Hauptman & Hauptman, PC

GUIDING FAMILIES THROUGH LIFE'S TRANSITIONS

Elder, Estate, & Special Needs Law

The Consumer's Guide To Starting Rehabilitation In A Nursing Home

INCLUDING:

- **How to choose a rehabilitation center?**
- **Who pays for rehabilitation?**
- **What happens when my family member comes home from rehabilitation?**

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Introduction

A family member is being discharged for rehabilitation in a Nursing Home. You have entered an unfamiliar area and you want to do what is best for your loved one. But it is just such a difficult decision you have to make and so stressful.

Some of the questions you maybe are asking yourself:

- How should I choose between nursing homes?
- What is the nursing home admission process like?
- Who pays for rehabilitation at the nursing home?
- What happens when Medicare stops paying for rehab?
- What should we expect during rehab?
- What happens if my loved one goes home after completing rehab?

In times like these, it is important that you pause, take a deep breath and understand there are things you can do that can make the experience a little easier. Good information is available and you can make the right choices for your loved one.

This booklet is designed to help provide you with information and answers to the questions that we, as elder law attorneys, answer for our clients on a daily basis.

This guide is brought to you as a service of

Hauptman & Hauptman, PC
Yale S. Hauptman, Esq.
Laurie A. Hauptman, Esq.
354 Eisenhower Parkway, Plaza I, 2nd Floor
Livingston, NJ 07039
(973) 994-2287
Website: www.HauptmanLaw.com
E-Mail: Yale@HauptmanLaw.com
Laurie@HauptmanLaw.com

Selecting A Nursing Home For Rehabilitation

How should I choose between nursing homes?

When someone is faced with the overwhelming task of finding a nursing home for rehabilitation for a loved one, the question often asked is "Where do I begin?" Although this is a job that no one wants, it can be done with the forethought and confidence that the best decision will be made.

Look for a nursing home that has an available rehab bed, is convenient to you and has a good care ranking. Some facilities specialize in rehabbing certain conditions so ask if they have such a specialty or concentration. Find the facility's online care rankings at www.Medicare.gov along with tips about what to look for in nursing homes. Ask for recommendations from others who've had similar experiences.

If your loved one might not be able to return home after rehab finishes, ask the facility whether he or she can stay at the nursing home for long-term care (which is different than rehab). Some nursing homes may accept a resident for rehab, but then require the resident to leave after rehab stops because they have no long-term beds available.

If there is the possibility or probability of needing Medicaid, ask whether the facility will have available Medicaid beds after rehab is completed, or how long to expect to wait for one.

If your loved one has Alzheimer's and wanders, look for a nursing home with a secure unit or a wander-alarm system.

You will have to make this decision quickly, under time pressure. And your preferred nursing home (s) may be full so you should consider more than one or two facilities. Start looking at nursing homes right away!

Get ready to tour the facilities you have chosen.

Don't schedule your tours, just show up during regular business hours. You will be able to meet with the administrative staff who will answer all your questions. You will want to tour a second time in the evening or on the weekend just to see if there is a drastic difference in the atmosphere of the facility or the care being provided. It is important to tour at least two facilities so you can see the difference in the physical layout and the staff.

When you are touring, pay attention to your gut feeling. Ask yourself the following questions…. Did I feel welcome? How long did I have to wait to meet with someone? Did the admission director find out my family member's wants and needs? Was the facility clean? Were there any strong odors? Was the staff friendly? Did they seem to generally care for the resident? Did the staff seem to get along with each other? Listen and observe. You can learn so much just by watching and paying attention.

When touring a facility, ask any questions that come to mind. There are no "dumb" questions. Here are a few examples of questions you will want to ask to make sure that the administration of the facility is giving proactive care instead of reacting to crisis.

- How do you ensure that call lights are answered promptly regardless of your staffing?
- If someone is unable to move or turn him or herself, how do you ensure that they are turned and do not develop bedsores?
- How do you make sure that someone is assisted with the activities of daily living like dressing, toileting and transferring?
- Can residents bring in their own supplies?
- Can residents use any pharmacy they choose?
- How many direct care staff members do you have on each shift? Does this number exceed the minimal number that state regulations say you have to have or do you just meet the minimum standard?
- What payer sources do you accept?
- How long has the medical director been with your facility?
- How were your last state survey results? (Ask to see a copy)
- How did you correct these deficiencies and what processes did you put in place to make sure you do not make these mistakes again?

- Has the state prohibited this facility from accepting new residents at any time during the last 2 years?
- Do you have references I can talk with?

Attached is a form you can use when touring facilities. This will help you keep track of which facility you liked best and those you did not care for.

Nursing home evaluation

As you visit nursing homes, use the following form for each place you visit. Don't expect every nursing home to score well on every question. The presence or absence of any of these items does not automatically mean a facility is good or bad. Each has its own strengths and weaknesses. Simply consider what is most important to your loved one and you.

Record your observations for each question by circling a number from one to five. (If a question is unimportant to you or doesn't apply to your loved one, leave the evaluation area for that question blank.) Then total all the numbers you circled.

Also, contact the state Department of Health and Senior Services for information about the nursing home. You can find a report card for each facility at www.nj.gov/health/healthfacilities/index.shtml. Also, get a copy of the facility's state inspection report for the nursing home from the agency that licenses (or certifies) nursing homes or the Ombudsman. You are able to view nursing home comparisons by visiting www.medicare.gov/NHCompare.

Nursing Home Evaluation Form

Name of Nursing Home:_____

Date Visited:_____

	Poor=Excellent 1= = = = = = 5
The Buildings and Surrounding	
What is your first impression of the facility?	1 2 3 4 5
What is the condition of the facility's exterior (paint, gutters and trim)?	1 2 3 4 5
Are the grounds pleasant and well kept?	1 2 3 4 5
Do you like the view from resident's rooms and other windows?	1 2 3 4 5
Do residents with Alzheimer's disease live in a separate Alzheimer's unit?	1 2 3 4 5
Does the nursing home provide a secure outdoor area?	1 2 3 4 5
Is there a secure area where a resident with Alzheimer's disease can safely wander on walking paths?	1 2 3 4 5
Are there appropriate areas for physical therapy and other occupational therapy?	1 2 3 4 5
Is there a well-ventilated room for smokers?	1 2 3 4 5
Are facilities for barber or beauty salon services available?	1 2 3 4 5
What is your impression of general cleanliness throughout the facility?	1 2 3 4 5
Does the facility smell clean?	1 2 3 4 5
Is there enough space in resident rooms and common areas for the number of residents?	1 2 3 4 5
How noisy are hallways and common areas?	1 2 3 4 5

Is the dining area clean and pleasant?	1 2 3 4 5
Is there room at and between tables for both residents and aides for those who need assistance with meals?	1 2 3 4 5
Are common areas like lounges and activity rooms in use?	1 2 3 4 5
Are residents allowed to bring pieces of furniture and other personal items to decorate their rooms?	1 2 3 4 5

The Staff, Policies and Practices

Does the administrator know residents by name and speak to them in a pleasant, friendly way?	1 2 3 4 5
Do staff and residents communicate with cheerful, respectful attitudes?	1 2 3 4 5
Do staff and administration seem to work well with each other in a spirit of cooperation?	1 2 3 4 5
Do residents get permanent assignment of staff?	1 2 3 4 5
Do nursing assistants participate in the resident's care planning process?	1 2 3 4 5
How good is the nursing home's record for employee retention?	1 2 3 4 5
Does the state ombudsman visit the nursing home on a regular basis?	1 2 3 4 5
How likely is an increase in private pay rates?	1 2 3 4 5
Are there any additional charges not included in the daily or monthly rate?	1 2 3 4 5

Residents' Concerns

What method is used in selecting roommates?	1 2 3 4 5
What is a typical day like?	1 2 3 4 5
Can residents choose what time to go to bed and wake up?	1 2 3 4 5
Are meaningful activities available that are appropriate for resident participation?	1 2 3 4 5

If activities are in progress, what is the level of resident participation?	1 2 3 4 5
Can residents continue to participate in interests like gardening or have contact with pets?	1 2 3 4 5
Does the nursing home provide transportation for community outings and activities?	1 2 3 4 5
Is a van or bus with wheel chair access available?	1 2 3 4 5
Do residents on Medicaid get mental health services or occupational, speech or physical therapies if needed?	1 2 3 4 5
What is your impression of the general cleanliness and grooming of residents?	1 2 3 4 5
How are decisions about method and frequency of bathing made?	1 2 3 4 5
How do residents get their clothes laundered?	1 2 3 4 5
What happens when clothing or other items are missing?	1 2 3 4 5
Are meals appetizing and served promptly at mealtime?	1 2 3 4 5
Are snacks available between meals?	1 2 3 4 5
If residents call out for help or use a call light do they get prompt, appropriate responses?	1 2 3 4 5
Does each resident have the same nursing assistant(s) most of the time?	1 2 3 4 5
How does a resident voice a complaint if there is a problem?	1 2 3 4 5
Do residents participate in care plan meetings when they are able to?	1 2 3 4 5
Does the nursing home have an effective resident council?	1 2 3 4 5

Family Considerations

How convenient is the nursing home's location to family members who may want to visit the resident?	1 2 3 4 5

Are there areas other than the resident's room were family members can visit?	1 2 3 4 5
Does the facility have safe, well-lighted, convenient parking?	1 2 3 4 5
Are hotels/motels nearby for out-of-town family members?	1 2 3 4 5
Are area restaurants suitable for taking residents out for a meal with family members?	1 2 3 4 5
How convenient will care planning conferences be for interested family members?	1 2 3 4 5
Is an effective family council in place?	1 2 3 4 5
Can family/staff meetings be scheduled to discuss and work out any problems that may arise?	1 2 3 4 5

Total Score:_____

Rehabilitation In A Nursing Home

What is the nursing home admission process like?

You will need to sign a contract and other forms that should be read and understood before signing.

For the admission conference at the nursing home, bring your insurance cards, Social Security card, Medicare card, Financial Power of Attorney, Health Care Power of Attorney, Living Will, HIPAA Medical Privacy Release, and Long-Term Care Insurance policy. The nursing home can make copies of those documents for you.

Know who to list on the "face sheet" that is required by HIPAA to give staff permission to talk with family and others.

Some practical things you want to be sure to do…. mark *every* piece of clothing with a permanent laundry marker. When a facility is washing clothes for 120 people, it is common for items to occasionally end up in the wrong room, however you can help ensure getting the item back if it is properly marked. If you are going to do your loved one's laundry yourself, post a sign on the closet door to notify staff and provide a laundry bag where dirty clothes can be placed. Also, bring in familiar items for the resident so that there is a feeling of home. However, realize that space is limited, especially in a semi-private room.

A very important point to remember is that the staff members of the facility are meeting your loved one for the first time. They do not know his or her likes or dislikes, or those little nuances that make providing care go more smoothly. The best way you can help your loved one is to tell the staff, in writing, as much information as possible about your loved one…his/her likes and dislikes, typical daily schedule, pet peeves, and so on.

It is important that you get to know the people who are caring for your loved one. Most importantly, stay involved. Let everyone know how much you care and how committed you are to your loved one's care. Also understand you will not help your loved one by becoming anxious or emotional. Assure

them that although this is not an ideal situation, you will be there to assist them in making it as pleasurable as possible.

What should we expect during rehabilitation?

Don't bring personal equipment such as a walker and wheelchair unless the facility requests it. Mark it with the resident's name.

Clothing: Bring at least a week's worth of clothing to the facility for the resident to wear that is modest but comfortable to move around in for therapy, and easy to put on and take off. Have either non-skid shoes or gripper socks.

Doctor visits during rehabilitation won't happen daily as in the hospital. Expect monthly doctor visits unless the resident is very sick.

Tell the facility if you worry about your loved one falling. Facilities are not allowed to restrain residents but they have ways to reduce the risk, such as lower beds, mats and therapy.

Be sure to COMMUNICATE with the primary care staff (CNAs, med-techs and nurses) and with administration. The facility can respond only if you tell them you have concerns or are not happy. Find out their ways of documenting any concerns in writing, and keep a record of issues and resolution.

Every facility posts a notice of the Bill of Rights for Nursing Home Residents. It includes the phone number for the local long-term care ombudsman who can investigate concerns and complaints.

Who pays for rehab at the nursing home?

Medicare Part A (hospital insurance) pays for rehabilitation in a skilled nursing facility (SNF) for a limited time under certain conditions.

To be eligible for these benefits in a SNF, you must meet these conditions:

- You have traditional Medicare Part A and have days left in your benefit *period*. The benefit period for SNF rehab is 100 days at most. But you can get a new benefit period (and another 100 days of

coverage) if you haven't received any inpatient hospital care or skilled care in a SNF for 60 days in a row.

- You must have a *qualifying hospital stay*. You must have been admitted as an inpatient at the hospital for at least 3 days. Also, you must enter the SNF soon afterward, generally within 30 days; otherwise you would need another qualifying hospital stay to start SNF benefits.
- You're getting skilled services, such as physical and occupational therapy, IV therapy, wound care, etc.
- During SNF rehabilitation, it you're eligible for Medicare you will pay:
- Days 1-20: You pay $0 for each benefit period. Medicare pays all costs for up to 20 days.
- Days 21- 100: You pay $170.50/day in 2019 as Medicare coinsurance. But this daily coinsurance is paid by many supplemental insurance policies (sometimes called Medigap policies). So you MIGHT be covered for 100 days. Check your supplemental policy to confirm whether it covers SNF rehabilitation.
- Days 101 and beyond: You pay all costs at the nursing home.
- **If rehab** stops, **Medicare stops**… Even *before* the 20 day and 100 days mentioned above! And when Medicare stops the insurance stops too. You will get written notice that Medicare is stopping, and you may want to exercise appeal rights described in that written notice.

These benefits are for traditional Medicare Part A. <u>If you have a Medicare HMO or Medicare Advantage your SNF coverage for rehab will be different!</u> Ask whether the nursing home accepts your plan, and how much you will have to pay from your own funds. DO NOT PRESUME that you'll have 20 days of coverage paid for. For example, some Medicare Advantage plans require you to pay $100/day immediately, starting on the very first day.

A rehab resident who refuses daily skilled care or therapy can lose Medicare SNF coverage. Loved ones with dementia often need extra encouragement from family to continue therapy.

If you leave a SNF to be readmitted to the hospital the nursing home is not required to have a bed waiting for you when your return again. You can however pay the SNF to hold the bed for you based on its bed-hold policy.

TRICARE benefits for retired military personnel can pay for SNF care beyond Medicare's 100 day limit, as long as the resident continues to require SNF services and does not have other health insurance.

What happens when Medicare stops paying for rehab?

Medicare and supplemental insurance stops when you stop rehabilitating or when the Medicare days are fully used. To remain at the nursing home you must find another way to pay for it. Otherwise you must leave the nursing home.

Besides Medicare, the other main ways to pay for nursing home care are: private pay (paying out of your own pocket as long as you can); long-term care insurance (if you have it); VA benefits (limited); and Medicaid (which has asset limits).

EXAMPLE: Mary is in the nursing home for rehab and her SNF Medicare benefit has stopped. Her husband Bob knows she needs continued nursing home care, because she needs more care than he can give at home. But Bob worries about running out of money if he has to pay nursing home bills of over $10,000 each month. The solution for Bob and Mary: With the right guidance, Bob can protect their home and nearly all of their assets while getting Mary the care she needs…. even if she survives him. He needs to talk with an elder law attorney to get a good result.

What happens if my loved one goes home after completing rehabilitation?

Medicare has limited benefits for care at home. For example, Medicare may pay briefly for limited therapy at home. However, Medicare does not cover custodial care at home.

Care at home is generally administered either by a family member, or by a home-care service. You can get more information about home care services at www.medicare.gov/coverage/home-health-services.html

How To Pay For Nursing Home Care Without Going Broke

What happens if my loved one can't go home after completing rehabilitation?

One of the biggest concerns people have about nursing home care is how to pay for that care.

There are basically five ways that you can pay the cost of a nursing home:

1. **Long-Term Care Insurance** - If you are fortunate enough to have this type of coverage, it may go a long way toward paying the cost of the nursing home. Unfortunately, there have been many changes in the long-term care insurance industry in the last few years and most people facing a nursing home stay do not have this coverage.

2. **Pay with Your Own Funds** - This is the method many people are required to use at first. Quite simply, it means paying for the cost of a nursing home out of your own pocket. Unfortunately, with nursing home bills averaging approximately $13,000 per month or more in our area, few people can afford a long-term stay in a nursing home.

3. **Veterans Administration** – The United States Department of Veterans Affairs operates over 100 nursing facilities. Nursing home care is provided without cost to veterans with service-connected disabilities. For other veterans there are eligibility factors, including an income limit. There are three homes for veterans and their families in New Jersey. Eligibility requirements vary for veterans, their spouses and parents.

4. **Medicare** - This is the national health insurance program primarily for people 65 years of age and older, certain younger disabled people, and people with kidney failure. Medicare provides short term assistance with nursing home costs, but only if you meet the strict qualification rules.

5. **Medicaid** - This is a federal and state funded and state administered medical benefit program which can pay for the cost of the nursing home if certain asset and income tests are met.

Since the first two methods of private pay (i.e. using your own funds and long-term care insurance) are self-explanatory and the third method is only available to a small segment of the population, our discussion will concentrate on Medicare and Medicaid.

What about Medicare?

There is a great deal of confusion about Medicare and Medicaid.

As discussed before, Medicare is the federally funded and state administered health insurance program primarily designed for older individuals (i.e. those over age 65). There are some limited long-term care benefits that can be available under Medicare. In general, if you are enrolled in the traditional Medicare plan, and you've had a hospital stay of at least three days, and then you are admitted into a skilled nursing facility (often for rehabilitation or skilled nursing care), Medicare may pay **for a while**. (If you are a Medicare Managed Care Plan beneficiary, a three-day hospital stay may not be required to qualify.) If you qualify, traditional Medicare **may** pay the full cost of the nursing home stay for the first 20 days and **can** continue to pay the cost of the nursing home stay for the *next* 80 days, but with a deductible that's $170.50 (in 2019) per day. Some Medicare supplemental insurance policies will pay the cost of that deductible. For Medicare Managed Care Plan enrollees, there is no deductible for days 21 through 100, as long as the strict qualifying rules continue to be met. So, in the best-case scenario, the traditional Medicare or the Medicare Managed Care Plan may pay up to 100 days for each "spell of illness." In order to qualify for this 100 days of coverage, however, the nursing home resident must be receiving daily "skilled care" and generally must continue to "improve." (Note: Once the Medicare and Managed Care beneficiary has not received a Medicare covered level of care for 60 consecutive days, the beneficiary may again be eligible for the 100 days of skilled nursing coverage for the next spell of illness.)

While it's never possible to predict at the outset how long Medicare will cover the rehabilitation, from our experience, it usually falls far short of the

100 day maximum. Even if Medicare does cover the 100 day period, what then? What happens after the 100 days of coverage have been used?

At that point, in either case you're back to one of the other alternatives...long-term care insurance, paying the bills with your own assets, or qualifying for Medicaid.

What is Medicaid?

Medicaid is a benefits program which is primarily funded by the federal government and administered by each state. This means that the Medicaid rules can, and do, vary from state to state. The information in this guide deals only with New Jersey's Medicaid program.

One primary benefit of Medicaid is that, unlike Medicare (which only pays for skilled nursing), the Medicaid program will pay for long-term care in a nursing home once you've qualified. Medicare does not pay for treatment for all diseases or conditions. For example, a long-term stay in a nursing home may be caused by Alzheimer's or Parkinson's disease, and even though the patient receives medical care, the treatment will not be paid for by Medicare. These stays are called custodial nursing stays. Medicare does not pay for custodial nursing home stays. In that instance, you'll either have to pay privately (i.e. use long-term care insurance or your own funds), or you'll have to qualify for Medicaid.

New Jersey's Medicaid program

New Jersey's Medicaid program pays for nursing home level care in a nursing home, assisted living or the applicant's own home (although only in a nursing home will it pay for 100% of the care that is needed).

Applicants must have no more than $2,000 in assets. There is an income limitation as well ($2,313 per month in 2019), although applicants with income greater than the income cap can qualify by placing excess income into a qualified income trust (Miller trust).

Why plan for Medicaid?

As life expectancies and long-term care costs continue to rise, the challenge quickly becomes how to pay for these services. Many people cannot afford to pay $13,000 per month or more for the cost of a nursing home, and those who can pay for a little while may find their life savings wiped out in a matter of months, rather than years.

Fortunately, the Medicaid program is there to help. In fact, in our lifetime, Medicaid has become the long-term care insurance of the middle class. But the eligibility to receive Medicaid benefits requires that you pass certain tests on the amount of income and assets that you have. The reasons for Medicaid planning are simple. First, you need to provide enough assets for the security of your loved ones -- they too may have a similar crisis. Second, the rules are extremely complicated and confusing. Not only that, but Medicaid rules are constantly changing, and you need to be correctly informed. Without planning and advice, many people **spend more than they should** and their family security is jeopardized.

Exempt assets and countable assets: What can you keep and what is at risk?

To qualify for Medicaid, applicants must pass some fairly strict tests on the amount of assets they can keep. To understand how Medicaid works, we first need to review what are known as *exempt (non-countable)* and *non-exempt* (countable) *assets.*

Exempt assets are those which Medicaid will not take into account (at least for the time being). In general, the following are the primary exempt assets:

- **Home**, For a single person, home equity must be less than $878,000 (in 2019). The home must be the principal place of residence. The nursing home resident may be required to show some "intent to return home" even if this never actually takes place.
- **$2,000 cash** or other countable asset.
- **Personal belongings and household goods**.

- **One car** is totally excluded if necessary for employment or as a means of transportation for medical treatment.
- **Medical devices**, wheelchairs, prosthetic devices and similar equipment unless others in the household use them as well.
- **Burial spaces** and certain related items for applicant and spouse. Up to $1,500 designated as a burial fund for applicant and spouse.
- **Irrevocable prepaid funeral contract**.
- **Cash value of life insurance** if face value is $1,500 or less.

All other assets are generally ***non-exempt***, and are countable. Basically, all money and property, and any item that can be valued and turned into cash, is a *countable asset* unless it is one of those assets listed above as exempt. This includes:

- Cash, savings, and checking accounts, credit union share and draft accounts.
- Certificates of Deposit.
- U.S. Savings Bonds.
- Individual Retirement Accounts (IRA), Keogh plans (401K, 403B).
- Trusts (depending on the terms of the trust).
- Real estate (other than the residence).
- More than one car.

While the Medicaid rules themselves are complicated and tricky, it's safe to say that a single person will qualify for Medicaid as long as he/she has only exempt assets plus a small amount of cash and/or money in the bank, up to $2,000.

Some Common Questions

I've added my kids' names to our bank account. Do they still count?

Yes. The entire amount is counted unless you can prove some or all of the money was contributed by the other person who is on the account.

Can't I just give my assets away?

Many people wonder, can't I give my assets away? The answer is, generally, No. The law has severe penalties for people who simply give away their assets to create Medicaid eligibility. So even though the Federal Gift Tax laws allow you to give away up to $15,000 (in 2019) per year without gift tax consequences, those gifts could result in a period of ineligibility for Medicaid.

Though some families do spend virtually all of their savings on nursing home care, Medicaid often does not require it. There are a number of strategies which can be used to protect family financial security.

Should I prepay my funeral?

Generally, yes. We all know that we will pass away eventually. A person on Medicaid can only have $2,000 in countable assets. Certainly, this is not enough to pay for an average funeral. It is usually best to pay for the funeral in advance. It converts countable assets to non-countable assets. But when you prepay your funeral it can make a difference. For a married couple it is usually best to wait until after the person enters the nursing home. This is when, from a Medicaid planning perspective, the couple will get the most benefit in preserving family assets.

Medicaid planning for married couples

There is more flexibility in Medicaid planning for married couples, as opposed to planning for a single person. The Medicaid law, in effect, recognizes that it makes little sense to impoverish both spouses when only one needs to qualify for Medicaid assistance for nursing home care.

As a result of this recognition, the law allows the spouse at home (called the "Community Spouse") to keep a certain amount of countable assets in his/her own name, so as to avoid being impoverished in the community. This amount is called the Community Spouse Resource Allowance (CSRA). Currently, the CSRA is $126,420 (for 2019). Remember, the nursing home spouse is allowed to keep up to $2,000 in his/her own name.

Each state also establishes a monthly income floor for the at-home spouse. This is called the Minimum Monthly Maintenance Needs Allowance. This permits the community spouse to keep a minimum monthly income ranging from about $2,057.5 to $3,160.5 (for 2019).

If the community spouse does not have at least $2,057.5 (in 2019) in income, then he or she is allowed to take the income of the nursing home spouse in an amount large enough to reach the Minimum Monthly Maintenance Needs Allowance (i.e., up to at least $2,057). The nursing home spouse's remaining income goes to the nursing home. This avoids the necessity (hopefully) for the at-home spouse to dip into savings each month, which would result in gradual impoverishment.

To illustrate, assume the at-home spouse receives $800 per month in Social Security. Also assume that her needs are calculated to be the minimum of $2,057. With her Social Security, she is $1,257 short each month.

$2,057	at-home spouse's monthly needs (as determined by formula)
$800	at-home spouse's Social Security
$1,257	shortfall

In this case, the community spouse will receive $1,257 (the shortfall amount) per month from the nursing home spouse's Social Security and the rest of the nursing home spouse's income will then go to pay for the cost of his care.

This does not mean, however, that there are no planning alternatives which the couple can pursue. Consider the following case studies:

Case Study: Medicaid planning for married people

Navigating through the long-term care system usually requires a team of advisors. Although the elder law attorney is, no doubt, a pivotal person, the accountant, financial advisor, and insurance specialist are equally important. When one piece isn't properly in place, it can be catastrophic. Betty's story is illustrative.

Betty and Tom decided to sell their home in which they raised their four children. They invested the majority of the proceeds in annuities and decided to rent and live on the income from their investments and Social Security. Tom, however, had already exhibited some signs of dementia.

After the sale of their home, Tom's condition deteriorated rapidly. He became restless and, at times, physical with Betty, who weighed a hundred pounds less than Tom. She could no longer keep him at home. Betty came to us for help, thinking she could get Tom on Medicaid in a nursing home. She didn't realize that the $300,000 she invested in annuities was now a countable asset and would have to be spent down to $128,420($126,420 community spouse and $2,000 Medicaid recipient) before Tom could get Medicaid.

Betty was distraught. "I am only sixty-five. How can I live on $100,000?" she asked me. I told her not to worry. She could cash in the annuities, buy another home with that money, and keep it as an exempt asset. After Tom qualifies for Medicaid, she could then resell the home if she wanted, to reinvest for income again.

Then we examined the annuities. That's when I discovered the surrender charges of 7% that Betty would have to pay. Although there was a provision that waived the charges if the owner needed to cash them in for long-term care expenses, the problem was that Betty, and not Tom, was the owner. Betty told me that Tom had definitely been diagnosed with dementia at the time that these decisions were made, but couldn't recall any conversations about long-term care or how to provide for it. Big mistake!

We were able to help Betty get Tom into a quality nursing home. She privately paid for seven months, cashed in the annuities, paid a surrender

charge, and bought a home. We helped Betty preserve the majority of their savings-money she will need to provide for her own care down the road. But, there are lessons to be learned here.

The result could have been so much better had Betty come to us before she sold her home and before she bought the annuities. We might have suggested that she wait until Tom entered the nursing home before selling her home. We also would have cautioned Betty about purchasing investments that couldn't easily be liquidated if a large expense (i.e., nursing home care) became necessary. No one thought to ask what would happen if Tom needed care sooner rather than later. And that's why having a team of advisors working together is so important. All tax, financial, and legal aspects of any decision should be analyzed carefully, and that's more than any one advisor is capable of doing.

Case Study: A trust for a disabled child

Margaret and Sam have always taken care of their daughter, Elizabeth. She is 45, has never worked, and has never left home. She is "developmentally disabled" and receives SSI (Supplemental Security Income). Margaret and Sam have always worried about who would take care of her after they die. Some years ago, Sam was diagnosed with dementia. His health has deteriorated to the point that Margaret can no longer take care of him. Now she has placed Sam in a nursing home and is paying $12,000 per month out of savings. Margaret is even more worried that there will be no money left for Elizabeth's care.

Margaret is satisfied with the nursing home Sam is in. The facility has a Medicaid bed available that Sam could have if he were eligible. Medicaid would pay his bill. However, according to the information she got from the social worker, Sam is $100,000 away from Medicaid eligibility. Margaret wishes there was a way to save the $100,000 for Elizabeth after she and Sam are gone. There is.

Margaret can consult an elder law attorney to set up a *"special needs trust"* with the $100,000 to provide for Elizabeth. As soon as she does, Sam will be eligible for Medicaid. Elizabeth won't lose her benefits, and her security is assured.

Of course, all trusts must be reviewed for compliance with Medicaid rules. Also, failure to report assets is fraud, and when discovered, will cause loss of eligibility and repayment of benefits. Still, some people question making gifts before entering a nursing home.

I heard I can give away $15,000 per year. Can I?

As discussed earlier, many people have heard of the federal gift tax provision that allows them to give away $15,000 per year without paying any gift taxes. What they do not know is that this refers to a gift tax exemption. It is not an absolute right. Having heard of the exemption, they wonder, **"Can't I give my assets away?"** The answer is, maybe, but only if it's done within the strict allowances of the law.

So even though the federal gift tax law allows you to give away up to $15,000 per year without incurring tax, those gifts could result in a period of ineligibility for months. Still, some parents want to make gifts to their children before their life savings are all gone. Consider the following case study:

Case Study: Financial gifts to children

After her 73 year old husband, Harold, suffers a paralyzing stroke, Mildred and her daughter, Joan, need advice. Dark circles have formed under Mildred's eyes. Her hair is disheveled. Joan holds her hand.

"The doctor says Harold needs long-term care in a nursing home," Mildred says. "I have some money in savings, but not enough. I don't want to lose my house and all our hard-earned money. I don't know what to do."

Joan has heard about Medicaid benefits for nursing homes, but doesn't want her mother left destitute in order for Harold to qualify for them. Joan wants to ensure that her father's medical needs are met, but she also wants to preserve Mildred's assets.

"Can't Mom just give her money to me as a gift?" she asks. "Can't she give away $15,000 a year? I could keep the money for her so she doesn't lose it when Dad applies for Medicaid."

Joan has confused federal gift tax law with the issue of transfers and ***Medicaid eligibility***. A "gift" to a child in this case is actually a transfer, and Medicaid has very specific rules about transfers.

At the time Harold applies for Medicaid, the state will "look back" five years to see if any gifts have been made. The state won't let you just give away your money or your property to qualify for Medicaid. Any gifts or ***transfers for less than fair market value*** that are uncovered in the look-back period will cause a delay in Harold's eligibility for Medicaid.

For example, a $15,000 gift during each of the five years prior to a Medicaid application creates a 7.17 month period of ineligibility. Since the Deficit Reduction Act was signed into law on February 8, 2006, this penalty period will not begin until the later of 1) Harold is in a nursing home, 2) he is under the asset and income requirements, and 3) he applied for Medicaid. At that point, Medicaid will not pay for Harold's nursing home care through the 7.17 month penalty period.

So what can Harold and Mildred do? They can institute a plan, save a good portion of their estate, and still qualify for Medicaid. The plan may involve transfers of money for value received, such as a care contract, and it may involve gifts. However, as we stated above, the gifts must not violate the federal law or the Medicaid rules. Generally, if done properly, you can often save as much as one half of your assets or more this way.

But remember, when it's given away, it's given away. Studies have shown that "windfall" money received by gift, prize, or lawsuit settlement is often gone within three years. In other words, even when the children promise that money will be available when needed, their own "emergencies" may make them spend the money. You must consult a knowledgeable advisor on how to set a plan that complies with the law and achieves your goals.

Will I lose my home?

Many people who apply for medical assistance benefits to pay for nursing home care ask this question. For many, the home constitutes much or most of their life savings. Often, it's the only asset that a person has to pass on to his or her children.

Under the Medicaid regulations, the home is an unavailable asset. This means that it is not taken into account when calculating eligibility for Medicaid. However, in 2006 the rules changed. Now, for a single person, equity in the home cannot exceed $878,000 (in 2019) in New Jersey. If equity is above this amount, it must be reduced before the person can qualify for Medicaid. Once a person qualifies for Medicaid owning a home, both single and married person must worry about "estate recovery." The estate recovery law requires states to try to recover the value of Medicaid payments made to nursing home residents.

Estate recovery does not take place until the recipient of the benefits dies. Then, federal law requires that states attempt to recover the benefits paid from the recipient's **"**estate". Generally, the probate estate consists of assets that the deceased person owned in his or her name alone without beneficiary designation. Some believe the federal law permits states to go even further and recover from non-probate assets, including assets owned jointly or payable to a beneficiary.

The net result is that the state can and will file a lien on the home and other property of the Medicaid recipient and also file a claim against the recipient's estate. In some cases, the state may go after real estate or other assets in the hands of children or other third parties.

About two-thirds of the nation's nursing home residents have their costs paid in part by Medicaid. Obviously, the Estate Recovery law affects many families. The asset most frequently caught in the Estate Recovery web is the home of the Medicaid recipient. A nursing home resident can own a home and receive Medicaid benefits without having to sell the home. But upon death, if the home is part of the estate, the state may seek to force the sale of the home in order to reimburse the state for the payments that were made.

Since Medicaid rules are constantly changing, you will need assistance from someone knowledgeable about these rules.

"Secret Dollars":
Vet benefit for long-term care revealed

As elder law attorneys, we have only in recent years learned how to help clients who may need an important VA benefit available to wartime veterans who may be facing substantial medical and care expenses. A veteran who is confined to their home or needs assisted living facility care may qualify for benefits. The Department of Veterans Affairs recently reported that the VA is reaching out to veterans and spouses to alert them to an under used benefit called "Aid and Attendance" (A & A). It has been reported by the VA that tens of thousands of veterans across the country may not be receiving the VA disability benefits they are entitled to. One of the VA's best kept secrets, which is an excellent potential source of funds for long-term care (at home or in an assisted living facility) are veterans benefits for a non-service connected disability. Most VA benefits and pensions are based on a disability, which was incurred during a veteran's wartime service. This particular benefit, A & A, is available to individuals who are disabled due to the issues of old age, such as Alzheimer's, Parkinson's, multiple sclerosis, and other physical disabilities. For those veterans and widow(er)s who are eligible, these benefits can especially be a blessing for the disabled individual who is not yet ready for a nursing home. This benefit can be as high as $2,230.00 per month (in 2019) for a married veteran. This money can potentially be used for home healthcare or assisted living facilities. We were shocked to learn that so many veterans may be missing out on this valuable benefit, which they have a legal right to receive. The benefit is not generally used for the cost of nursing home benefits, although nursing home residents can access the benefits as well.

The pension benefits provided by the Veterans Administration generally fall into two categories: service connected and non-service connected. This article focuses on non-service connected benefits which are available to certain wartime veterans (or their dependents) who are disabled because of a non-service connected condition and who are in financial need due to their recurrent unreimbursed medical expenses. Once the veteran's eligibility requirements are met, a family member may be able to obtain benefits based on his or her status as the veteran's dependent.

There is a specific portion of the pension program, which is of particular importance. This program is "Aid and Attendance" (A & A) and is available

to a veteran who is not only disabled, but has the additional requirement of needing the aid and attendance of another person in order to avoid the hazards of his or her daily environment. What that means in English is that someone needs to help you to prepare meals, to bathe, to dress and to otherwise take care of yourself.

Under this program, a married veteran can receive a maximum of $2,230.00 per month in benefits and a widow or widower can receive up to $1,209.00 as a maximum benefit for A & A for the year 2019. The applicant must be determined to be "permanently and totally disabled". The applicant does not need to be helpless – he/she need only show that he/she is in need of aid and attendance on a regular basis. Someone who is housebound, or in an assisted living facility, and over the age of 65 is presumed by the Veterans Administration to be in need of aid and attendance.

This particular program does have substantial limitations related to the income and assets that are held by the applicant. It is very important to meet with a knowledgeable Veterans Service Officer or an experienced elder law attorney for a pre-filing consultation to determine whether or not you may qualify for this benefit and to review the estate planning work that may be done to assist you in qualifying for this particular benefit. It is very confusing to many individuals how to determine what is the countable income that is measured by the Veterans Administration. It may appear on first blush that anyone who has a countable income in excess of $18,000.00 per year is not eligible for this benefit. However, the countable income for veterans benefits is determined by taking an individual's gross income and subtracting from that all of their recurrent unreimbursed medical expenses to determine a lower income, which is their Income for Veteran Administration purposes. Income for Veteran Administration Purposes (IVAP) is the countable income, which is used to determine whether or not a person qualifies.

In computing the income of the applicant, certain items can be deducted. Specifically, recurrent unreimbursed medical expenses (UMEs) paid by an individual may be used to reduce the applicant's income.

Home attendants or aides are an allowable medical expense deduction, as long as that attendant is providing some medical or nursing services for the disabled person. A family member can be the person proving the services but he/she must be compensated so that the service is counted as an expense.

The cost of an assisted living facility, and even part or all of the cost of an independent living facility, can also be an allowable medical deduction to reduce your gross income to a much lower net countable income that may qualify you for veterans benefits. To file a claim for this benefit, it is wise to seek the involvement of an elder law attorney who is well versed in these benefits, as well as being familiar with estate planning, disability, and Medicaid benefits. That attorney can provide a veteran and the veteran's family with appropriate pre-filing consultations to determine the appropriate steps that must be taken to be able to decide if it would be right to apply for this VA benefit.

Legal assistance

Aging persons and their family members face many unique legal issues. As you can tell from our discussion of the Medicaid program, the legal, financial, and care planning issues facing the prospective nursing home resident and family can be particularly complex. If you or a family member needs nursing home care, it is clear that you need expert legal help. Where can you turn for that help? It is difficult for the consumer to be able to identify lawyers who have the training and experience required to provide expert guidance during this most difficult time.

Generally, nursing home planning and Medicaid planning is an aspect of the services provided by elder law attorneys. Consumers must be cautious in choosing a lawyer and carefully investigate the lawyer's credentials.

How do you find a law office that has the knowledge and experience you need? You may want to start with recommendations from friends who have received professional help with nursing home issues. Whom did they use? Were they satisfied with the services they received? Hospital social workers, Alzheimer and other support groups, accountants, and other financial professionals can also be good sources of recommendations.

In general, a lawyer who devotes a substantial part of his or her practice to nursing home planning should have more knowledge and enough experience to address the issues properly. Don't hesitate to ask the lawyer what percentage of his practice involves nursing home planning. Ask whether the lawyer is a member of any Elder Law planning organizations. Is the lawyer involved

with committees or local or state bar organizations that are concerned with Medicaid regulations and their effect upon payment for nursing home care? Does the lawyer lecture on nursing home planning? This should help you decide if this is the lawyer for you.

The leading national organization of Elder Law attorneys is the **National Academy of Elder Law Attorneys (NAELA)**. While mere membership in the Academy is open to any lawyer and is no sure sign that the attorney is an experienced elder law practitioner, membership does at least show that the lawyer has some interest in the field. In addition, the Academy runs educational sessions twice each year to help lawyers stay current on the latest aspects of elder law and nursing home planning. Attending these sessions takes time and commitment on the part of the lawyer and is a good sign that the lawyer is attempting to stay up to date on nursing home issues. You may want to look for an attorney who is a member of NAELA and has recently attended one or more of its educational sessions.

In the end, follow your instincts and choose an attorney who knows this area of the law. Find someone you can trust, who will listen to you, and who will cater to the unique wants and needs of you and your family.

In conclusion

In the previous pages, we've talked about how to find the right nursing home for rehabilitation, how to receive good care, and how to pay for it without going broke.

As you can see, there are a number of strategies that you can use, if the rehabilitation stay in a nursing home turns into long-term care in a nursing home, to qualify for Medicaid and still preserve some or all of the estate you've spent a lifetime building.
These strategies are legal. They are moral. They are ethical. Please be advised however, to take advantage of these Medicaid planning techniques requires a great deal of knowledge on the ins and outs of the system. Work with an experienced advisor who knows the rules and can advise you accordingly.

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