call for publications on topics such as alternative therapies, controlling diabetes, complications of diabetes, and diabetes in Asian, Hispanic, and other ethnic groups. Spanish-language publications are available.

National Digestive Diseases Information Clearinghouse (NDDIC)

National Institute of Diabetes and Digestive and Kidney Diseases (NIDDK)
National Institutes of Health (NIH)
2 Information Way
Bethesda, MD 20892-3570

Phone: (800) 891-5389 (toll-free)
(301) 654-3810
Fax: (301) 907-8906
E-mail: nddic@info.niddk.nih.gov
Web site: <http://www.niddk.nih.gov>

NDDIC, funded by NIDDK, part of NIH, provides referrals to digestive diseases organizations and support groups, as well as searches from its database of patient and professional education materials. Fact sheets are available on gastroesophageal reflux disease, hemorrhoids, constipation, ulcers, and irritable bowel syndrome.

National Eye Health Education Program (NEHEP)

National Eye Institute (NEI)
National Institutes of Health (NIH)
2020 Vision Place
Bethesda, MD 20892-3655

Phone: (301) 496-5248
Fax: (301) 402-1065
E-mail: 2020@nei.nih.gov
Web site: <http://www.nei.nih.gov>

NEHEP, funded by the NEI, part of NIH, is a partnership of professional, civic, and voluntary organizations and federal agencies. NEHEP provides referrals to vision professionals and other health resources. The Program offers free materials to educate the public about how to protect eye health and prevent vision loss, and distributes information on such topics as preventing diabetic eye disease, glaucoma, and low vision.

National Family Caregivers Association (NFCA)

10400 Connecticut Avenue, #500
Kensington, MD 20895-3944

Phone: (800) 896-3650 (toll-free)
Fax: (301) 942-2302
E-mail: info@nfcacares.org
Web site: <http://www.nfcacares.org>

NFCA is a grass roots organization providing advocacy, support, and information for family members who care for chronically ill, older, or disabled relatives. There is no charge for family members to be on the mailing list and to receive the newsletter, *Take Care!* Contact NFCA for help finding resources.

National Gerontological Nursing Association (NGNA)

7794 Grow Drive
Pensacola, FL 32514

Phone: (800) 723-0560 (toll-free)

Fax: (850) 484-8762

E-mail: ngna@puetzamc.com

Web site: <http://www.ngna.org>

NGNA, an organization of nurses specializing in the care of older adults, informs the public on health issues affecting older people, supports education for nurses and other health care practitioners, and provides a forum to discuss topics such as nutrition in long-term care facilities and elder law for nurses. NGNA offers information on gerontological nursing and conducts nursing research related to older people.

National Health Information Center (NHIC)

Office of Disease Prevention and Health Promotion (ODPHP)

Department of Health and Human Services

PO Box 1133

Washington, DC 20013-1133

Phone: (800) 336-4797 (toll-free)

(301) 565-4167

Fax: (301) 984-4256

Faxback: (301) 468-1204

E-mail: nhicinfo@health.org

Web site: <http://www.health.gov/NHIC>

NHIC, a service of the federal government, links consumers and health professionals with resources and information. The Center provides health information, contacts for federally supported health information centers, lists of national health observances, and toll-free numbers sponsored by the federal government.

National Heart, Lung, and Blood Institute (NHLBI) Information Center

PO Box 30105

Bethesda, MD 20824-0105

Phone: (800) 575-WELL (9355) (toll-free) (recorded information)

(301) 592-8573

Fax: (301) 592-8563

E-mail: NHLBIinfo@rover.nhlbi.nih.gov

Web site: <http://www.nhlbi.nih.gov>

The Information Center, funded by NHLBI, part of NIH, provides referrals to resource organizations and information on elevated cholesterol, high blood pressure, heart disease, exercise, risk of and recovery from stroke, chronic cough, asthma, cystic fibrosis, and sleep disorders. Publications include two newsletters, *HeartMemo* and *AsthmaMemo*.

National Hispanic Council on Aging (NHCoA)

2713 Ontario Road, NW
Washington, DC 20009

Phone: (202) 265-1288

Fax: (202) 745-2522

E-mail: nhcoa@worldnet.att.net

Web site: <http://www.nhcoa.org>

NHCoA is a national organization providing advocacy, education, and information for older Hispanic people. Contact the Council for facts and resources on health, employment, housing, strengthening families, and building communities, as well as referrals to local Council chapters. Publications in English and Spanish are available.

National Hospice and Palliative Care Organization (NHPCO)

1700 Diagonal Road, Suite 300
Alexandria, VA 22314

Phone: (800) 658-8898 (toll-free) (Hospice Helpline and Locator)
(703) 837-1500

E-mail: info@nhpco.org

Web site: <http://www.nhpco.org>

NHPCO is a nonprofit, membership organization working to enhance the quality of life for individuals who are terminally ill and advocating for people in the final stage of life. Contact NHPCO for information, resources, and referrals to local hospice services. Publications, fact sheets, and Web site resources are available on topics including how to find and evaluate hospice services.

National Hospice Foundation (NHF)

1700 Diagonal Road, Suite 300
Alexandria, VA 22314

Phone: (800) 338-8619 (toll-free)

(703) 516-4928

Fax: (703) 525-5762

E-mail: info@nhpco.org

Web site: <http://www.hospiceinfo.org>

NHF, a nonprofit, charitable organization affiliated with the National Hospice and Palliative Care Organization, provides support and information about hospice care options. NHF publications include *Hospice Care: A Consumer's Guide to Selecting a Hospice Program*, *Communicating Your End-of-Life Wishes*, and *Hospice Care and the Medicare Hospice Benefit*.

National Human Genome Research Institute (NHGRI)

National Institutes of Health (NIH)
Office of Policy and Public Affairs
Building 31; Room 4B09
Bethesda, MD 20892

Phone: (301) 402-0911
Website: <http://www.nhgri.nih.gov>

NHGRI, part of NIH, coordinates the Human Genome Project, an international research effort to characterize the genomes of human and selected model organisms through complete mapping and sequencing of their DNA.

National Indian Council on Aging (NICOA)
10501 Montgomery Boulevard, NE, Suite 210
Albuquerque, NM 87111-3846

Phone: (505) 292-2001
Fax: (505) 292-1922
E-mail: dave@nicoa.org
Web site: <http://www.nicoa.org>

NICOA provides services, advocacy, and information on aging issues for older American Indian and Alaska Native people. Contact NICOA for information about its resources and support groups serving the national Indian community, and NICOA's clearinghouse for issues affecting older Indian people. Publications are available, including the newsletter *Elder Voices*.

National Information and Referral Support Center (NIRSC)
1225 I Street, NW, Suite 725
Washington, DC 20005-3914

Phone: (202) 898-2578
Fax: (202) 898-2583
E-mail: staff@nasua.org
Web site: <http://www.nasua.org>

NIRSC provides technical assistance, consultation, and training to state and area Agencies on Aging and to local information and referral providers funded under the Older Americans Act. Contact the Center for referrals, resources, and information on how to locate services for older people. A list of Center publications is available.

National Institute of Allergy and Infectious Diseases (NIAID)
National Institutes of Health (NIH)
Bethesda, MD 20892-2520

Phone: (301) 496-5717
Fax: (301) 402-0120
E-mail: niaidoc@nih.gov
Web site: <http://www.niaid.nih.gov>

NIAID, part of NIH, conducts and supports research on the prevention, diagnosis, and treatment of HIV/AIDS and other infectious and allergic diseases. Contact NIAID for information on allergies, as well as viral and bacterial illnesses. The Institute provides referrals to specialists, support groups, and other resources; publications and fact sheets are available, some in Spanish.

National Institute of Child Health and Human Development (NICHD) Information Clearinghouse

PO Box 3006
Rockville, MD 20847

Phone: (800) 370-2943
Fax: (301) 984-1473
E-mail: NICHDClearinghouse@mail.nih.gov
Web site: <http://www.nichd.nih.gov>

The Clearinghouse, funded by NICHD, part of NIH, is a resource for publications and health issues related to NICHD research. The Institute conducts and supports research on neurobiologic, developmental, and behavioral processes that determine and maintain the health of children, adults, families, and populations. Spanish language resources are available.

National Institute of Dental and Craniofacial Research (NIDCR)

National Institutes of Health (NIH)
Bethesda, MD 20892-2290

Phone: (301) 496-4261
(301) 402-7364 (National Oral Health Information Clearinghouse - NOHIC)
TTY: (301) 656-7581
Fax: (301) 469-9988
E-mail: nidcrinfo@mail.nih.gov or
nohic@nidcr.nih.gov
Web site: <http://www.nidcr.nih.gov/> or
<http://www.nohic.nidcr.nih.gov>

NIDCR, part of NIH, conducts and supports research on the causes, treatment, and prevention of diseases of the teeth, gums, and facial bones. Contact NOHIC for facts about oral health in people with disabling conditions and referrals to additional resources. Contact NIDCR for information on available publications, audiovisual materials, and fact sheets.

National Institute of Environmental Health Sciences (NIEHS)

National Institutes of Health (NIH)
PO Box 12233
Research Triangle Park, NC 27709

Phone: (919) 541-3345
Web site: <http://www.niehs.nih.gov/home.htm>

NIEHS, part of NIH, conducts and supports research on potential environmental contributors to human illnesses and dysfunction, including asthma, Alzheimer's, bronchitis, cancer, lead poisoning, Parkinson's, and other chronic diseases. NIEHS also studies variable human susceptibilities to these environmental factors. The National Toxicology Program, headquartered at NIEHS, tests natural and man-made chemicals for safety.

National Institute of General Medical Sciences (NIGMS)

National Institutes of Health (NIH)

Office of Communications and Public Liaison
Bethesda, MD 20892-6200

Phone: (301) 496-7301
Fax: (301) 402-0224
E-mail: pub_info@nigms.nih.gov
Web site: <http://www.nigms.nih.gov>

NIGMS, part of NIH, conducts and supports research in medical fields such as genetics, cellular and molecular biology, and pharmacology. Publications include *Medicines for You* (also available in Spanish), and *Inside the Cell*.

National Institute of Mental Health (NIMH)

National Institutes of Health (NIH)
Bethesda, MD 20892-9663

Phone: (800) 421-4211 (toll-free)
(301) 443-4513
TTY: (301) 443-8431
Fax: (301) 443-4279
E-mail: nimhinfo@nih.gov
Web site: <http://www.nimh.nih.gov>

NIMH, part of NIH, conducts and supports mental health research, including mental disorders of aging. Contact NIMH for information on mental health and aging, Alzheimer's disease, anxiety disorders, depression, and suicide.

National Institute of Neurological Disorders and Stroke (NINDS)

National Institutes of Health (NIH)
Office of Communications and Public Liaison
Bethesda, MD 20892-2540

Phone: (800) 352-9424 (toll-free) (information service)
(301) 496-5751
Fax: (301) 402-2186
Web site: <http://www.ninds.nih.gov>

NINDS, part of NIH, conducts and supports research on stroke and neurological disorders. NINDS provides information on its research targets, including stroke, head and spinal injuries, tumors of the central nervous system, epilepsy, multiple sclerosis, Huntington's disease, Parkinson's disease, and Alzheimer's disease. A directory of voluntary health agencies is available.

National Institute of Nursing Research (NINR)

Office of Science Policy and Public Liaison
National Institutes of Health (NIH)
31 Center Drive
Building 31, Room 5B10
Bethesda, MD 20892-2178

Phone: (301) 496-0207
Fax: (301) 480-8845
Web site: <http://www.nih.gov/ninr>

NINR, part of NIH, conducts and supports basic and clinical research to establish a scientific basis for the care of individuals across the life span. Studies addressed by nurse researchers include the management of chronic diseases, health disparities, improving palliative end-of-life care, and telehealth technology.

National Institute on Aging (NIA)
National Institutes of Health (NIH)
Office of Communications and Public Liaison
Bethesda, MD 20892-2292

Phone: (800) 222-2225 (toll-free) (NIA Information Center - NIAIC)
(800) 438-4380 (toll-free) (Alzheimer's Disease Education and Referral Center-ADEAR)
(301) 496-1752
TTY: (800) 222-4225 (toll-free) (NIAIC)
Fax: (301) 589-3014 (NIAIC)
(301) 495-3334 (ADEAR)
E-mail: niainfo@jbs1.com (NIAIC)
adear@alzheimers.org (ADEAR)
Web site: <http://www.nih.gov/nia> or
<http://www.alzheimers.org>

NIA, part of NIH, conducts and supports biomedical, social, and behavioral research on aging processes, disease, and the special problems and needs of older people. NIA develops and disseminates publications on topics such as the biology of aging, exercise, doctor/patient communication, and menopause. The Institute produces the Age Pages - a series of fact sheets for consumers on a wide range of subjects including nutrition, medications, forgetfulness, sleep, driving, and long-term care. Information, publications, referrals, resource lists, and database searches on Alzheimer's disease are available through the Institute-funded ADEAR Center.

National Institute on Alcohol Abuse and Alcoholism (NIAAA)
National Institutes of Health (NIH)
Bethesda, MD 20892-7003

Phone: (301) 443-3860
Fax: (301) 443-6077
E-mail: niaaaweb-r@exchange.nih.gov
Web site: <http://www.niaaa.nih.gov>

NIAAA, part of NIH, conducts and supports research on alcoholism and alcohol abuse. Contact the NIAAA for information on genetic and behavioral aspects of alcoholism; physiologic effects of alcohol abuse; and diagnosis, treatment, and prevention of alcohol-related problems.

National Institute on Deafness and Other Communication Disorders (NIDCD)
National Institutes of Health (NIH)
Office of Communication and Public Liaison
Bethesda, MD 20892-2320

Phone: (800) 241-1044 (toll-free) (NIDCD Information Clearinghouse)
(301) 496-7243
TTY: (800) 241-1055 (toll-free) (NIDCD Information Clearinghouse)
(301) 402-0252
Fax: (301) 402-0018
E-mail: nidcd@nidcd.nih.gov
Web site: <http://www.nidcd.nih.gov>

NIDCD, part of NIH, conducts and supports research on normal mechanisms as well as diseases and disorders of hearing, balance, smell, taste, voice, speech, and language. NIDCD develops and disseminates health information to the public based on scientific discovery.

National Institute on Drug Abuse (NIDA)

National Institutes of Health (NIH)
Public Information and Liaison Branch
Bethesda, MD 20892-9561

Phone: (800) 729-6686 (toll-free) (National Clearinghouse for Alcohol and Drug Information–NCADI)
(301) 443-1124
TTY: (800) 487-4889 (toll-free)
Fax: (888) 644-6432 (toll-free) (NIDA Infofax)
(888) 889-6432 (toll-free) (TTY NIDA Infofax)
(301) 443-7397
E-mail: info@nida.nih.gov
Web site: <http://www.nida.nih.gov>

NIDA, part of NIH, conducts and supports research on the physiology of specific drug addictions, effects of abused substances, and current and potential treatments. Contact NIDA for scientific information, and patient and public education materials on drug abuse, its causes, consequences, prevention, and treatment. Spanish language resources are available.

National Interfaith Coalition on Aging (NICA)

National Council on Aging (NCOA)
409 3rd Street, SW, Suite 200
Washington, DC 20024

Phone: (800) 424-9046 (toll-free)
(202) 479-1200
Fax: (202) 479-0735
Web site: <http://www.ncoa.org>

The Coalition, a constituent unit of NCOA, consists of individuals and organizations of various faiths concerned with issues of religion, spirituality, and aging. NICA provides networking opportunities and educational programs.

National Kidney and Urological Diseases Information Clearinghouse (NKUDIC)

National Institute of Diabetes and Digestive and Kidney Diseases (NIDDK)
3 Information Way
Bethesda, MD 20892-3580

Phone: (800) 891-5390 (toll-free)
(301) 654-4415
Fax: (301) 907-8906
E-mail: nkudic@info.niddk.nih.gov
Web site: <http://www.niddk.nih.gov>

NKUDIC, funded by NIDDK, provides referrals to specialists, resource organizations, and support groups. Publications and information on subjects such as kidney stones, prostate gland problems, urinary incontinence, and urinary tract infections are available.

National Kidney Foundation (NKF)

30 East 33rd Street
New York, NY 10016

Phone: (800) 622-9010 (toll-free)
(212) 889-2210
Fax: (212) 779-0068
Web site: <http://www.kidney.org>

NKF is a nonprofit organization providing information on the diagnosis, treatment, and prevention of kidney and urinary tract diseases. The Foundation supports research and organ donation programs. Contact the NKF for a list of local chapters that provide services, including blood and drug banks, screening programs, transportation assistance, publications, and referrals to specialists.

National Legal Support for Elderly People with Mental Disabilities Project

Judge David L. Bazelon Center for Mental Health Law
1101 15th Street, NW, Suite 1212
Washington, DC 20005-5002

Phone: (202) 467-5730
TTY: (202) 467-4232
Fax: (202) 223-0409
E-mail: hn1660@handsnet.org
Web site: <http://www.bazelon.org>

The Project focuses on legal issues of older people, training legal aid lawyers, organizing workshops, and providing information on legal issues facing older people with mental disabilities. Contact the Project for publications on disability rights for older people.

National Library of Medicine (NLM)

National Institutes of Health (NIH)
Bethesda, MD 20894

Phone: (888) FIND-NLM (346-3656) (toll-free)
(301) 496-6308
Fax: (301) 496-4450
E-mail: custserv@nlm.nih.gov

Web site: <http://www.nlm.nih.gov> (MEDLINE) or
<http://www.nlm.nih.gov/medlineplus> (MEDLINEplus) or
<http://www.clinicaltrials.gov> (Clinical Trials database)

NLM, part of NIH, is the world's largest medical library. The collection can be consulted in the reading room or requested on interlibrary loan. NLM offers nationwide access to information through a National Network of Libraries of Medicine. The database, MEDLINE, is available via the Web. MEDLINEplus links the public to many sources of consumer health information.

National Library Service for the Blind and Physically Handicapped (NLSBPH)

Library of Congress
Reference Section
1291 Taylor Street, NW
Washington, DC 20542

Phone: (800) 424-8567 (toll-free)
(202) 707-5100
Fax: (202) 707-0712
E-mail: nls@loc.gov
Web site: <http://www.lcweb.loc.gov/nls/>

NLSBPH, funded by the Library of Congress, is a network of regional and local libraries that provide free library services to blind and physically disabled people. Contact NLSBPH about programs such as postage-free delivery and return-mailing of audio-books and books and magazines in Braille. Specially designed Talking Books and cassette players also are lent to the public free. NLSBPH provides information on blindness and physical disabilities.

National Long-Term Care Ombudsman Resource Center (NLTCORC)

National Citizens' Coalition for Nursing Home Reform (NCCNHR)
1424 16th Street, NW, Suite 202
Washington, DC 20036

Phone: (202) 332-2275
Fax: (202) 332-2949
E-mail: ombudcenter@nccnhr.org

NLTCORC is operated by the NCCNHR in collaboration with the National Association of State Units on Aging. The Center supports groups under federal mandate to identify and resolve residents' problems at long-term care facilities. Contact the Center for information and publications on nursing home reform and adult care.

National Long-Term Care Resource Center (NLTCRC)

Division of Health Services, Research and Policy
University of Minnesota School of Public Health
Mayo Mailcode 197, Room D527

420 Delaware Street, SE
Minneapolis, MN 55455

Phone: (612) 624-5171
Fax: (612) 624-5434
Web site: <http://www.hsr.umn.edu>

The Center assists state and area Agencies on Aging and other community-based service agencies to monitor, develop, and refine community long-term care systems through legal reform. NLTCRC provides information on long-term health care, rehabilitation and acute care reform, ethics, and quality of life issues in nursing homes. A list of publications is available.

National Medical Association (NMA)

1012 10th Street, NW
Washington, DC 2001

Phone: (888) 662-7497 (toll-free) (Automated Physician Referral)
(202) 347-1895
Fax: (202) 842-3293
E-mail: rwilliams@nmanet.org
Web site: <http://www.nmanet.org>

NMA promotes the interests of doctors and patients of African descent. NMA offers a physician referral service and the brochure *Looking for Dr. Right: Guide to Choosing a Physician Using 1-888-NMAPHYSicians*.

National Mental Health Association (NMHA)

1021 Prince Street
Alexandria, VA 22314-2971

Phone: (800) 969-NMHA (6642) (toll-free) (National Mental Health Information Center)
(703) 684-7722
Fax: (703) 684-5968
E-mail: infoctr@nmha.org
Web site: <http://www.nmha.org>

The NMHA Information Center provides referrals to mental health specialists, as well as publications such as *Coping with Growing Older*, and *Answers to Your Questions About Clinical Depression*.

National Multiple Sclerosis Society (NMSS)

733 3rd Avenue, 6th Floor
New York, NY 10017-3288

Phone: (800) FIGHT-MS (344-4867) (toll-free)
(212) 986-3240
Fax: (212) 986-7981
E-mail: nat@nmss.org
Web site: <http://www.nmss.org>

The Society is a nonprofit organization providing support and information on the diagnosis and treatment of multiple sclerosis (MS). Contact NMSS for referrals to specialists and local chapter offices. A list of free publications and films on MS is available from local chapters.

National Organization for Rare Disorders (NORD)

PO Box 8923
New Fairfield, CT 06812-8923

Phone: (800) 999-6673 (toll-free)
(203) 746-6518
TTY: (203) 746-6927
Fax: (203) 746-6481
E-mail: orphan@rarediseases.org
Web site: <http://www.rarediseases.org>

NORD is a federation of voluntary health organizations and individuals, dedicated to helping people with rare diseases and assisting the organizations that serve them. NORD is committed to the identification, treatment, and cure of rare disorders through education, advocacy, research, and service.

National Organization for Victim Assistance (NOVA)

1757 Park Road, NW
Washington, DC 20010

Phone: (202) 232-6682 (includes crisis hotline service)
Fax: (202) 462-2255
E-mail: nova@try-nova.org
Web site: <http://www.try-nova.org>

NOVA is a nonprofit organization dedicated to improving services to survivors of violent crimes or disasters. NOVA offers a toll-free, 24-hour crisis counseling hotline that refers victims to support services throughout the country. NOVA provides a list of publications on subjects, including older crime victims, victim assistance, and victim rights.

National Osteoporosis Foundation (NOF)

1232 22nd Street, NW
Washington, DC 20037-1292

Phone: (202) 223-2226
Fax: (202) 223-2237
Web site: <http://www.nof.org>

NOF is a nonprofit, voluntary health organization dedicated to promoting lifelong bone health to reduce the widespread prevalence of osteoporosis and related fractures. NOF works to find a cure for osteoporosis through research, education, and advocacy. The Foundation provides general information on osteoporosis; its quarterly newsletter and booklets are available through membership.

National Policy and Resource Center on Nutrition and Aging

Department of Dietetics and Nutrition

Florida International University (FIU)
University Park, OE200
Miami, FL 33199

Phone: (305) 348-1517
Fax: (305) 348-1518
E-mail: nutreldr@fiu.edu
Web site: <http://www.fiu.edu/~nutreldr>

The FIU Center, funded primarily by the Administration on Aging, works to reduce malnutrition and promotes good nutritional practices among older adults nationwide. The Center provides information dissemination, training and technical assistance, and policy analysis.

National Policy and Resource Center on Women and Aging (NPRCWA)

Heller Graduate School
Brandeis University, Mail Stop 035
PO Box 9110
Waltham, MA 02254-9110

Phone: (800) 929-1995 (toll-free)
(781) 736-3866
Fax: (781) 736-3865
E-mail: natwomctr@binah.cc.brandeis.edu
Web site: <http://www.brandeis.edu/heller/national/>

NPRCWA focuses on older women's issues and provides policy analysis, research, and assistance to the network of Administration on Aging-funded state and area Agencies on Aging. The Center provides information and publications on women's health, caregiving, income security, and housing as well as prevention of crime and violence toward older women.

National Prevention Information Network (NPIN)

Centers for Disease Control and Prevention (CDC)
Public Health Service
PO Box 6003
Rockville, MD 20849-6003

Phone: (800) 458-5231 (toll-free)
(301) 562-1098
TTY: (800) 243-7012 (toll-free)
Fax: (888) 282-7681 (toll-free)
(301) 562-1050
E-mail: info@cdcnpin.org
Web site: <http://www.cdcnpin.org>

NPIN, sponsored by the CDC, is a national reference, referral, and distribution service for information on HIV/AIDS, other sexually transmitted diseases, and tuberculosis. NPIN's services are designed to facilitate information sharing about prevention, treatment, and support services. NPIN does not provide medical advice.

National Psoriasis Foundation (NPF)

6600 SW 92nd Avenue, Suite 300
Portland, OR 97223-7195

Phone: (800) 723-9166 (toll-free)

(503) 244-7404

Fax: (503) 245-0626

E-mail: getinfo@npfusa.org

Web site: <http://www.psoriasis.org>

NPF is a nonprofit organization providing free information on psoriasis and psoriatic arthritis research and treatment. NPF provides directories of specialists and products, opportunities to volunteer for research projects, links to support groups, and educational newsletters and booklets.

National Rehabilitation Information Center (NARIC)

1010 Wayne Avenue, Suite 800
Silver Spring, MD 20910-5633

Phone: (800) 346-2742 (toll-free)

(301) 562-2400

Fax: (301) 562-2401

E-mail: naricinfo@kra.com

Web site: <http://www.naric.com>

NARIC, funded by the Department of Education, provides information on rehabilitation of people with physical or mental disabilities. Contact NARIC for database searches on all types of physical and mental disabilities, as well as referrals to local and national facilities and organizations. All of NARIC's database information is available online, free.

National Resource and Information Center (NRIC)

Women's Bureau (WB)
Department of Labor
200 Constitution Avenue, NW, Room S-3111
Washington, DC 20210

Phone: (800) 827-5335 (toll-free)

(800) 347-3741 (toll-free)

TTY: (800) 326-2577 (toll-free)

NRIC, funded by the WB, provides information on issues of concern to working women, their families, and employers. Contact NRIC for facts on programs such as the Fair Pay Clearinghouse, which provides updates on efforts to identify and eliminate sexism, ageism, racism, and other forms of workplace discrimination. Single copies of publications, including *Work and Elder Care* and *Hiring Someone to Work in Your Home*, are available free.

National Resource Center: Diversity and Long-Term Care (NRCDLTC)

The Heller School Schneider Institute for Health Policy
Brandeis University

PO Box 9110
Waltham, MA 02454-9110

Phone: (800) 456-9966 (toll-free)
(781) 736-3930
Fax: (781) 736-3965
Web site: <http://www.sihp.brandeis.edu>

NRCDLTC, a partnership between Brandeis University and San Diego State University, provides information on methods, resources, systems, and services for caring for older people. The Center provides referrals to health policy resources and information on issues of diversity in aging, including disabilities, race, ethnicity, gender, generations, and chronic diseases. A list of publications is available on request.

National Resource Center on Native American Aging (NRCNAA)

PO Box 9037
Grand Forks, ND 58202-9037

Phone: (800) 896-7628 (toll-free)
(701) 777-3437
Fax: (701) 777-2389
Web site: <http://www.und.edu/dept/nrcnaa>

The Resource Center, funded by the Administration on Aging, provides support, advocacy, and information for older Native Americans, including American Indians, Alaska Natives, and Native Hawaiians. Contact the Center for legal information and references, geriatric leadership training, cultural awareness, and a variety of publications.

National Resource Center on Supportive Housing & Home Modifications

USC Andrus Gerontology Center
3715 McClintock Avenue
Los Angeles, CA 90089-0191

Phone: (213) 740-1364
Fax: (213) 740-7069
Web site: <http://www.homemods.org>

The Center is funded in association with the Archstone Foundation and the California Endowment. Contact the Center for information on government-assisted housing, assisted living policies, home modifications for older people, training and education courses, and technical assistance. Publications and fact sheets are available.

National Rural Health Association (NRHA)

One West Armour Boulevard, Suite 203
Kansas City, MO 64111

Phone: (816) 756-3140
Fax: (816) 756-3144
Web site: <http://www.nrharural.org>

NRHA is a nonprofit, professional organization targeting health care problems unique to rural areas and serving as a liaison between rural health care providers and older people. Contact NRHA for information on health care delivery to rural providers and for its quarterly *Journal of Rural Health*.

National Self-Help Clearinghouse (NSHC)
365 Fifth Avenue, Suite 3300
New York, NY 10016-4309

Phone: (212) 817-1822
Fax: (212) 817-2990
E-mail: info@selfhelpweb.org
Web site: <http://www.selfhelpweb.org>

NSHC collects and distributes information about support and self-help groups nationwide. Contact NSHC for publications or referrals to self-help groups, helping networks, and support systems.

National Senior Citizens Education and Research Center (NSCERC)
8403 Colesville Road, Suite 1200
Silver Spring, MD 20910

Phone: (301) 578-8900
Fax: (301) 578-8947
Web site: <http://www.nscerc.org>

NSCERC is a nonprofit organization providing employment opportunities, conducting research programs and workshops, and publishing its research findings.

National Senior Citizens Law Center (NSCLC)
1101 14th Street, NW, Suite 400
Washington, DC 20005

Phone: (202) 289-6976
Fax: (202) 289-7224
E-mail: nsclc@nsclc.org
Web site: <http://www.nsclc.org>

NSCLC offers assistance to Legal Aid Offices and private lawyers working on behalf of low-income older and disabled people. The Center does not accept individual clients but acts as a clearinghouse of information on legal problems such as age discrimination, Social Security, pension plans, Medicaid, Medicare, nursing homes, and protective services.

National Senior Games Association (NSGA)
3032 Old Forge Drive
Baton Rouge, LA 70808

Phone: (225) 925-5678
Fax: (225) 216-7552
Web site: <http://www.nsga.com>

NSGA is a nonprofit organization promoting healthy lifestyles for older people through education, fitness, and sports. Its Web site announces Association events and activities and offers videotapes of group activities.

National Sleep Foundation (NSF)

1522 K Street, NW, Suite 500
Washington, DC 20005

Phone: (202) 347-3471
Fax: (202) 347-3472
E-mail: nsf@sleepfoundation.org
Web site: <http://www.sleepfoundation.org>

NSF is a nonprofit organization providing services and information about sleep disorders. Contact the Foundation for a list of accredited sleep centers and local specialists. A variety of NSF publications on sleep, sleep disorders, and related topics are available.

National STD and AIDS Hotlines

Centers for Disease Control and Prevention (CDC)
Public Health Service
1600 Clifton Road
Atlanta, GA 30333

Phone: (800) 342-AIDS (2437) (toll-free) (English)
(800) 227-8922 (toll-free) (English)
(800) 344-SIDA (7432) (toll-free) (Spanish)
TTY: (880) 243-7889 (toll-free)
E-mail: hivnet@ashastd.org
Web site: <http://www.ashastd.org>

The Hotlines offer information, referrals, and free publications about prevention, risks, and treatment of sexually transmitted diseases.

National Stroke Association (NSA)

9707 East Easter Lane
Englewood, CO 80112-3747

Phone: (800) STROKES (787-6537) (toll-free)
(303) 754-0930
Fax: (303) 649-1328
Web site: <http://www.stroke.org>

The Association provides information about stroke prevention, acute treatment, recovery, and rehabilitation to the public. NSA offers referrals to support groups, care centers, and local resources for stroke survivors, caregivers, and family members.

National Urban League
120 Wall Street, 8th Floor
New York, NY 10005

Phone: (212) 558-5300
Fax: (212) 344-5332
Web site: <http://www.nul.org>

The Urban League is a nonprofit, community service organization helping older African Americans through advocacy and service programs, which include health awareness, nutrition, housing, and intergenerational activities. Contact the League for information about its Seniors in Community Service Program, which provides training and part-time employment to low-income, older people. The Health Promotion Project helps local groups plan and carry out disease prevention activities in communities nationwide. Newsletters and bulletins are available.

National Women's Health Information Center (NWHIC)

Phone: (800) 994-WOMAN (96626) (toll-free)
TTY: (888) 220-5446 (toll-free)
E-mail: 4woman@soza.com
Web site: <http://www.4woman.gov>

NWHIC, part of the federal government, is a health and referral center for women. Spanish language resources are available.

National Women's Health Network (NWHN)

514 10th Street, NW, Suite 400
Washington, DC 20004

Phone: (202) 347-1140
Fax: (202) 347-1168
Web site: <http://www.womenshealthnetwork.org>

NWHN works to ensure that women have access to quality, affordable health care, serving as a clearinghouse of information on women's health issues. The Network also lobbies for increased governmental support for women's health care. Contact NWHN for information and publications on women's health issues.

Native Elder Health Care Resource Center (NEHCRC)

University of Colorado Health Sciences Center
Campus Box A011-13
4455 East 12 Avenue
Denver, CO 80220

Phone: (303) 315-9228
Fax: (303) 315-9579
E-mail: dawn.wright@uchsc.edu
Web site: <http://www.uchsc.edu/sm/nehcrc>

NEHCRC promotes the health of older Native people, including Alaska Natives and Native Hawaiians by increasing cultural competence among health care professionals. The Center focuses on four target areas: determining health status, improving medical standards, increasing access to care, and mobilizing community resources. Contact NEHCRC for information on its programs and publications.

NIH Osteoporosis and Related Bone Diseases National Resource Center (NIH-ORBD-NRC)

1232 22nd Street, NW
Washington, DC 20037-1292

Phone: (800) 624-BONE (2663) (toll-free)
(202) 223-0344
TTY: (202) 466-4315
Fax: (202) 293-2356
E-mail: orbdnrc@nof.org
Web site: <http://www.oste.org>

The Resource Center provides patients, health professionals, and the public with resources and information on osteoporosis, Paget's disease of the bone, osteogenesis imperfecta, and other metabolic bone diseases. The Center is supported by the National Institute of Arthritis and Musculoskeletal and Skin Diseases and six other Institutes and Offices.

North American Menopause Society (NAMS)

PO Box 94527
Cleveland, OH 44101

Phone: (440) 442-7550
Fax: (440) 442-2660
E-mail: info@menopause.org
Web site: <http://www.menopause.org>

NAMS is a nonprofit multidisciplinary organization promoting women's health during midlife and beyond through an understanding of menopause. The Society supports research and serves as a resource for women and health care professionals. Spanish language resources are available.

Office on Smoking and Health (OSH)

Centers for Disease Control and Prevention
Mail Stop K-50
4770 Buford Highway, NE
Atlanta, GA 30341-3741

Phone: (800) CDC-1311 (232-1311) (toll-free)
(770) 488-5705
Fax: (770) 488-5939
E-mail: tobaccoinfo@cdc.gov
Web site: <http://www.cdc.gov/tobacco>

OSH, part of the federal government, develops and distributes the annual *Surgeon General's Report on Smoking and Health*. Contact OSH for information on tobacco and details about the smoking and health database which is available on CD-ROM. Print publications on smoking also are available.

Older Women's League (OWL)

666 11th Street, NW, Suite 700
Washington, DC 20001

Phone: (800) TAKE-OWL (825-3695) (toll-free)
(800) 863-1539 (toll-free) (PowerLine)
(202) 783-6686
(202) 783-6689 (PowerLine)
Fax: (202) 638-2356
E-mail: owlinfo@owl-national.org
Web site: <http://www.owl-national.org>

OWL is a national organization advocating for the special concerns of older women. OWL helped develop the Campaign for Women's Health and the Women's Pension Policy Consortium. Contact OWL's 24-hour PowerLine for information about legal and political activity related to health care, access to housing, economic security, individual rights, and violence against women and older people. OWL newsletters are available.

Opticians Association of America (OAA)

7023 Little River Turnpike
Annandale, VA 22003

Phone: (703) 916-8856
Fax: (703) 916-7966
E-mail: aaa@aaa.org
Web site: <http://www.aaa.org>

OAA represents the optometric industry and provides information on eye health and industry regulation. OAA sets industry standards for prescription eyeglasses, contact lenses, and low-vision aids and can give referrals to qualified opticians. Contact the OAA for publications on optometry news and information.

Organization of Chinese Americans (OCA)

1001 Connecticut Avenue, NW, Suite 601
Washington, DC 20036

Phone: (202) 223-5500
Fax: (202) 296-0540
E-mail: oc@ocanatl.org

Web site: <http://www.ocanatl.org>

OCA advocates for the rights of Chinese Americans. Contact OCA for referrals to legal specialists and legislative information on age discrimination, education, and employment opportunities for Chinese Americans, as well as access to health care and Social Security. OCA also publishes a national directory of Asian and Pacific American organizations.

Paget Foundation for Paget's Disease of Bone and Related Disorders (PF)

120 Wall Street, Suite 1602
New York, NY 10005-4001

Phone: (212) 509-5335

Fax: (212) 509-8492

E-mail: PagetFdn@aol.com

Web site: <http://www.paget.org>

PF provides information and programs for consumers and medical professionals about Paget's disease of bone and other bone disorders including primary hyperparathyroidism, fibrous dysplasia, osteoporosis, breast cancer metastatic to bone, and prostate cancer metastatic to bone.

Parkinson's Disease Foundation (PDF)

833 West Washington Boulevard
Chicago, IL 60607

Phone: (800) 457-6676 (toll-free)

(312) 733-1893

Fax: (312) 664-2344

PDF is a nonprofit organization providing research funding, information, and supportive services to people with Parkinson's Disease. Contact the Foundation for referrals to specialists. Publications are available.

Partnership for Caring, Inc. (PFC)

America's Voices for the Dying
1620 Eye Street, NW, Suite 202
Washington, DC 20006

Phone: (800) 989-9455 (toll-free)

Fax: (202) 296-8352

Web site: <http://www.partnershipforcaring.org/>

PFC is a national, nonprofit organization providing advocacy, resources, and information on the reform and enhancement of care for the dying. Contact the Partnership for referrals to resources and support groups, legal assistance, information on end-of-life issues, and the Consumers' End-of-Life Bill of Rights. Links to member organizations, publication, and fact sheets are available.

Pension and Welfare Benefits Administration (PWBA)

See Employee Benefits Security Administration (EBSA)

Pension Rights Center (PRC)
1140 19th Street, NW, Suite 602
Washington, DC 20036

Phone: (202) 296-3776
Fax: (202) 833-2472
E-mail: pnsnrightrights@aol.com

PRC's Legal Outreach Program advocates for the pension rights of workers, retirees, and their families. Contact the PRC for referrals to pension attorneys or for publications on pension law, divorce, federal retirement plans, self-help guides on pension problems, or pension plan handbooks. Spanish language resources are also available.

President's Council on Physical Fitness and Sports (PCPFS)
Hubert H. Humphrey Building, Room 738-H
200 Independence Avenue, SW
Washington, DC 20201

Phone: (202) 690-9000
Fax: (202) 690-5211
Web site: <http://www.fitness.gov>

PCPFS is an advisory body to the President and Secretary of the Department of Health and Human Services. The Council promotes opportunities in physical activity, fitness, and sports for all Americans. Contact PCPFS for information on physical activity/fitness, nutrition, health, and Council programs. Publications on physical education and health are available on the Web site.

Prevent Blindness America (PBA)
500 East Remington Road
Schaumburg, IL 60173

Phone: (800) 331-2020 (toll-free)
(847) 843-2020
Fax: (847) 843-8458
E-mail: info@preventblindness.org
Web site: <http://www.preventblindness.org>

PBA sponsors community services and public education about eye care, safety, and the diagnosis, treatment, and prevention of eye diseases. Local chapters offer community services, including vision screenings and self-help groups for those with glaucoma. Contact PBA for information and a list of publications.

Project Aliento
National Association for Hispanic Elderly (Asociación Nacional Por Personas Mayores)
1452 West Temple Street, Suite 100
Los Angeles, CA 90026

Phone: (213) 487-1922
Fax: (213) 202-5905

Project Aliento works to make the Administration on Aging-funded network of state and area Agencies on Aging accessible to older Hispanic people and their families. Contact Project Aliento for information, publications, and videos about community care and in-home support issues, as well as links to the formal aging network. Publications are available in English and Spanish.

Pulmonary Fibrosis Foundation (PFF)

1075 Santa Fe Drive
Denver, CO 80204

Phone: (720) 932-7850

Fax: (303) 825-5078

E-mail: breathe@pulmonaryfibrosis.org

Web site: <http://www.pulmonaryfibrosis.org>

PFF is a private, nonprofit organization providing assistance, resources, and information on pulmonary fibrosis and its related illnesses. Contact PFF for information on the diagnosis and treatment of PF and idiopathic pulmonary fibrosis, as well as referrals to specialists, resources, and support groups. Publications are available.

Restless Legs Syndrome Foundation

819 Second Street, SW
Rochester, MN 55902

Phone: (507) 287-6465

Fax: (507) 287-6312

E-mail: RLSFoundation@rls.org

Web site: <http://www.rls.org/foundation>

The Foundation is a nonprofit agency that provides information about restless legs syndrome. It develops support groups and seeks to find better treatments and a definitive cure.

Robert Wood Johnson Foundation (RWJF)

Route 1 College Road
Princeton, NJ 08543

Phone: (609) 452-8701

Fax: (609) 987-8845

E-mail: mail@rwjf.org

Web site: <http://www.rwjf.org>

The RWJ Foundation is a private, philanthropic organization that supports basic health services and pursues improved services for people with chronic illnesses, prevention of substance abuse, and control of health care costs. Publications about the Foundation's programs on health care issues are available.

Self Help for Hard of Hearing People, Inc. (SHHH)

7910 Woodmont Avenue, Suite 1200
Bethesda, MD 20814

Phone: (301) 657-2248
Fax: (301) 913-9413
E-mail: national@shhh.org
Web site: <http://www.shhh.org>

SHHH provides information and services for people who are hard of hearing, including assistance on education, legal issues, and self-help. Local SHHH chapters can provide information on community references and referrals to specialists. Contact SHHH for information on coping with hearing problems, hearing aids, and educational workshops for older people with hearing loss. A list of publications and materials is available.

Senior Job Bank

PO Box 30064
Savannah, GA 31410

E-mail: info@seniorjobbank.org
Web site: <http://www.seniorjobbank.org>

Senior Job Bank is an online resource that provides free job information and resources for members. Contact the Job Bank to find listings for occasional, part-time, flexible, temporary, or full-time jobs for older people.

SeniorNet (SN)

121 Second Street, 7th Floor
San Francisco, CA 94105

Phone: (800) 747-6848 (toll-free)
(415) 495-4990
Fax: (415) 495-3999
E-mail: press@seniornet.org
Web site: <http://www.seniornet.org>

SeniorNet is a nonprofit, educational organization that provides information and services to help older people become computer literate. Locally funded SN teaching sites offer introductory computer classes on various topics, providing older people with discounts on computer hardware, software, and publications. Members can access SN from any online computer and order publications on buying and using computers.

Simon Foundation for Continence

PO Box 835
Wilmette, IL 60091

Phone: (800) 237-4666 (toll-free)
(847) 864-3913
Fax: (847) 864-9758
Web site: <http://www.simonfoundation.org>

The Simon Foundation is a nonprofit, educational organization providing information on urinary and bowel incontinence. It offers support to people with incontinence and publications on its diagnosis and treatment. A guide booklet and videotapes are available.

The Skin Cancer Foundation

245 Fifth Avenue
New York, NY 10016

Phone: (800) SKIN-490 (754-6490) (toll-free)
(212) 725-5176
Fax: (212) 725-5751
Web site: <http://www.skincancer.org>

The Skin Cancer Foundation is a nonprofit organization providing information on the detection and treatment of skin cancer. The Foundation's brochures, newsletters, posters, and a new membership program give medical information and practical guidance on skin cancer. Send a self-addressed, stamped envelope for a list of publications.

Social Security Administration (SSA)

Office of Public Inquiries
6401 Security Boulevard
Baltimore, MD 21235

Phone: (800) 772-1213 (toll-free)
Fax: (410) 965-0695
Web site: <http://www.ssa.gov>

SSA, part of the federal government, is the agency responsible for Social Security retirement programs, survivor benefits, disability insurance, and Supplemental Security Income. Contact SSA for information and assistance with Social Security benefits as well as eligibility and disability issues. A directory is available listing the SSA offices in each state.

Society for Neuroscience

11 Dupont Circle, NW, Suite 500
Washington, DC 20036

Phone: (202) 462-6688
Fax: (202) 462-1547
E-mail: info@sfn.org
Web site: <http://www.sfn.org>

The Society is an organization of scientists and physicians interested in the brain, spinal cord, and peripheral nervous system. Contact the Society for the fact sheet series called *Brain Briefings*, short newsletters explaining how basic neuroscience research leads to clinical applications.

SPRY (Setting Priorities for Retirement Years) Foundation

10 G Street, NE, Suite 600
Washington, DC 20002

Phone: (202) 216-0401
Fax: (202) 216-0779
E-mail: spryfoundation@nepssm.org
Web site: <http://www.spry.org>

SPRY is a nonprofit foundation that develops research and education programs to help older adults plan for a healthy and financially secure future. The Web site links consumers to national health resources.

Substance Abuse and Mental Health Services Administration (SAMHSA)

Department of Health and Human Services
5600 Fishers Lane
Rockville, MD 20857

Phone: (800) 729-6686 (toll-free) (National Clearinghouse for Alcohol and Drug Information- [NCADI])

TTY: (800) 487-4889 (toll-free)

Fax: (301) 468-7394

E-mail: info@samhsa.gov

Web site: <http://www.samhsa.gov>

SAMHSA, part of the federal government, is responsible for improving the quality and availability of prevention, treatment, and rehabilitation services in order to reduce the illness, death, disability, and cost resulting from substance abuse and mental illness. Spanish language resources are available from NCADI.

United Seniors Health Council (USHC)

409 3rd Street, NW, Suite 200
Washington, DC 20024

Phone: (800) 637-2604 (toll-free) (orders only)

(202) 479-6973

Fax: (202) 479-6660

E-mail: info@unitedseniorshealth.org

Web site: www.unitedseniorshealth.org/

USHC is a nonprofit organization dedicated to helping older consumers, caregivers, and professionals. The Council produces publications on topics such as financial planning, managed care, and long-term care insurance. The Council pioneered a Health Insurance Counseling Program, which helps consumers understand their many insurance options. Its Eldergames program is a comprehensive series of materials designed to stimulate the imagination and memories of older people.

United Way of America

701 North Fairfax Street
Alexandria, VA 22314-2045

Phone: (800) 892-2757 (toll-free)

(703) 836-7100

Fax: (703) 683-7813

Web site: <http://www.unitedway.org>

United Way is a philanthropic organization providing support for community programs. Contact the United Way to find local chapters linking people with resources such as dental and health services for low-income people or to volunteer for service programs in the community.

Vestibular Disorders Association (VEDA)

PO Box 4467
Portland, OR 97208-4467

Phone: (800) 837-8428 (toll-free)
(503) 229-7705
Fax: (503) 229-8064
E-mail: veda@vestibular.org
Web site: <http://www.vestibular.org>

VEDA is a nonprofit organization providing information and support for people with disorders such as Meniere's disease, BPPV, and labyrinthitis. The Association provides lists of clinics and vestibular specialists and offers information on disorders of the inner ear and management and diagnosis of dizzy spells. Publications are available on recent advances, rehabilitation, and support therapy.

Visiting Nurse Associations of America (VNAA)

11 Beacon Street, Suite 910
Boston, MA 02108

Phone: (888) 866-8773 (toll-free)
(617) 523-4042
Fax: (617) 227-4843
E-mail: vnaa@vnaa.org
Web site: <http://www.vnaa.org>

VNAA is an association of nonprofit, community-based home health care providers. Visiting nurses offer quality in-home medical care including physical, speech, and occupational therapy; social services; and nutritional counseling. Local agencies operate adult day-care centers, wellness clinics, hospices, and meals-on-wheels programs. A fact sheet and caregiver's handbook are available.

Volunteers of America

1660 Duke Street
Alexandria, VA 22314

Phone: (800) 899-0089 (toll-free)
(703) 341-5000
Fax: (703) 341-7000
Web site: <http://www.VolunteersofAmerica.org>

Volunteers of America is a national, nonprofit, spiritually based organization providing local human service programs and opportunities for individual community involvement. Specific programs include housing, assisted living, meals-on-wheels, transportation, and health care services.

Well Spouse Foundation (WSF)

30 East 40th Street
New York, NY 10016

Phone: (800) 838-0879 (toll-free)
(212) 685-8815
Fax: (212) 685-8676
E-mail: wellspouse@aol.com
Web site: <http://www.wellspouse.org>

WSF is a not-for-profit association of spousal caregivers. It offers support to the wives, husbands, and partners of chronically ill or disabled people. The Foundation has lists of support groups nationwide and sponsors recreational respite opportunities.

Young Men's Christian Association (YMCA)

101 North Wacker Drive, 14th Floor
Chicago, IL 60606

Phone: (800) USA-YMCA (872-9622) (toll-free)
(312) 977-0031
Fax: (312) 977-9063
Web site: <http://www.ymca.net>

YMCA is a membership organization providing physical fitness and health programs. Local YMCAs nationwide design Active Older Adult programs to meet the needs of older members, provide volunteer opportunities for senior citizens, and offer intergenerational programs.

Young Women's Christian Association (YWCA)

350 Fifth Avenue, Suite 301
New York, NY 10118

Phone: (212) 273-7800
Fax: (212) 465-2281
Web site: <http://www.ywca.org>

YWCA is a membership organization providing health, fitness, and community services for women. Educational workshops, recreational activities, and counseling services are available. ENCORE programs for women after breast cancer surgery combine group discussion with exercise to promote recovery. Informational brochures are available.

Note: There is no single correct way to search for information on the Internet. The only meaningful measure of success is if you get the results you desire. It's a good idea to try to use multiple search services and a combination of terms to increase the likelihood of your results being complete. Popular search engines include google.com, yahoo.com, askjeeves.com, dogpile.com, and many others.

FEDERAL AGENCIES

The 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

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

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 and provide information on services, programs, and opportunities for consumers and professionals.

State	Phone Number	Fax Number	Web site
Alabama	(334) 242-5743	(334) 242-5594	http://www.ageline.net
Alaska	(907) 465-3250	(907) 465-4716	http://www.alaskaaging.org
Arizona	(602) 542-4446	(602) 542-6575	http://www.de.state.az.us
Arkansas	(501) 682-2441	(501) 682-8155	http://www.state.ar.us/dhs/aging
California	(916) 322-5290	(916) 324-1903	http://www.cda.ca.gov
Colorado	(303) 866-2800	(303) 866-2696	http://www.cdhs.state.co.us/ads/aas/index1
Connecticut	(860) 424-5277	(860) 424-4966	http://www.ctelderlyservices.state.ct.us

Delaware	(302) 255-9390	(302) 577-4793	http://www.DSAAPD.com
District of Columbia	(202) 724-5622	(202) 724-4979	http://www.dcoa.dc.gov
Florida	(850) 414-2000	(850) 414-2004	http://elderaffairs.state.fl.us/
Georgia	(404) 657-5258	(404) 657-5285	http://www2.state.ga.us/Departments/DHR/aging.html
Hawaii	(808) 586-0100	(808) 586-0185	http://www2.hawaii.gov/eoa
Idaho	(208) 334-3833	(208) 334-3033	http://www.idahoaging.com
Illinois	(217) 785-2870, (217) 524-6911	(217) 785-4477	http://www.state.il.us/aging
Indiana	(317) 232-7123	(317) 232-7867	http://www.ai.org/fssa/HTML/PROGRAMS/2bAging.html
Iowa	(515) 242-3333	(515) 242-3300	http://www.state.ia.us/elderaffairs
Kansas	(785) 296-5222	(785) 296-0256	http://www.k4s.org/kdoa
Kentucky	(502) 564-6930	(502) 564-4595	http://www.chs.ky.gov/aging/
Louisiana	(225) 342-7100	(225) 342-7133	http://www.louisiana.gov/gov-office.asp
Maine	(207) 287-9200	(207) 287-9229	http://www.state.me.us/dhs/beas
Maryland	(410) 767-1100	(410) 333-7943	http://www.mdoa.state.md.us
Massachusetts	(617) 727-7750	(617) 727-9368	http://www.mass.gov/elder or http://www.800ageinfo.com
Michigan	(517) 373-7876	(517) 373-4092	http://www.miseniors.net
Minnesota	(651) 296-2770	(651) 297-7855	http://www.mnaging.org or http://www.MinnesotaHelp.info
Mississippi	(601) 359-4925	(601) 359-4370	http://www.mdhs.state.ms.us/aas.html
Missouri	(573) 751-3082	(573) 751-8687	http://www.dss.state.mo.us/da

Montana	(406) 444-5622	(406) 444-7743	http://www.dphhs.state.mt.us/sltc
Nebraska	(402) 471-2307	(402) 471-4619	http://www.hhs.state.ne.us/ags/agsindex.htm
Nevada	(702) 486-3545	(702) 486-3572	http://www.nvaging.net/
New Hampshire	(603) 271-4680	(603) 271-4643	http://www.dhhs.state.nh.us or http://www.state.nh.us/service/mlink/
New Jersey	(609) 943-3345	(609) 943-3343	http://www.state.nj.us/health
New Mexico	(505) 476-4799	(505) 827-7649	http://www.nmaging.state.nm.us/
New York	(518) 474-5731	(518) 474-0608	http://aging.state.ny.us
North Carolina	(919) 733-3983	(919) 733-0443	http://www.dhhs.state.nc.us/aging/home.htm
North Dakota	(701) 328-8910	(701) 328-8989	http://www.state.nd.us/human/services/services/adultsaging
Ohio	(614) 466-5500	(614) 466-5741	http://www.state.oh.us/age
Oklahoma	(405) 521-2327	(405) 521-2086	http://www.okdhs.org/aging/index.html
Oregon	(503) 945-5811	(503) 373-7823	http://www.sdsd.hr.state.or.us
Pennsylvania	(717) 783-1550	(717) 772-3382	http://www.aging.state.pa.us
Puerto Rico	(787) 721-5710	(787) 721-6510	N/A
Rhode Island	(401) 462-0500	(401) 462-0503	http://www.DEA.state.ri.us
South Carolina	(803) 898-2501	(803) 898-4515	http://www.dhhs.state.sc.us
South Dakota	(605) 773-3656	(605) 773-6834	http://www.state.sd.us/asa
Tennessee	(615) 741-2056	(615) 741-3309	http://www.state.tn.us/comaging
Texas	(512) 424-6840	(512) 424-6890	http://www.tdoa.state.tx.us/
Utah	(801) 538-3910	(801) 538-4395	http://www.hsdaas.state.ut.us/

Vermont	(802) 241-2400	(802) 241-2325	http://www.dad.state.vt.us
Virginia	(804) 662-9333	(804) 662-9354	http://www.vda.virginia.gov
Virgin Islands	(340) 774-0930	(340) 774-3466	http://www.usvi.org/humanse rvices/index.html
Washington	(360) 725-2310	(360) 438-8633	http://www.aasa.dshs.wa.gov/
West Virginia	(304) 558-3317	(304) 558-5699	http://www.state.wv.us/senior services/
Wisconsin	(608) 266-2536	(608) 267-3203	http://www.dhfs.state.wi.us/aging
Wyoming	(307) 777-7986	(307) 777-5340	http://wdhfs.state.wy.us/aging /

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	Web site
Alabama	(334) 281-8780	http://www.rehab.state.al.us
Alaska	(907) 465-2814	http://www.labor.state.ak.us/dvr/home.htm
American Samoa	(684) 699-1371	N/A
Arizona	(800) 352-8168	http://www.de.state.az.us/rsa/vr.asp
Arkansas	(800) 330-0632	http://www.arsinfo.org/
California	(800) 952-5544	http://www.rehab.cahwnet.gov/default.htm
Colorado	(303)866-4150	http://www.cdhs.state.co.us/ods/dvr/ods_dvr1.html
Connecticut	(800) 842-4510	http://www.dss.state.ct.us/svcs/rehab.htm
Delaware	(800) 273-9500	http://www.delawareworks.com/dvr/welcome.shtml
District of Columbia	(202) 442-8400	http://dhs.dc.gov/dhs
Florida	(800) 451-4327	http://www.rehabworks.org/
Georgia	(404) 232-3910	http://www.vocrehabga.org
Guam	(671) 475-2000	N/A
Hawaii	(808) 586-4996	http://www.state.hi.us/dhs/

Idaho	(208) 334-3390	http://www.state.id.us/idvr/idvrhome.htm
Illinois	(800) 843-6154	http://www.dhs.state.il.us/ors/vr/
Indiana	(574) 232-4861	http://www.ai.org/fssa/servicedisabl/vr/index.html
Iowa	(515) 281-4211	http://www.dvrs.state.ia.us
Kansas	(785) 267-5301	http://www.srskansas.org/rehab/index.htm
Kentucky	(800) 372-7172	http://kydvr.state.ky.us/
Louisiana	(504) 483-4777	http://www.dss.state.la.us/departments/lrs/vocational_rehabilitation.html
Maine	(207) 624-5950	http://www.state.me.us/rehab/
Maryland	(410) 554-9361	http://www.dors.state.md.us
Massachusetts	(800) 245-6543	http://www.state.ma.us/mrc/
Michigan	(800) 605-6722	http://www.michigan.gov/mdcd/0,1607,7-122-25392---.00.html
Minnesota	(651) 296-9981	http://www.mnworkforcecenter.org/rehab/
Mississippi	(662) 234-3171	http://www.mdrs.state.ms.us/
Missouri	(573) 751-3251	http://www.vr.dese.state.mo.us/vr/co/VRWebsite.nsf/web/VROffices?opendocument
Montana	(877) 296-1197	http://www.dphhs.state.mt.us/dsd/govt_programs/vrp/index.htm
Nebraska	(402) 471-3644	http://www.vocrehab.state.ne.us
Nevada	(775) 684-4070	http://detr.state.nv.us/rehab/reh_vorh.htm
New Hampshire	(603) 271-3471	http://www.ed.state.nh.us/VR/index.htm
New Jersey	(609) 292-5987	http://www.state.nj.us/labor/dvrs/vrsindex.html
New Mexico	(505) 841-5723	www.dvrgetsjobs.com/Public/SpecialPrograms/DVRServicesSpecialProgramsCAREERS.asp
New York	(800) 222-JOBS (5627)	http://www.vesid.nysed.gov/
North Carolina	(919) 733-7807	http://dvr.dhhs.state.nc.us/
North Dakota	(701) 328-8950	http://www.crisnd.com/cris/program.html?program=1046
Ohio	(614) 438-1250	http://www.state.oh.us/rsc/index2.asp
Oklahoma	(405) 951-3400	http://www.okrehab.org/
Oregon	(503) 945-5880	http://www.dhs.state.or.us/vr/
Pennsylvania	(215) 560-1900	http://www.dli.state.pa.us/landi/cwp/browse.asp?a=128&bc=0&c=27855
Puerto Rico	(787) 728-6550	N/A
Rhode Island	(401) 421-7005	http://www.ors.state.ri.us
South Carolina	(803) 896-6500	http://www.scvrd.net/
South Dakota	(605) 773-3195	http://www.state.sd.us/dhs/drs/index.htm
Tennessee	(800) 669-1851	http://www.state.tn.us/humanserv/DRS.html
Texas	(800)628-5115	http://www.rehab.state.tx.us/index.html
Utah	(801) 538-7530	http://www.usor.utah.gov/

Vermont	(866) 879-6757	http://www.vocrehabvermont.org/
Virginia	(800) 552-5019	http://www.vadrs.org/
Washington	(800) 637-5627	http://www1.dshs.wa.gov/dvr/
West Virginia	(304) 256-6900	http://www.wvdrs.org/
Wisconsin	(608) 261-0050	http://www.dwd.state.wi.us/dvr
Wyoming	(307) 777-7389	http://wydoe.state.wy.us/doe.asp?ID=5

THE BETTER BUSINESS BUREAU

The Better Business Bureau (BBB) system in the United States extends across the nation—coast-to-coast, and in Hawaii, Alaska, and Puerto Rico.

Since the founding of the first BBB in 1912, the BBB system has proven that the majority of marketplace problems can be solved fairly through the use of voluntary self-regulation and consumer education.

The BBB's core services include:

1. Business Reliability Reports
2. Dispute Resolution
3. Truth-in-Advertising
4. Consumer and Business Education
5. Charity Review

The following list provides contact information by state for local BBBs (some which serve multiple areas). Also see <http://www.bbb.org> for additional information.

Alabama

The Better Business Bureau
 Web site: <http://www.birmingham-al.bbb.org>
 E-mail: info@birmingham-al.bbb.org
 Phone: (205) 558-2222
 Fax: (205) 558-2239
 PO Box 55268
 Birmingham, AL 35255-5268

BBB of West Georgia-East Alabama
 Web site: <http://www.columbus-ga.bbb.org>
 E-mail: info@columbus-ga.bbb.org
 Phone: (706) 324-0712
 Fax: (706) 324-2181
 PO Box 2587
 Columbus, GA 31902-2587

BBB of North Alabama
 Web site: <http://www.northalabama.bbb.org>
 E-mail: info@northalabama.bbb.org

Phone: (256) 533-1640
 Fax: (256) 533-1177
 PO Box 383
 Huntsville, AL 35804

BBB of South Alabama
 Web site: <http://www.bbbsouthal.org>
 E-mail: info@mobile.bbb.org
 Phone: (251) 433-5494
 Fax: (251) 438-3191
 PO Box 2008
 Mobile, AL 36652-2008

Alaska

Better Business Bureau, Inc.
 Web site: <http://www.alaska.bbb.org>
 E-mail: info@anchorage.bbb.org
 Phone: (907) 562-0704
 Fax: (907) 562-4061
 2805 Bering Street, Suite 5
 Anchorage, AK 99503-3819

Arizona

The Better Business Bureau
Web site: <http://www.phoenix.bbb.org>
E-mail: info@phoenix.bbb.org
Phone: (602) 264-1721
Fax: (602) 263-0997
4428 N. 12th Street
Phoenix, AZ 85014-4585

BBB of Tucson

Web site: <http://www.tucson.bbb.org>
E-mail: info@tucson.bbb.org
Phone: (520) 888-5353
Fax: (520) 888-6262
434 S. Williams Blvd., Suite 102
Tucson, AZ 85711

Arkansas

AR (Arkansas) BBB of the Mid-South,
Inc.
Web site: <http://www.midsouth.bbb.org>
E-mail: info@bbbmidsouth.org
Phone: (901) 759-1300
Fax: (901) 757-2997
3693 Tyndale Drive
Memphis, TN 38125-0036

BBB of Arkansas

Web site: <http://www.arkansas.bbb.org>
E-mail: info@bbbarkansas.org
Phone: (501) 664-7274
Fax: (501) 664-0024
12521 Kanis Road
Little Rock, AR 72211-2605

California

BBB of the San Joaquin Valley, Inc.
Web site: <http://www.cencal.bbb.org>
E-mail: info@bbbcencal.org
Phone: (559) 222-8111
Fax: (559) 228-6518
2519 W. Shaw, #106
Fresno, CA 93711

Better Business Bureau

Web site: <http://www.oakland.bbb.org>
E-mail: info@oakland.bbb.org
Phone: (510) 238-1000
Fax: (510) 238-1018
510 16th Street, Suite 550
Oakland, CA 94612-1584

BBB of Northern Nevada, Inc.

Web site: <http://www.renobbb.org>
E-mail: information@renobbb.org
Phone: (775) 322-0657
Fax: (775) 322-8163

991 Bible Way
Reno, NV 89502-2122

Sacramento Valley BBB

Web site:
<http://www.northeastcalifornia.bbb.org>
E-mail: info@northeastcalifornia.bbb.org
Phone: (916) 443-6843
Fax: (916) 441-3356
400 S. Street
Sacramento, CA 95814-6997

BBB of the Southland

Web site: <http://www.labbb.org>
E-mail: info@labbb.org
Phone: (909) 825-7280
Fax: (909) 825-6246
PO Box 970
Colton, CA 92324-3052

BBB of San Diego

Web site: <http://www.sandiego.bbb.org>
E-mail: info@sandiego.bbb.org
Phone: (858) 496-2131
Fax: (858) 496-2141
5050 Murphy Canyon, Suite 110
San Diego, CA 92123

BBB of Santa Clara Valley, Ltd.

Web site: <http://www.bbbsilicon.org>
E-mail: info@bbbsilicon.org
Phone: (408) 278-7400
Fax: (408) 278-7444
2100 Forest Ave., Suite 110
San Jose, CA 95128

BBB of San Mateo County

Web site: <http://www.sanmateo.bbb.org>
E-mail: info@sanmateo.bbb.org
Phone: (650) 552-9222
Fax: (650) 652-1748
510 Broadway, Suite 200
Millbrae, CA 94030

BBB of the Tri-Counties

Web site: <http://www.santabarbara.bbb.org>
E-mail: info@santabarbara.bbb.org
Phone: (805) 963-8657
Fax: (805) 962-8557
PO Box 129
Santa Barbara, CA 93102

Better Business Bureau, Inc.

Web site: <http://www.midcalbbb.org>
E-mail: info@midcalbbb.org
Phone: (209) 948-4880
Fax: (209) 465-6302
11 S. San Joaquin Street, Suite 803
Stockton, CA 95202-3202

Colorado

Better Business Bureau of Southern
Colorado
Web site: <http://www.bbbsc.org>
E-mail: info@bbbsc.org
Phone: (719) 636-1155
Fax: (719) 636-5078
25 North Wahsatch
Colorado Springs, CO 80903-

BBB of the Mountain States
Web site: <http://www.fortcollins.bbb.org>
E-mail: info@rockymtn.bbb.org
Phone: (970) 484-1348
Fax: (970) 221-1239
1730 S. College Ave., #303
Fort Collins, CO 80525
BBB Four Corners
Web site: <http://www.farmington.bbb.org>
E-mail: info@farmington.bbb.org
Phone: (505) 326-6501
Fax: (505) 327-7731
308 North Locke
Farmington, NM 87401-5855

Denver Area BBB
Web site: <http://www.denver.bbb.org>
E-mail: info@denver.bbb.org
Phone: (303) 758-2100
Fax: (303) 758-8321
1020 Cherokee Street
Denver, CO 80204-4039

BBB of Southern Colorado
Web site: <http://www.pueblo.bbb.org>
E-mail: info@pueblo.bbb.org
Phone: (719) 542-6464
Fax: (719) 542-5229
119 W. 6th Street, Suite 203
Pueblo, CO 81003-3119

Connecticut

The Better Business Bureau
Web site: <http://www.connecticut.bbb.org>
E-mail: info@ctbbb.org
Phone: (203) 269-2700
Fax: (203) 269-3124
821 N. Main Street Ext. Parkside Building
Wallingford, CT 06492-2420

BBB of Central New England
Web site: <http://www.worcester.bbb.org>
E-mail: info@worcester.bbb.org
Phone: (508) 755-2548
Fax: (508) 754-4158
32 Franklin Street, Suite 404
Worcester, MA 01608-1900

Delaware

BBB of Delaware
Web site: <http://www.delaware.bbb.org>
E-mail: info@delaware.bbb.org

Phone: (302) 230-0108
Fax: (302) 230-0116
1415 Foulk Road, Suite 202
Foulkstone Plaza
Wilmington, DE 19803

District of Columbia

BBB of Metro Washington, DC and Eastern
Pennsylvania
Web site: <http://www.dc.bbb.org>
E-mail: info@dc.bbb.org
Phone: (202) 393-8000
Fax: (202) 393-1198
1411 K Street, NW, 10th Floor
Washington, DC 20005-3404

Florida

BBB of Northeast Florida
Web site: <http://www.bbbnefla.org>
E-mail: info@bbbnefla.org
Phone: (904) 721-2288
Fax: (904) 721-7373
4417 Beach BV., Suite 202
Jacksonville, FL 32207

BBB Serving Miami, Ft. Lauderdale, and
West Palm Beach Areas
Web site:
<http://www.bbbsoutheastflorida.org>
E-mail: westpalm@gte.net
Phone: (561) 842-1918
Fax: (561) 845-7234
2924 N Australian Ave.
West Palm Beach, FL 33407

BBB of West Florida
Web site: <http://www.clearwater.bbb.org>
E-mail: info@bbbwestflorida.org
Phone: (727) 535-5522
Fax: (727) 539-6301
PO Box 7950
Clearwater, FL 33758-7950

BBB of Northwest Florida
Web site: <http://www.nwfl.bbb.org>
E-mail: info@nwfl.bbb.org
Phone: (850) 429-0002
Fax: (850) 429-0006
PO Box 1511
Pensacola, FL 32591-1511

BBB of Central Florida, Inc.
Web site: <http://www.orlando.bbb.org>
E-mail: info@orlando.bbb.org
Phone: (407) 621-3300
Fax: (407) 786-2625
151 Wymore Road, Suite 100
Altamonte Springs, FL 32714

Georgia

BBB of Metropolitan Atlanta
Web site: <http://www.atlanta.bbb.org>

E-mail: info@atlanta.bbb.org
Phone: (404) 766-0875
Fax: (404) 768-1085
P.O. Box 161447
Atlanta, GA 30321

The Better Business Bureau
Web site: <http://www.augusta-ga.bbb.org>
E-mail: info@augusta-ga.bbb.org
Phone: (706) 722-1574
Fax: (706) 724-0969
PO Box 2085
Augusta, GA 30903-2085

Better Business Bureau
Web site: <http://www.chattanooga.bbb.org>
E-mail: tngabbb@bellsouth.net
Phone: (423) 266-6144
Fax: (423) 267-1924
1010 Market Street, Suite 200
Chattanooga, TN 37402-2614

BBB of West Georgia-East Alabama
Web site: <http://www.columbus-ga.bbb.org>
E-mail: info@columbus-ga.bbb.org
Phone: (706) 324-0712
Fax: (706) 324-2181
PO Box 2587
Columbus, GA 31902-2587

Better Business Bureau of the Southeast
Atlantic
Web site:
<http://www.bbbsoutheastatlantic.org>
E-mail: email@bbbsoutheastatlantic.org
Phone: (912) 354-7521
Fax: (912) 354-5068
6606 Abercorn Street, Suite 108C
Savannah, GA 31405-5817

BBB of Central Georgia
Web site: <http://www.centralgeorgia.bbb.org>
E-mail: info@centralgeorgia.bbb.org
Phone: (478) 742-7999
Fax: (478) 742-8191
277 Martin Luther King, Jr. Blvd., Suite 102
Macon, GA 31201-3495

Hawaii
BBB of Hawaii
Web site: <http://www.hawaii.bbb.org>
E-mail: info@hawaii.bbb.org
Phone: (808) 536-6956
Fax: (808) 523-2335
First Hawaiian Tower
1132 Bishop Street, Suite 1507
Honolulu, HI 96813-2822

Idaho
BBB of Southwest Idaho
Web site: <http://www.boise.bbb.org>
E-mail: info@boise.bbb.org

Phone: (208) 342-4649
Fax: (208) 342-5116
4355 Emerald Street, Suite 290
Boise, ID 83706

BBB of Eastern Idaho & Western Wyoming
Web site: <http://www.idahofalls.bbb.org>
E-mail: inquiries-bbb@nsicom.net
Phone: (208) 523-9754
Fax: (208) 227-1630
320 Memorial Dr., Suite 2
Idaho Falls, ID 83402-3615

The Better Business Bureau serving Eastern
Washington, North Idaho and Montana
Web site: <http://www.thelocalbbb.com>
E-mail: info@thelocalbbb.com
Phone: (509) 455-4200
Fax: (509) 838-1079
508 West Sixth Avenue, Suite 401
Spokane, WA 99204-2356

Illinois
Tri-State BBB
Web site: <http://www.evansville.bbb.org>
E-mail: info@evansville.bbb.org
Phone: (812) 473-0202
Fax: (812) 473-3080
1139 Washington Square
Evansville, IN 47715

BBB Chicago & N. Illinois
Web site: <http://www.chicago.bbb.org>
E-mail: feedback@chicago.bbb.org
Phone: (312) 832-0500
Fax: (312) 832-9985
330 N. Wabash, Suite 2006
Chicago, IL 60611

BBB of Central Illinois
Web site: <http://www.peoria.bbb.org>
E-mail: bbb@heart.net
Phone: (309) 688-3741
Fax: (309) 681-7290
413 S.W. Washington Street
Peoria, IL 61602

BBB of E. Missouri & S. Illinois
Web site: <http://www.stlouis.bbb.org>
E-mail: bbbstl@stlouisbbb.org
Phone: (314) 645-3300
Fax: (314) 645-2666
12 Sunnen Drive, Suite 121
Saint Louis, MO 63143

Indiana

Cincinnati BBB
Web site: <http://www.cinbbb.org>
E-mail: info@cinbbb.org
Phone: (513) 421-3015
Fax: (513) 621-0907
898 Walnut Street
Cincinnati, OH 45202-2097

BBB of Northeastern Indiana
Web site: <http://www.fortwayne.bbb.org>
E-mail: info@neindianabbb.org
Phone: (260) 423-4433
Fax: (260) 423-3301
1203 Webster Street
Fort Wayne, IN 46802-3493

BBB of Northwest Indiana
Web site: <http://www.nwin.bbb.org>
E-mail: info@nwin.bbb.org
Phone: (219) 769-8053
Fax: (219) 884-2123
6111 Harrison Street, Suite 101
Merrillville, IN 46410

BBB of Central Indiana
Web site: <http://www.indybbb.org>
E-mail: info@central-in.bbb.org
Phone: (317) 488-2222
Fax: (317) 488-2224
Victoria Centre, 22 E. Washington Street,
Suite 200
Indianapolis, IN 46204-3584

The Better Business Bureau
Web site: <http://www.ky-in.bbb.org>
E-mail: info@ky-in.bbb.org
Phone: (502) 583-6546
Fax: (502) 589-9940
844 S. 4th Street
Louisville, KY 40203-2186

Tri-State BBB
Web site: <http://www.evansville.bbb.org>
E-mail: info@evansville.bbb.org
Phone: (812) 473-0202
Fax: (812) 473-3080
1139 Washington Square
Evansville, IN 47715

Iowa

BBB of Central & Eastern Iowa
Web site: <http://www.desmoines.bbb.org>
E-mail: info@dm.bbb.org
Phone: (515) 243-8137
Fax: (515) 243-2227
505 5th Ave., Suite 950
Des Moines, IA 50309-2375

Better Business Bureau, Inc.
Web site: <http://www.heartlandbbb.org>
E-mail: info@heartlandbbb.org

Phone: (402) 391-7612
Fax: (402) 391-7535
11811 P Street
Omaha, NE 68137

Better Business Bureau
Web site: <http://www.siouxlandbbb.org>
E-mail: info@siouxlandbbb.org
Phone: (712) 252-4501
Fax: (712) 252-0285
600 Fourth Street, Suite 900
Sioux City, IA 51101-1750

Kansas

BBB of Greater Kansas City
Web site: <http://www.kansascity.bbb.org>
E-mail: info@kansascity.bbb.org
Phone: (816) 421-7800
Fax: (816) 472-5442
8080 Ward Parkway, Suite 200
Kansas City, MO 64114

BBB of Northeast Kansas
Web site: <http://www.topeka.bbb.org>
E-mail: topekabb@kansasone.com
Phone: (785) 232-0454
Fax: (785) 232-9677
501 Southeast Jefferson, Suite 24
Topeka, KS 66607-1190

The Better Business Bureau
Web site: <http://www.wichita.bbb.org>
E-mail: info@wichita.bbb.org
Phone: (316) 263-3146
Fax: (316) 263-3063
328 Laura
Wichita, KS 67211-1707

Kentucky

Cincinnati BBB
Web site: <http://www.cinbbb.org>
E-mail: info@cinbbb.org
Phone: (513) 421-3015
Fax: (513) 621-0907
898 Walnut Street
Cincinnati, OH 45202-2097

BBB of Central & Eastern Kentucky, Inc.
Web site: <http://www.lexington.bbb.org>
E-mail: info@ky.bbb.org
Phone: (859) 259-1008
Fax: (859) 259-1639
1460 Newtown Pike
Lexington, KY 40511

The Better Business Bureau
Web site: <http://www.ky-in.bbb.org>
E-mail: info@ky-in.bbb.org
Phone: (502) 583-6546
Fax: (502) 589-9940
844 S. 4th Street
Louisville, KY 40203-2186

Tri-State BBB
Web site: <http://www.evansville.bbb.org>
E-mail: info@evansville.bbb.org
Phone: (812) 473-0202
Fax: (812) 473-3080
1139 Washington Square
Evansville, IN 47715

Louisiana
Better Business Bureau
Web site: <http://www.alexandria-la.bbb.org>
E-mail: info@alexandria-la.bbb.org
Phone: (318) 473-4494
Fax: (318) 473-8906
5220-C Rue Verdun
Alexandria, LA 71303

BBB of South Central Louisiana
Web site: <http://www.batonrouge.bbb.org>
E-mail: jims@batonrouge.bbb.org
Phone: (225) 346-5222
Fax: (225) 346-1029
748 Main Street
Baton Rouge, LA 70802

BBB of Southwest Louisiana
Web site: <http://www.lakecharles.bbb.org>
E-mail: info@lakecharles.bbb.org
Phone: (337) 478-6253
Fax: (337) 474-8981
PO Box 7314
Lake Charles, LA 70606-7314

BBB of Northeast Louisiana
Web site: <http://www.monroe.bbb.org>
E-mail: info@bbbnela.org
Phone: (318) 387-4600
Fax: (318) 361-0461
141 Desiard Street, Suite 808
Monroe, LA 71201-7345

BBB/Greater New Orleans Area
Web site: <http://www.neworleans.bbb.org>
E-mail: info@neworleans.bbb.org
Phone: (504) 581-6222
Fax: (504) 524-9110
1539 Jackson Ave., Suite 400
New Orleans, LA 70130-5843

The Better Business Bureau
Web site: <http://www.shreveport.bbb.org>
E-mail: info@shreveport.bbb.org
Phone: (318) 222-7575
Fax: (318) 222-7576
PO Box 1812
Shreveport, LA 71166-1812

BBB of Acadiana
Web site: <http://www.acadiana.bbb.org>
E-mail: info@acadiana.bbb.org

Phone: (337) 981-3497
Fax: (337) 981-7559
4007 West Congress Street, Suite B
Lafayette, LA 70506

Maine
BBB of Maine
Web site: <http://www.bosbbb.org>
E-mail: info@bosbbb.org
Phone: (207) 878-2715
Fax: (207) 797-5818
812 Stevens Ave.
Portland, ME 04103-2648

Maryland
BBB of Greater Maryland
Web site: <http://www.baltimore.bbb.org>
E-mail: info@bbbmd.org
Phone: (410) 347-3992
Fax: (410) 347-3936
1414 Key Highway, Suite 100
Baltimore, MD 21230-5189

BBB of Metro Washington DC, and Eastern
Pennsylvania
Web site: <http://www.dc.bbb.org>
E-mail: info@dc.bbb.org
Phone: (202) 393-8000
Fax: (202) 393-1198
1411 K Street, NW, 10th Floor
Washington, DC 20005-3404

Massachusetts
BBB Serving Eastern Massachusetts, Maine
& Vermont
Web site: <http://www.bosbbb.org>
E-mail: info@bosbbb.org
Phone: (508) 652-4800
Fax: (508) 652-4820
235 West Central Street, Suite 1
Natick, MA 01760-3767

BBB of Central New England
Web site: <http://www.worcester.bbb.org>
E-mail: info@worcester.bbb.org
Phone: (508) 755-2548
Fax: (508) 754-4158
32 Franklin Street, Suite 404
Worcester, MA 01608-1900

Michigan
BBB of Detroit & Eastern Michigan
Web site: <http://www.detroit.bbb.org>
E-mail: info@detroit.bbb.org
Phone: (248) 644-9100
Fax: (248) 644-5026
30555 Southfield Road, Suite 200
Southfield, MI 48076-7751

BBB of Western Michigan
Web site: <http://www.grandrapids.bbb.org>
E-mail: bbbinfo@iserv.net
Phone: (616) 774-8236
Fax: (616) 774-2014
40 Pearl, NW, Suite 354
Grand Rapids, MI 49503

BBB Serving NW Ohio & SE Michigan
Web site: <http://www.toledobb.org>
E-mail: info@toledobb.org
Phone: (419) 531-3116
Fax: (419) 578-6001
3103 Executive Parkway, Suite 200
Toledo, OH 43606-1310

Minnesota

Better Business Bureau
Web site: <http://www.mnd.bbb.org>
E-mail: ask@mnd.bbb.org
Phone: (651) 699-1111
Fax: (651) 699-7665
2706 Gannon Road
Saint Paul, MN 55116-2600

Mississippi

The Better Business Bureau of Mississippi,
Inc.
Web site: <http://www.bbbmississippi.org>
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Phone: (601) 977-1020
Fax: (601) 977-0704
PO Box 3302
Ridgeland, MS 39158-

BBB of the Mid-South, Inc.
Web site: <http://www.midsouth.bbb.org>
E-mail: info@bbbmidsouth.org
Phone: (901) 759-1300
Fax: (901) 757-2997
3693 Tyndale Drive
Memphis, TN 38125-0036

Missouri

BBB of Greater Kansas City
Web site: <http://www.kansascity.bbb.org>
E-mail: info@kansascity.bbb.org
Phone: (816) 421-7800
Fax: (816) 472-5442
8080 Ward Parkway, Suite 200
Kansas City, MO 64114

BBB of E. Missouri & S. Illinois
Web site: <http://www.stlouis.bbb.org>
E-mail: bbbstl@stlouisbbb.org
Phone: (314) 645-3300
Fax: (314) 645-2666
12 Sunnen Drive, Suite 121
Saint Louis, MO 63143

BBB of Southwest Missouri
Web site: <http://www.springfield-mo.bbb.org>
E-mail: info@springfield-mo.bbb.org
Phone: (417) 862-4222
Fax: (417) 869-5544
1516 St. Louis Street
Springfield, MO 65802-3128

Montana

The Better Business Bureau serving Eastern
Washington, North Idaho and Montana
Web site: <http://www.thelocalbbb.com>
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Phone: (509) 455-4200
Fax: (509) 838-1079
508 West Sixth Avenue, Suite 401
Spokane, WA 99204-2356

Nebraska

Cornhusker BBB
Web site: <http://www.lincoln.bbb.org>
Phone: (402) 436-2345
Fax: (402) 476-8221
3633 O Street, Suite 1
Lincoln, NE 68510-1670

Better Business Bureau, Inc.
Web site: <http://www.heartlandbbb.org>
E-mail: info@heartlandbbb.org
Phone: (402) 391-7612
Fax: (402) 391-7535
11811 P Street
Omaha, NE 68137

Better Business Bureau
Web site: <http://www.siouxlandbbb.org>
E-mail: info@siouxlandbbb.org
Phone: (712) 252-4501
Fax: (712) 252-0285
600 Fourth Street, Suite 900
Sioux City, IA 51101-1750

Nevada

BBB of Southern Nevada, Inc.
Web site: <http://www.vegasbbb.org>
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Phone: (702) 320-4500
Fax: (702) 320-4560
2301 Palomino Lane
Las Vegas, NV 89107-4503

BBB of Northern Nevada, Inc.
Web site: <http://www.renobbb.org>
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Phone: (775) 322-0657
Fax: (775) 322-8163
991 Bible Way
Reno, NV 89502-2122

New Hampshire

BBB of New Hampshire, Inc.
Web site: <http://www.concord.bbb.org>
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Fax: (603) 228-9035
410 S. Main Street
Concord, NH 03301-3483

New Jersey

BBB of New Jersey
Web site: <http://www.trenton.bbb.org>
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Phone: (609) 588-0808
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1700 Whitehorse Hamilton Square, Ste. C-3
Trenton, NJ 08690-3596

New Mexico

BBB of New Mexico
Web site: <http://www.bbbnm.com>
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2625 Pennsylvania NE, Suite 2050
Albuquerque, NM 87110-3657

BBB Four Corners

Web site: <http://www.farmington.bbb.org>
E-mail: info@farmington.bbb.org
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308 North Locke
Farmington, NM 87401-5855

New York

Better Business Bureau
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E-mail: info@upstatenybbb.org
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741 Delaware Ave., Suite 100
Buffalo, NY 14209-2201

BBB of Metropolitan New York

Web site: <http://www.newyork.bbb.org>
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257 Park Avenue South
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North Carolina

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Asheville, NC 28801-3408

BBB of the Southern Piedmont
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Fax: (704) 525-7624
5200 Park Road, Suite 202
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BBB of Central North Carolina

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BBB of Greater Hampton Roads

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Raleigh, NC 27612-2621

The BBB of NW North Carolina

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Fax: (336) 777-3727
500 W. 5th Street, Suite 202
Winston Salem, NC 27101-2728

BBB of Coastal Carolina

Web site: <http://www.carolina.bbb.org>
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North Dakota

Better Business Bureau
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Ohio

BBB of Akron
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222 W. Market Street
Akron, OH 44303

BBB/Canton Regional
Web site: <http://www.cantonbbb.org>
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Phone: (800) 362-0494
Fax: (330) 456-8957
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898 Walnut Street
Cincinnati, OH 45202-2097

BBB of Central Ohio, Inc.
Web site: <http://www.columbus-ohbbb.org>
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1335 Dublin Road, #30-A
Columbus, OH 43215-1000

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Phone: (216) 241-7678
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2217 E. 9th Street, Suite 200
Cleveland, OH 44115-1299

BBB of Dayton/Miami Valley, Inc.
Web site: <http://www.dayton.bbb.org>
E-mail: info@dayton.bbb.org
Phone: (937) 222-5825
Fax: (937) 222-3338
40 W. Fourth Street, Suite 1250
Dayton, OH 45402-1830

BBB Serving NW Ohio & SE Michigan
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Fax: (419) 578-6001
3103 Executive Parkway, Suite 200
Toledo, OH 43606-1310

BBB of Mahoning Valley
Web site: <http://www.youngstownbbb.org>
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Phone: (330) 744-3111
Fax: (330) 744-7336
PO Box 1495
Youngstown, OH 44501-1495

The BBB Serving West Central Ohio
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Phone: (419) 223-7010
Fax: (419) 229-2029
PO Box 269
Lima, OH 45802-0269

Oklahoma

BBB of Central Oklahoma
Web site: <http://www.oklahomacity.bbb.org>
E-mail: info@oklahomacity.bbb.org
Phone: (405) 239-6081
Fax: (405) 235-5891
17 S. Dewey
Oklahoma City, OK 73102-2400

BBB of Tulsa

Web site: <http://www.tulsabbb.org>
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Phone: (918) 492-1266
Fax: (918) 492-1276
University Club Tower
1722 South Carson Ave, Suite 3200
Tulsa, OK 74119

Oregon

BBB of Southwest Idaho
Web site: <http://www.boise.bbb.org>
E-mail: info@boise.bbb.org
Phone: (208) 342-4649
Fax: (208) 342-5116
4355 Emerald Street, Suite 290
Boise, ID 83706

Better Business Bureau of Oregon and Western Washington

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Fax: (206) 431-2211
PO Box 1000
DuPont, WA 98327

Pennsylvania

BBB of Western Pennsylvania
Web site: <http://www.pittsburgh.bbb.org>
E-mail: info@pittsburgh.bbb.org
Phone: (412) 456-2700
Fax: (412) 456-2739
300 Sixth Avenue, Suite 100-UL
Pittsburgh, PA 15222-2511

BBB/Northeastern PA

Web site: <http://www.nepa.bbb.org>
E-mail: info@nepa.bbb.org
Phone: (570) 614-4222
Fax: (570) 342-1282
4099 Birney Avenue
Moosic, PA 18507-

BBB of Metro Washington DC and Eastern

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Web site: <http://www.dc.bbb.org>
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Phone: (202) 393-8000
Fax: (202) 393-1198
1411 K Street, NW, 10th Floor
Washington, DC 20005-3404

Puerto Rico

BBB of Puerto Rico
E-mail: info@sanjuan.bbb.org
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Fax: (787)758-0095
PO Box 363488
San Juan, PR 00936-3488

Rhode Island

BBB of Rhode Island, Inc.
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E-mail: info@rhodeisland.bbb.org
Phone: (401) 785-1212
Fax: (401) 785-3061
120 Lavan Street
Warwick, RI 02888-1071

South Carolina

The Better Business Bureau
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E-mail: info@augusta-ga.bbb.org
Phone: (706) 722-1574
Fax: (706) 724-0969
PO Box 2085
Augusta, GA 30903-2085

BBB of the Southern Piedmont
Web site: <http://www.charlotte.bbb.org>
E-mail: info@charlotte.bbb.org
Phone: (704) 527-0012
Fax: (704) 525-7624
5200 Park Road, Suite 202
Charlotte, NC 28209-3650
Better Business Bureau of the Southeast
Atlantic
Web site:
<http://www.bbbsoutheastatlantic.org>
E-mail: email@bbbsoutheastatlantic.org
Phone: (912) 354-7521
Fax: (912) 354-5068
6606 Abercorn Street, Suite 108C
Savannah, GA 31405-5817

Better Business Bureau, Inc.
Web site: <http://www.columbia.bbb.org>
E-mail: info@columbia.bbb.org
Phone: (803) 254-2525
Fax: (803) 779-3117
PO Box 8326
Columbia, SC 29202

Better Business Bureau
Web site: <http://www.greenville.bbb.org>
E-mail: info@greenville.bbb.org

Phone: (864) 242-5052
Fax: (864) 271-9802
408 North Church Street
Suite C
Greenville, SC 29601-2164

BBB of Coastal Carolina
Web site: <http://www.carolina.bbb.org>
E-mail: cseft@sc.rr.com
Phone: (843) 626-6881
Fax: (843) 626-7455
2501 N. Kings Hwy, Unit 76
Myrtle Beach, SC 29577-3054

South Dakota

Better Business Bureau
Web site: <http://www.siouxlandbbb.org>
E-mail: info@siouxlandbbb.org
Phone: (712) 252-4501
Fax: (712) 252-0285
600 Fourth Street, Suite 900
Sioux City, IA 51101-1750

Tennessee

Better Business Bureau
Web site: <http://www.chattanooga.bbb.org>
E-mail: tngabbb@bellsouth.net
Phone: (423) 266-6144
Fax: (423) 267-1924
1010 Market Street, Suite 200
Chattanooga, TN 37402-2614

BBB of Greater East Tennessee
Web site: <http://www.knoxville.bbb.org>
E-mail: info@knoxville.bbb.org
Phone: (865) 692-1600
Fax: (865) 692-1590
PO Box 31377
Knoxville, TN 37930

BBB of the Mid-South, Inc.
Web site: <http://www.midsouth.bbb.org>
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Phone: (901) 759-1300
Fax: (901) 757-2997
3693 Tyndale Drive
Memphis, TN 38125-0036

BBB of Nashville/Middle Tennessee
Web site:
<http://www.middletennessee.bbb.org>
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Phone: (615) 242-4222
Fax: (615) 250-4245
PO Box 198436
Nashville, TN 37219-8436

Texas

Abilene BBB
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Fax: (325) 691-0309
3300 S. 14th Street, Suite 307
Abilene, TX 79605-5052

BBB of Amarillo Inc.
Web site: <http://www.amarillobbb.org>
E-mail: info@amarillobbb.org
Phone: (806) 379-6222
Fax: (806) 379-8206
PO Box 1905
Amarillo, TX 79105-1905

The Better Business Bureau
Web site: <http://www.centraltx.bbb.org>
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Phone: (512) 445-2911
Fax: (512) 445-2096
2101 S. Ih 35, Suite 302
Austin, TX 78741-3854

BBB of Southeast Texas
Web site: <http://www.bbbsetexas.org>
E-mail: bureau@bbsetexas.org
Phone: (409) 835-5348
Fax: (409) 838-6858
PO Box 2988
Beaumont, TX 77704-2988

BBB of Brazos Valley
Web site: <http://www.bbbbryan.org>
E-mail: info@bbbbryan.org
Phone: (979) 260-2222
Fax: (979) 846-0276
PO Box 3868
Bryan, TX 77805-3868

BBB of the Coastal Bend
Web site: <http://www.caller.com/bbb>
Phone: (361) 852-4949
Fax: (361) 852-4990
4301 Ocean Drive
Corpus Christi, TX 78412

BBB of Metropolitan Dallas
Web site: <http://www.dallas.bbb.org>
E-mail: info@dallas.bbb.org
Phone: (214) 220-2000
Fax: (214) 740-0321
1600 Pacific
Suite 2800
Dallas, TX 75201

BBB of El Paso
Web site: <http://www.bbbelpaso.com>
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221 N. Kansas, Suite 1101
El Paso, TX 79901

BBB/Ft. Worth
Web site: <http://www.fortworth.bbb.org>

E-mail: info@fwbbb.org
Phone: (817) 332-7585
Fax: (817) 882-0566
101 Summit Ave., Suite 707
Fort Worth, TX 76102-5978

BBB of Metropolitan Houston
Web site: <http://www.bbbhou.org>
E-mail: bbbinfo@bbbhou.org
Phone: (713) 341-6167
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1333 West Loop South, Suite 1200
Houston, TX 77027-

BBB of the South Plains
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Fax: (806) 744-9748
3333 66th Street
Lubbock, TX 79413-5711

BBB of the Permian Basin
Web site: <http://www.permianbasinbbb.org>
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PO Box 60206
Midland, TX 79706

The Better Business Bureau
Web site: <http://www.sanantonio.bbb.org>
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1800 Northeast Loop 410, Suite 400
San Antonio, TX 78217-5296

Better Business Bureau
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Phone: (254) 755-7772
Fax: (254) 755-7774
2210 Washington Avenue
Waco, TX 76701-1019

BBB of San Angelo
Web site: <http://www.sanangelo.bbb.org>
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PO Box 3366
San Angelo, TX 76902-3366

BBB of North Central Texas
Web site: <http://www.bbbnorcentx.org>
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Phone: (940) 691-1172
Fax: (940) 691-1175
4245 Kemp Blvd., Suite 900
Wichita Falls, TX 76308-2830

BBB of Central East Texas
Web site: <http://www.tyler.bbb.org>
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PO Box 6652
Tyler, TX 75711-6652

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Utah

Better Business Bureau of Utah
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5673 S. Redwood Rd., #22
Salt Lake City, UT 84123-5322

Vermont

BBB Serving Eastern Massachusetts, Maine
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Virginia

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BBB of Greater Hampton Roads
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Fax: (804) 648-3115
701 E. Franklin, Suite 712
Richmond, VA 23219-2332

BBB of Western Virginia
Web site: <http://www.vabbb.org>
E-mail: info@roanoke.bbb.org
Phone: (540) 342-3455
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31 West Campbell Avenue
Roanoke, VA 24011-1301

Washington

The Better Business Bureau serving Eastern
Washington, North Idaho and Montana
Web site: <http://www.thelocalbbb.com>
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West Virginia

BBB of Metro Washington, DC and
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Wisconsin

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10101 W. Greenfield Avenue, Suite 125
West Allis, WI 53214

Wyoming

BBB of the Mountain States
Web site: <http://www.fortcollins.bbb.org>
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Phone: (970) 484-1348
Fax: (970) 221-1239
1730 S. College Ave., #303

Fort Collins, CO 80525

BBB of Eastern Idaho & Western Wyoming

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Fax: (208) 227-1630

320 Memorial Dr., Suite 2

Idaho Falls, ID 83402-3615

TELECOMMUNICATIONS SERVICES FOR DEAF AND SPEECH-IMPAIRED PEOPLE

You may notice that some of your elderly clients are having difficulty hearing you. Perhaps you think they no longer understand you when, in fact, they are experiencing age-related hearing loss. This section can help you help them identify resources for enhanced communication devices. Telecommunications Relay Services (TRS) enable standard voice telephone users to talk to people who have difficulty hearing or speaking on the telephone. Under Title IV of the Americans with Disabilities Act, all telephone companies must provide free relay services either directly or through state programs throughout the 50 states, the District of Columbia, Puerto Rico, and all of the U.S. territories. Businesses, government agencies, family, friends, and employers of persons with hearing and speech disabilities make and receive relay calls everyday.

How Does TRS Work?

TRS uses operators, called "communications assistants" (CAs), to facilitate telephone calls for people who have difficulty hearing or speaking, and other individuals. Federal Communications Commission (FCC) rules require telephone companies to provide TRS nationwide on a 24 hour-a-day, 7 day a week basis, at no extra cost to callers.

Conversations are relayed in real-time and CAs are not permitted to disclose the content of any conversation. Relay callers are not limited in the type, length, or nature of their calls.

What Is a TTY

Also called text telephones, TTYs have a typewriter keyboard and allow persons to type their telephone conversations via two-way text. The conversation is read on a lighted display screen and/or a paper printout on the TTY.

What Types of TRS Are Available?

There are several types of TRS available. Any of these may be initiated by an individual with a hearing or speech disability, or by a conventional telephone user.

Text-to-voice TRS. This type of TRS uses a CA who speaks what a TTY user types, and types what a voice telephone user replies. The first step of this type of TRS is the TTY user's call to the TRS center. This is functionally equivalent to receiving a "dial tone." The caller then gives the number of the party that he or she wants to call to the CA. The CA in turn places an outbound voice call to the called party. The CA serves as the "link" in the conversation, converting all TTY messages from the caller into voice messages, and all voice messages from the called party into typed messages for the TTY user. The process is performed in reverse when a voice telephone user initiates the call.

Voice carry over. Voice carry over (VCO) TRS enables a person who is hard of hearing, but who wants to use his/her own voice, to speak directly to the receiving party and to receive responses in text form through the CA. No typing is required by either the calling or the called party. This service is particularly useful to senior citizens who have lost their hearing, but who can still speak.

Hearing carry over. Hearing carry over (HCO) TRS enables a person with a speech disability to type his part of the conversation on a TTY. The CA reads these words to the called party, and the caller hears responses directly from the other party.

Speech-to-speech relay. With this option, a person with a speech disability uses a CA specially trained in understanding a variety of speech disorders. The CA repeats what the caller says in a manner that makes the caller's words clear and understandable. No special telephone is needed for this option.

Video relay services. This type of TRS enables individuals who use sign language to make relay calls through CAs who can interpret their calls. The caller signs to the CA with the use of video equipment and the CA voices what is signed to the called party and signs back to the caller. This type of relay service is not required by the FCC, but is offered on a voluntary basis by certain TRS programs. This option is helpful for people who use American Sign Language (ASL), and for people who cannot type on a TTY easily, such as children who are ASL users.

Spanish relay services. Telephone companies must provide interstate (between states) relay services in Spanish. While Spanish language relay is not required for calls within (intrastate) states, many states with large Spanish-speaking populations already offer this service on a voluntary basis.

7-1-1 Access to TRS

Just as you can call 4-1-1 for information, you can dial 7-1-1 to connect to relay service anywhere in the United States. 7-1-1 will make it easier for travelers to use relay because they will not have to remember relay numbers in every state.

Don't Hang Up!

Some people hang up on relay calls because they think the CA is a telemarketer. If you answer the phone and hear, "Hello, this is the relay service. Have you received a relay call before?" don't hang up. You are about to talk to a person who is deaf or hard-of-hearing or who has a speech disability, on your phone.

More Information on TRS and Equipment

To learn more about TRS, visit the Federal Communications Commission's (FCC) Web site at www.fcc.gov/cgb/dro/trs.html. If you have questions, need assistance on other disability issues, or if you would like to receive free information about disability issues on a regular basis via e-mail, contact the FCC's Consumer and Governmental Affairs Bureau at fccinfo@fcc.gov.

In addition, the FCC has established two special telephone numbers to help serve the public in an effective and efficient manner:

- (888) CALL FCC (voice)
- (888) TELL FCC (TTY)

Source: Federal Communications Commission, 2004; also see:

<http://www.fcc.gov/cgb/consumerfacts/trs.html>

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

University of Alabama, Birmingham
University of North Alabama, Florence
University of South Alabama, Mobile

Alaska

University of Alaska, Anchorage

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 Central Arkansas, Conway

California

American River College, Sacramento
California Council on Gerontology and Geriatrics, Aptos
California State University, Fullerton
California State University, Sacramento
Chaffey College, Rancho Cucamonga
Charles R. Drew University, Los Angeles
College of the Canyons, Santa Clarita
Los Angeles Pierce College, Woodland Hills
Rio Hondo College, Whittier
San Diego State University, San Diego
San Francisco State University, San Francisco
San Jose State University, San Jose
Stanford University, Stanford
University of California–Los Angeles
University of California–San Francisco
University of LaVerne, LaVerne
University of the Pacific, San Francisco
University of Southern California, Los Angeles
VA of Greater Los Angeles Healthcare System, Los Angeles

Colorado

Colorado State University, Ft. Collins
Metropolitan State College of Denver, Denver
University of Colorado–Colorado Springs
University of Denver, Denver
University of Northern Colorado, Greeley
University Seniors Association, Denver

Connecticut

Quinnipiac College, Hamden
Southern Connecticut State University, New Haven
St. Joseph College, West Hartford
University of Connecticut, Storrs

Florida

Barry University, Miami Shores
Florida Atlantic University, Boca Raton
Florida Gulf Coast University, Fort Meyers
Florida International University, North Miami
Florida State University, Tallahassee
New York Life Insurance AARP Operations, Tampa
University of Central Florida, Orlando
University of Florida, Gainesville
University of South Florida, Tampa

Georgia

Columbus State University, Columbus
Georgia Southern University, Statesboro
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

College of Southern Idaho, Twin Falls

Illinois

Concordia University, River Forest
Eastern Illinois University, Charleston
Illinois State University, Normal
Midwestern University, Downers Grove
National Louis University, Evanston
Northeastern Illinois University, Chicago
Northwestern University, Chicago
Rush University, Chicago
Southern Illinois University, Edwardsville/Carbondale
University of Illinois at Springfield, Springfield
Wilbur Wright College, Chicago

Indiana

Ball State University, Muncie
Bethel College, Mishawaka
Indiana University, Bloomington

Manchester College, North Manchester
Purdue University, Ft. Wayne
Purdue University, West Lafayette
University of Evansville, Evansville University of Indianapolis, Indianapolis
University of St. Francis, Ft. Wayne

Iowa

Des Moines University Osteopathic Medical Center, Des Moines
Iowa State University, Ames
University of Iowa, Iowa City
University of Northern Iowa, Cedar Falls

Kansas

Avilia University, Kansas City
Kansas State University, Manhattan
Pittsburgh State University, Pittsburgh
University of Kansas, Lawrence

Kentucky

Campbellsville University, Campbellsville
University of Kentucky, Lexington
Western Kentucky University, Bowling Green

Louisiana

University of Louisiana, Monroe
University of New Orleans, New Orleans

Maine

University of New England, Biddeford

Maryland

Maryland Consortium for Gerontology in Higher Education (ten affiliates), Anne Arundel
Community College, University of Baltimore, Community Colleges of Baltimore County, UMD—
Baltimore, Baltimore County, College Park, University College, College of Notre Dame,
Salisbury University, Towson University
Montgomery College, Rockville
University of Maryland, Baltimore
University of Maryland, College Park

Massachusetts

American International College, Springfield
Assumption College, Worcester
Boston University, Boston
Brandeis University, Waltham

Holyoke Community College, Holyoke
University of Massachusetts, Boston
University of Massachusetts, Lowell
University of Massachusetts, North Dartmouth

Michigan

Central Michigan University, Mt. Pleasant
Eastern Michigan University, Ypsilanti
Grand Rapids Community College, Grand Rapids
Michigan State University, East Lansing
Northern Michigan University, Marquette
Wayne State University, Detroit
Western Michigan University, Kalamazoo

Minnesota

Bethel College, St. Paul
College of St. Scholastica, Duluth
Luther Theological Seminary, St. Paul
Minnesota State University, Mankato
St. Cloud State University, St. Cloud
St. Mary's University of Minnesota, Minneapolis
University of Minnesota, Minneapolis
White Earth Tribal and Community College, Mahnomon

Mississippi

East Central Community College, Decatur
Mississippi Valley State University, Itta Bena
University of Mississippi, University

Missouri

Avila College, Kansas City
Central Missouri State University, Warrensburg
Madonna University, Livonia
University of Missouri and Lincoln University Consortium, Columbia
Missouri Southern State College, Joplin
Missouri Western State College, St. Joseph
Southwest Missouri State University, Springfield
St. Louis University, St. Louis
University of Missouri, Columbia, Kansas City, Rolla, St. Louis
Webster University, St. Louis

Montana

University of Montana, Missoula

Nebraska

University of Nebraska, Omaha

Nevada

The Fielding Institute, Reno

Peru State College, Peru

University of Nevada, Las Vegas

University of Nevada, Reno

New Jersey

Felician College, Lodi

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

William Paterson College, Wayne

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

Hofstra University, Hempstead

Ithaca College, Ithaca

Keuka College, Keuka Park

Maria College, Albany

Marist College, Poughkeepsie

Molloy College, Rockville Centre

Mount Sinai Medical Center, New York City

Nazareth College, Rochester

Oswego State University, Oswego

Rockland Community College, Suffern

State University of New York, Albany, Buffalo, Cortland

Syracuse University, Syracuse

Touro College, Dix Hills

Utica College of Syracuse University, Utica

Yeshiva University, New York City

North Carolina

Appalachian State University, Boone

Bowman Gray School of Medicine, Winston–Salem

Central Piedmont Community College, Charlotte
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

Ohio

Bowling Green State University, Bowling Green
Case Western Reserve University, Cleveland
Cleveland State University, Cleveland
College of Mount St. Joseph, Cincinnati
Cuyahoga Community College, Cleveland
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
Sinclair Community College, Dayton
University of Akron
University of Findlay, Findlay
Wright State University, Dayton
Youngstown State University, Youngstown

Oklahoma

Langston University, Langston
Oklahoma State University, Stillwater
Southeastern 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 State University, Corvallis

Pennsylvania

California University of Pennsylvania–California

Cedar Crest College, Allentown
Chatham College, Pittsburgh
East Stroudsburg University, East Stroudsburg
Immaculata College, Immaculata
Indiana University of Pennsylvania, Indiana
Kendal Corporation, West Chester
King's College, Wilkes Barre
Lancaster Institute for Health Education, Lancaster
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
Widener University, Chester

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
North Greenville College, Tigerville
University of South Carolina, Columbia
Winthrop University, Rock Hill

South Dakota

Augustana College, Sioux Falls
South Dakota State University, Brookings

Tennessee

Austin Peay State University, Clarkville
Middle Tennessee State University, Murfreesboro
University of Tennessee, Knoxville

Texas

Abilene Christian Academy, Abilene
Baylor University, Waco
Del Mar College, Corpus Christi
Eastfield College, Mesquite
Lee College, Baytown
Texas A&M, Kingsville

University of Houston, Houston
University of North Texas Health Science Center, Ft. Worth
University of North Texas, Denton
University of Texas–Austin, El Paso
University of Texas Health Science Center, Houston
University of Texas Medical Branch, Galveston
University of Texas Southwestern Medical Center, Dallas

Utah

Brigham Young University, Provo
University of Utah, Salt Lake City
Utah State University, Logan

Vermont

University of Vermont, Burlington

Virginia

George Mason University, Fairfax
James Madison University, Harrisonburg
Lynchburg College, Lynchburg
Radford University, Radford
Virginia Commonwealth University, Richmond
Virginia Polytechnic Institute and State University, Blacksburg

Washington, DC

AARP Foundation
Howard University
National Committee to Preserve Social Security and Medicare
University of the District of Columbia

Washington State

Gonzaga University, Spokane
Spokane Falls Community College, Spokane
University of Washington, Seattle

West Virginia

Mountain State University, Beckley
West Virginia State College, Institute
West Virginia University, Morgantown
Wheeling Jesuit University, Wheeling

Wisconsin

Concordia University of Wisconsin, Mequon
Mount Mary College, Milwaukee
University of Wisconsin, LaCrosse; Madison; Menomonie, Milwaukee

Alberta, Canada

Education Resource Center for Continuing Care, Calgary

Mount Royal College, Calgary

Manitoba, Canada

University of Manitoba, Winnipeg

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/PrimePlus services.

AICPA Training Courses

The AICPA ElderCare/PrimePlus 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/PrimePlus Services practitioner. Five seminar courses (also available in self-study) are currently available to meet your training needs.

- *Developing and Managing an ElderCare/PrimePlus Practice* (product number 730073). 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/PrimePlus Services.
- *ElderCare/PrimePlus: The Medical and Psychosocial Effects of Aging* (product number 731461). 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.
- *ElderCare/PrimePlus: The Financial Issues of Aging* (product number 731781). This course addresses the planning needs and financial concerns of aging, including planning for the costs of long-term care.
- *ElderCare/PrimePlus: 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/PrimePlus practitioner.

In addition, you can gain valuable training from the following highly recommended courses:

- *Professional Ethics: The AICPA's Comprehensive Course* (product number 732305). 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.

- *Tax, Health Care and Asset Protection Planning for Aging Clients* (product number 732077). 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/PrimePlus Marketing Toolkit

The AICPA contracted with the advertising firm of Hill, Holiday, Connors & Cosmopoulos to develop an ElderCare/PrimePlus Marketing Toolkit for practitioners offering CPA ElderCare/PrimePlus services or for those who wish to develop a practice in this area. The AICPA ElderCare/PrimePlus Services Task Force oversaw the development of this kit. The advertising kit contains two direct mail letters, four brochures, and 16 advertisements suitable for your local market. Letters are targeted directly to the older person 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/PrimePlus Services—2002 (product number 006634)

Serving as both an update on new developments as well as an introduction to those unfamiliar with CPA ElderCare/PrimePlus services, this Alert contains an abundant amount of information, a list of helpful Web sites and a listing of ElderCare/PrimePlus 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/PrimePlus 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 order through their Web site.

National Association of Professional Geriatric Care Managers
 1604 North Country Club Road
 Tucson, AZ 85716-3102
 Phone: (520) 881-8008
 Fax: (520) 325-7925

E-mail: info@caremanager.org
 Web site: <http://www.caremanager.org/>

How to Protect Your Life Savings from Catastrophic Illness(4th e.d, 1997)

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 older 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
 Phone: (520) 881-4005
 Fax (520) 325-7925
 Web site: <http://www.naela.org/>

AICPA ELDERCARE/PRIMEPLUS SERVICES TASK FORCE MEMBERS

The ElderCare/PrimePlus Services Task Force welcomes your comments and questions about the emerging practice area of CPA ElderCare/PrimePlus services. The following table provides contact information.

Name	Address	Phone/Fax/E-mail
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Kimberly Smith Australian Liaison	Kimberly Smith & Associates P.O. Box 106 104 Auburn Road Hawthorn, Victoria, 3122 Australia	Phone: (613) 9818-8166 Fax: (613) 9818-8144 E-mail: advice@kimberlysmith.com.au Domain: http://www.kimberlysmith.com.au

A collection of military medals and a pair of glasses on a wooden surface. The medals include a red ribbon with a circular emblem, a blue ribbon with a circular emblem, and a white star-shaped medal with a central emblem. A pair of gold-rimmed glasses is also visible. The background is a light-colored wooden surface.

CPA ElderCare/PrimePlus Services

A Multidisciplinary Approach to
the Needs of
Older Adults and Families

*Provided Exclusively by
Certified Public Accountants*

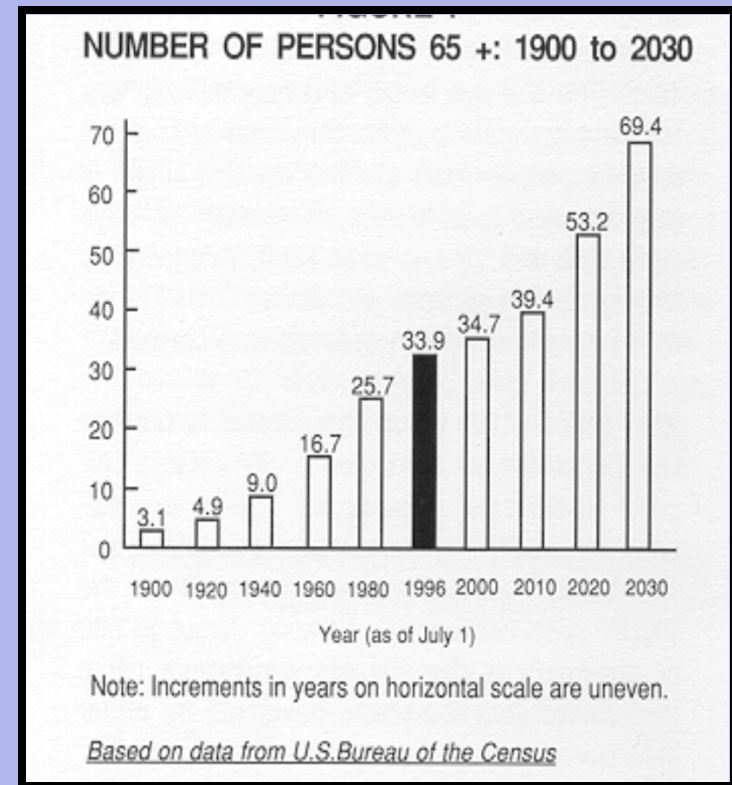
Insert Firm Name Here

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SERVICES
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CPA ElderCare/PrimePlus Services: Why Now?

- ◆ America is aging—fast!
 - By the year 2010, approximately 40 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





The Need for Our Services

- ◆ CPA ElderCare/PrimePlus 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

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SERVICES
Resources • Strategies • Solutions

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



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.



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

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SERVICES
Resources • Strategies • Solutions



Types of Services Available

- ◆ Consulting Services
- ◆ Direct Services
- ◆ Assurance 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
 - Communication of expectations to care providers



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



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



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.



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



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, and provide time-saving considerations
- ◆ Provide assurance that specific goals are being met



CPA ElderCare/PrimePlus 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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