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# Tough Love: Making Residential Decisions for the Incapacitated

*Many of us in time will face the difficulty of helping a parent or elderly loved one make the transition to an assisted-living arrangement. Of the myriad options for care and covering expenses, which are the best? This overview provides elder law practitioners with insights to aid in assisting clients with these tough choices.*

**By Vicki J. Bowers**

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**I**t is 2:00 A.M. Mary's phone rings, awakening her suddenly. Instinct tells her it is her mother. In the fleeting moment as Mary reaches for the phone, her mind races through a multitude of possibilities, as panic and fear consume her. Has her mother fallen? Or, is she confused again, believing Mary is late picking her up

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for a 8:00 A.M. doctor appointment? If so, Mary will be irritated, but thankful there are no broken bones to deal with. It could be that her mother simply wants to chat, clueless that it is the middle of the night.

Mary answers the phone, and the responding voice is shaky and urgent. "Mary! Call a plumber; come quickly . . . ." A plumber is not necessary. Once again, Mary's mother has taken an unsupervised bath. Once again, she forgot to turn the water off, and the house is flooded. Relieved that at least it wasn't the stove this time, Mary wearily gets up and prepares to go.

As she nears her mother's house, Mary's heart aches as she ponders the decision she knows she must make. The constant calls, disasters, but most of all, the safety risks are now routine. Since her father's death, her mother's mental and physical decline has accelerated. Mary realizes that her father had concealed the extent of her mother's disability. Now there is no one to cover, no one to closely monitor, and no one to protect her mother from herself. No one except Mary, an only child. Knowing she will encounter her mother's vehement opposition, Mary realizes her mother is incapable of understanding the extent of her disability and the danger she encounters. In what seems like an instant, but in reality has been a long struggle, the parent-child role has reversed. If Mary cannot convince her mother to concede to alternative living arrangements, she will have to force her.<sup>1</sup>

## Determining Living-Arrangement Options

Mary is not alone in her dilemma. She is joined by innumerable adult children and other family members and caregivers nationwide who face tough choices on behalf of a failing loved one. Numerous

factors determine what alternatives are viable, but the primary considerations are the level of care needed by the incapacitated individual, the financial resources available to pay for such care, and the available support system.

### ***Independent Living at Home***

There is no place like home. Often, foresight and adjustments within the home differentiate between the ability or inability to manage living at home. Although some solutions sound like common sense, they are not obvious to the novice caregiver. In addition, denial takes hold, making it difficult for the caregiver to acknowledge the degree of decline and dependency of one who has always been independent and self-sufficient. The difficulty is compounded when the incapacitated individual does not realize, or will not accept, his or her limitations.

At these critical decision points, communication among the family and/or caregiver, as well as directly with the incapacitated person to the extent possible, is paramount. The caregiver should begin by learning what the average day of the incapacitated person is like. Determine whether the root of the disability is physical, mental, or both. Define the needs by examining the extent of the disability and the individual's level of function. One suffering from arthritis and poor vision has different needs than an ambulatory dementia patient who is prone to leave a stove on or wander. Does he or she need help with activities of daily living (ADLs) such as eating, dressing, bathing, toileting, and transferring?<sup>2</sup> Or, can the individual eat without assistance if someone prepares the meals and reminds them to eat? Can the individual bathe, but not safely get into the tub or shower unsupervised? Is the individual mobile, albeit slow, wheelchair-bound, or bedridden? Is the individual a fall risk?

For the visually impaired, insecticides and other hazardous chemicals must be well-marked with large lettering and appropriately stored so they will not be confused with other substances. Bug spray in a bathroom cabinet can be mistaken for hair spray, or a tube of super glue can resemble a tube of eye drops. Adequate and evenly distributed lighting with no glare is important. Dishes, food, and other items must be within easy reach and placed in familiar locations. Do not rearrange a cabinet or furniture because the mentally or visually impaired individual may be unable to remember the changes, causing frustration or, worse, a fall.

Special tools can assist with jars, cans, and other hard-to-open items. Buttons replaced by Velcro can make independent dressing easier. Grippers help pull on socks and pants.<sup>3</sup>

Telephones and flashlights placed by the bed and on chair-side tables provide easy access in an emergency. Wheelchairs and walkers equipped with a carry pouch allow an extra portable phone, flashlight, and medications to be close by at all times. Adjust thresholds, remove area rugs, and clear hallways and walk areas to avoid tripping and allow easy wheelchair access. If structurally feasible, doorways can be widened. Use non-slip wax on vinyl and tile floors. Bathroom safety handles, hallway handrails and nonslip, easy-to-wear shoes further reduce fall risk.

Label medications carefully and monitor dosage. Hot water heaters set at a lower temperature reduce scalding risk. Regularly change smoke detector batteries, make sure the person recognizes the alarm sound, and practice using emergency numbers and exit routes. Purchase a small, easy-to-use fire extinguisher. Consider a monitored fire or theft system, and a monitored medical alert system, particularly if the person is a "wanderer." A medical alert bracelet or necklace that includes identification and emergency information can be a life saver.<sup>4</sup>

Outside sources can contribute to keeping the individual independent at home. Meals on Wheels can supplement family-provided meals.<sup>5</sup> Home health aids can assist with personal care and may perform some medical care and light housekeeping. Companion sitters keep the person company, help with minor tasks, and provide general assistance. Local newspapers often list senior-centers' activities for social stimulation for the individual and respite for the caregiver.

Of paramount importance, determine who comprises the available support system. Complete honesty by all concerned is imperative because, no matter how sincere, good intentions alone cannot provide good care. Does the disabled person live alone, or is there a spouse, other relative, or friend at home, either all day or on a regular schedule? Does the person need twenty-four-hour supervision, or will a few hours of daily assistance suffice? Geriatric care managers can assess the needs and assist in management of all or some of the care, particularly if the primary family member or caregiver is out of town.

### **Home Sharing**

If living alone is not feasible, another alternative is for the incapacitated person and the caregiver to share living arrangements. As with monitoring care, of paramount importance is complete honesty and candidness. Living with an incapacitated person will greatly impact the lifestyle of the entire household. Carefully evaluate the individual's needs, and, equally important, evaluate the caregiver's needs and those of and his or her family. Is there a private, but safe, room for an extra person, particularly a person with special needs? Will the caregiver and his or her family, as well as the incapacitated person, have adequate privacy? Is the time and attention the incapacitated person requires reasonable?<sup>6</sup> Caregivers should educate themselves and their families about the disease or incapacity they will be dealing with so they know what to expect before making such a commitment.<sup>7</sup>

Adult day-care programs can provide social interaction for the incapacitated individual and provide the caregiver respite or the ability to have outside employment. Home health aids or visiting nurses can also ease the burden of caring for the disabled individual at home. The individual's doctor, the local yellow pages, and the area agency on aging are all sources to help locate dependable, bonded, and insured assistance.

Eventually, however, the well-meaning, caring family must often put aside their own feelings of love and, yes, guilt, to concede that the best place for the loved one is in a care facility.

### **Assisted Living**

Assisted-living facilities (ALFs)<sup>8</sup> are ideal for persons requiring some daily assistance, but not constant supervision or medical services.<sup>9</sup> Residents are encouraged to be independent and active.<sup>10</sup> Most offer three meals a day, usually in a common dining room, which also encourages socialization.<sup>11</sup> Advantages of ALFs include transportation, recreation, housekeeping and/or laundry services, assistance with ADLs, and accessible medical services. Some ALFs offer private rooms, and residents can usually bring their own furniture and furnishings to create a homelike environment.<sup>12</sup> Many provide a variety of assistance levels, ranging from monitoring to administering medications. Incontinent individu-

als or those requiring a significant amount of attention, such as dementia patients, may not qualify.<sup>13</sup>

Adult foster-care homes are included in the assisted-living category. The advantage to this type of facility is that the number of residents is limited, allowing more personalized attention. Disadvantages include the cost involved and the disqualification of individuals with significant medical or personal care needs.<sup>14</sup>

When considering an ALF, obtain a detailed list of the services offered and base and incidental price lists. Consider the mix and functioning level of facility residents to determine if the incapacitated person will be compatible. Ask how roommates are chosen and how the facility handles incompatible situations.<sup>15</sup>

The cost of ALFs is broad, ranging from \$300 to \$3,000 per month.<sup>16</sup> Typically, neither Medicare nor Medicaid will pay for ALFs, but state assistance may be available through rent subsidies.<sup>17</sup> In addition, limited Medicaid-waiver programs may be available. For those who planned ahead, some long-term care policies provide ALF coverage.<sup>18</sup> ALFs are governed by state law.<sup>19</sup>

### **Continuing Care Retirement Communities**

Continuing care retirement communities (CCRCs) are also governed by state law.<sup>20</sup> However, even though federal law does not specifically regulate CCRCs, they generally must comply with federal law governing quality of care, and CCRCs that include nursing home facilities must comply with applicable federal laws.<sup>21</sup> An eliminating factor for many individuals is the hefty entrance fee required, which may be anywhere from \$20,000 to more than \$200,000.<sup>22</sup> Although part of the fee may be returned to the resident's estate at death, there is no guarantee,<sup>23</sup> and typically, there are monthly fees in addition to the entrance fee.<sup>24</sup>

Typical CCRCs offer varying degrees of living arrangements, and residents can move within the facility as level-of-care needs change.<sup>25</sup> This advantage can enable a family to stay together longer. For example, if a husband needs nursing home care but his wife requires assisted living, both can live within the same community, yet have their individual needs met.<sup>26</sup>

CCRCs often provide tiered purchase levels. All-inclusive contracts, which are still subject to the entry and monthly fees, include all services needed

during life.<sup>27</sup> If unlimited nursing care is anticipated and the individual can afford the cost, this is an attractive alternative. Modified contracts may cover only a limited number of nursing home care days annually, with a copayment required for excess days.<sup>28</sup> Fee-for-service arrangements may provide independent and assisted living, but require full payment for skilled nursing care.<sup>29</sup> A prospective resident is well advised to have an attorney review any contract before signing.<sup>30</sup> Attorneys should always check the cancellation, discharge, and eviction policies. Some states limit the grounds for eviction that a contract can include.<sup>31</sup> The facility's financial stability and the soundness of its financial assumptions should also be examined. A few seriously ill residents for whom the CCRC has complete responsibility could bankrupt the facility, collectively affecting all residents.<sup>32</sup>

### **Nursing Homes**

Chronic physical conditions requiring skilled nursing care most often leave the family with no alternative but to seek the highest level of care in the most restrictive living environment.<sup>33</sup> More than forty percent of those over age sixty-five will likely require nursing home care at some time.<sup>34</sup> An individual may require a nursing home temporarily during recuperation and rehabilitative therapy, or, once admitted, may remain for life. The level of care achieved in a nursing home setting is almost impossible to duplicate at home. Skilled nursing facilities provide assistance not only with ADLs, but also medical care administered by nurses and other medical staff.

Nursing homes are regulated by state and federal laws.<sup>35</sup> The Nursing Home Reform Act of 1987 enacted comprehensive federal standards for nursing homes.<sup>36</sup> The Act was designed to address abuses in the nursing home industry and establish a standard of care for all nursing home residents.<sup>37</sup>

As with ALFs, the nursing home chosen will depend on location, the level of care needed, and, to the extent practicable, the incapacitated person's preference. A severely demented Alzheimer's patient may require a locked unit facility. A ventilator patient requires specialized skilled care. One should obtain information about the various facilities, narrow down the choices, and visit the homes. Make an unscheduled visit and roam the halls to observe whether residents appear happy and cared for. Notice whether staffing appears adequate and

whether the staff responds quickly and appropriately. Cleanliness, or lack thereof, will be obvious. Ask how and where meals are served. A review of the facility's Health Care Financing Administration survey will reveal any complaints or violations.<sup>38</sup>

Nursing home residents retain many rights, including the right to a dignified existence, self-determination, and communication with and access to persons and services both inside and outside the facility.<sup>39</sup> Since the facility is required to protect and promote such rights, it is important to be familiar with them.

Skilled nursing home care averages \$3,500 to \$4,000 per month, not counting incidentals and medications.<sup>40</sup> When comparing prices, confirm what the base price includes. The Health Care Financing Administration has identified forty-four different names for the various levels of care provided by nursing homes.<sup>41</sup> Extra services may significantly increase the cost.<sup>42</sup> A Consumer Reports survey revealed that some nursing homes charge up to \$1,000 per month for "extras."<sup>43</sup>

### **Determining Financial Alternatives**

The financial element in determining residential and care needs cannot be ignored. The cost of long-term care, at home or in a facility, can be prohibitive or financially devastating.

#### **Private Payment**

Only the wealthy can continually privately pay for supplemental care, the annual cost of which can easily range from \$14,000 to \$60,000 or more, not including medications, clothing, food, and other necessities. Erratic or irregular income-producing assets may require restructuring to produce more stable income. Or, investments may need staggering so that dividends or interest pay out in a manner to create a regular income stream.<sup>44</sup> For example, stocks producing small dividends may need to be sold in order to purchase a single-premium annuity that will pay out for either the lifetime of the annuitant or a set amount per month for an exact time period. Tax consequences must be considered, however, as well as Medicaid rules if the need for future eligibility is anticipated.

If assets must be sold, consider selling those with a low cost basis last to delay capital gains taxes. Remember that as medical costs increase, usually with age, such costs are deductible itemized expenses. Although the expenses will not reduce

capital gains, they can help reduce the ultimate tax liability.<sup>45</sup>

The thought of selling one's home is traumatic, even for individuals who accept that they must live elsewhere. Losing one's home causes a loss of the security and comfort provided by knowing that the home is still ready and waiting. Many believe or fear that the decision to move out of the home means they can no longer keep the home. Often, too, the incapacitated person wants to retain the home to eventually pass to children. "Well spouses" fear they must sell the home to pay for the ill spouse's care, leaving them broke and homeless. Many erroneously believe that they will never be able to take advantage of governmental assistance until they sell their home and spend the money. Whether the home should or must be sold depends on state law and individual circumstances, but once the home is sold, without proper planning, the proceeds can disqualify the individual for governmental assistance.<sup>46</sup> Thus, it can be a tremendous mistake to immediately sell the home without full knowledge of the consequences and available alternatives, particularly if a "well spouse" still resides in the home. The children, as the eventual heirs, may be willing and able to contribute toward the ill parent's care. Or, an adult child may agree to live in an exempt home rent free, in exchange for paying maintenance, insurance, and taxes. A reverse mortgage, discussed below, can also help preserve the home in appropriate circumstances.

### **Family Supplement**

Sometimes the family can and will supplement the elder. Section 151 of the Internal Revenue Code (Code) provides that if the elder meets certain following criteria, he or she can be claimed as a dependent on the other person's tax return. Basically, the elder must be a U.S. citizen, a relative of a twelve-month resident in the home, cannot file a joint tax return with a spouse, must have gross income less than \$2,750 (1998), and the taxpayer must have provided more than half of the dependent elder's support, including all sources of income.<sup>47</sup>

In addition, Code Section 21(a)(1) provides a tax credit for care of an elderly dependent. A tax credit is more advantageous than a deduction. Generally, the taxpayer is an adult child. He or she can claim a credit for employment-related expenses of caring for an elderly dependent living in the

taxpayer's house, such as the expense of a non-medical sitter or household-help expense incurred while the taxpayer works.<sup>48</sup> IRS Form 2441 is used to apply for the credit, which is on a sliding scale up to \$720 per qualifying person (maximum two).<sup>49</sup>

### **Long-Term Care Insurance**

For those who preplanned and have long-term care insurance or those still eligible to purchase insurance, the policy terms are key to determining how much financial assistance will actually be derived. Even a limited policy may buy the caregiver some time while deciding on long-term care options.

"Benefit triggers" indicate what conditions must be present to initiate benefits.<sup>50</sup> The requirements may vary from policy to policy, and state to state.<sup>51</sup> Triggers are usually based on inability to perform certain activities of daily living (ADLs) such as bathing, toileting, continence, dressing, eating, and transferring.<sup>52</sup> Typical policies require the insured be unable to perform at least two or three of the six ADLs.<sup>53</sup> Qualifications differ depending on whether or not the policy is tax-qualified. Federally tax-qualified policies require the inability to perform certain ADLs as a benefit trigger.<sup>54</sup> For example, such a policy may require the insured to be unable to do at least two out of five or unable to do no more than two of six ADLs.<sup>55</sup> Alternatively, non-tax-qualified policies can offer a different combination of benefit triggers, including ADLs and medical necessity.<sup>56</sup> While tax-qualified policies must require that a disability be expected to last a minimum of ninety days, non-tax-qualified policies do not. Furthermore, some policies may differentiate between the need for hands-on assistance and standby assistance.<sup>57</sup>

Policies should be evaluated for custodial, adult day-care, and respite-care coverages. While some provide coverage for nursing home and in-home care, as well as some assisted living, others do not. Most policies today cover mental incapacity, but only if caused by Alzheimer's disease or other dementia.<sup>58</sup> Other mental or nervous disorders or diseases and alcohol or drug addiction usually are not covered.<sup>59</sup> If an individual is mentally incapacitated but still able to perform most ADLs, some policies may not provide coverage.<sup>60</sup> Tax-qualified policies require that the mentally incapacitated person require substantial supervision, while non-tax-qualified policies may not.<sup>61</sup>

Once the individual qualifies for coverage, the per diem rate, including whether the policy has inflation coverage and the elimination period, will give the caregiver an idea of how much financial output will be required before the policy begins paying. Typically a long-term care policy has an elimination period of zero to one-hundred days for nursing home care, but the period for home health may differ.<sup>62</sup> Similar to a deductible, this is the period of time the insured must be in a nursing home or receive home care under a physician's orders before the policy starts paying. It is important to note whether going home and then returning for a second stay requires another elimination period.<sup>63</sup> All of these factors must be considered when determining if, and the extent to which, other resources will be necessary to supplement payments available under the long-term care policy.<sup>64</sup>

### **Reverse Mortgage**

An often-overlooked source of financial assistance for cash-strapped seniors is hidden within what is also often their greatest financial asset. The term "reverse mortgage" is self descriptive. Unlike a conventional mortgage through which a homeowner uses his or her home as collateral to obtain cash and then make regular repayments, a reverse mortgage allows the homeowner to borrow against his or her home, obtain cash, and defer repayment.<sup>65</sup> The U.S. Department of Housing and Urban Development (HUD) and Fannie Mae administer the two largest reverse-mortgage programs in the United States.<sup>66</sup> A relatively new alternative, HUD established the FHA-insured Home Equity Conversion Mortgage (HECM) in 1989.<sup>67</sup> Fannie Mae designed the HomeKeeper reverse mortgage, as well as a unique concept called Home Keeper for Home Purchase which allows a senior to obtain a reverse mortgage while purchasing a home all in one transaction.<sup>68</sup> Fannie Mae, the largest investor in HUD HECMs as well as in reverse mortgages overall, purchases Home Keeper mortgages from the private lender. In Canada, the reverse mortgage is called the Canadian Home Income Plan.<sup>69</sup> Other reverse-mortgage programs may be available, depending upon location and lender.<sup>70</sup>

Although not always appropriate, a reverse mortgage can transform home equity into available funds without creating an additional monthly payment obligation. Reverse-mortgage proceeds can be used in any manner. Such lucrative terms can

allow a senior to benefit by using home equity to obtain investment cash and consequently increase available cash flow and income during his or her lifetime.<sup>71</sup> For example, in a slow-growing real estate market, properly invested reverse-mortgage proceeds could increase the value of the equity money by a greater percentage than if the equity remained in the home. However, one should consider the initial closing costs and interest accrual to carefully calculate the total cost before making such a decision.<sup>72</sup>

A reverse mortgage can be appropriate for an individual able to remain at home with assistance, but who lacks sufficient income to pay for the care. Without a reverse mortgage, nursing home care, likely funded or supplemented by Medicaid, may be the only alternative. In this situation, a reverse mortgage enhances the person's quality of life by allowing him or her to remain at home, while potentially reducing the government's burden because Medicaid is not utilized. As a general rule, one must intend to remain in the home at least five years in order to offset the initial costs involved.<sup>73</sup>

An elder facing reduced income following death of a spouse may suddenly be unable to meet monthly obligations including, but not limited to, maintenance, taxes, and insurance on the home. A reverse mortgage can provide funds to pay off the creditors and other expenses without creating another monthly bill. The elder's disposable income is thus automatically increased.<sup>74</sup> For example, a 78-year-old widow may be able to borrow \$40,000 against her \$90,000 home, enabling her to pay off her existing low-balance mortgage and retain the rest as an available line of credit to meet emergencies.<sup>75</sup> One must consider, however, that a recipient of certain government benefits may become disqualified for other benefits if the equity money is used to purchase an annuity, some of which may be counted as income, or if excess nonexempt resources are accumulated.<sup>76</sup>

Depending on the lender, the homeowner can choose to obtain funds in a lump sum, through regular payments, a line of credit to draw on as needed, or combinations thereof.<sup>77</sup> Some plans may provide access to more equity than others. Typically, thirty to seventy-five percent of the property value is available, but the reverse mortgage must be a first lien, so any existing mortgage(s) must be paid off.<sup>78</sup>

As an added benefit, available but unused HECM lines of credit actually accrue interest

earned at the note rate.<sup>79</sup> Because reverse-mortgage payments or proceeds received are a loan, they are not subject to federal income tax.<sup>80</sup> As previously stated, unlike typical home equity loans requiring regular repayments, repayment of a reverse mortgage is deferred. The amount of the loan simply continues to increase until the homeowner sells or refinances the home, dies, or permanently moves.<sup>81</sup> Usually, twelve to eighteen months or more absence from the home is required before a move is considered permanent.<sup>82</sup> Lenders cannot force the borrower to leave the home even if the loan amount eventually exceeds the home's worth. In addition, lenders can only look to the home itself to satisfy the lien, even if the home value is insufficient.<sup>83</sup> That feature protects the owner's other assets from risk. At the owner's death, heirs wishing to keep a reverse-mortgaged home have the option to pay off the balance due.<sup>84</sup>

A disadvantage of the reverse mortgage is that the home's equity depletes each month, and the initial and overall costs can add up quickly. Strict requirements include a minimum age, usually sixty-two.<sup>85</sup> Factors that determine the amount that can be borrowed include the property's appraised value, the age and number of borrowers, the expected interest rate, the adjusted property values, and the maximum amount allowed.<sup>86</sup> In addition, HUD<sup>87</sup> caps the amount available for HECMs at the FHA median home value for each county.<sup>88</sup> The Home Keeper Mortgage insured by Fannie Mae also has a cap that changes from time to time, but remains consistent among counties.<sup>89</sup>

Since reverse mortgages are not for everyone, careful consideration is necessary. The complex nature of the mortgage coupled with the reluctance of the older generation to borrow against the one asset they worked so hard to own outright contribute to the underutilization of this resource.<sup>90</sup> To help eliminate misunderstandings and inappropriate mortgages, HECMs require counseling by a FHA-approved agency, and Fannie Mae requires education sessions.<sup>91</sup> One should thoroughly investigate the mortgage product and all other alternatives before making a decision.<sup>92</sup>

### **Veteran's Benefits**

Veterans' benefits should not be overlooked as a payment source for medical bills, home care, or

skilled care.<sup>93</sup> Title 38 of the United States Code addresses veteran's benefits.

### **Medicaid**

Medicaid is a joint federal-state, needs-based health insurance program. Congress created the program by enacting Title XIX of the Social Security Act of 1954.<sup>94</sup> Each state administers its own program. A state is not required to participate in the program, but once it does it must comply with applicable federal law that provides certain minimum standards from which states mold an individual program.<sup>95</sup> Thus, eligibility and coverage requirements can vary dramatically among states.

Generally, an individual must be aged, blind, or disabled and residing in and requiring the requisite level of care provided at a skilled-nursing, Medicaid-provider facility.<sup>96</sup> A nursing home resident who needs Medicaid assistance and his or her spouse are only allowed to own limited countable resources.<sup>97</sup> Exempt resources that do not count may include, but are not limited to, the individual's home, car, household furnishings, and burial arrangements.<sup>98</sup> All but a minimal amount of the individual's income will be paid to the nursing home unless there is a spouse residing in the community who qualifies to receive a portion of the nursing home resident's income.<sup>99</sup> Medicaid supplements the difference between the nursing home resident's income and the Medicaid contract-payment amount.<sup>100</sup> Some states impose a limit on the amount of income in determining eligibility. Only the nursing home resident's income counts in determining eligibility.<sup>101</sup> The income of a spouse is irrelevant except when considering diversion of the resident's income to the spouse.<sup>102</sup> However, the spouse's resources are considered and a maximum countable resource limit is imposed, which varies among states.<sup>103</sup>

In addition, federal law requires that states deny Medicaid eligibility for a period of time when an applicant *or the applicant's spouse* transfers certain resources or income to a nonspouse prior to applying for or receiving Medicaid benefits.<sup>104</sup> Any action not compensated by fair market value that reduces or eliminates the applicant's ownership or control of an asset creates a transfer.<sup>105</sup> In addition, disclaimer of income or resources that the applicant *or the applicant's spouse* is entitled to but does not



receive because of their own action or action of another person, court, or administrative body with legal authority to act in place of the individual spouse, creates a transfer.<sup>106</sup> An ineligibility period is triggered when the transfer is made during or after the thirty-six-month (sixty-month for trusts) "look-back" period immediately before the date of application for benefits. Ineligibility is determined by dividing the uncompensated value of the transferred asset (the gift amount) by the state's average monthly cost to private pay for nursing home care.<sup>107</sup>

In addition to transfers between spouses, the following transfers are exempt from the transfer rules:

1. Transfers to an applicant's spouse or to another for the sole benefit of the spouse;
2. Transfers to an applicant's blind or disabled child or to a trust for that child's benefit; and
3. Transfers to a trust established for the sole benefit of a disabled individual under age 65.<sup>108</sup>

The applicant's home may be transferred without penalty when transferred to the applicant's

1. Spouse;
2. Dependent child under age 21 or dependent child who is blind or disabled;
3. Sibling with an equity interest in the home who has resided in the home for one year prior to the applicant's admission to a nursing home facility; or
4. Adult child of applicant who has lived in the home for the two-year period immediately prior to the applicant's institutionalization and provided care to the applicant during that period.<sup>109</sup>

Transfers to revocable or irrevocable living trusts do not always defeat the transfer or resource rules.<sup>110</sup> A transfer to a revocable trust by the applicant or the applicant's spouse is not penalized because the corpus of the trust is still considered a resource, and any payments are considered income.<sup>111</sup> If any part of the trust corpus or income is used for any purpose other than the benefit of the applicant or the applicant's spouse, a transfer *has* occurred and a penalty is triggered.<sup>112</sup> Transfers to an irrevocable trust will trigger transfer and penal-

ty rules, and any income or rights retained are available to the applicant.<sup>113</sup> Since careful planning and precise wording are required, the assistance of an attorney competent in this area of law is recommended.

The Omnibus Budget Reconciliation Act of 1993 (OBRA '93) mandated that states enact recovery systems for benefits paid on or after October 1, 1993. Usually, a Medicaid recipient owns no assets at death and thus leaves nothing from which Medicaid can seek recovery. However, assets that are Medicaid-exempt during lifetime, such as income-producing rental property, may not be exempt at death. A life insurance policy payable to the estate is available to pay creditors' claims, including Medicaid. Or, a Medicaid recipient may inherit property shortly before or after death. However, Medicaid will release its claim if there is a surviving spouse, if the decedent was under age fifty-five, if there are minor or dependent children, or if repayment creates an undue hardship.<sup>114</sup>

In summary, Medicaid planning is not for the novice. The rules can be complex, and qualification criteria can vary among states. Although specific Medicaid planning advice is beyond the scope of this article, it is important for the practitioner and the public to know that what worked for Aunt Sally in California is not likely to work the same way for Aunt Jane in Florida. Medicaid recipients relocating to another state may find themselves ineligible upon arrival. One is well advised to consult an elder law attorney knowledgeable in Medicaid well in advance of need and application.

## Summary

Tough love is necessitated by the reversal of the parent-child roles when the parent can no longer make rational residential, financial, and care decisions. Adult children or caregivers should not rush into decisions, but often the urgency peaks, finding the family unprepared and leaving caregivers shocked and desperate. Alternatives are many, but each situation is unique. Commitment and knowledge, coupled with careful consideration of individual needs, and the human and financial resources available to meet those needs, are imperative. Otherwise, good decisions that can ease the burden on all concerned,

while appropriately meeting the incapacitated person's needs, are impossible.

## Endnotes

1. A court-ordered guardianship is often necessary to give a child or other caregiver authority to force an uncooperative individual to submit to residential changes or necessary medical attention that is in his or her best interest. Guardianship is beyond the scope of this article.
2. See generally Robert G. Hayes et al., *What Attorneys Should Know About Long-Term Care Insurance*, 7 ELDER L. J. 1 (1999).
3. For a list of catalogs and medical supply stores from which to obtain personal and medical aids, see VIRGINIA MORRIS, HOW TO CARE FOR AGING PARENTS 416 (1996). For additional information on obtaining products for the disabled, call the National Rehabilitation Information Center, 1-800-346-2742 or the Access Foundation at 516-568-2715. *Id.* I.R.S., PUBLICATION 907 4-5 (1999) explains the deduction allowed by the IRS for medical equipment and furnishings. *Id.* at 37.
4. For suggestions on home modification and ideas to enhance at-home living for impaired or incapacitated individuals, as well as a list of resources for housing modification ideas and materials, see JOHN P.S. SALMEN, AIA, THE DO-ABLE RENEWABLE HOME (1998). See also MORRIS, *supra* note 3, at 136-52.
5. To find local meal-delivery programs, call the area agency on aging or the National Meals on Wheels Foundation, 1-800-999-6262. See MORRIS, *supra* note 3, at 174.
6. See MORRIS, *supra* note 3, at 194-98.
7. The Alzheimer's Association is one of many organizations offering support groups, help lines, newsletters, books, and other reference materials. The Alzheimer's Association can be contacted at 1-800-272-3900, through its web site, <<http://www.alz.org>>, or by checking the local yellow pages for regional associations.
8. States use a variety of terms to refer to facilities that provide care and supervision but not nursing services. In addition to "assisted-living facilities," other terms include "personal-care homes," "residential care facility" and "residential care facilities for the elderly." See ERIC M. CARLSON, LONG-TERM CARE ADVOCACY § 5.02[1], at 5-10 (1999). For a summary of state law provisions governing assisted-living facilities, see *id.* §§ 5.101-5.152. For list of state licensing agencies, see *id.* § 5.401.
9. See MORRIS, *supra* note 3, at 205.
10. See *id.*
11. See *id.*
12. See *id.*
13. See *id.*
14. See CARLSON, *supra* note 8, § 5.02[1].
15. For a suggested list of evaluation considerations, see MORRIS, *supra* note 3, at 417-20. See also CARLSON, *supra* note 8, § 5.202[1], at 5-164-5-169. Also, a free consumer checklist is available from the Assisted Living Federation of America, 1-703-691-8100, or its website at <<http://www.alfa.org>>. For information on ALFs, call AHCA at 1-888-419-3456.
16. See MORRIS, *supra* note 3, at 206.
17. See *id.* Also check with the local area office on aging and the Department of Housing and Urban Development. The United States Housing Act of 1937, 12 U.S.C. § 1701, supplies the basis for federally subsidized housing.
18. See generally NATIONAL ASSOCIATION OF INSURANCE COMMISSIONER'S, A SHOPPER'S GUIDE TO LONG-TERM CARE INSURANCE (1999) [hereinafter SHOPPER'S GUIDE]. A SHOPPER'S GUIDE can be obtained by contacting the National Association of Insurance Commissioners at 1-816-842-3600.
19. See, e.g., Fla. Stat. ch. 400, which governs Florida's nursing homes and assisted-living facilities.
20. See CARLSON, *supra* note 8, § 6.03.
21. See *id.* § 6.03.
22. See MORRIS, *supra* note 3, at 207.

23. *See id.* *See also* CARLSON, *supra* note 8, § 6.08[2]. Some states' laws merely require that refund rights be included in a disclosure statement. Other states' laws require that the amount retained not exceed the cost of the resident's care or a certain percentage of the entrance fee for each month the individual lived in the community. *See id.*
24. *See* MORRIS, *supra* note 3, at 207.
25. *See* MORRIS, *supra* note 3, at 206–07.
26. *See* CARLSON, *supra* note 8, § 6.04[1].
27. *See* MORRIS, *supra* note 3, at 207.
28. *See id.*
29. *See id.* at 207–08.
30. *See id.* at 208.
31. For a discussion of states' differences in evictions and transfers within and without the community, see CARLSON, *supra* note 8, §§ 6.09[1]–[2].
32. In Florida, the Department of Insurance is the primary regulator of CCRCs. *See e.g.*, FLA. STAT. chs. 651.021 (providing that a facility must have a certificate of authority which requires a feasibility study of the project), 651.035 (requiring that the facility maintain an escrow of at least the annual mortgage payments plus 30 percent of one year's operating costs), 651.055 (requiring that: (a) the life-care agreement used by the facility indicate the type of services provided, the term, and whether services will be provided inside or outside the facility; (b) the facility have a 30-day cancellation policy exercisable by either side; and (c) the facility provide 60-day notice of fee increases).
33. For a listing of relevant state statutes and admission requirements, see CARLSON, *supra* note 8, §§ 3.101–3.152.
34. *See* MORRIS, *supra* note 3, at 209. The odds increase to 60 percent for a person over age seventy-five to require nursing home care. *See* HAYES, *supra* note 2, at 3 (citing PHYLLIS R. SHELTON, LONG TERM CARE PLANNING GUIDE 2 (1998)).
35. For a listing of state nursing home statutes, see CARLSON, *supra* note 8, §§ 2.101–2.152. State law applies to every nursing home within the respective state, while the Nursing Home Reform Law applies only to Medicare and/or Medicaid participating facilities. *Id.* at 2-91. The Nursing Home Reform Law is codified at 42 U.S.C. § 1395i-3 as to Medicare facilities, 42 U.S.C. § 1396r as to Medicaid facilities. However, the Nursing Home Reform Law applies to every federally certified facility, regardless of the patient's payment source. *See* CARLSON, *supra* note 8, § 2.03.
36. *See* 42 U.S.C. §§ 1395i-3, 1396r; *see also* 42 C.F.R. § 483.
37. State laws relating to nursing home resident's rights, transfers and discharge, and restraints are found in FLA. STAT. ch. 400. The full text of all states' statutes and legislation is available on the internet at <<http://www.prairienet.org>> and can be searched for applicable statutes.
38. A nursing home comparison and inspection results, including the scope and severity of deficiencies reported can be obtained at <<http://www.medicare.gov>>. For a list of considerations suggested in selecting a nursing home, see MORRIS, *supra* note 3, at 417–20; JOHN J. REGAN ET AL., TAX, ESTATE & FINANCIAL PLANNING FOR THE ELDERLY: FORMS & PRACTICE § 15.03 (1999).
39. Medicare and Medicaid participating nursing homes must meet minimum standards outlined in the Nursing Home Reform Law (the Omnibus Budget Reconciliation Act of 1987).
40. For information on average cost of care and Medicaid information, see Fleming & Curti, P.L.C. (visited August 14, 2000) <<http://www.elder-law.com/search.asp>>. For estimated private pay rates in all states, see CARLSON, *supra* note 8, § 7.401.
41. *See* MORRIS, *supra* note 3, at 212.
42. *See id.*
43. *See id.*
44. *See generally*, Toddi Gutner, *Making the Money Last—And Then Some*, BUSINESS WEEK, July 20, 1998, at 84 [hereinafter BUSINESS WEEK].

45. See I.R.C. § 213.
46. For example, under Florida's constitutional and statutory homestead protections, the home is protected from forced sale or creditor claims.
47. See I.R.C. § 152.
48. See I.R.C. § 21(a)(1)
49. See *id.*
50. See SHOPPER'S GUIDE, *supra* note 18, at 16.
51. See *id.* Since some states require certain benefit triggers, it is wise to check with the proper state insurance department for requirements. *Id.* The benefit triggers may also vary between nursing home care and home health care. *Id.* For a state-by-state listing of insurance departments and area agencies on aging, see *id.* at 31–37.
52. See *id.* at 16.
53. See *id.*
54. See *id.*
55. See SHOPPER'S GUIDE, *supra* note 18, at 16–17.
56. See *id.* at 10.
57. See *id.* at 17.
58. See *id.* at 15.
59. See *id.*
60. See SHOPPER'S GUIDE, *supra* note 18, at 17.
61. See *id.* at 10.
62. See *id.* at 18.
63. See *id.* at 18.
64. For a comprehensive discussion of long-term care insurance policies, see HAYES, *supra* note 2. If the incapacitated individual has a well spouse, the well spouse may be well-advised to consider purchasing a policy for himself or herself. See generally SHOPPER'S GUIDE, *supra* note 18 for a good reference on choosing a policy.
65. See generally, David W. Myers, *Reversal of Fortune*, MODERN MATURITY, March/April 1995, at 59 [hereinafter MODERN MATURITY]; see also Carolyn H. Sawyer, *Reverse Mortgages: An Innovative Tool for Elder Law Attorneys*, 26 STETSON L. REV. 617 (1996); see also BUSINESS WEEK, *supra* note 44.
66. See *National Reverse Mortgage Lender's Association* (visited August 14, 2000) <<http://www.reversemortgage.org>>.
67. See *id.* Although the first reverse mortgage was closed in Portland, Maine, in 1961, the government-insured reverse mortgage was not created until 1989. See also Sawyer, *supra* note 65, at 621.
68. See *id.*
69. See *id.*
70. See generally AARP Webplace (visited August 14, 2000) <<http://www.aarp.org>>; FannieMae (visited August 14, 2000) <<http://www.fanniemae.com>>; *National Reverse Mortgage Lender's Association* (visited August 14, 2000) <<http://www.reverse-mortgage.org>>; and National Center for Home Equity Conversion, *Consumer Information on Reverse Mortgages* (visited August 14, 2000) <<http://www.reverse.org>> for information on various mortgages programs. See also BUSINESS WEEK, *supra* note 44, at 84.
71. See generally, FANNIE MAE, YOUR REVERSE MORTGAGE: FIVE STEPS TO SAFETY (1998) [hereinafter FANNIE MAE].
72. See CUSTOMER EDUC. GROUP, FANNIE MAE, MONEY FROM HOME: A CONSUMER'S GUIDE TO REVERSE MORTGAGE OPTIONS 16–17, 36–37 (1997) [hereinafter MONEY FROM HOME]. Several Internet sites provide online calculators to estimate the amount that can be obtained in various situations, as well as the initial cost involved. See generally, *Alliance Mortgage Company* (visited August 14, 2000) <<http://www.alliance-mortgage.com>>; Department of Housing and Urban Development, *Homes and Communities* (visited August 14, 2000) <<http://www.hud.gov>>; National Center for Home Equity Conversation, *Consumer Information on Reverse Mortgages* (visited August 14, 2000) <<http://www.reverse.com>>; and *National Reverse Mortgage Lender's Association* (visited August 14, 2000) <<http://www.reversemortgage.com>>.

73. See generally, BUSINESS WEEK, *supra* note 44, at 84. Closing costs can range from \$5,000 to \$7,000. See *id.*
74. See generally, BUSINESS WEEK, *supra* note 44.
75. See *id.* at 84. See generally Lawrence A. Frolik, *The Special Housing Needs of Older Persons: An Essay*, 26 STETSON L. REV. 647, 657-58 (1996).
76. See generally MODERN MATURITY, *supra* note 65, at 72.
77. See generally, MONEY FROM HOME, *supra* note 72. For an explanation of various types of reverse mortgages, see Sawyer, *supra* note 65, at 643-46.
78. See BUSINESS WEEK, *supra* note 44, at 84.
79. For a side-by-side comparison between interest-bearing and non-interest-bearing credit lines, see National Center for Home Equity Conversion, Consumer Information on Reverse Mortgages (visited August 14, 2000) <<http://www.reverse.com>>.
80. See generally, MODERN MATURITY, *supra* note 72; MONEY FROM HOME, *supra* note 72; FANNIE MAE, *supra* note 71; Sawyer, *supra* note 65.
81. See 12 U.S.C. § 1715z-20(j).
82. See MONEY FROM HOME, *supra* note 72, at 17, 37.
83. See 12 U.S.C. § 1715z-(20)(d)(7).
84. See MONEY FROM HOME, *supra* note 72, at 3.
85. See generally FANNIE MAE, *supra* note 71.
86. See generally MONEY FROM HOME, *supra* note 72.
87. See *id.* at 23.
88. See *id.* at 26.
89. See MONEY FROM HOME, *supra* note 72, at 6. The Federal National Mortgage Association offers a consumer guide to FHA Home Equity Conversion mortgages. They can be reached at 1-800-732-6643. AARP also offers free booklets. Call 1-800-424-3410. In addition, the National Center for Home Equity Conversion, 1-651-222-6775, can help locate a local lender. Also check with local banks.
90. See Sawyer, *supra* note 65, at 62.
91. See MONEY FROM HOME, *supra* note 72, at 5, 25, 56-57.
92. For a listing of additional resources for information on various home equity conversion options, see MONEY FROM HOME, *supra* note 72, at 87-88; Alliance Mortgage Company (visited August 14, 2000) <<http://www.alliance-mortgage.com>>.
93. See REGAN *supra* note 38, § 4.02[2]. The Federal Manual for Veterans and Dependents, forms, and other information are available at the Department of Veteran's Affairs' (visited August 14, 2000) <<http://www.va.gov>>, or by calling 1-800-827-1000.
94. See 42 U.S.C §§ 1396-1396s.
95. See 42 U.S.C. § 1396a(a)(10); 42 C.F.R. '§ 442.210, 440.220. All of the United States, as well as Puerto Rico, Guam, the Virgin Islands, and the Northern Mariana Islands, participate in the Medicaid program. See Regan, *supra* note 38, § 10.02[2].
96. See 42 U.S.C. § 1396r.
97. See generally, REGAN *supra* note 38, § 10.11[3]; 42 U.S.C. § 1396r-5(f)(2); CARLSON, *supra* note 8, §§ 7.07[2], 7.401.
98. See CARLSON, *supra* note 8, § 7.07 at 7-5-7-6.
99. See REGAN, *supra* note 38, § 10.11[2]; 42 U.S.C. § 1396r-5.
100. See generally CARLSON, *supra* note 8, § 7.08 for a discussion of the income limitations and application. See also *id.* § 7.401.
101. See *id.*
102. See *id.*
103. See *id.*
104. See generally, 42 U.S.C. § 1396p(c)(1). For a discussion of penalties and allowances of assets transfers, see CARLSON, *supra* note 8, § 7.12.

105. *See id.*
106. *See id.*
107. The Florida average monthly cost is \$3,300. *See* 65A-1.712(3); 65-A-1.716(5)(d)FAC; HRS Manual 165-22 at 1630-20-01. There is no limit to the potential ineligibility period. Thus, timing of application can be critical. *See* also 42 U.S.C. § 1396p(c)(1)(B)(ii)(I).
108. 42 U.S.C. § 1396p(c)(2)(B).
109. 42 U.S.C. § 1396(c)(2)(A).
110. Rules relating to transfers to trusts are found at 42 U.S.C. § 1396p(d).
111. *See* 42 U.S.C. § 1396p(d)(3)(A).
112. *See id.*
113. *See* 42 U.S.C. § 1396p(d)(3)(B).
114. *See* 42 U.S.C. §§ 1396p(b)(1), (2).