

The Alzheimer s Legal Survival Guide

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Disclaimer

This monograph is intended to convey information by which you may better understand the legal issues affecting your business and personal life. It is not intended as *personal* legal advice. Personal legal advice may be provided only after an examination of your objectives and of the pertinent facts and law.

Introduction

Lucille and Cindy s Journey:

Lucille and her daughter Cindy are making chocolate cake for a birthday party. As Lucille prepares the batter, she recites the recipe. Cindy heard the recipe recited many times before, but she listened carefully. The cake is a family favorite that Lucille makes from memory. For three generations, the recipe has never been written down, and it will not be written down now.

Lucille paused, I can t remember, dear, she says. Did I put in the eggs?

Cindy noticed egg shells in the sink and recalled the first time she and her mother prepared this recipe together. Yes, she replied, you did. Now, what s the next step?

Lucille s long-term memory helps her recite the recipe, but Cindy realizes that her mother s short-term memory occasionally lapses.

Everett s Journey:

Everett has told no one, but he knows something is wrong, and it bothers him. Yesterday, his son s friend asked him what he used to do for a living. It was a simple question, but Everett could not answer. The words seemed to hide from him. He could not find the ones that would tell the young man that he was a retired mechanical engineer. And this morning, trying as hard as he could, he could not remember his three grandchildren s first names.

Phyllis and George s Journey:

Phyllis answered the telephone at work just after 3 p.m. Her neighbor and longtime friend, Connie, greeted her, then hesitated.

It s George, Connie said. He s been sitting under the tree in my back yard all afternoon.

Phyllis took a deep breath.

I finally went out and walked him home, Connie said. He didn t seem to know me. Is he feeling all right?

A sinking feeling gripped Phyllis stomach. She closed her eyes and sighed.

Early Steps

Everyone forgets things now and then. Momentary lapses are common, often laughed off as senior moments. Incidents like this may simply mean a person is distracted, preoccupied or under stress. But in some cases they may be the first steps in a journey leading to increasing confusion, loss of memory.

These episodes may signal an illness that was once considered a normal part of the aging process. Years ago, people called it senility, hardening of the arteries or organic brain disease. Symptoms may come and go, and they may not be easy to recognize as they unfold. That is especially true because the signs vary widely from one person to another. As time passes, however, the episodes occur more and more often.

While there never seems to be a single event marking the beginning point of the journey, as time passes the victim and his or her family are able to look back and realize that they were traveling together for quite some time. In those cases, episodes of forgetting or becoming disoriented are symptoms of a progressive illness known as dementia. Dementia, the decline of a person s intellectual or emotional level, may have a variety of causes. Some are treatable, some are not. Particular symptoms vary from person to person.

What is Alzheimer s Disease?

Alzheimer s Disease is the most common form of dementia. It affects approximately four million Americans. The disease is characterized by progressive changes in behavior and personality, and may include gradual declines in mental abilities (*e.g.*, thinking, memory, judgment).

The brain is a complex communication system that works by connecting nerve cells. With Alzheimer's Disease, that communication system fails to work properly. While this type of dementia was described by ancient Greeks and Romans, little was known about it until the 20th Century. In 1906, German physician Alois Alzheimer identified the physical characteristics of brain cells that define the disease. Little more knowledge accumulated until the 1980s. During the past 20 years, however, researchers have discovered more about the causes, diagnosis and treatment of the disease. Drugs are being developed to treat symptoms. Even today, however, diagnosis is difficult and often depends on increased frequency or worsening of symptoms.

Early Signs

Memory loss or forgetfulness is the best known sign of early Alzheimer's Disease. This might include difficulty remembering recent events, performing familiar tasks, using words correctly, finding the way home, making decisions or locating lost items.

Someone with dementia may often lose keys or other objects, forget whether an ingredient has been added to a recipe, withdraw from the usual activities or have trouble driving or finding the way to a familiar destination.

Families that include a loved one with Alzheimer's Disease face issues they never anticipated. The illness forces changes in the usual forms of planning. At first, the priority is ensuring that the loved one receives appropriate medical care, emotional support and companionship. Soon, however, other caregiving issues arise, including supervision to ensure personal safety and financial security, along with assistance in providing personal care and household tasks. Throughout this time, family members must plan to protect loved ones who may not always be able to plan for themselves.

Are You on a Journey?

If you or a family member has dementia, you are embarking on a journey. You may not know where you are going, and you cannot always see around the next bend in the road. As you go, some places will offer beauty and sunshine, other showers or storms. This monograph will serve as a road map to guide you on that journey.

Do this:

In the space below, jot down signs and symptoms that you have noticed in yourself or loved one. Take this list along to the next doctor's appointment.

Do this:

Use this page to keep track of symptoms, doctors visits, medications prescribed, as well as any side effects to the medications. Make copies of the form as necessary to compile all the information into a complete history.

Date: _____ Doctor seen: _____

Symptoms or behaviors prior to visit (describe): _____

Medication prescribed: _____

Symptoms or behaviors *after* visit (note any changes): _____

Side effects of medication: _____

Next appointment scheduled: _____

First Legal Steps

Talking with Shirley:

A few weeks after Shirley s doctor told her she might have Alzheimer s Disease, her son Mike visited her.

Mom, I ve been thinking we might need to talk, he said. You know, ever since Dad died, I ve been trying to help you with the financial details he usually handled.

Shirley nodded, but said nothing.

Now, don't get me wrong, Mom. We know you're still doing pretty well on your own right now, Mike continued, and we hope you'll do so for years.

Shirley folded her hands in her lap. So then, let's not worry about it now.

Mike sat quietly for a few minutes.

I understand that you don't want to think about it, Mike said, but the doctor said that somewhere down the road you might not be able to tell me what you want me to do. You might not remember your stocks, or even what bank your CDs are in. Or suppose you got really sick, I'd want to know what you want me to do, but you could be too sick to tell me.

Oh, Mike, Shirley said, you're my son; you'd know what I would want.

That's the point, Mom, I'm not really sure what you want, but I'd want to understand enough to do just that — whatever you'd want. For example, I don't even know today where all those old insurance policies are. Wouldn't it make sense to go over things like that? Why don't we write it all down together and take it to a lawyer to see if we need to do anything else with it?

Shirley glanced out the window, but didn't seem to be looking at anything. Well, I still don't think it's necessary, she said in a quiet voice, but if it makes you feel better, I guess we can.

Because Shirley is in the early — or mild — stage of dementia, she may retain her mental faculties for months or even years. During this stage, she may experience only short episodes of impaired mental function and long periods of clear understanding and sound judgment. While in this early stage, she can still receive, understand and evaluate information. More to the point, she can use that information to make rational decisions and execute legal documents.

As the disease progresses, however, the episodes of dementia may become more frequent and last longer. Still, she will likely continue to enjoy decision-making abilities into the mid-stage of the illness. Then, as the disease progresses, her thinking and judgment will become impaired. She may no longer meet the California tests for legal capacity, a requirement for valid execution of legal documents and instruments.

What if Shirley loses those abilities?

If Shirley lacks capacity, she will be unable to execute enforceable legal documents and instruments at the very time she and her family are facing so many troubling legal issues. For example, she may need to deal with bank accounts, or remove or add assets to a trust, or otherwise liquidate her assets to pay for health care. Eventually, she may need assistance from public entitlement programs such as Medi-Cal, a state-federal program that pays for health care, in-home and long term care for qualified applicants.

If Shirley cannot meet the California capacity tests, someone else must make decisions and execute documents and instruments on her behalf. Who that person is and how that person is appointed takes place in one of two ways: a validly-executed power of attorney, or through a probate court proceeding.

Act early.

If Shirley acts early in the course of her Alzheimer's Disease, she can ensure that her wishes concerning financial and health care matters are followed when she later becomes unable to express herself or make her own decisions. That is why her son wanted to discuss financial and medical matters as soon as possible, and why he wanted to see an attorney.

Do this:

If you or a family member is suspected of having Alzheimer's Disease, immediately see an attorney to put in place the legal instruments that grant decision-making authority to someone who can help with financial and medical matters, and who can communicate for you or that family member when that day arrives. Because the rate of progression is unpredictable, putting those instruments in place permits flexibility, avoids the time and expense of probate court involvement, and smooths the way in dealing with the health and financial challenges involved.

The instruments include powers of attorney for health care and property, and may be given immediate effect or drafted to delay the powers of the agent until you actually lose capacity.

What is a durable power of attorney for health care?

All or most states have enacted statutes authorizing and recognizing *durable* powers of attorney. These are powers of attorney that continue in effect if the principal becomes incompetent. To be durable, a specific provision is required. Here is a typical provision:

By this document I intend to create a durable power of attorney for health care as authorized by the *California Probate Code*. This power of attorney shall remain in force despite my subsequent incapacity."

A variation on the durable power of attorney is now in common use: the *springing* durable power of attorney. Here, the terms of the authority granted are set when signed, but the authority of the agent is delayed until the day arrives when you (as the principal) are no longer competent or otherwise able to express an opinion on the subject matter. In effect, you have granted *no* authority while able to act on the subject matter personally, and the agent merely stands in the wings, ready to take over if, as, or when required. This is the usual form for a durable power of attorney for *health care*, and frequently employed for durable powers of attorney for *property*.

In the durable power of attorney for health care, you: (1) name the agent authorized to act on your behalf in dealing with health care providers, along with one or more alternate agents; (2) define "health care decision"; (3) express your wishes in connection with life support systems, nutrition and hydration; (4) name a person (usually the agent) to serve as conservator of your person if one is ever needed; and (5) both authorize and express your wishes with respect to releasing medical records, signing waivers and releases, autopsy, gift of body parts and burial arrangements.

You might use a *Directive to Physician* on the matter of life support systems. Although it may be coordinated with the power of attorney, it adds little.

What is a durable power of attorney for property?

In the durable power of attorney for property, you (1) name the agent authorized to act on your behalf in dealing with creditors, investments, reporting taxes, managing property, etc., (2) specify appropriate limitations on the powers delegated, and (3) name a person (usually the agent) to serve as conservator of the person if one is ever needed.

In both instances, printed form instruments are available through stationery stores and (health care) through the California Medical Association. The problem with printed forms is that they never cover all the needs. Here are some examples:

— The health care power may provide insufficient guidance to permit well-thought-out choices on life support systems and whether nutrition and hydration is desired after withdrawal of those systems. They also do not provide for limitations imposed by particular religions.

— The property power never allows gifts in the manner required for most Medi-Cal eligibility planning. If gifts are permitted at all, they are authorized only if a gift pattern was followed by the principal in prior years, in amounts not to exceed the gift tax annual exclusion amount (\$11,000 per donee per year) and never to the agent. In most eligibility plans, the gift tax plays little or no role, and property transfers should be made to the agent (along with siblings or other objects of the principal's bounty).

– The authorization to prepare and sign tax returns for the principal is inadequate in meeting the information and standards required by IRS. Therefore, by the time this is discovered, the principal may no longer have capacity to sign the IRS (tax returns) power of attorney (*Form 2848*).

– The powers must be signed in a particular manner; *e.g.*, health care powers with two witnesses or acknowledged by a Notary Public, with additional requirements if residing in a health care facility at the time, and property powers acknowledged by a Notary Public. Many purchasers of printed forms fail to properly execute them, leaving them with an invalid power of attorney when it is too late to correct the situation.

The artful use of your durable power of attorney for health care.

To place the durable power of attorney for health care (DPAHC) in context with other personal management tools, keep this in mind:

– A living trust permits the trustee to manage the *property you transfer to the trust*, for your benefit.

– A durable power of attorney for property is used to manage *non-trust assets*, collect income, pay bills and report taxes.

– A DPAHC is the preferred means of carrying out your wishes with respect to *health care decisions* when you cannot make them yourself.

– Only *you* or (if you cannot do so) your conservator, may *determine where you live*. If, for example, life circumstances force you to move to a skilled nursing facility for physical therapy, or custodial care when you can no longer attend to personal needs, the agent appointed under your DPAHC to make your health care decisions cannot place you there against your will. In the face of non-cooperation from you, someone must petition the court for appointment as your conservator and seek court approval to move you. The court will not do that over your objections unless convinced that it is in your best interests.

California's *Health Care Decisions Law* (HCDL) went into effect July 1, 2000. It continues and recasts the former law governing the DPAHC. In the terminology of the HCDL, a DPAHC is one of several ways to make arrangements for health care decision-making, but remains clearly the best method of doing so. The various methods are described below, but this section deals primarily with the DPAHC.

There are five main approaches to your health care decision-making needs:

– **Power of Attorney.** California has a detailed statute governing the DPAHC. It requires the appointment of an *agent* to carry out your wishes as *principal*, and serves to express those wishes clearly and completely. You may also convey to the agent other attitudes, values and wishes consistent with, but not set forth in, your DPAHC. Beyond that, the agent has the authority to act in your best interests where those attitudes, values and wishes are unknown.

– **Natural Death Act, Living Will.** California's *Natural Death Act* (NDA) provides for a declaration concerning the continuation of life support systems where you are in a terminal condition, in a long-term coma or will survive but only in a permanent vegetative state. Under the original NDA, you would execute a *Directive to Physicians*. Under the HCDL, this type of writing is called an individual instruction (although it may also be given verbally). Court cases validate your expressions of health care desires in ways that fall under what Ann Landers calls the Living Will. The HCDL integrates these forms into a comprehensive statute.

– **Statutory Surrogacy.** A surrogate is defined as a deputy or delegate, someone who steps into your shoes and acts on your behalf. As is the case with wills and trusts, most people do not have either a DPAHC or a directive to physician. While estimates vary, it is safe to say that only 10% to 20% of adults have advance directives of *any* kind. From a public policy standpoint, this tells us that the law governing powers of attorney and other advance directives potentially affects far *fewer* people than would a law on consent by family members and other surrogates who may act if there *is* no DPAHC.

– **Court-Appointed Conservator.** California law provides a highly-developed probate guardianship and conservatorship law. The *Lanterman-Petris-Short Act* provides a special type of conservatorship for the gravely disabled who present a physical danger to themselves and others. These bodies of law are unchanged by the HCDL.

– **Other Judicial Intervention.** A special procedure for court-authorized medical treatment is available for adults without conservators. In a related revision, the HCDL conforms the scope of this procedure to the other changes wrought by the act.

Fundamental to all considerations is that you have the right to make your own decisions regarding medical care as long as you are legally capable of giving informed consent. In *Bartling vs Superior Court*, the court stated:

"If the right of the patient to self-determination as to his own medical treatment is to have any meaning at all, it must be paramount to the interest of the patient's hospital and doctors."

If you are unable to give informed consent, the responsibility and authority rests with a surrogate decision maker. That surrogate is the agent named in your DPAHC. If you have no DPAHC, the courts look to immediate family members for a surrogate decision maker, sensitive to those who are "in the best position to know [your] feelings and desires [about treatment preferences]." If no family members with the required understanding of your needs can be found, a friend will be considered. Rarely is it necessary to seek appointment of a conservator to make health care decisions.

If there is no surrogate decision maker and the family cannot agree on a course of treatment, the physician will ordinarily keep any life support systems in place until a decision can be made that will not expose the physician to professional liability.

Keeping in mind that the DPAHC gives your agent the power to act as your surrogate only if you are no longer able to make your own health care decisions, the physician is to explain to your agent your medical condition, the treatment options and the possible consequences of the various options. The decision-making becomes more of a process than an event. In order for you and your agent to make quality decisions, the process of informing should be early and regular.

Before placing you on life support systems or terminating their use at a time when you lack the capacity to make your own health care decisions, the physician should provide your agent the same information that would be provided you if you were competent. That includes the diagnosis, the prognosis and the options for treatment. While medical recommendations are helpful, the decision is the agent's to make.

If that decision violates the ethical or religious beliefs of the physician, the physician may decline to participate. At that time, the agent may associate another doctor or terminate the relationship and seek a new one for you. From the standpoint of both the physician and the agent, such a decision should be made only for reasons of conscience and after serious efforts are made to reconcile the views of the parties.

If the direction given the physician by the agent appears inconsistent with the wishes you previously expressed, the physician should examine those issues carefully with the agent. If the physician remains convinced that the directions provided violate your wishes or best interests, he or she should decline to follow them, stating the reasons. Consultation with a bio-ethics committee may prove helpful. If the agent is clearly acting against your interests, legal steps to replace him or her may be required.

Life support systems may be started and they may be stopped. It may be necessary, for instance, to start them in order to give you or your agent time to consider the proposed treatment options. For whatever reasons, your dignity, hygiene and comfort is the primary consideration in starting or terminating the systems. If your condition is terminal, medication may be given to

you as needed for pain or discomfort, even if its result is to addict you or to hasten death; it should not, however, be used with that intent.

It is important that your agent and family understand the reasons for the use or termination of medically administered hydration and nutrition, if employed, because of its powerful symbolism. Where life support systems are withheld or withdrawn, it is especially important to have a clear medical record. Such a record should include the following:

- The physician's progress notes on the treatment decision, the plan of treatment, the diagnosis and prognosis, how they were determined and any consulting opinions.
- The physician's notes on the basis for withholding or withdrawing life support systems.
- A written order directing the withholding or withdrawing of the life support systems.

If the decision is properly made and documented, there is no civil or criminal liability for the physician.

The physician will usually be familiar with the DPAHC, its uses and limitations. It is appreciated because it simplifies the process, avoids court intervention, permits discussion and reflection leading to better quality decisions and provides assurance that your wishes will be followed.

Any communications from you regarding your wishes and preferences for medical treatment will be given great weight by the court. This is especially true if given in writing, and particularly if given in the form of a DPAHC. If you have not done so, or if a previous effort was inadequate to fully communicate your wishes, take action now. Your life and your dignity are at stake.

Me? On Medi-Cal?

Tyrone and Marian's Story:

Tyrone thought his \$20,000 savings account plus his pension from the railroad would carry him through for the rest of his life. He often told his daughter Marian that he had plenty of money and that she would get a nice inheritance.

But when the doctor told Marian that her father's Alzheimer's Disease had progressed to the point where he needed long term care in a nursing home for the rest of his life, Marian learned a difficult lesson.

I called around and found that long term care facilities in my area cost around

\$4,500 per month, she told the doctor. Medicare won't pay for it, and Dad's savings will only last a few months. He thought he had saved plenty of money, but I guess he didn't count on *this* happening.

Paying for Long Term Care

Medicare provides acute care and limited benefits at the skilled and intermediate nursing home level. It leaves wholly unaddressed the enormous costs of long term care at the *custodial* level.

The terms used to describe levels of long term care are *skilled*, *intermediate* and *custodial*. They represent descending levels of medical services intensity. *Skilled* nursing facilities are those for which patients require registered nurses for at least two shifts daily to provide medication and emergency medical attention. *Custodial* care facilities are those for which patients do not require that level of attention from registered nurses, but *do* require assistance with dressing, bathing, eating, etc. *Intermediate* care facilities provide elements of both. Most facilities have dropped their intermediate license, because reimbursement from Medicare and Medicaid is near those for custodial services; intermediate care cannot be provided at a profit in the absence of private resources to make up the difference.

Medicare pays less than 2% of long term care costs nationally, insurance even less. As a result, the costs of long-term care are paid mainly from savings, reducing thousands of people to abject poverty every year.

Of the roughly 40 million Americans over age 64 in 2000, nearly six million need -- or *will* need -- long-term care, according to the National Center for Health Statistics.

Complicating all this is the situation facing the baby boomers, now often referred to as "the sandwich generation." These are the first to face the need to help parents for whom government programs may prove inadequate, and at the same time be required (or expected) to assist children through school and in getting started in life. With baby-boomer wives as well as husbands employed outside the home, few of them can stop work to care for an enfeebled *parent*.

If Medicare will not pay for long term care, and insurance is inadequate, unaffordable or unavailable, where do we turn to avoid the prospect of becoming both an economic and an emotional burden for our children as we grow older? We turn, from necessity, to Medicaid. While Medicare provides almost nothing for this category of expense, Medicaid can be all you need.

Other Options:

One thing we cannot escape is that Medicaid — or *Medi-Cal* as the California adaptation of the program is called — is *welfare*. It is means-tested, and implies a certain loss of dignity. Therefore, if a useful alternative is available, you should consider it.

There is an old line: Most lawyers work hard, live well, and die broke. Most people spend their working lives preparing to retire at a dignified standard of living. Where possible, planning for long term care should be conducted with that same goal in mind.

That goal may not matter much if finances dictate the choices, or if your mental condition is such that no luxury can be appreciated. Where there *is* a choice, consider avoiding Medi-Cal altogether: the planning requires asset transfers that can be disturbing to you and your anxiety is compounded by moving from familiar to new surroundings.

What Medi-Cal Covers:

Medi-Cal automatically pays for hospital-medical services for those who qualify for Supplemental Security Income. It provides medical coverage to those who qualify for a cash grant welfare program. Medi-Cal also provides in-home support services. Each of these areas come with eligibility rules different from those for long term care. These remarks are limited to the long term care program.

In addition to a full range of medical, hospital and skilled nursing benefits, Medi-Cal provides long term *custodial* care, a benefit *not* found under Medicare.

What it Does Not:

Other than shaves or shampoos performed by the nursing home staff as part of patient care, Medi-Cal participants have to pay personally for beauty shop services, cosmetics, denture cleaning, combs and brushes and such things.

After considering all the private options, long term care under the Medi-Cal program may be the logical choice. If so, we have to address the basic *aim* of Medi-Cal eligibility planning: to *get it without first going broke*.

Eligibility Requirements:

Generally, you are entitled to the full cost of long term care when (1) *nonexempt assets* are within the allowed value (the term for which is *Property Reserve*) and (2) you are *institutionalized*. You need *both*, although the planning often precedes institutionalization by months or years.

The Property Reserve is \$2,000 for you and \$3,000 *combined* when both you and your spouse are applying for long term care coverage.

The asset categories are *counted* assets, *exempt* assets and assets *deemed unavailable*. A

discussion of their relevance follows the list of defined terms below.

As with any bureaucratic endeavor or arcane specialty, there are terms of art:

– If you are *married*, your spouse is called the *Individual's Spouse* prior to the time you move to the long term care facility, and the *Community Spouse* after that date.

– If you have a spouse, he or she is entitled to retain counted assets of \$60,000, adjusted annually for inflation. This is called the *Community Spouse Resource Allowance*. Community and separate property distinctions are ignored in determining the amount chargeable to the *Community Spouse Resource Allowance*, so it matters not that the *Community Spouse* has separate property.

– The eligibility determination is based on the assets held by you and your spouse in the month in which the application is received by the county. It is called the *Snapshot Rule*, and its import is that the *Community Spouse* can receive and own assets in *any* amount, as long as they are acquired *after* the month in which the application goes in.

– The phrase, *Eligible for a Day, Eligible for the Whole Month* refers to a Department of Health Services rule under which any fraction is dropped in calculating a period of Medi-Cal ineligibility.

– The *Minimum Monthly Maintenance Needs Allowance* is an amount, originally set at \$1,500 per month and adjusted for inflation. It represents the minimum needed by the *Community Spouse* for a dignified standard of living, and is used in determining how much of your income can be allocated to that spouse in order to bring him or her up to that level (or as close to it as a 100% allocation will permit).

– The *Name on the Check Rule* means income is attributable to the spouse whose name appears on the check. It has an important effect on the reallocation of income from you to your spouse under the *Minimum Monthly Maintenance Needs Allowance*, and applies without regard to any state laws relating to community property.

– The *Personal Needs Allowance* is for Medi-Cal beneficiaries in long term care. The amount is \$41 per month, and is taken from income otherwise applied to your *Share of Cost*. It is used to meet needs that are not funded by the long term care program.

– *Share of Cost* is another key term. Although no income limit is imposed on you with respect to Medi-Cal eligibility, you cannot receive benefits unless you spend almost all of your monthly income on long term care and medical expenses. The part of the income spent that way is called your *Share of Cost*.

After transferring assets as part of the eligibility planning engagement, passive income is received with the name of the new owner on the check. Therefore, only Social Security, Railroad Retirement and pension income remains (in most cases) with your name on the check. From that amount, the Personal Needs Allowance and medical insurance premiums are deducted, then all or part of the remainder may be allocated to your spouse (if there *is* one, and if his or her income is less than the Minimum Monthly Maintenance *Needs* Allowance). The rest is your Share of Cost.

Asset Transfers and the Penalty Period:

Exempt assets are those which are *excluded* from the Property Reserve -- thus not counted in determining eligibility. Some are exempt without limit, and others are exempt only to stated amounts. Among those exempt *without limit as to value*, are:

- ‡ The residence;
- ‡ Heirloom jewelry;
- ‡ One motor vehicle, if used primarily to transport the Applicant;
- ‡ Furniture, fixtures, appliances and other household effects located at the residence of the Applicant;
- ‡ Personal effects of the Applicant;
- ‡ Recreational equipment (golf clubs, etc.);
- ‡ Musical instruments;
- ‡ Burial insurance;
- ‡ Burial trust or prepaid burial contract;
- ‡ Burial plots, vaults and crypts;
- *Maybe* rental real property used wholly or partly for self-support; and
- The assets of a *business*. Its equipment, inventory, licenses and materials are exempt as long as the business is earning a profit of 6% or more on net assets. As to that, *working* capital is also exempt for an amount up to three times average monthly business expenses.

Other categories having *limited value* exempt status include life insurance cash values, if the aggregate death benefits are less than \$1,500.

Assets "deemed unavailable" to you for Medi-Cal eligibility purposes, like *exempt* assets, are not considered in determining eligibility. These are assets which cannot be reduced to cash within a reasonable period of time, and those over which you have no control. Neither the statutes nor the cases define "availability." So we have to turn to federal law for help. There, deemed unavailable assets include at least the following:

— The assets of an irrevocable trust are counted in determining eligibility if the trust was established *by* you, by *your spouse*, by an *agent* of yours or by *court order*. On the other hand, the trust is deemed unavailable if created by someone *other than* you, your spouse, an agent or court order.

— The value of a "work-related" annuity -- that is, a pension, profit-sharing, non-qualified deferred compensation, 401k, SEP or Keogh -- is deemed unavailable for eligibility purposes if you have no right to require a lump-sum distribution. They are off-limits for benefit recovery purposes.

— IRAs are deemed unavailable if minimum distributions are being made. They are also off-limits for benefit recovery purposes.

— The classification of commercial annuities as unavailable is now fully developed. Basically, it is unavailable if the payout rate will liquidate the principal on or before expiration of life expectancy under the annuity tables published by Medicaid in *Transmittal 64*. There is much more to it, but I commend my book to you for the details.

Asset *transfers* have to comply with certain rules:

— The gift of *non-exempt* assets made within 30 months prior to application and to anyone other than your spouse, starts a period of Medi-Cal ineligibility we call the *Penalty Period*. The Penalty Period is calculated by dividing the state-wide average private pay rate for nursing homes into the net value of the gift after subtracting the Property Reserve. The state-wide average figure is announced each year by the Eligibility Branch of the California Department of Health Services, around February. You also drop the fraction and back up the date of the gift to the first day of the month in which it was made.

— There is no Penalty Period for gifts to your spouse, although we may have to deal with assets in his or her hands exceeding the Community Spouse Resource Allowance.

— The gift of property classified as exempt for Medi-Cal eligibility purposes can be made before or after application without effect on eligibility, because it cannot be deemed "made for the

purpose of qualifying" for Medi-Cal if it is not counted anyway. That same logic applies to "deemed unavailable assets.

The trick, then, is to transfer counted assets into exempt or deemed unavailable categories, so they can be transferred without a Penalty Period. Where that cannot be done, we may have to take the hit and make the transfers with the Penalty Period, then wait it out.

Typical Plan:

The usual plan involves a widow who is competent, has a home paid-for, furnishings, \$50,000 in the bank and is either in long term care, or needs to be. The home has a low basis. The kids may be scattered, but all are concerned about their mother.

The widow may spend some of the cash to make repairs and improvements to the house, thereby shifting counted cash into an exempt residence. Then she may prepay her funeral and burial expenses. Finally, she will give everything to the children. The children then re-gift those assets to a Special Needs Trust held for the benefit of their mother. Because the trust was created voluntarily and without prearrangement by the children, from assets they owned at the time, the trust is deemed unavailable to their mother.

Gift of the cash may trigger a Penalty Period, so the trust pays for the widow's living expenses or long term care expenses until that period expires. She then applies for Medi-Cal. From that point forward, the trust pays only for expenses *not* covered by Medi-Cal. The widow will also sign a durable power of attorney for health care.

The gift deed for the house will contain a reservation of her personal right to live in the home rent-free, or to *return* there to live rent-free. This is something less than the life estate that would hand the Department of Health Services a right to put a lien on the house at her death to recover benefits paid, but it is enough to cause the house to be included in the widow's gross estate for estate tax purposes. That, in turn, will lead to a basis adjustment to its date of death value on death of the widow. The children can then sell it without capital gain taxation.

The result in this illustration is that all long term and medical costs of the widow are shifted to the Medi-Cal program, costs not covered by the program are paid from the trust, and on her death, the trust terminates and the property is distributed to the children, free from any benefit recovery claim from the state.

In another fact situation, the widow may be *incompetent*. If that is the case, we have to establish a probate conservatorship, then ask the court to exercise its substituted judgment powers to approve the plan. If, as, or when the plan is approved, we petition to terminate the conservatorship of the estate, leaving only a conservatorship of the person.

Just as often, the disabled party is married. There, the usual plan is to transfer everything to the Community Spouse, then redeploy into exempt categories to the extent practical, then transfer everything to a revocable living trust providing for the Community Spouse for life, remainders over to the children.

If the Community Spouse ends up with more counted assets than are allowed by the Community Spouse Resource Allowance, we look first to see if her income is less than the Minimum Monthly Maintenance Needs Allowance. If so, we petition for an increase in the allowance, rather than take a reallocation of the Applicant's income. That is because (a) we want to avoid spending down the excess assets, and (b) a reallocation of the disabled spouse's income will end or reduce on his or her death. The probate court or state administrative law judge is required to grant the petition for increased allowance. If excess assets still remain, we may be able to raise the Minimum Monthly Needs Allowance *and* the Community Spouse Resource Allowance. We may alternatively be able to gift them to the children without penalty (depending on where they came from, and whether the Community Spouse got them before or after the Applicant's institutionalization). The last-ditch option is to use the excess to purchase an annuity in order to move excess assets into the deemed unavailable category.

If the disabled spouse is incompetent, the spouse may petition the probate court asking for approval of the asset transfers *without* having to start a conservatorship proceeding. To proceed in that manner, the spouse must be both competent and willing to serve as petitioner.

Six Steps to Take Right Now

When Alzheimer's Disease affects you or a family member, learning as much as possible about the disorder and the related legal issues is important.

Do this:

- _____ 1. Learn all you can about Alzheimer's Disease. Ask questions of your doctor. Read books and internet sources.
- _____ 2. Contact the nearest chapter of the Alzheimer's Association for additional information, including recent medical research developments into its cause and treatment. Write the chapter's telephone number here _____
- _____ 3. Join a support group for people with Alzheimer's Disease and their families.
- _____ 4. Discuss your condition and your feelings with family members or a close friend.

- _____ 5. Schedule an appointment with an experienced elder law attorney to begin any necessary planning. Put the attorney's telephone number here _____
- _____ 6. Gather the financial documents and information you will need to take to the appointment the attorney (deed, property tax bill, life insurance policy, Medicare supplement, stock trading account statements, bank statements, prepaid funeral and burial papers, etc.).

Do this:

Relax. After taking these steps, you will have put in place a plan to safeguard your economic security and that of your family. Now take the time to enjoy each precious moment with your loved ones.

Legal Assistance

For those in California, my biographical sketch is attached. For California eligibility planning strategies, order *When Health is Lost* at www.bentleymooney.com. To find a specialist in each of the other 49 states, contact the National Academy of Elder Law Attorneys at www.naela.org.