

# SENIOR CITIZENS HANDBOOK

*Laws and Programs  
Affecting  
Senior Citizens  
in Missouri*

**Eighteenth Edition**



*Legal Services of Eastern Missouri*

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## **ACKNOWLEDGEMENTS FOR THE 18TH EDITION**

Welcome to the Eighteenth Edition of the Senior Citizens Handbook. If the Senior Citizens Handbook were a person, that person could now vote. Alas, it is not. However, it is a product of many persons of voting age or above who have tirelessly toiled over the years to make this publication so helpful to so many persons. The Seventeenth Edition was distributed to more than 30,000 persons. We are so grateful.

We are grateful to Kathy Case Tahan, a gentle woman, a scholar and a judge of good content. She made contact with all the authors and was instrumental in gathering together all the necessary information for this update. If the Senior Citizen Handbook were a train, she would be the conductor and chief engineer. So, sticking with the train analogy, Kathy Case Tahan receives a special “toot out.”

THE MISSOURI BAR and the MISSOURI BAR FOUNDATION have become an integral and instrumental to the success of this project, publication, distribution, and support on various levels. Dan Lehman has been very valuable and very hands on. Keith Birkes has been supportive and very helpful. By naming two, I little doubt have omitted others. We know the book goes through a number of hands and we are grateful to ALL OF YOU!

We continue with our now established tradition of tying particular authors to particular chapters. Our deepest appreciation to those of you who year in and year out recognize the value of the publication and take the time to respond to our entreaties to UPDATE, UPDATE, UPDATE. THANK YOU. THANK YOU. THANK YOU. While we endeavor to miss no one, it may happen on occasion. LET STAN KNOW. My sincere apology in the event of an oversight. As always, all of the fine and helpful information contained herein is attributable to the contributors. Any mistakes of information or errors of any other type are attributable to the General Editor.

Stan Platke  
General Editor

## PREFACE

This edition of *Laws and Programs Affecting Senior Citizens in Missouri* is the eighteenth. The first edition was prepared by staff personnel for the Legal Aid Society of the City and County of St. Louis (LAS), presently Legal Services of Eastern Missouri, Inc. (LSEM), with the assistance of members of the Committee on Aging of the Young Lawyers Section of the Bar Association of Metropolitan St. Louis. Seed funding for the project was provided through a grant from the Mid-East Area Agency on Aging. That grant, along with additional money contributed by the Young Lawyers Section of Bar Association of Metropolitan St. Louis, made the first edition possible.

The originator of the concept for the book, as well as general project supervisor and original researcher, was Barbara J. Gilchrist, J.D., Ph.D., then a VISTA attorney in the Elderly Unit of LAS and a member of the Committee on Aging of the Bar Association's Young Lawyers Section, subsequently a staff attorney with LSEM, and presently a professor of law at St. Louis University Law School. Most chapters in this book were topics in a lecture series presented for the elderly in the St. Louis area by Ms. Gilchrist under the sponsorship of the Mid-East Area Agency on Aging. Dan K. Joyce, who was then a law student at the St. Louis University School of Law, completed the adaptation of the original lecture material, performed additional writing, research, and editing, as well as organized and supervised production.

Special thanks for that initial concept go to many people for their helpful contributions to the book. Their suggestions were incorporated into the final product. Thanks to: David Lander, then the Executive Director, Legal Aid Society; Doreen Dodson, then the supervising attorney of The Elderly Law Unit, LAS, and member of the Committee on Aging of the Young Lawyers Section of the Bar; Kathy O'Blennis, then a staff attorney, LAS, and member of the Committee on Aging; Artie Wolf and Mamie Rogers, then Human Services students at Washington University; Mary Lynn Cook of the community relations staff at St. Louis Children's Hospital; and all the staff members of the Mid-East Area Agency on Aging who assisted on the project.

The Missouri Bar Foundation, the Missouri State Office of Aging and the nine regional Missouri Area Agencies on Aging provided additional funding for the second edition. The Missouri Office of Aging and the nine regional Missouri Area Agencies on Aging provided funding and coordination for the third edition. Funding and coordination for the third edition was provided by the Missouri Office of Aging, E.C. Walker, director, through the Older Americans Advocacy Assistance Program, Gerald J. Cohen, legal services developer. The fourth revised and expanded edition also received funding by the Missouri Division of Aging, through the Older Americans Advocacy Assistance Program, as did the fifth edition, Jenny B. Neidens, legal services developer. Initial funding for the sixth edition was provided by the St. Louis Area Agency on Aging. The Missouri Bar Young Lawyers' Section Council, the Missouri Lawyer Trust Account Foundation, and the Missouri Bar Foundation provided substantial funding. The Missouri Bar Foundation, the Missouri Lawyer Trust Account Foundation and the Missouri Bar Young Lawyers' Section Council provided funding for the seventh edition. Funding for the eighth edition was provided by The Missouri Bar Young Lawyers' Section Council, the Missouri Lawyer Trust Account Foundation, and the Missouri Bar Foundation. Funding for the ninth edition was provided by The Missouri Bar Young Lawyers' Section Council, the Missouri Bar Foundation, the Anheuser-Busch Foundation, and the Mid-East Area Agency on Aging. Major funding for the tenth edition was provided by the Missouri Bar Foundation. Funding was also provided by the Missouri Young Lawyers' Section Council and the Missouri Lawyer Trust Account Foundation. From the 11th edition forward, the major funding for the *Senior Citizens Handbook* has been the Missouri Bar Foundation. We are truly appreciative and grateful. We would further like to acknowledge and thank The Missouri Bar for printing this publication and for the extraordinary efforts toward distribution. The strong commitment of The Missouri Bar to this project has been instrumental in its success. It is truly difficult to overstate the importance of The Missouri Bar and Missouri Bar Foundation to this publication. Their effort has been and continues to be extraordinary.

Along the way, many individuals have contributed to various editions of this handbook. The list is lengthy, but important to include because cooperative effort has always been and continues to be the keystone to the continued success of this work. Those individuals include Dorothy O'Driscoll, Ann B. Lever, Kevin Crinn, Susan Alverson, Jay Whaley, Richard Chase, Kayla Vaughan, Nina Balsam, Michael Ferry, Gayle Williams, Judy Freiberg, Jo Ann Greenberg, Merton C. Bernstien, Michael M. Greenfield, Carol Indelicato, Kathleen Murray, Mary E. Wyrick, Betty Springfield, Fran Grecco, Marsha Griffin, Sara Henryson, Thomas Borek, Dennis Capriglione, John Essner, Karen Shelly, Colleen Landefeld, Ted Tahan, Pauline Davis, Daniel Claggett, Catherine Nelson, Virginia Neel, Dianne Taylor, Melton Lewis, Kathy Tahan, Kerry Kaufmann, Richard Wise, Pam Coffin, Jacob Gobel, Philip Senturia, Daniel Claggett, Paul Hargadon, David Purcell, Joel Ferber, Harry Charles and Karen Warren. To all these individuals and to those who escaped notice and attention, thank you one and all.

Stan Platke  
General Editor

## FINANCIAL ASSISTANCE

### THE BASICS OF SOCIAL SECURITY AND SUPPLEMENTAL SECURITY INCOME

*Editors' Note: The information in this booklet on Social Security and Supplemental Security Income (SSI) is designed to give you a brief idea of what these programs are all about and what you have to do to qualify for them. All figures used to determine eligibility for benefits are current as of January 2009, and are subject to change at any time. For more detailed information about Social Security and SSI, call or visit the Social Security Administration Office nearest you.*

#### Introduction to Social Security

For most American workers, the initials "FICA" on their paychecks may mean nothing more than a payroll deduction. Some refer to it as "just another tax," while other persons only know that it means money they have earned and cannot spend.

Actually, the letters "FICA" stand for "Federal Insurance Contributions Act," the official name for the federal law that set up the Social Security Program of 1935. Social Security provides a minimum income for eligible workers and their families when the worker retires, becomes severely disabled, or dies. Following are some basic facts you should know about Social Security.

#### General Eligibility

Full retirement age for individuals born in 1937 or earlier is 65 years old. For each year later a person was born, their retirement age goes up two months, until 1943. Individuals born from 1943 through 1954 will all retire at age 66. After 1954, the retirement age moves upward again two months per year through 1960. For instance, someone born in 1938 reaches full retirement age at 65 years and two months of age, while someone born in 1959 reaches full retirement age at 66 years and 10 months of age. For individuals born in 1960 or later, full retirement age is 67.

Eligibility for Social Security benefits depends on how long you have contributed to the program as a worker. In order to qualify for retirement, disability or survivors benefits for you or your family, you must have a certain number of years of coverage. Historically, workers generally earned a quarter of coverage for each three-month calendar quarter in which wages of \$50 or more were paid. A quarter of coverage is now often called a "credit" because the quarters of coverage can be earned at any time during a year. A highly paid worker can earn all four quarters, or credits, in the beginning of the year. (Four quarters, of course, make one year of coverage.)

In 2011, for example, a worker receives one credit for each \$1,120 of earnings, up to a maximum of four credits based on annual earnings of \$4,480 or more. This amount goes up each year, and was lower in the past. This amount includes gross wages paid and net self-employment income.

Just more than 10 years of coverage (40 quarters) will generally fully insure a worker and family for life, but less than that will also be enough for full coverage if the worker has achieved a certain amount of work credit. The work credit requirement differs, depending on whether you are applying for retirement benefits or whether your spouse and dependents are applying for survivors benefits after your death. To find out how many quarters you have or how many you need to qualify, contact your local Social Security Administration office.

To be eligible for **disability** payments, you must meet the following test:

- (1) You were recently employed; and
- (2) You possess the same amount of work credit that would be required if you reached retirement age in the year you were disabled; and
- (3) You have 20 quarters (five years) of coverage out of the preceding 40 calendar quarters (10 years) before you became disabled. The required coverage is lower if you became disabled before the age of 31. It is important to apply for disability benefits soon after you become disabled, because a lengthy delay may make you ineligible.

NOTE: For those disabled by blindness, (1) and (2) above are required, but not (3).

## How Much to Expect

Being "covered" or insured only means that you and your family can get benefits. The amount you receive in monthly paychecks depends on the **average yearly earnings** of your working career under Social Security. These basic benefits are now automatically adjusted upward every January to keep pace with the cost of living. Because workers do not pay FICA tax beyond a certain amount of earnings in a year, there is always a maximum amount for retirement benefits. As of January 2011, the normal maximum monthly amount of retirement insurance benefits for an individual who reaches full retirement age in 2011 is \$2,366. Sometimes a retired person's dependents (such as spouse or minor children) will also receive payments, up to a total of about 50 percent more.

If you are retired or near retirement and you want to figure out your Social Security benefits, call the Social Security Administration toll free at 1-800-772-1213 and ask to receive a **Personal Earnings and Benefit Estimate Statement** (PEBES). These statements are now also automatically sent annually to any individual who paid taxes on income during the previous year.

Social Security also now encourages people to file applications and seek information via their website, [www.socialsecurity.gov](http://www.socialsecurity.gov), which has many useful functions, including frequently asked questions and complete lists of the rules and regulations covering Social Security's programs.

The amount of retirement benefits you receive can be affected by whether you take "early retirement." You may choose to retire as early as age 62. However, for each month you take your benefits early, your monthly benefits are permanently reduced by a certain percentage (depending on your full retirement age). For an individual born in 1943, for instance, taking retirement at age 62 instead of age 66 (four years early) would result in a 25 percent reduction of their monthly payments on a permanent basis.

## Working After Payments Start

After retirement, you may get an opportunity to go back to work on a full-time or part-time basis. Before you decide to work, you should know how your earnings would affect your Social Security benefits.

Workers younger than full retirement age can earn \$14,160 in 2011 (\$1,180 per month) without affecting their retirement checks at all. For every two dollars (\$2) of earned income above that limit, Social Security will reduce their checks by one dollar (\$1).

A worker can earn \$37,260 (as of 2011) in the year they reach full retirement age without affecting their retirement checks. For every three dollars (\$3) of earned income above that limit, Social Security will reduce a check by one dollar (\$1). However, Social Security will only count earnings prior to the month in which the individual reaches full retirement age. Starting that month, earnings no longer reduce retirement benefits.

NOTE: For more information about recent changes in Social Security rules relating to work activity, ask for a copy of the free publication, *How Work Affects Your Benefits*, at any Social Security Administration office.

## A Note about So-Called "Notch Babies"

The term "notch" refers to Social Security benefits paid to people born between 1917 and 1921. The notch resulted from a 1972 change in the Social Security law that used a flawed formula to calculate how much someone's benefits should be. This flawed formula provided excess benefits to those people whose benefits were calculated under it. Before Congress corrected this error in 1977, the benefits for many people born between 1910 and 1916 were calculated using the flawed benefit formula; as a result, they received an unintended windfall from Social Security.

When Congress fixed the mistake, it wanted to avoid an abrupt change for those who were about to retire, so it provided a transition period. Therefore, when Social Security benefits are calculated for people born between 1917 and 1921, two computations are used. One calculation uses the new (and correct) 1977 formula, and the other uses a special transition formula. Benefits are based on whichever calculation pays the higher benefit. Benefits for everyone born in 1922 and later are calculated using only the new and correct 1977 formula, which generally results in lower benefits than those computed using the "notch" calculation method.

Thus, the "notch babies" (those born between 1917 and 1921) receive less money than those people born before 1917 who had similar work histories, but generally receive more benefits than those born in 1922 or later. Thus, the argument of "pro-notch baby" groups is that beneficiaries born between 1917 and 1921 should get more money simply because people born between 1910 and 1916 are getting too much money. Naturally, the people born after 1921 would also want to receive this extra money. This would result in the whole system changing back to the incorrect formula from 1972, resulting in billions and billions of extra dollars spent each year. The government has completed an investigation into the notch and determined that no changes will be made.

The discontent of “notch babies” is kept alive by profiteering lobbying groups who mislead people born between 1917 and 1921 into thinking that they are receiving fewer benefits than people both older and younger than they are. This is not true.

### **Introduction to Supplemental Security Income (SSI)**

The Social Security Administration also administers the Supplemental Security Income (SSI) program. This program provides a basic monthly income to blind, disabled and elderly (age 65 or older) persons who urgently need financial assistance. Unlike Social Security, you can receive SSI checks even if you have never worked or if you do not qualify for Social Security for some other reason.

### **Who Qualifies?**

SSI is available to persons who meet the income requirements and who are 65 or older, blind, or disabled.

"Blindness" is defined under the SSI program as central visual acuity of 20/200 or less in the better eye with the use of a corrective lens or visual field restriction to 20 degrees or less.

SSI defines a person as "disabled" if that person is unable to engage in any substantial gainful employment due to a physical or mental impairment that has lasted or is expected to last for at least 12 months or is expected to result in death.

As of January 2011, one's individual “countable” income must be less than \$674 a month. A couple's countable income cannot be more than \$1,010 a month. Social Security uses the term “countable” because not all income counts. The first \$20 of most income, \$65 more of wages, one-half of wages above \$65, food stamps, home energy and housing assistance, and other exemptions are not counted as income. The Social Security Administration considers gross wages, rather than net income, or “take home” pay.

*NOTE: By law, the above figures are subject to change once a year.*

A single person can have **available assets** (i.e. easily converted to cash) up to \$2,000 and still receive SSI. A couple can have up to \$3,000. In addition, you may own a car worth \$4,500 or less, a home of any market value as long as you reside in it, household goods worth \$2,000 and a life insurance policy worth \$1,500 (face value) without losing SSI benefits. There are some exceptions to these limitations. Contact the Social Security Administration office in your community for more information.

### **What May Reduce Your SSI Benefits?**

Any unearned income greater than \$20 a month reduces the amount of your SSI check. This type of income includes Social Security payments, pensions, gifts and other unearned money. People who work while receiving SSI can earn up to an additional \$65 per month without having their benefits reduced. For every two dollars (\$2) of earned income above that amount, their SSI check is reduced by one dollar (\$1).

Eligible people living in a friend's or relative's home may face a reduction in SSI benefits. Also, an unmarried couple living together may be listed by the Social Security Administration as "holding out as husband and wife." When this happens, and both persons are receiving SSI, each check will be reduced, if necessary, so that the two checks together will equal the amount that a couple would receive. If you feel that such rulings are wrongly applied to your situation, you can challenge them administratively or in court. (See Appeals Process.)

### **Appeals Process**

If your application for Social Security or SSI benefits is denied or if any of your benefits are reduced or terminated, you have the right to appeal the decision. Here are the steps:

(1) After the action is taken against you, you must make a written request for **reconsideration** or for a **hearing** in front of an administrative law judge within 60 days of the denial. Note: If you previously were receiving benefits, and you are being terminated because you have medically improved and are now able to work, and you disagree, and you file your request for reconsideration or hearing within 10 days of the denial, your benefits will continue until the reconsideration decision is made.

(2) If you win an appeal at any level, you will be entitled to all of the benefits you would have received if your application had been granted right away.

(3) If an administrative law judge finds against you, you have a right to request a review by the Social Security Appeals Council in Virginia within 60 days of the adverse decision. The council can refuse to review the case.

(4) If the council refuses to review or decides against you, you have another 60 days to appeal to the U.S. District Court.

Under an experimental new appeals structure, many Missouri applicants for benefits based on disability are able to skip the reconsideration stage.



Forms are available from any Social Security Administration office or on the Internet at <http://www.socialsecurity.gov>. You are allowed to have a friend or relative assist in any appeal proceeding. You may also want to contact an attorney to help with an appeal or any other matter concerning the Social Security and SSI programs. In new claims for benefits, most attorneys only charge a fee if the claim is successful and charge a percentage of the retroactive benefits award. Consult the listing at the end of this booklet for legal assistance information.

It is illegal for attorneys or other representatives to charge any fee for help in any Social Security matter without getting the approval of the Social Security Administration.

### **Representative Payees**

Some Social Security recipients receive checks on behalf of beneficiaries. These recipients are known as **representative payees**. Their primary responsibility is to use the Social Security money for the basic or personal needs of the beneficiary.

The representative payee is usually a spouse or other relative, friend or legal guardian. An institution such as a nursing home can also be designated as a representative payee.

Appointment of a representative payee begins with a friend or relative notifying the Social Security office that an individual is incapable of handling her or his own affairs. A doctor's statement to that effect must also be filed. The Social Security Administration then determines whether the individual is mentally competent to continue receiving her or his own checks. If the Social Security Administration finds that the individual is not competent to do so, it will select a representative payee. This selection may be challenged.

If, at some point after the appointment of a representative payee, an individual feels competent to personally receive the Social Security checks, that individual can ask the Social Security Administration to stop payment to the representative payee. For more details about stopping representative payments or changing your representative payee, call or visit the Social Security office nearest you.

## **FINANCIAL ASSISTANCE**

### **FOOD STAMP PROGRAM/SUPPLEMENTAL NUTRITION ASSISTANCE PROGRAM (SNAP)**

*By Karen Warren and Paul Hargadon of Legal Services of Eastern Missouri, Inc. Karen is the co-managing attorney of the Health & Welfare Unit at Legal Services working with the Public Benefits Project. Paul is a public benefits specialist with the Public Benefits Project.*

*Editors' Note: This information is designed to give you a brief description of the Food Stamp Program and what you have to do to qualify for it. The rules listed below are specific to individuals 60 and older; other rules may apply if you are younger than 60 or are an immigrant (non-citizen). All figures are current as of October 2010, but are subject to change. For more information, call or visit the Family Support Division Office (formerly the Division of Family Services) nearest to you. Information on the Food Stamp program and other programs administered by the Family Support Division is available on the Internet at <http://www.dss.mo.gov/fsd/index.htm>. The Food, Conservation, and Energy Act of 2008 renamed the Food Stamp program the "Supplemental Nutrition Assistance Program" (SNAP) effective October 1, 2008. At this time, the program is still called the Food Stamp Program in Missouri.*

#### **Introduction**

Steadily rising food costs pose special problems for millions of older Americans on fixed incomes. The Food Stamp Program helps stretch the food budgets of persons with eligible incomes. Food stamp benefits are issued on an electronic benefits transfer (EBT) card. It is issued by

the federal government and looks like a credit/debit card, but it can only be used to purchase food.

#### **How to Get Food Stamps**

To apply for food stamps, you can have an application mailed to you or you can visit the nearest Missouri Family Support Division (FSD) office to apply in person. FSD is

required to take your application *on the same day* that you visit the office. If you request an application by mail, FSD is required to mail you one *on the same day* that you request an application. You can download and print off and complete a food stamp application at <http://www.dss.mo.gov/fsd/fstamp/index.htm>. You can return the application in person, by mail or by fax. You can view a list of address information and fax numbers for FSD county offices at <http://www.dss.mo.gov/fsd/office/index.htm>.

As with all financial assistance programs, you must meet certain income eligibility requirements. You should provide proof to the FSD office of all income, rent, utility, child care, and medical expenses – including out-of-pocket expenses for health insurance premiums, doctor bills, prescription bills, required medical equipment or supplies, and transportation costs you incur to obtain medical services. Because income and expenses are evaluated for program eligibility, you should be careful to provide documentation and verification in order to obtain the maximum amount of food stamp benefits. However, do not delay applying if you do not have all of these pieces of verification.

The application process starts the day you apply, even if you do not have all of the verifying information. FSD has 30 days to process the application. However, if you have less than \$150 in monthly gross income and \$100 or less in liquid resources, or your rent and utilities exceed your income and resources, you are eligible for “expedited” food stamps, which means that FSD must give you food stamps within seven days of your application. The only piece of information required for expedited food stamps is verification of your identity.

At initial application and when there is a break in the food stamps certification period, applicants will be screened for expedited (emergency) food stamp benefits. Expedited food stamp benefits are prorated from the date of application through the end of the application month. In some circumstances, the eligibility specialist (caseworker) may screen the household to determine if the criteria for expedited service benefits are met for the following month.

### **Income Requirements**

Eligibility is determined on a “household” income basis. A “household” is a person living alone or people living together who meet two tests: (1) they buy food together, and (2) they prepare food together. FSD uses the term “eligibility unit” when referring to a household. If you share a residence and buy and store your food separately from that of your companions, you will not be considered part of the household for food stamps purposes. Certain household members are mandatory food stamps

household members, regardless of how they purchase and prepare meals. These household members are as follows: (1) spouses; (2) parents and children under 22 years old; and (3) children, except foster children, under 18 years old who are under the parental control of a person other than their parents and that individual is exercising parental control (i.e., grandparents may apply for grandchildren in their care, even if they do not have “legal” custody).

**NOTE:** Foster children may be included in the food stamps household, but their income must also be included in determining the household income.

However, if you are at least 60 years old, living with others, and unable to purchase and prepare food because of a permanent disability, you can be your own household as long as the others with whom you live do not have an income greater than 165% of the poverty level. The burden is on you to show that situation exists if you want to be considered for food stamps apart from other household members.

If the entire household consists of persons who are elderly (age 60 years or older) or meet the Food Stamp Program definition of disabled, the countable income is the net monthly income. Net monthly income is the gross monthly income (monthly income before deductions) minus the following: 20 percent of gross earned income; a standard deduction, based on the number of eligible members in the household; dependent care expenses; shelter and utility costs that exceed 50 percent of income; and allowable medical expenses greater than \$35 a month. It is important for you to tell your eligibility specialist (caseworker) about all your medical expenses, including over the counter medications you take at your doctor’s direction and any transportation costs for getting medical care.

Many people mistakenly believe that the Food Stamp Program is designed to help only the desperately poor or non-working people. However, elderly and disabled households are often eligible for a \$16 minimum monthly benefit. In addition, households with an elderly or disabled member are not subject to a gross income test.

### **Resource Limits**

Households with at least one member 60 years old or older may have resources up to \$3,000.

The following assets do not count as resources in determining food stamp eligibility: your home and surrounding property; income producing property; personal belongings and household goods; burial plots; the cash value of life insurance policies and pension plans; rental property if rented at fair market value;

property and equipment used for self-employment; resources such as trust funds or security deposits not readily available as cash; and the value of all vehicles.

### **Food Stamp Exclusions**

Food stamps may be used only to purchase food. However, hot food that has already been prepared cannot be purchased with food stamp benefits (i.e., food prepared at grocery store salad bars, buffets, and meat departments, and the purchase of meals at restaurants). In addition, you may not use food stamp benefits to purchase non-food items, and the regulations explicitly exclude the purchase of tobacco, pet food, alcoholic beverages, and paper products with food stamp benefits.

### **Denial: Right to Appeal**

If your application for food stamp benefits is denied, you may appeal the denial through the fair hearing process. To request a hearing, you may visit the FSD office, contact your eligibility specialist (caseworker) by

telephone, or send a written request. A fair hearing must be requested within 90 days of the date of denial. Just as with Social Security and SSI, you may want the help of an attorney. FSD can provide information to you regarding free legal assistance available in your area.

If FSD sends a notice to terminate or reduce your food stamp benefits, you may also request a fair hearing. If the request is made within 10 days of the date of the notice, you may request to continue to receive benefits, at the current benefit amount, until the decision from the fair hearing is received. If the hearing decision is in your favor, you will continue to receive benefits. However, if the hearing decision is not in your favor, you may be required to pay back the benefits that you received.

If you are not satisfied with the decision from the fair hearing, you may appeal to the circuit court in your county. This appeal must be made within 90 days of the date of the fair hearing decision.

## **FINANCIAL ASSISTANCE**

### **TAX RELIEF FOR THE ELDERLY**

*By Harry Charles, attorney at law and CPA. Mr. Charles is a sole practitioner concentrating on tax disputes. He is also an adjunct tax professor at Washington University School of Law. All tax sections are attributable to Mr. Charles.*

#### **The Missouri Property Tax Credit (commonly called “circuit breaker”)**

The State of Missouri has expanded the Property Tax Credit (PTC). If a taxpayer is single and a renter or part year homeowner, the first question is whether their total household income is \$27,500 or less. If married filing combined, the total income must be \$29,500 or less. For 100 percent service connected disabled veterans, VA payments can be excluded from the income calculation. For those taxpayers who owned and occupied their home for the entire year, the income limit for a single person is \$30,000. For those filing married combined, the income limit is \$34,000. As before, 100% service connected disabled veterans can exclude their VA payments. Taxpayers must have paid real estate taxes or rent on the home that they occupied.

Secondly, taxpayers must truthfully state that they did not employ illegal or unauthorized aliens.

The final test is whether the taxpayer or their spouse was 65 years of age or older as of December 31, 2008 and either was a Missouri resident for the entire 2009 calendar year. If neither the taxpayer nor their spouse was 65 years or older as of December 31, 2009, and neither was a full-year Missouri resident, the state provides the first of three fallback qualifiers. If the taxpayer or their spouse was 100 percent disabled as a result of military service, then they qualify for the PTC. The second fallback qualifier allows the PTC if the taxpayer or their spouse was 100 percent disabled in 2009. The third fallback qualifier allows the PTC if the taxpayer was 60 years of age or older as of December 31, 2009 and received surviving spouse Social Security benefits.

Qualifying taxpayers who are not required to file a federal tax return should file Form MO-PTC. For those who are required to file a federal return but do not claim an income modification or a pension exemption, file MO-1040P. Those who must file a federal tax return and

have modifications to income or claim other tax credits should use both MO-1040 and MO-PTS.

The Department of Revenue offers free preparation of the Missouri individual income tax return and/or property tax credit by Department of Revenue employees at the Tax Assistance Offices. The offices are located in Jefferson City (573-751-7191), St. Louis (314-877-0177), Cape Girardeau (573-290-5850), Springfield (417-895-6474), Joplin (417-629-3070), Kansas City (816-889-2920) and St. Joseph (816-387-2230). Additional information is available at <http://dor.mo.gov/tax/assistance.htm>.

### **Homestead Preservation Credit**

The Homestead Preservation Credit offered qualified taxpayers (65 or over and/or 100 percent disabled) a tax credit if their real estate property taxes increase 2.5 percent in a non-reassessment year (even-numbered year) or 5 percent in a reassessment year (odd-numbered year). The credit is for the amount that exceeds the 2.5 or 5 percent tax increase. The legislature must appropriate money for the credit and taxpayers must claim it each year that they qualify. The filing period for the 2009 HPC will be from **April 1, 2009 to October 15, 2009**. No extensions are available. The HPC program expired on August 28, 2010.

## **FINANCIAL ASSISTANCE**

### **INCOME TAXES**

#### **Taxable Income**

The basic federal rules are as follows. For taxpayers who are single and 65 or over at the end of 2009, they must file a return if their gross income was at least \$10,750. For taxpayers filing as head of household who were 65 or older, the income required for filing is \$13,400. For those filing married jointly, if one is 65 or over, the income required for filing is \$19,800. For married filing jointly, and both are 65 or over, the income required for filing is \$20,900. For married filing separately at any age, the income required for filing is \$3,650. For qualifying widow(er) with dependent child and 65 or over, the income required for filing is \$16,150.

The taxable part of Social Security benefits is usually no more than 50 percent. However, up to 85 percent can be taxed if the total of one half of the taxpayer's benefits and all of their other income is more than \$34,000 (\$44,000 for married filing jointly) or the taxpayer filed "married filing separately" and lived with their spouse at any time during 2009.

#### **Deductions from Income**

Taxpayers are allowed to deduct from their adjusted gross income the greater of either their standard or itemized deductions. The standard deductions for most people are as follows: (1) for single or married filing separately, the standard deduction is \$5,700; (2) for married filing jointly or qualifying widow(er) with dependent child, the number is \$11,400; and for (3) head of household, the standard deduction is \$8,350. There

are higher standard deductions for taxpayers or their spouses who were born before January 2, 1944 and/or blind. Each condition (age and blindness) increases the deduction.

There is a federal tax credit for the elderly or the disabled, which is available to taxpayers who were 65 or older at the end of 2009 or were under 65 but permanently and totally disabled, received taxable disability income in 2009, and as of January 1, 2009 had not reached mandatory retirement age. The federal credit has income limits which are set forth in IRS Publication 524, "Credit for the Elderly or the Disabled."

Missouri increased its standard deduction amounts.

#### **Residential Dwelling Accessibility (DAT) Tax Credit**

Missouri enacted a tax credit for making a taxpayer's principal residential dwelling accessible for individuals with disabilities. The disabled individual must permanently live in the dwelling. The credit is issued on a first come, first served basis and is available to any individual or married couple with a federal adjusted gross income of \$30,000 or less. These qualifying taxpayers can get a credit equal to the lesser of 100 percent of their cost or \$2,500 per taxpayer, per year. For taxpayers with incomes between \$30,000 and \$60,000, the limit is 50 percent of cost, or \$2,500, whichever is less. The credit cannot be obtained in successive tax years. The credit must be claimed by

April 15 of the tax year via Forms MO-DAT and MO-TC.

### **Selling a Home**

If a taxpayer decides to sell his/her home and receives more for the home than was paid, including improvements, the taxpayer has realized a gain on the sale, which may be taxable. For taxpayers who sold their main home in 2009, they may be able to exclude up to \$250,000 (\$500,000 on a joint return). IRS Publication 523, "Selling Your Home," sets forth the rules and includes charts on calculating the gain. In recognition of current economic problems, there are special rules for foreclosures or repossessions of a principal residence. If a lender cancels a taxpayer's duty to pay back their principal home mortgage, this can trigger a Form 1099-C, "Cancellation of Debt," which is an income document, reported to the IRS. For discharges of indebtedness as described above made after 2006 and before 2013, taxpayers can exclude from their gross income this "phantom income." However, they must reduce the basis of their home by the amount excluded. IRS Form 882 sets forth the rules.

### **Dependents**

The rules for claiming dependents on a tax return are complicated. Essentially, dependents can be qualifying children or qualifying relatives. Qualifying children are your son, daughter, stepchild, foster child, brother, sister, half brother, half sister, stepbrother, stepsister, or a descendant of any of them. The child must be less than age 19 at the end of the year, less than age 24 at the end of the year and a full-time student, or any age if

permanently and totally disabled. Qualifying relatives are not qualifying children and do not have to live with the taxpayer. These include a child, stepchild, foster child (or a descendant of any of them), brother, sister, half brother, half sister, stepbrother, stepsister, father, mother, grandparent, or other direct ancestor, but not foster parent, stepfather, stepmother, son or daughter or your brother or sister, the taxpayer's son-in-law, daughter-in-law, mother-in-law, brother-in-law or sister-in-law. A taxpayer generally cannot claim a married person as a dependent if they filed a joint return. The taxpayer must have provided more than half the support for a qualifying relative; a qualifying child must not have provided more than half of their own support. The rules are set forth in IRS Publication 501, "Exemptions, Standard Deduction and Filing Information."

### **Midwest Disaster Exemption**

Taxpayers may be able to claim a \$500 exemption if they provided housing to a person displaced by a Midwestern disaster. IRS Form 8914 covers the rules.

### **Foreclosure**

IRS Publication 4681 deals with canceled debts, foreclosures, repossessions, and abandonments. The most important issues for many taxpayers concern foreclosure or abandonment of a taxpayer's main home. Taxpayers who receive IRS Form 1099-C (Cancellation of Debt) or Form 1099-A (Acquisition or Abandonment of Secured Property) should consult the publication and/or a tax professional to properly report the disposition of their property.

## **FINANCIAL ASSISTANCE**

### **PRIVATE PENSIONS**

*By Pam Coffin of Mercer, Inc. a human resource consulting firm. Ms. Coffin specializes in pension work. She is also a long-term participant in the Legal Services, Inc., Volunteer Lawyers Program.*

### **Eligibility**

Many retired and disabled workers who are receiving Social Security benefits have worked in one or more jobs that were covered by an employer-sponsored retirement plan, such as a pension plan or a 401(k) plan. This chapter describes plans subject to a federal law

called ERISA, which covers many retirement investment plans. Those plans that are not subject to ERISA (primarily plans for employees of government and church-related organizations) are subject to different rules. If the plan requires employees to contribute in order to participate, employees have a 100 percent "vested" right to the benefits for which they have paid.

Employer-paid benefits are usually subject to a “vesting” schedule, which may require employees to work for as long as five years in order to “vest” in all or part of the employer-paid benefits. Employees who last worked for a company before 1989 may not have a vested right to employer-paid benefits if they worked for less than 10 years.

Vesting is based on “service” with the employer. Service usually means a calendar year or other 12-month period during which an employee is credited with 1,000 hours. However, some plans simply require 12 months of work and do not count hours. If an employee terminates employment before that person has a vested right to any part of the benefit and does not return to work for the employer for five or more years, prior service will be lost. Once the employee becomes vested, however, that employee will always be vested in the benefits earned under that plan. In a plan, such as a 401(k) plan, that requires employee contributions, an employee who makes employee contributions and who has any service on or after January 1, 2006 cannot lose prior vesting service no matter how long he is gone. Slightly different rules apply if an employee last worked for a company before 1989.

#### **Payment of Benefits Upon Termination or Retirement**

Many plans automatically “cash out” employees whose vested benefit is worth \$5,000 or less by paying the entire benefit in a lump sum. However if the employee has not reached the plan’s normal retirement age, a lump sum in excess of \$1,000 can be distributed without consent only if the plan sponsor establishes an IRA for the employee and deposits the benefit in the IRA. The employee can withdraw the money from the IRA at any time (subject to a 10 percent penalty unless the employee is at least age 59-1/2 or meets certain other requirements). Many plans – especially pension plans – either (1) do not cash out benefits worth more than \$1,000, or (2) require the employee’s consent to pay lump sums between \$1,000 and \$5,000. This avoids the need to set up an IRA. An employee who was cashed out is not entitled to a pension from the plan at retirement because that employee has already received the benefit.

If the plan does not cash out small benefits – or if the employee’s pension was too large to cash out – the employee will be entitled to receive a benefit upon reaching the plan’s “normal retirement age” – usually age 65. Many plans permit payment to begin earlier – at the “early retirement date” if the employee meets the plan’s eligibility rules. Early retirement eligibility rules typically require the employee to be 55 or 60 years old with 5, 10 or 15 years of service. Monthly payments

under early retirement pensions are normally smaller than monthly payments beginning at normal retirement because the employee has fewer years of service and because the payment period will be longer.

Pension plans must pay benefits in the form of an annuity, although they can offer other optional forms. An annuity means that periodic payments are made (usually monthly) as long as the employee lives. Married employees are entitled to receive a form of payment called a “qualified joint and survivor annuity.” A qualified joint and survivor annuity usually pays a reduced monthly benefit during the employee’s life in order to provide periodic payments (usually 50 percent of the employee’s payment) to the surviving spouse after the employee’s death. Under this form of payment, the spouse to whom the employee was married at retirement is entitled to the survivor benefit even if they are later divorced (or the spouse dies and the employee remarries). Beginning in 2008, married employees must also be offered a “qualified optional survivor annuity” that pays a reduced benefit during the employee’s life and a different percentage (usually 75 percent) of the employee’s payment to the spouse after the employee’s death. A married employee can elect to receive a form of payment other than a joint and survivor annuity with his spouse as beneficiary only if the spouse consents both to the form of payment and to any non-spouse beneficiary.

Usually, 401(k) plans pay benefits in the form of a lump sum or in installments.

Plan distributions generally must begin by April 1 following the calendar year in which the employee reaches age 70-1/2 or, if later, the calendar year in which the employee stops working for the company that sponsors the plan.

#### **Disability Benefits**

Some pension plans pay disability pensions to employees who must quit working for the company because they become disabled. Some plans require the employee to qualify for Social Security disability; others have different standards. Most pay disability benefits only to employees who become disabled after completing a minimum period of service – such as 10 or 15 years.

#### **Pre-Retirement Death Benefits**

If the employee dies after becoming vested and *before* receiving any benefits under the plan and if the employee was married at death, the surviving spouse will be entitled to a surviving spouse benefit under a pension plan. However, some plans permit the employee to waive the coverage (with the spouse’s consent). Many

plans automatically “cash out” a surviving spouse whose pre-retirement death benefit is worth \$5,000 or less by paying the entire benefit in a lump sum. A survivor benefit that is too large to cash out is usually paid in the form of an annuity for the life of the survivor beginning at the employee’s death or, if later, when the employee could have elected to begin receiving benefits had the employee survived. Most pension plans do not pay pre-retirement death benefits to non-spouse beneficiaries, although this is becoming more common, especially in a type of pension plan called a “cash balance” plan. A non-spouse beneficiary can be automatically cashed out regardless of the amount.

In a 401(k) plan, the surviving spouse is entitled to receive the employee’s vested account balance unless the employee designated a non-spouse beneficiary (with spousal consent). An unmarried employee can also name a non-spouse beneficiary for the account. Death benefits in a 401(k) plan are typically payable in a lump sum after the employee’s death.

#### **Post-Retirement Death Benefits**

After payment begins to the employee under a plan, a death benefit will be payable only if a death benefit is provided under the form of payment in effect at retirement. If the employee was married and if payment was made in the form of a joint and survivor annuity, the surviving spouse will receive payments (usually 50 or 75 percent of the employee’s payment, depending on the employee’s election) for life. If payment was being made for the life of the employee only, no death benefit will be payable.

#### **Taxation of Benefit Payments**

Monthly benefit payments – or installment payments made over a period of 10 or more years – are generally taxable to the recipient and are subject to federal income tax withholding, just like wages, regardless of who receives them. However, unlike wages, the recipient may elect not to have tax withheld from these pension benefits. Plan distributions are not subject to Social Security (FICA) tax.

Employees (and surviving spouses) who are entitled to receive taxable lump sums or installments over a period of less than 10 years from an employer-sponsored retirement plan generally must be allowed to choose between taking the distribution in cash or having it “directly rolled over” to an eligible retirement plan that accepts rollovers. Eligible retirement plans include traditional IRAs, Roth IRAs, tax-qualified retirement plans, tax-sheltered annuities and certain eligible state or local government deferred compensation plans. Taxable amounts that are rolled over are generally not taxed until

they are actually paid out. Taxable amounts that are rolled over to a Roth IRA are included in the recipient’s income for the current year. However, if certain rules are met, distributions from the Roth IRA (including any investment earnings) will be tax-free. See **Individual Retirement Plans**, below. Taxable amounts that are not directly rolled over are subject to 20 percent mandatory federal income tax withholding.

After-tax employee contributions can also be rolled over to an eligible retirement plan (other than a state or local government deferred compensation plan) that accepts after tax amounts.

Distributions that are required to be made because the employee is over age 70-1/2 and hardship distributions from 401(k) plans cannot be rolled over.

A non-spouse beneficiary may be entitled to elect to directly roll over a lump sum distribution into an IRA or a Roth IRA. Taxable amounts that are not directly rolled over are subject to 20% mandatory federal income tax withholding.

#### **Common Problems**

- The employee or survivor fails to notify the employer of changes in address after the employee leaves employment (or dies).
- The employee or survivor fails to apply for benefits when eligible.
- The employer’s or the plan’s records are incomplete or incorrect with respect to the employee’s eligibility for plan benefits.
- The employee does not work for an employer long enough to become “vested.”
- The employee does not work in an eligible classification long enough to earn a benefit.
- Union membership does not guarantee coverage under a pension plan – the employee must also work for employers who contribute to the plan.

In some cases, the insolvency of the plan or the employer will affect benefits. The PBGC – a federal insurance agency – guarantees some (but not all) benefits under most types of pension plans. Benefits under other types of plans – such as 401(k) plans – are not guaranteed or insured. However, the employer and others who operate plans of all kinds are required by law to use plan assets only for the purpose of paying benefits and expenses.

If a plan is terminated or a former employee who is entitled to a benefit cannot be located, the PBGC or the Social Security Administration may be asked to notify the employee that a benefit is due.

### **Qualified Domestic Relations Orders**

As a general rule, an employee's benefits in a retirement plan cannot be assigned or reached by creditors before they are paid to the employee. However, a court can order a plan to pay benefits to a spouse, former spouse, or child to satisfy the employee's support obligations or to divide marital property in a divorce. The order will be valid only if it meets certain requirements. In many cases, payment cannot be made to the spouse or other person under the order until the employee is eligible to receive benefits from the plan. A lump sum paid to a spouse or former spouse under a qualified domestic relations order can be directly rolled over to an IRA or other plan (and is subject to 20 percent federal income tax withholding if it is not directly rolled over).

### **Information About the Plan**

Federal law requires the employer (or the plan administrator) to furnish plan participants and beneficiaries with a summary plan description that contains information about the important provisions of the plan. A copy of the plan document must also be made available upon request. Participants are entitled to request a benefit statement once a year, showing the benefit earned to date and whether it is vested.

### **Claims for Benefits**

If an employee or beneficiary applies for a benefit and is denied (or receives less than the applicant believes said applicant is entitled to receive), the plan must provide a written explanation of the reasons for the denial, a description of any additional information needed to review the claim, and a copy of the plan's claim review procedures. The employee must make a claim for benefits in writing and retain a copy as a record. An employee's request for review of a denied claim must be made in writing and must follow the rules set forth in the plan's claim procedures (including the plan's time limit for filing the request). The plan must, in turn, provide its decision on the review in writing.

Sometimes a claim is denied because the employer or the plan has incomplete or incorrect information. The employee may use the employee's own records, Social Security records, or the employer's records to support the claim. Sometimes a claim is denied because the plan is not being operated in compliance with applicable law (or with the terms of the plan document). In such a case, the employee may be able to get a court to force the employer to comply.

If the claim is denied on review, the employee may have to obtain the assistance of an attorney. Pension

cases are seldom easy. Even if the employee wins, no damages are available under ERISA. A court can award the employee the benefit due and attorneys' fees. In some cases, the court may also order the employer to pay the employee a penalty for failing to provide plan information on a timely basis. If the employee loses, however, the employee may be ordered to pay the opposing side's attorney's fees.

Questions about your ERISA rights can be directed to the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory (314-539-2691 in St. Louis) or contact:

Division of Technical Assistance and Inquiries  
Employee Benefits Security Administration  
U.S. Department of Labor  
200 Constitution Avenue NW  
Washington D.C. 20210

You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publication hotline of the Employee Benefits Security Administration at 1-866-444-3272 or by visiting its web site at [www.dol.gov/ebsa](http://www.dol.gov/ebsa).

### **Individual Retirement Programs**

Individual retirement programs are available to employees and people who are self-employed. The most common is the Individual Retirement Account or "IRA." Most people who are working can contribute the maximum amount each year to an IRA, even if they are covered under a retirement plan at work. Spouses can also set aside the maximum amount each year, even if they are not working. The annual contribution limit is \$5,000. Individuals who are age 50 or over by the end of the calendar year can also make a "catch-up" contribution for the calendar year. The maximum annual "catch-up" contribution is \$1,000 per individual. Most people can choose between making tax-deductible contributions to a traditional IRA or nondeductible contributions to a Roth IRA. Both types of IRA have advantages and disadvantages. Traditional IRA distributions are generally fully taxable and must begin after the individual reaches age 70-1/2. Roth IRA distributions are tax-free if certain requirements are met. An individual who works past age 70-1/2 can contribute to a Roth IRA. Distributions from Roth IRAs are not required to begin after the individual reaches age 70-1/2.

**Self-employed persons also have the option of setting up a retirement plan – called a "Keough" plan – that enables them to set aside more money than an IRA. If the person has employees, they must also be covered under the plan.**



# AGE DISCRIMINATION IN EMPLOYMENT

*By Rebecca Stith, a senior trial attorney with the Equal Employment Opportunity Commission and frequent contributor to this publication.*

It is increasingly common for senior citizens to delay their retirement or to work in post-retirement jobs to supplement a fixed income. Despite more than four decades of federal and state laws prohibiting age discrimination, such discrimination still exists in the job market.

The federal Age Discrimination in Employment Act of 1967 (ADEA) applies to employers with at least 20 employees and protects individuals, both applicants and employees, age 40 and older from discrimination in hiring, promotions, terminations, and the terms and conditions of employment. This law applies to private employers, employment agencies, labor organizations, state employers, and federal employers. The State of Missouri also prohibits age discrimination against those 40 to 70 years of age under a law known as the Missouri Human Rights Act (MHRA). Missouri's law applies to private and state (but not federal) employers with at least six employees. Individuals alleging age discrimination at work may file a charge with the Equal Employment Opportunity Commission (EEOC) or the Missouri Commission on Human Rights (MCHR). A charge filed with one agency is considered "dual" filed with the other.

The EEOC enforces four other laws: Title VII of the Civil Rights Act of 1964 (prohibiting discrimination based on race, color, sex, pregnancy, national origin, and religion); the Americans with Disabilities Act or ADA (prohibiting discrimination based on disability); the Equal Pay Act or EPA (prohibiting pay discrimination based on gender); and the Genetic Nondiscrimination Act of 2008 or GINA (prohibiting or severely restricting the use of genetic information in the workplace). With the exception of GINA protections, Missouri's anti-discrimination law generally prohibits the same types of discrimination. This article focuses primarily on age discrimination.

## **Age Discrimination and Retaliation**

Age discrimination can take many forms. For example, an advertisement expressly seeking applicants under age 40 (e.g., "young faces sought") could be a violation under the ADEA and the MHRA, unless the job plainly requires a much younger person, such as a job modeling children's clothing. Most age

discrimination is less obvious. An employer may pass over older employees to promote less qualified under-40 employees, or terminate older employees while hiring younger workers to perform the same duties. If you believe that you are experiencing age or other prohibited discrimination, whether as an applicant seeking a position or as a current employee, then you should report such discrimination to the employer and contact the EEOC or MCHR about filing a charge. Federal and Missouri laws also prohibit retaliation for reporting or opposing what you reasonably believe is discrimination, or participating in the EEOC/MCHR investigation process. If you believe your employer has retaliated against you, then you will want to include an allegation of retaliation in your charge. If such retaliation occurs as a result of your filing a charge, then you can amend that charge to add retaliation or file a second charge.

## **Federal Older Workers Benefit Protection Act**

The ADEA has a special provision known as the Older Workers Benefit Protection Act (OWBPA). Under the OWBPA, if an employer offers an age-protected employee a severance package in return for the employee's waiver of ADEA rights, the employer first must advise the employee in writing to consult with an attorney. The employer must give the employee at least 21 days to consider the offer. In a large termination program, sometimes called a reduction-in-force or RIF, age-protected employees must be given a minimum of 40 days to consider the offer. In a RIF, the employer must inform such employees in writing of the group or class of employees offered such exit incentive, eligibility factors required for participation, applicable time limits, job titles and ages of all eligible employees, and ages of those employees in the same job or organizational unit not offered the exit incentive. Even if an age-protected employee signs such a waiver, that employee has up to seven days to revoke it. It is highly recommended that an employee timely consult with an experienced attorney before signing a waiver and accepting a severance package. If you sign a waiver but still have concerns about discrimination, contact the EEOC.

## **Important Charge-Filing Deadlines**

A victim of possible age or other prohibited discrimination may file a charge with the EEOC or MCHR. To preserve a possible claim under MHRA, the employee must file a charge within 180 days of the last alleged act of age discrimination. To preserve a possible

claim under the ADEA, the employee must file a claim within 300 days of the last alleged act of age discrimination. This “last alleged act” is usually the date on which the employee first learned of the alleged discrimination, even if the result of discrimination will not occur until later. For example, if an employer told an employee on January 1 that she would be terminated on February 1, then the employee should file a charge within 180 days of January 1, rather than February 1, which is more likely to preserve rights under Missouri anti-discrimination law, and within 300 days of January 1, which is more likely to preserve rights under federal anti-discrimination law.

### **Filing a Charge of Discrimination**

If you contact the EEOC in person or by telephone about filing a charge, then you will be interviewed by an investigator about the alleged discrimination. There is no fee charged for being interviewed or filing a charge. The EEOC does not allow you to file charges online, but does allow you to submit an online “EEOC Assessment System” questionnaire, which asks general questions to help you decide whether the EEOC can assist you and specific questions about your employment situation. To learn more about the EEOC, the laws enforced by the agency, and information on filing a charge, go to [www.eeoc.gov](http://www.eeoc.gov).

If you decide to file a charge, then the EEOC intake investigator typically will draft a charge for your review and signature. If you decide to file a charge, the EEOC will “docket” the charge and your employer (or prospective employer if you were an applicant) will be promptly sent a copy of the charge and given an opportunity to respond. Occasionally, a charge may be dismissed quickly if, for example, it does not appear to state a violation of the laws enforced by the EEOC or it was filed more than 180 (with the MHRC) or 300 days (with the EEOC) after the last alleged discriminatory act. In most instances, the charge will be investigated. Never hesitate to contact the investigator about the progress of the investigation or to provide additional information about documents or witnesses.

### **What Happens after a Charge is filed?**

The investigation may take several months or even longer because of the backlog of charges filed with the EEOC. As part of the EEOC’s processing of a charge, you and the employer may be asked to participate in a free mediation to help settle the matter before the investigation is completed. If either party declines, then no mediation will occur. Even if no mediation takes place, the EEOC investigator may ask the parties to consider settlement or help the parties negotiate a settlement. If the charge is not settled during the

investigation period, then the EEOC may conclude after an investigation that a violation of the law has occurred and issue a “determination” letter to the charging party and the employer. At that point, the EEOC will attempt to “conciliate” a settlement between the parties. If that conciliation effort is not successful, then a notice of right-to-sue will issue to the charging party. Please keep in mind that the EEOC determines that a violation of law occurred in fewer than 10 percent of all charges investigated. Even if the EEOC does not find a violation based on your charge, you will still have the right to file suit as explained below.

If the charge is not settled and the EEOC has completed its investigation, then you will receive a written “notice of right-to-sue,” which allows you to sue regardless whether the EEOC concluded that unlawful discrimination occurred. You also may request a notice of right-to-sue before the investigation has been completed. If such a request is considered premature, then the investigator will explain why there may be a delay in issuing you the notice of right-to-sue. Once the EEOC has issued a notice of right-to-sue, then you have 90 days from receipt of the notice to file suit.

MCHR’s procedures for issuing a notice of right-to-sue under the MHRA have undergone some changes in recent years, but are generally more restrictive. For instance, MCHR may administratively close a charge file without issuing a state notice of right-to-sue. In addition, MCHR typically will not issue such notice until at least 180 days have passed since the charge was filed, although one may obtain a notice at an early point under some circumstances. If MCHR closes the file without issuing such notice, then in an employee’s right-to-sue under state law may be forfeited. If MCHR does issue a state notice of right-to-sue, then a suit alleging age discrimination (or any other prohibited discrimination) under Missouri law must be filed within 90 days of the date on which MCHR mailed the notice, not 90 days of the date on which you received it. In addition, under the Missouri law, the suit must be filed within two years of the last alleged discriminatory act.

The procedures followed by the EEOC and MCHR, and the laws the two agencies enforce, are complex, varied, and subject to differing court interpretations and legislative amendment. Because this article primarily addresses age discrimination under federal law. Anyone considering filing a charge with either agency is strongly advised to seek legal advice from an experienced attorney.

### **Should I File Suit?**

Even with the most compelling evidence, filing a lawsuit can be a great risk. Few cases get to a jury; a significant percentage are settled or dismissed. In addition, under the ADEA damages are limited. One may seek back pay. For example, if a court or jury concludes that an employee who earned \$50,000 per year was terminated because of age, then that employee may obtain back pay, \$50,000 or a pro-rated amount for the period since his or her termination, less any interim money earned at another job held since the unlawful termination. For a willful ADEA violation, the employee may obtain double back pay, also known as liquidated damages, but it can be very difficult to prove willfulness.

Damages under Missouri law can be more generous than the ADEA. In addition to back pay, a prevailing employee may be able to obtain damages for emotional distress and possibly punitive damages, which are meant to deter and punish the employer for committing unlawful discrimination. In deciding whether to file suit, you must keep in mind that litigation can be very demanding and continue for many months, or even years. It can exact a huge personal cost in both money and emotional (and even physical) health.

### **Extra Guidance for State Government Employees**

Employees who work for Missouri state government, school districts, municipalities, and similar public entities cannot sue their employers under the ADEA according to the U.S. Supreme Court's interpretation of that law, but may be able sue such employers in state court under the Missouri Human Rights Act. Despite this restriction on ADEA lawsuits, state employees still may file charges of age discrimination with either the EEOC or MCHR.

### **A Word of Caution**

Not every person 40 or older who is not hired, terminated from a job, denied a promotion, or treated worse than other employees in the workplace has an age or other viable claim of discrimination. An employer may discharge or refuse to hire or promote a senior citizen for any reason, as long as it is not based on age or some other basis prohibited by law (e.g., sex, race,

national origin, disability). Even if the "real" or main reason for the employer's decision was age, such discrimination may be very difficult to prove. Lawsuits can be extraordinarily costly in terms of dollars, time, and emotional demands. They may take many months or years to settle or go to trial. Some claims are dismissed without a trial.

As noted above, any applicant or employee who may have experienced discrimination is strongly advised to contact an experienced attorney before filing a charge or lawsuit. Most attorneys will charge a fee for consultation but that fee can be the most important investment you make. For private attorney referral information, please contact the EEOC at the numbers below, the Bar Association of Metropolitan St. Louis at (314) 621-6681, or the local affiliate of the National Employment Lawyers Association/NELA-St. Louis at (314) 621-8363.

### **More Questions?**

These federal and state laws, including their deadlines and procedures concerning age and other forms of unlawful discrimination, are complex and confusing, subject to frequent legislative amendment, and sometimes inconsistent with each other. To find out more information on employees' rights under the ADEA and other laws enforced by the EEOC, visit the EEOC's web site, <http://www.eeoc.gov>. You may contact the EEOC by calling 314-539-7800 or going in person to its St. Louis office at 1222 Spruce Street, 8th Floor, St. Louis, MO 63101. For information on Missouri law, visit [www.labor.mo.gov/mohumanrights](http://www.labor.mo.gov/mohumanrights) or call the state agency at 877-781-4236.

### **Illinois Human Rights Act**

While this article does not address one's rights under Illinois anti-discrimination law, such information may be obtained at [www.state.il.us/dhr](http://www.state.il.us/dhr) or by calling 312-814-6200 (Chicago), 217-785-5100 (Springfield), or 618-993-7463 (Marion). Charges against employers located in southern Illinois generally may be filed with the EEOC's St. Louis office.

# HEALTH CARE

## MEDICARE

By Barbara J. Gilchrist, J.D., Ph.D., a professor at St. Louis University School of Law, and a founder of this publication.

*Editor's Note: The information in this booklet on Medicare is designed to give a brief description of this program, what the benefits are, and how one qualifies. This information is current as of November, 2010, but is subject to change at any time. For more detailed information, call the Social Security Administration Office.*

### **What Is Medicare?**

Medicare is a health insurance program administered by the Centers for Medical Services (CMS). It is designed to help meet the hospital and other medical costs of senior citizens (age 65 or older) and some disabled persons under 65.

### **PART A – Medicare Hospital Insurance**

To be eligible for Part A (hospital insurance), you must be:

1. 65 or older and qualify for Social Security benefits; or
2. Disabled and have received Social Security disability benefits for two years; or
3. Receive dialysis or need a kidney transplant because of permanent kidney failure.

Persons with 0-29 quarters for Social Security purposes may receive Part A coverage by paying a premium of \$461. Persons not entitled to Social Security or Railroad Retirement, but who have at least 30 quarters, may pay a premium of \$254.

Part A covers some of the costs of a hospital stay, as well as care in a skilled nursing facility or in one's home (by a home health care agency) after leaving the hospital. Part A also covers hospice care. Doctor services are not covered by Part A.

### **PART B – Supplemental Medical Insurance**

Part B covers some doctor and outpatient services, medical supplies, and some preventive services.

Eligibility for Part B (supplemental medical insurance) is the same as for Part A, but a monthly premium of \$96.40 for those already enrolled and \$110.50 for new enrollees must be paid. (About 4% of enrollees with income in excess of \$85,000 and couples with income in excess of \$170,000 will pay a higher premium.) The Part B premium will automatically be taken out of your monthly Social Security check unless you ask not to be in the program. It is important to note that if one delays in signing up after becoming eligible to

enroll, the monthly premium will increase each year of the delay.

### **PART C – Medicare Advantage**

**Medicare Advantage** refers to private managed care health plans for Medicare recipients that have been available since 1997 in some geographic areas. These plans may take the form of HMOs, PPOs, or fee-for-service. All of them restrict the patient's choice of healthcare provider.

Medicare Advantage plans provide benefits equivalent to Parts A and B and may offer a range of supplemental benefits to cover out-of-pocket costs such as deductibles and co-insurance. These plans also include coverage for those Medicare beneficiaries who exhaust their hospital inpatient benefits. Some plans offer coverage for other benefits not covered by Medicare, such as routine eye exams, annual physicals, hearing exams, eyeglasses, or hearing aids. Medicare Advantage plans must also offer a Medicare Part D plan.

### **PART D – Prescription Drug Benefit**

Part D is the newest benefit and the most complicated in terms of choosing the best plan. Medicare beneficiaries may enroll either with a stand-alone prescription drug plan or a Medicare Advantage plan that offers prescription drug benefits. Monthly premiums are estimated to be \$46.58, but will vary between plans. Which medications are covered will also vary between plans. Low-income persons will be eligible for Part D without paying a premium or by paying a sliding scale premium depending upon income and assets.

### **Enrolling and Switching Plans**

The initial enrollment period for Medicare begins three months prior to the person's 65th birthday and lasts seven months. There is an annual general enrollment period from October 15 – December 31 when you can switch plans – from regular Medicare to a Medicare Advantage plan or vice versa or from one Medicare Advantage plan to another. These changes take effect January 1 of the next calendar year.

### **Services and Supplies Covered by Medicare**

The following hospital services are covered by Part A, if the costs are considered reasonable and the services are necessary: bed and board; nursing and related services; use of hospital facilities; natural and synthetic drugs, supplies, appliances and equipment normally furnished by the hospital; operating and recovery room costs; and other diagnostic or therapeutic items or services normally furnished by the hospital, including rehabilitative services.

The following skilled nursing home services are covered by Part A on a limited basis: nursing care; bed and board; physical, occupational, respiratory and speech therapy; medical social services; and drugs and other health services generally provided by a skilled nursing facility. Medicare does not pay for custodial care.

All hospice services are covered under Part A, but the patient pays 5 percent of the cost and must forgo all other benefits – except for physician services and treatment of conditions not related to the terminal illness.

Part B of Medicare covers the following services and items: physician services; hospital outpatient services and supplies furnished as incidental to physician services (such as diagnostic x-ray tests and x-ray, radium and radioisotope therapy); and other medical and health services (including surgical dressings, splints, and casts; rental or purchase of durable medical equipment; ambulance services and prosthetic devices).

Some prevention and screening services have been added to Part B. An annual wellness visit, flu and pneumonia shots, mammograms, certain cancer screenings, glaucoma screening, two annual foot exams and nutrition therapy for diabetics are all covered under Part B. Occupational therapy and speech therapy may also be covered for persons with Alzheimer's disease.

Medicare covers the rental or purchase of durable medical equipment (DME) used in a patient's home under Part B. A physician must prescribe the equipment. DMEs include hospital beds, wheelchairs, hemodialysis equipment, oxygen tents, crutches, canes, and many others. Before purchasing or renting, the beneficiary should find out whether the supplier is approved by Medicare. If a recipient enters a nursing home, any DMEs provided by Medicare will not be covered. Therefore, it will be necessary for the patient to return these items or pay for them as out-of-pocket expenses.

Both Part A and Part B of Medicare pay for a limited amount of home health care administered by a public or private home health care agency. Home health services covered include: part-time skilled nursing care, physical therapy and speech therapy. Medicare can also pay for occupational therapy, part-time services of home health aides, medical social services, and medical supplies and equipment provided by the agency if skilled nursing care, speech or physical therapy is necessary.

Part B supplemental medical insurance helps pay for medically necessary physician and related medical services no matter where they are received – whether at home, in the doctor's office, a clinic, a nursing home or hospital. Related services include medically necessary supplies such as wheelchairs and hospital beds, as well as outpatient services such as laboratory tests and X-rays. Physical and occupational therapy, mental health services, and mammograms are also covered.

### **What Medicare Pays and What You Pay**

No private health insurance program pays for all of the costs for a visit with the doctor or a stay in the hospital. Medicare, although a public program, is no different. Both Parts A and B have initial deductibles that the patient must pay before Medicare pays anything. Both parts also have co-insurance payments, which go into effect after Medicare has paid all costs up to a certain limit. When that limit is reached, the patient must pay a certain amount of the remaining costs. Medigap policies and Medicare Advantage plans can be effective ways to handle those costs not covered by Medicare.

The Medicare program measures the use of services under Part A (hospital insurance) through benefit periods – also called spells of illness. The first benefit period begins the first time you enter a hospital after the insurance goes into effect. A new benefit period begins when you enter the hospital again, as long as it is at least 60 days after the last discharge from a hospital or other facility providing skilled nursing or rehabilitation services. There is no limit to the number of spells of illness (benefit periods) you can have.

Part A provides up to 90 days of hospital care for each spell of illness. However, there is a deductible charged at the beginning of the hospital stay and co-insurance after 60 days, both of which are the patient's responsibility. Recipients also have 60 lifetime "reserve days," but they are not renewable for the next spell of illness. The hospital deductible is \$1,100 for each spell of illness. If you are in the hospital for more than 60 days, the co-insurance amount is \$275 per day. After 90 days of hospitalization, if you choose to use reserve

days, the co-insurance amount is \$550 per day. Medicare pays the remainder of all covered expenses.

Part A also provides up to 100 days of care in a skilled nursing facility (SNF) per spell of illness, but the patient must be admitted within 30 days after leaving the hospital and have been in the hospital for three consecutive days prior to entering the SNF. In order to be covered, the care in the SNF must be for the condition for which the patient received care in the hospital or for a condition that emerged while the patient is receiving care in the SNF following hospital care. The condition must also be one that requires daily skilled nursing or skilled rehabilitation services that cannot practically be provided anywhere except a SNF.

Medicare pays all covered expenses for the first 20 days. For days 21-100, there is a daily co-insurance of \$137.50. Medicare also pays for home health care visits if skilled nursing care or rehabilitation that can be provided in the home is required.

Part B, the supplemental medical insurance part of the Medicare program, has a basic payment rule for all charges for covered medical expenses. There is a \$155 deductible for all approved charges in each calendar year. Medicare then pays 80 percent of all additional approved charges for covered medical expenses. The patient is responsible for the remaining 20 percent of the costs of all covered medical expenses over that amount. If there are charges that are not approved by Medicare, these will be the patient's responsibility, unless that physician has agreed to accept assignment. This means that the physician has agreed to only charge the amount approved by Medicare.

Part D, the prescription drug benefit, has an annual deductible of \$310 and co-payments that vary depending upon the total annual drug costs above the initial \$310. For costs between \$310 and \$2,830, the co-pay is 25 percent (up to \$630). Costs greater than \$2,830, but less than \$6,440, are entirely the responsibility of the enrollee. Costs in excess of \$6440 will have a co-pay of 5 percent or \$2.50 for a generic drug and \$6.30 for a brand name drug.

**Part D Out-of-Pocket Costs Example:**

Deductible	\$ 310.00
Initial Coverage (\$2830-310) x 25 percent	630.00
Coverage gap (\$6440-2,830) x 100 percent	<u>3,610.00</u>
	4,550.00*

\*Anyone reaching the coverage gap (donut hole) in 2010 will receive a rebate check for \$250. Each year for the next 10 years the gap will be decreased until the co-pay is at 25 percent.

**Medically Reasonable and Necessary Charges**

Medicare pays only those medical bills that they determine to be "medically reasonable and necessary." Medicare uses a system called "Diagnostic Related Groupings" (DRGs) to determine what hospitalization expenses are reasonable and necessary for each "spell of illness" incurred. A simplified explanation of DRGs is as follows: When admitted to the hospital, a recipient is assigned a category within the list of possible DRGs. Medicare pays a predetermined amount to the hospital based on this category no matter how long you are in the hospital and no matter what the actual costs of care.

Prior to the time Medicare runs out for a "spell of illness," the hospital must notify the recipient in writing that a discharge is upcoming. If that discharge is based on the lapse of Medicare coverage and the patient feels that a longer hospital stay is necessary, the patient may appeal the Medicare decision to the Quality Improvement Organization (QIO), which decides if Medicare was correct in determining coverage. By law, the QIO must decide the appeal within three working days of its receipt. If you disagree with the QIO decision, it can be appealed similarly to any other Medicare decision. If a patient is in the hospital and wants to appeal the Medicare decision regarding length of stay, the patient should contact a social worker at the hospital concerning how to file an appeal.

Generally, Medicare coverage continues until the QIO makes its decision. If Medicare coverage runs out (i.e., the DRGs are exceeded), the patient will then be responsible for paying for the care. If the patient pays for the care and subsequently wins the appeal, Medicare will pay retroactive benefits.

**How Insurance Payments Are Made**

It is not necessary to send in any bills for care received from a participating hospital, skilled nursing facility, or home health agency under Medicare Part A. In addition, a hospice provider will normally make the claim for care received by a recipient and Medicare will pay its share of the costs directly to the proper agency. The recipient will receive a notice explaining what was paid under Medicare coverage.

Payment is made two ways under Medicare Part B. Medicare can pay the doctor or medical service provider directly, if that is agreed upon, or can pay the recipient directly. Direct payment to a doctor is called assignment.

Under the assignment method, the doctor or health service provider completes the Request for Medical Payment form and submits it. Medicare then pays the doctor or provider 80 percent of the Medicare-approved charge (which is often less than the doctor charges) after subtracting that portion of the \$155 deductible that has not yet been met. The advantage of this method is that the participating doctor or health care provider agrees to make the Medicare-approved charge his or her total charge – even if the actual charge is higher.

If the doctor or supplier does not agree to the assignment plan, the doctor still must file the Request for Medical Payment form. The medical insurance payment will then come to the patient. Remember that under the "payment-to-patient" plan, the doctor or supplier can bill for the actual charge, even if that charge exceeds Medicare's approved charge. If that happens, the patient is responsible for the amount over the approved charge.

Whichever payment plan is chosen under Part B, the patient or the patient's Medigap policy still must pay directly the doctor or health service supplier the 20 percent of the approved charge, plus any unpaid portion of the \$155 deductible. The patient should always ask the health care provider to provide an itemized bill.

### **Services Not Covered**

Even though the Medicare program has broad coverage, there are many services and supplies that Medicare does not pay. These charges include: custodial care in a nursing home, residential care facility, or in your own home; services not reasonable or necessary, as defined by Medicare; services for which the patient has no legal obligation to pay; services paid for by a governmental agency; personal comfort items; routine checkups; full-time home nursing care; hearing aids; eyeglasses and examinations for eyeglasses; drugs; and medicine purchased for oneself with or without a doctor's prescription. In general, Medicare does not pay for cosmetic surgery, dental care, private rooms, orthopedic shoes, or most chiropractic services. Supplemental plans (Medigap) or Medicare Advantage may cover some of these items.

### **Qualified Medicare Beneficiary (QMB), Specified Low-Income Medicare Beneficiary (SLMB), and Qualified Individual Program (QI1)**

**QMB** is a program under which Medicaid acts as a supplemental (Medigap) policy for Medicare recipients whose income is higher than that allowed for Medicaid eligibility, but below the federal poverty level plus \$20. In Missouri, the QMB program is handled through the Missouri Department of Social Services, Family Support Division (FSD), and the state pays the Part A and Part B

Medicare premiums, deductibles, and co-insurance charges for eligible recipients. To qualify, an individual's income must be less than \$903 per month and assets must be valued at less than \$6,600. To qualify as a married couple, combined income must be less than \$1215 and assets must be valued at less than \$9100.

Individuals with income up to \$1,083 per month and couples with income up to \$1,457 may qualify for the **SLMB1** program where the state pays the Part B Medicare premium. The **SLMB2** program also pays for the Part B Medicare premium for individuals with income less than \$1,219 and couples with income less than \$1,640. For both **SLMB1** and **SLMB2**, assets must be valued at less than \$6,000 for an individual and \$9,100 for an eligible couple.

**NOTE:** The income limits change annually in April.

Inquiries about each of these programs should be made to the local FSD office.

### **Right of Appeal**

If a recipient disagrees with a Medicare decision on a claim, by law he or she is entitled to ask for a review. Generally, a Medicare appeal is only possible after care has been received and coverage denied.

A general overview of the appeals process is available at:  
[www.medicare.gov/Basics/appealoverview.asp](http://www.medicare.gov/Basics/appealoverview.asp).

There are preprinted Medicare appeal forms for each stage in the process. These are available from the fiscal intermediary, the carrier, or any Social Security Administration district office. Beneficiaries may also call 1-800/MEDICARE or go online:  
[www.medicare.gov/Basics/forms/default.asp](http://www.medicare.gov/Basics/forms/default.asp).

The use of these forms is not mandatory, however. All coverage denial notices and Medicare appeal decisions received by a beneficiary include instructions on how to request the next stage of appeal and the applicable time limits. Beneficiaries may use their MSN (Medicare Summary Notice) as an appeal form by simply circling the item that they wish to appeal, writing in why they disagree, signing the form, and sending it to the address on the MSN.

Other rights may also be available, including appeal to the federal courts. If a patient determines that an appeal is warranted, it may be wise to consult with a friend, relative, or an attorney regarding the appeal process. Check the listing at the end of this book for legal assistance information.

### **If You Need More Information**

This section on Medicare cannot present all of the information that may be needed regarding hospital and medical insurance programs. One resource for more information is Missouri's Free Senior Health Insurance Assistance Program, which uses the name **CLAIM**. It can be reached at 1-800-390-3330.

Another source for information on benefits, eligibility, or any Medicare question is the local Social Security Administration Office. In addition, you may wish to obtain the *Medicare Handbook*, available from that office. CMS also has a publication that may be helpful, which is entitled *Medicare and You 2010*. Information on obtaining the publication is available from CMS at 800-633-4227. In addition to contacting CMS for general information on Medicare, the Medicare intermediary in your area may be contacted.

## **HEALTH CARE**

### **MEDICAID (MO HealthNet)**

*By Julie Berkowitz, Esq. Ms. Berkowitz is certified as an elder law Attorney by the National Elder Law Foundation. She is a sole practitioner who focuses her practice on MO HealthNet issues, Disability and Estate Planning, Probate issues, Guardianships and Conservatorships.*

*Editor's Note: The information in this booklet on MO HealthNet is designed to give a brief description of this program, what the benefits are and how one qualifies. This information is current as of January, 2011, but is subject to change at any time. For more detailed information call your local Family Support Division office or seek the advice of an elder law Attorney.*

#### **Introduction**

Effective August 28, 2008, the MO HealthNet program in Missouri was renamed "MO HealthNet". MO HealthNet is a joint Federal-State program designed to help pay some of the costs of health care for financially needy individuals. The Family Support Division (FSD) of the Missouri Department of Social Services administers the MO HealthNet program in Missouri. The FSD decides who is eligible for the program based on federal and state requirements.

The MO HealthNet program is different from the Medicare program. The Medicare program is run by the Social Security Administration. There are no financial need requirements for eligibility for the Medicare program. Most Medicare recipients have a red, white and blue card. Medicare recipients can also receive MO HealthNet assistance if eligible. Missouri MO HealthNet recipients have a red MO HealthNet card.

The MO HealthNet eligibility rules and applicable regulations are extremely complex. If an individual is interested in applying for MO HealthNet benefits, he or she may benefit by seeking the assistance of an attorney who is knowledgeable in MO HealthNet eligibility issues.

#### **Expenses Covered by MO HealthNet**

Generally, MO HealthNet will cover the following: physician's services, some prescription drugs, emergency ambulance services, hospice services, in-patient and out-patient hospital services, laboratory and x-ray services, periodic diagnosis and screening, and some home health services.

There is a procedure that allows a MO HealthNet recipient to make a "medical exception" request for MO HealthNet to pay for a service not included in the MO HealthNet program. If the MO HealthNet Division (formerly the Division of Medical Services (DMS)) denies coverage for a procedure or service, a recipient may call the Recipient Services' number on the back of the MO HealthNet card to ask about a medical exception. A person's doctor must provide documentation to establish that a service or equipment should be provided and is medically necessary.

Some drugs and services require prior authorization under the MO HealthNet program. Usually medical services providers (for example, the doctors) will apply for prior authorization. Certain prescriptions, however, require prior authorization forms completed both by the patient and by the doctor. In most cases, the MO



HealthNet office will notify the medical service provider, not the individual recipient, of its decision to grant or withhold prior approval of payment. If an individual learns from the medical service provider that MO HealthNet approval was withheld, one may appeal the decision. (See next section for how to appeal.)

Vendor MO HealthNet benefits will help to cover the cost of nursing home care for those who qualify. A Vendor MO HealthNet recipient must be in a "MO HealthNet certified bed", in a nursing home. Generally, a Vendor MO HealthNet recipient must use his or her income to pay for the nursing home care, and MO HealthNet benefits cover the balance to the nursing home.

No provider of medical services can be forced to accept payments from MO HealthNet if he or she does not wish to do so. If the health care provider will not accept MO HealthNet, one has two options: change the health care provider or pay with one's own funds.

### **Missouri MO Health Net Programs**

There are a number of different MO HealthNet programs that provide assistance with health care costs for individuals who meet certain medical and financial requirements. This section outlines some of the main MO HealthNet programs for elderly and disabled individuals.

#### **Eligibility for a MO HealthNet Program**

In order to qualify for a Missouri MO HealthNet program, an individual:

- must be a U. S. Citizen or "qualified alien," *and*
- must be a Missouri resident, *and*

must be 65 years or older (elderly), blind or permanently and totally disabled *and*

must meet the financial eligibility requirements of the MO HealthNet program to which he or she is applying.

#### **MO HealthNet for Basic Medical Care (Medical Assistance- Non-Vendor)**

Medical Assistance - Non- Vendor is the MO HealthNet program that provides coverage for certain Medical expenses for elderly, blind or disabled individuals. This program does not provide benefits to cover nursing home costs. *See MO HealthNet for Nursing Home Care.*

#### **Non Financial Eligibility Requirements:**

An individual must meet all of the requirements set forth above under Eligibility for a MO HealthNet Program.

#### **Financial Eligibility Requirements:**

##### **Income Limit Requirements:**

Individuals applying for Medical Assistance must have incomes below the program's income standards. These amounts change every year. The figures below are current as of January, 2011.

An unmarried individual must have monthly income of \$768 or less, after allowable deductions.

A married individual and his or her spouse must have a combined monthly income of \$1033 or less, after allowable deductions.

Individuals with incomes above the applicable limit, but who meet all of the other eligibility factors, may still qualify for assistance. He or she will be given a "spenddown" amount. This is like a monthly deductible. *See "Spenddown MO HealthNet".*

##### **Asset Limit Requirements:**

These asset limits are not tied to the federal poverty level and have never been increased. They do not change every year like the income limits.

an unmarried individual must have no more than \$999.99 in non-exempt assets.

a married individual and his or her spouse must have less than \$2,000 in combined non-exempt assets.

##### **Exempt vs. Non-Exempt Assets**

The \$999.99, or \$2,000 if married, asset limits apply only to non-exempt assets. Certain assets are considered exempt and their value is not counted in the applicable asset limit total.

The assets that are exempt and that do not count include: the applicant's home (up to an equity limit of \$505,500) and furnishings, one motor vehicle, personal effects, burial lot, certain income producing property, and either a pre-paid irrevocable funeral plan or up to \$1,500 in cash surrender value in life insurance.

##### **"Spenddown MO HealthNet"**

If an individual has a "spenddown" amount, he or she is responsible for a certain amount of medical expenses each month, before MO HealthNet benefits

will cover other medical costs. The spenddown amount is based upon the individual's income. An individual's spenddown amount is calculated by totaling monthly income from all sources, and applying certain deductions as follows:

- (1) Subtract the first \$65 of any income (wages or self-employment income) and then subtract one-half of the remainder. For example: the deduction is  $((\text{earned income} - \$65) \div 2)$ .
- (2) Total the adjusted earned income and all *unearned* income, such as Social Security, SSDI, private pensions and VA benefits.
- (3) Subtract payments for any medical insurance premiums paid (including Medicare and private insurance):
- (4) Subtract \$20 (personal income exemption).
- (5) Compare the resulting net income to the program's income limit. (currently \$768 for a single individual and \$1033 for a married couple)

**The remainder, after all allowable deductions, is your monthly spenddown amount**

Note: If there are minor children in the household, do not include their income or expenses in the spenddown budget.

An individual can meet his or her spenddown in one of two ways:

- by paying a monthly premium to the State, so that one has no break in coverage; or
- by submitting incurred medical expenses to his or her caseworker each month.

If you choose the second option, your MO HealthNet coverage for each month will become effective the day bills meet or exceed the spenddown amount. (Bills given to the caseworker to meet spenddown will not be paid by MO HealthNet.)

If you are eligible under the spenddown program, your case will stay open whether or not you meet spenddown in any one month. You will receive an invoice each month that you can use to pay your spenddown "up-front" for the next month. When you receive an invoice, you are being billed for the next month's premium in advance. However, you can also pay your premiums retroactively for certain months.

If you do not meet spenddown for six consecutive months, you will no longer receive invoices, but your case will still stay open.

**MO HealthNet for Nursing Home Care (Vendor MO HealthNet)**

MO HealthNet may cover some of the cost of nursing home care. The eligibility requirements are slightly different than stated above for basic Medical Assistance eligibility. In addition certain transfer of assets rules apply. MO HealthNet for nursing home care is referred to as "Vendor MO HealthNet".

**Non Financial Eligibility Requirements:**

In addition to the non-financial requirements set forth under Eligibility for a MO HealthNet Program, an individual must reside in a "MO HealthNet vendor bed" in a nursing home that is eligible with the State to receive MO HealthNet funds.

**Financial Eligibility Requirements:**

**Income Limit Requirements:**

There are no actual income limit requirements for Vendor MO HealthNet. However, as a practical matter, an individual's income must be less than the monthly cost of his/her nursing home care. Otherwise MO HealthNet benefits are usually not needed.

An individual is required to use his or her income (minus allowable exemptions) to pay for his or her nursing home costs. Vendor MO HealthNet benefits cover the remaining nursing home and uninsured medical costs.

**Asset Limit Requirements**

These asset limit requirements apply to non-exempt assets. *For information on what is an exempt asset, see "Exempt vs. Non-Exempt Assets."*

- an unmarried individual must have no more than \$999.99 in non-exempt assets.
- married individuals, both of whom reside in a nursing home must have no more than \$2,000 in combined non-exempt assets.
- married individuals whose spouse does not also reside in a nursing home, must have no more than \$999.99 in non-exempt assets. However, the spouse who does not live in the nursing home is entitled to a "Community Spouse Resource Allowance" ("CSRA").

*Community Spouse Resource Allowance.* The FSD will compute a "Community Spouse Resource Allowance" for the spouse of a married individual applying for Vendor MO HealthNet assistance. The Community Spouse Resource Allowance is calculated during a Division of Assets Assessment.

During the Division of Assets Assessment, the FSD caseworker determines the non-exempt assets that the individual and the spouse own individually, together, or with someone else. These non-exempt assets are totaled together. The total amount of these non-exempt assets is divided. The Community Spouse Resource Allowance is calculated by dividing the assets in half and applying a minimum and maximum standard amount.

The community spouse will be entitled to one-half of the non-exempt asset total as long as that amount is greater than the minimum, and no more than the maximum. If the total assets are less than the minimum, then the community spouse will be entitled to the minimum. If one-half of the non-exempt assets is more than the maximum amount, then the community spouse will only be entitled to the maximum amount. The minimum and maximum standard amounts are increased each year. As of January 2011, the minimum Community Spouse Resource Allowance amount is \$21,912 and the maximum amount is \$109,560.

Once the couple's total non-exempt assets are equal to or are less than the couple's Community Spouse Resource Allowance, the spouse in the nursing home will be eligible for benefits.

In addition to the Community Spouse Resource Allowance, a community spouse is also allowed to keep the couple's exempt assets. Also, the community spouse's income is his or hers to keep and is not a factor in the other spouse's eligibility.

In certain situations the community spouse may be entitled to additional income from his or her spouse and/or be entitled to an increased Community Spouse Resource Allowance. Such a situation occurs when the community spouse has low income (according to State standards) and/or has high living expenses or extraordinary costs. An Administrative Appeal is required in order to increase the community spouse's portion of assets. The assistance of an elder law attorney is strongly recommended in these circumstances to ensure that the community spouse receives the maximum amount to which he or she is entitled.

#### **Transfer of Assets Rules Apply**

The rules regarding transfers of assets were changed by the federal government in the beginning of 2006 in legislation entitled the Deficit Reduction Act. The new law became effective in Missouri as of February 8, 2006, and applies to transfers occurring after that date. Transfers occurring prior to February 8, 2006, are governed by the prior law.

Under the current law, if a MO HealthNet applicant gives away or transfers property for less than fair market value within 60 months (5 years) of applying for vendor MO HealthNet, that individual will be ineligible for MO HealthNet benefits for a certain period of time (penalty period). The length of the penalty period will be based upon the amount or value involved in the transfer of property.

The penalty period will begin to run when the MO HealthNet applicant has no more than \$999.99 in non-exempt assets, is otherwise eligible for benefits, and has applied for MO HealthNet benefits. Essentially, the penalty period will run from the date of application and not the date of transfer.

Consult an elder law attorney before making such a transfer, and before filing a MO HealthNet application. The date that an applicant files a MO HealthNet application has legal significance. In addition, some transfers are not subject to penalty. There are limited exceptions.

#### **MO HealthNet Estate Recovery**

While an individual can own certain exempt assets, such as a home, while receiving Vendor MO HealthNet assistance, the Department of Social Services has a right of recovery against the MO HealthNet recipient's estate at his or her death. However, there are certain exceptions and circumstances in which the State does not have a legal right to such a claim. Potential beneficiaries of a deceased MO HealthNet recipient who have been contacted by the State regarding a recovery claim should consult with an elder law attorney to determine their rights.

In addition to a right of recovery against a MO HealthNet recipient's home after his or her death, the Department of Social Services also has a right to file a lien against the MO HealthNet recipient's home while the MO HealthNet recipient is still alive. Just as in the case of a post-death recovery action, the Department of Social Services does not have this right in every case. There are limited exceptions.

#### **If Your MO HealthNet Application is Rejected**

If an individual is denied MO HealthNet eligibility, that individual has a right to an appeal. The appeal is initiated by making a request to the caseworker or other FSD personnel for a hearing. This request must be made within 90 days of the denial of the MO HealthNet application. It is advisable to get the help of an attorney if you are requesting an appeal.

If an individual is receiving MO HealthNet benefits and FSD attempts to terminate or reduce said benefits, the individual may also appeal that decision. If the individual appeals within 10 days of notice of the termination or reduction, the individual has a right to continue receiving full benefits pending the outcome of

the hearing. If the individuals continue to receive full benefits during the appeal process and lose the appeal, the state can seek repayment from the individual for those expenses.

## HEALTH CARE

### NURSING HOMES

*By Kerry Kaufmann, administrator of Normandy Nursing Center, a position she has held for 14 years. Prior to that, Ms. Kaufmann was the assistant director of the St. Louis Long Term Care Ombudsman Program, and she has sat on various boards and committees concerning the elderly. Kerry has been involved with various projects with Legal Services of Eastern Missouri since serving a paralegal internship there in 1987.*

#### Introduction

If you are looking for a nursing home for yourself, a friend or family member, this section hopefully will help you choose a long-term care facility that will meet your needs, medically and financially. You will also be able to use the information provided to handle problems or concerns that may arise in the nursing home during residency.

#### Regulatory Agencies

The Department of Health and Senior Services (formerly the Division of Aging) provides licensure and inspections to all long-term care facilities in Missouri. When inspecting a nursing home, the Department of Health and Senior Services considers all aspects of the resident's living environment, in accordance with the state law and regulation. This not only includes nursing care and procedures, but also housekeeping, dietary needs, safety standards, resident funds, activities, and social services.

Federal regulations, set forth under the Centers for Medicare and Medicaid also cover the facilities that are in the Medicare and/or Medicaid programs. Therefore, the Department of Health and Senior Services inspects nursing homes based on both state and federal requirements.

Nursing homes receive two unannounced inspections every year and may be subject to other inspections based upon complaints received through the Elder Abuse Hotline (1-800-392-0120). Residents and families are encouraged to participate in the inspections.

#### Levels of Care

There are four levels of nursing home care that are licensed and regulated by the State of Missouri based on services offered and staffing available.

*Skilled Nursing Facilities* (SNF) provide a skilled level of nursing care and treatment for individuals requiring 24-hour-a-day care by licensed nursing personnel, including: physician-ordered treatments; medication administration; IV therapy; physical, speech and occupational therapy; and specialized care. This is a step away from the hospital, although some hospitals have distinct parts that are set up as SNFs within the hospital itself. A patient at the hospital has the choice of using the hospital's SNF or choosing an outside long-term care facility.

Many SNFs accept Medicare and Medicaid as payment. Those facilities are not only licensed by the State of Missouri, but are also certified by the Medicare and Medicaid programs and are regulated under those guidelines.

It is the choice of the facility whether or not to participate in either the Medicare or Medicaid program. The facility may also choose the number of beds offered through either program. Even though a facility may have Medicare or Medicaid certified beds, that does not mean that there is always one available for a resident when that individual enters the facility or depletes assets.

*Intermediate Care Facilities* (ICF) also provide 24-hour protective oversight and nursing care, including distribution of medications. These facilities are a step

down from a skilled nursing facility and provide more custodial care. Medicare does not pay for custodial care. However, Medicaid will pay for custodial care if financial requirements are met and the resident is in a Medicaid-certified bed.

*Residential Care Facility II* (RCF II) provides more of a boarding home-like atmosphere for the resident with protective oversight. The facility provides all meals, helps in the bathing, dressing and grooming of the resident, and also distributes medications. An RCF II can provide medical care for a resident returning from the hospital and needing minimal care for a temporary period of time.

*Residential Care Facility I* (RCF I) is the one of the least restrictive living arrangements for a resident in licensed long-term care. It provides protective oversight, meals, medications, and minimal grooming.

*Assisted Living* is a new type of living arrangement that has become very popular in the past few years. This is an independent type of living arrangement and is now licensed or regulated by the Department of Health and Senior Services.

Assisted living usually consists of the resident occupying an apartment and being provided with one or more meals a day, light housekeeping and laundry services. It does not include medical care. However, many places offer some personal aide services. At this time there is no financial aid provided for residents in assisted living facilities except for some personal aide services for residents who qualify.

### **Choosing a Nursing Home**

Choosing a nursing home for yourself or someone else can be a difficult and frustrating task. To make matters a little easier, you need to first look at what the needs are of the individual. Consider some of the following questions:

Is this going to be a long or short-term stay?

Does the individual need therapy?

Is the facility able to meet any of the special needs of the individual?

Are there other residents who have the same needs as the individual, people he/she can relate to?

Is the facility easily accessible for family members and friends to visit?

By understanding the needs of the potential resident, you can better match up the facility to the individual.

Be honest about the needs of the potential resident and the expectations of both the resident and the family. If the resident has wandered away from home several times, it is important for the facility staff to be aware of this so safeguards can be put into place to protect the resident. Remember, the nursing home is not a hospital nor is it set up to do private nursing. The nursing home must provide services within the constraints of the law and financial capabilities. Not every nursing home is going to be right for every resident.

Once you determine a resident's needs, you can begin searching for a facility. Some of the attributes that you want to look for in a long-term care facility are:

1) *Licensure*: Make sure the home is licensed and that the license is in good standing with the State of Missouri. Ask to see the most recent inspection report and make sure that whatever was cited has been corrected.

2) *Nursing Service*: Talk to the nurses and make sure that the level of nursing services matches the resident's needs. If there is a closed or locked unit, find out if this unit is appropriate for the individual.

3) *Physician*: Determine if your physician will provide services at the particular nursing home. Not all physicians go to nursing homes to provide services. If the attending physician does not go to the facility, you may need to make provisions for the resident to see the physician in the physician's office. Each facility has a number of physicians associated with it. The resident may choose from one of the physicians offered through the facility if he/she wishes to, or continue to use their private physician.

Each facility will have a designated medical director. The medical director is the physician who will oversee all resident care in the facility and is responsible for ensuring the other physicians are providing proper care.

4) *Finances*: The facility should be able to provide you with a list of all charges involved, including items not paid for by Medicare or Medicaid. If the resident is eligible for Medicare and/or Medicaid, the facility should be able to provide information on both programs and assist the resident as needed.

5) *Dietary Services*: Try to stop by the facility during a meal. See if the meals look appetizing and attractive. Pay attention to whether or not the other residents are

enjoying their meals and the entire dining experience. Ask to see a copy of the planned meals and find out if special diets can be provided.

The dietary manager should work with the residents on individualizing their menus to meet the needs of the resident, including preferences.

6) *Therapy*: If the resident is going to need physical therapy, occupational therapy and/or speech therapy, check out the therapy department. Find out when therapists are available and what special equipment they have that can help meet the resident's needs. If the resident is Medicaid only, the facility must still provide the therapy needed. Find out if there is an active restorative program in the facility that will continue with therapy after the resident is discharged from the actual therapy program.

7) *Medications*: Most nursing homes have a contract with a pharmacy to provide medications. The resident has the choice of using the facility pharmacy or another of their choice. If the resident chooses another pharmacy, that pharmacy must meet the guidelines set by the nursing home as far as packaging and delivery needs. The facility must also develop a plan for supplying emergency medications when required.

8) *Activities*: Each nursing home should have a program that provides the residents with daily activities. Activities are important because they help to keep the resident alert and involved. Talk with the activity director and other residents about the facility's program. Ask to see a calendar of future activities.

Activities are an important part of anyone's life and even more so in a facility. The residents' individual preferences should be taken into consideration, including access to telephones, newspapers, magazines and other items that will help maintain the residents' interests.

9) *Safety*: As you walk through the facility, check for safety issues. Make sure the handrails are on the walls tightly, wet floor signs are used, evacuation plans are posted, etc. The latest state inspection report will provide information on any safety issues including fire safety.

10) *Cleanliness*: The facility should have a housekeeping department that keeps the resident areas, including bedrooms and bathrooms, neat and clean.

11) *Policies*: Talk to the admissions coordinator or social worker about any facility policies that could affect

the resident's stay including level of care and financial issues.

12) *Access to Administration*: The nursing home staff, including the administrator, social workers, the bookkeeper, the director of nursing and other department heads should be accessible to residents and family members. Ask about their hours and availability in off-hours.

It is important to ask the facility about care plans and when the resident's care plan meeting will be held. The care plan is formed in a meeting when all disciplines work together on mapping a plan to meet the resident's needs. This plan should be discussed with the resident and family so that all parties involved understand what the goals are and what is to be expected.

Nursing homes are supposed to provide a homelike environment for the resident. That means that the staff should show a friendly attitude to both residents and visitors. They should try to make the residents feel good about themselves and find ways for the residents to attain their highest possible goals. The staff should create a respectful and caring environment. Watch resident reactions to the staff and other individuals.

If possible, talk with other residents in the facility. They are your best indicator of what life in the facility is like. Look and see if the residents look happy, clean and neat. As you tour the facility, look into the residents' rooms and see if they are individualized, not institutionalized.

Lists of nursing homes can be provided through the following agencies:

- The Department of Health and Senior Services, P.O. Box 1337, Jefferson City, MO 65101;
- Missouri Family Support Division, your local office;
- Area Agency on Aging, your local office;
- Ombudsman Program, your local office;
- Hospital the individual may be in or a physician with whom he or she may be associated;
- Disease-related organizations often carry lists of appropriate facilities, and there are now listings you can receive through online services.

### **Resident Rights**

While a resident is living in a nursing home, the resident is entitled to a dignified existence and to exercise his or her rights without fear of interference, coercion, or reprisal.

Federal and state laws guarantee that, as a nursing home resident, you have the right to:

- (1) Be free from physical, verbal, mental or sexual abuse, or mistreatment or neglect of any type;
- (2) Be free from any chemical or physical restraints without a physician's order that shows the restraint is treating a medical symptom and is only approved for a specific period of time;
- (3) Participate in your care, including choosing a doctor, being informed of your care and treatment, and any changes in your health or treatments;
- (4) Make choices about your life that are important to you, such as what clothes you wear or when you bathe;
- (5) Receive services based on your individual needs and preferences;
- (6) Manage your own financial affairs, including giving the facility written permission to hold any monies for you, spending your money as you choose, and receiving a quarterly financial report if the facility is to hold your funds;
- (7) Be fully informed of your rights during your stay and any rules that are set by the facility;
- (8) Review all your medical records upon request;
- (9) Have access to the latest facility inspections without requesting them;
- (10) Privacy for all treatments, telephone calls, visits, mail, resident meetings and all of your records;
- (11) Receive or refuse visits from friends or relatives;
- (12) Receive visits 24 hours per day from family members; and
- (13) Remain in the facility (see section on transfers/ discharges).

These rights are guaranteed under both state and federal laws. Residents who feel that their rights have been violated should talk to a representative from the facility first. Each nursing home needs to have a written process in place to handle residents' grievances.

The process should be one that takes into consideration the resident's physical, medical and emotional condition. A specific staff member, such as the social worker, should be identified to the resident as to whom to make the complaint. The complaint should be dealt with to the resident's satisfaction within a reasonable amount of time.

If the complaint is not resolved to the satisfaction of the resident, there are additional steps a resident can take. The resident may file a complaint with the ombudsman Program in his/her area. The Ombudsman Program, usually found in conjunction with the local Area Agency on Aging, can help mediate between the

resident and the facility to find an adequate solution. This is often the best solution, in that the Ombudsman is a trained resident advocate and mediator.

The alternative is to contact the Department of Health and Senior Services at 1-800-392-0210. Depending upon the seriousness of the complaint, it may not be resolved immediately. Any complaint that is not risking the welfare of the resident may be delayed by the Department of Health and Senior Services until the next inspection, which may be months away.

Should the complaint pertain to abuse or neglect, the Department of Health and Senior Services, 1-800-392-0210, should be notified immediately. The resident's health and safety could be in jeopardy. By notifying the Department of Health and Senior Services, an inspector can take the action necessary to protect the resident immediately.

#### **Discharges from a Nursing Home**

It is the resident's right to remain in the nursing home for as long as they choose. A facility may only discharge a resident if:

- 1) The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility;
- 2) The resident's health has improved sufficiently so the resident no longer needs the services provided by the facility;
- 3) The health and safety of the individuals in the facility is endangered.
- 4) The facility issues an emergency discharge;
- 5) After notice, the resident fails to pay for a stay at the facility; or
- 6) The facility ceases operation.

When the facility discharges a resident, they must provide the resident with a 30-day written notice of their intent to discharge. In this notice, the resident must be given the right to appeal the discharge. The appeal is made to the Division of Legal Services in Jefferson City. A resident may represent himself or herself at the hearing or have a friend, family member, or legal counsel represent him or her. An attorney will represent the facility. It is the responsibility of the facility to provide enough information to show that the resident cannot remain in the facility.

If the facility transfers the resident based on an emergency discharge, the facility must immediately notify the resident as to their intent not to take the resident back and the reason, plus give the resident the right to appeal.

After the appeal process, the resident and facility will be provided the results of the hearing in written form. If the resident wins the appeal, the resident has the right to remain in or return to the facility. Should the resident lose the appeal, the resident needs to find placement somewhere else within 10 days. The facility must help the resident to relocate if this is the case. No resident can be transferred until a safe and appropriate place is found for that resident.

### Financial Information

There are a few different ways to pay for nursing home care. However, not every nursing home accepts every type of payment. You must make sure the nursing home meets not only the medical needs but also the financial needs of the individual.

*Medicare:* With a three-day prior hospitalization, a resident may be eligible for Medicare coverage for up to 100 days. The first 20 days are completely covered under Medicare and all services are paid for. After the twenty-first day, there is a co-insurance payment per day. This can be paid privately by the resident or paid through a medi-gap insurance plan. Missouri Medicaid no longer pays this co-insurance.

Medicare only pays for a resident in a Medicare bed and only covers those residents who need a high level of care, such as tube feeding, ventilators, IVs, or therapy. It does not cover custodial care and there is no guaranteed coverage time. Medicare can cover between 1 to 100 days. Medicare coverage is dependent upon what services the resident requires and continues to require. The facility must provide appropriate notice as to when the resident will be taken off Medicare. The decision to take the resident off Medicare can be appealed by the resident. The nursing home should provide the resident with information on this appeal process.

*Medicaid:* The Missouri Family Support Division (FSD) administers the Medicaid Vendor program, which is designed to pay for the care of nursing home residents when they do not have the resources to pay themselves. Not every nursing home is Medicaid-certified. Therefore, you must make certain that the facility has a Medicaid bed if this payment source is, or may become, a necessity.

Under the Medicaid program, all resident needs are provided for, including room and board and medical needs. The facility must provide a resident with a list of any services or items not provided for under Medicaid. The resident should turn over the amount of money listed by FSD as his or her surplus. For example, if a

resident's Social Security is \$500 per month, the resident needs to turn over \$470 to the nursing home as his/her share of payment and is allowed to keep \$30 for personal needs. Failure to turn the surplus over to the nursing home could result in a discharge letter for non-payment.

Oftentimes, the nursing home becomes the representative payee of the Social Security check and provides to the resident the \$30 personal needs allowance. Social Security will notify the resident if the facility applies to be payee representative.

To qualify for Medicaid payments, you must:

- (1) Be in a Medicaid-certified bed;
- (2) Have resources (assets) less than \$1,000 (a house is no longer considered a resource if you move from your home to the hospital and then to the facility, or from your home into a long-term care facility);
- (3) Meet the minimum 21-point medical qualification; and
- (4) Have an insurance policy not greater than \$1,500 (cash surrender value). Instead, an individual can have a prepaid burial plan of the same value or an irrevocable burial trust in a "reasonable amount."

*Medicaid and Married Couples:* There are special provisions under the Medicare Catastrophic Coverage Act of 1988 that provide for married couples when one must enter a long-term care facility. Upon entering a Medicaid-certified bed, you and/or your spouse may request a "division of assets" assessment for the local Division of Family Services office.

Under this provision, a married couple's assets are divided by the caseworker. The amount the community spouse will be permitted to retain will depend on the total amount of assets. Once the institutionalized spouse's share is spent down to under \$1,000, he/she would then be eligible for Medicaid, and the community spouse has his/her share for his/her needs while living in the community, plus a monthly allotment if eligible.

A Medicaid-certified resident in a nursing home is entitled to equal treatment just as if he/she were a private-pay resident. Admission policies must not require that a resident "private-pay" for a certain number of months before applying for Medicaid. Transfer or discharge cannot be based upon Medicaid eligibility unless the facility does not accept Medicaid or there are no Medicaid beds available. Should a resident feel that he/she is being discriminated against because of Medicaid eligibility, contact the local Legal Services office, as well as the local Long-Term Care Ombudsman office, seeking advice, information, and advocacy.



*Supplemental Nursing Care (Cash Grant):* This Medicaid program partially pays for a resident's care in either a licensed residential care facility or a skilled nursing facility. You must meet the guidelines (above) for Medicaid eligibility. Amounts paid vary depending on the level of care of the facility.

*Private Pay:* If a resident is going to be paying privately for his/her long term care, it is extremely important that he/she read the nursing home contract, which should describe the daily rates, any increases for levels of care, and specific costs for special services or medical items. The facility should provide you with a list of all these items and the costs involved. Private pay residents need to consider the extra costs which may be charged to them, including but not limited to pharmacy, physicians, labs, x-rays and medical supplies.

*Long-Term Care Insurance:* Many insurance companies offer long-term care insurance policies. If a resident is using this as a form of payment, make sure that the nursing home is informed and agrees to accept the payment. Most long-term policies ask the facility to provide monthly statements listing the resident's level of care, diagnosis, and special needs. The policy also may not pay the full daily rate, so the potential resident needs to determine what out-of-pocket expenses are going to be required.

*Life Care Contracts:* Although not as popular as they once were, many facilities still offer life care contracts. A life care contract is a binding agreement between the facility and the prospective resident that usually calls for the facility to provide room, board and other incidentals for the resident in consideration for the resident's assignment of property and money to the facility.

A life care contract should only be entered into after careful consideration. Consult an attorney and try to insert items in the contract that expressly define the type of care and service that the facility is to provide. If a contract is entered into with the belief that the resident has an illness which will require care until death, or has a possible terminal illness, it may be wise to insert a clause in the contract which will allow for cancellation of the contract if the person improves in health such that care will no longer be needed at the facility.

When considering a life care contract, it is important to get in writing the facility's responsibility to the resident should the resident require a higher level of care than the facility can provide or in the event that the facility should close. Either of these issues could potentially become a problem if there is no guarantee from the facility as to what steps the facility would take to provide for the resident. It is always a good choice to have an attorney review any contracts prior to signing them.

## HOUSING

### LEGAL INFORMATION ABOUT LANDLORD-TENANT RELATIONS

*By Mary DeVries and John Ammann. John Ammann is the director of St. Louis University School of Law's Clinical Law Program. Mary DeVries is a staff attorney with the Housing Unit of Legal Services of Eastern Missouri, Inc.*

#### **Duties**

Both landlords and tenants are often not informed of the basic rights and responsibilities they have toward one another. Tenants especially suffer as a result of this situation. Some tenants pay illegally hiked rents or unknowingly agree to premature termination of their leases. Such actions hurt elderly fixed-income tenants more severely. The following are a few of the basic duties of landlords and tenants.

#### **Some Duties of the Tenant**

1. Must pay rent on time.
2. Must keep apartment clean and dispose of garbage, rubbish, etc.
3. Must not deliberately destroy or damage the structure.
4. May not take on additional occupants or sublease without permission of the landlord.
5. Must use plumbing and electrical fixtures in a reasonable way.

6. Must give written notice 30 days before the next rent is due when leaving a month-to-month (no formal lease) tenancy.
7. Must not commit or allow the illegal possession, sale or distribution of controlled substances upon the rented premises.

### **Some Duties of the Landlord**

1. Must not turn off water, electricity or gas.
2. Must provide adequate heat in winter.
3. Must not lock tenant out or prevent tenant from entering or leaving apartment. (A landlord needs a court order to legally evict a tenant).
4. May not raise rent during term of formal lease or without giving 30-day written notice before the next rent is due in a month-to-month tenancy.
5. Must keep apartment and public areas safe, secure, sanitary, and in substantial compliance with the housing code. If the tenant damages the apartment, the landlord may have to repair the damage and charge the tenant.

### **Abandonment**

If a tenant abandons the dwelling unit, the landlord may have the right to enter and remove the tenant's belongings. The landlord has the right to do this only when the tenant is 30 days or more behind on the rent and the tenant fails to respond to the landlord's notice to the tenant of the landlord's belief of abandonment. The landlord's notice must be in writing and mailed to the tenant by first class mail and certified mail. Moreover, the landlord cannot claim abandonment if the tenant either pays all rent due or responds in writing within 10 days of the posting of the landlord's notice that the tenant does not intend to abandon the dwelling unit.

The tenant's best protection from a landlord claiming abandonment is to avoid getting behind in rent. If the tenant is going to be absent from the unit while also being behind on rent, the tenant should be sure to inform the landlord in writing that he or she still intends to occupy the unit and it is not abandoned. Moreover, if the landlord does send a notice claiming abandonment, then the tenant must be sure to respond in writing and to explicitly deny the allegations of abandonment (make and keep a copy of the notice you send).

### **Foreclosure of Rental Unit**

If the unit you are renting is foreclosed, you have rights under recent federal laws (these laws are temporary unless extended past December 31, 2014). In most cases, you have the right to finish your lease and the new owner must honor your lease (including Section 8 voucher leases). If you have a month-to-month lease, or less than 90 days remaining on your lease, the new

owner must give you a 90-day notice requesting that you move. **Remember:** the new owner cannot legally evict or lock out a tenant without a court order.

### **When the Tenant Fails To Pay Rent**

If one is going to be late with the rent or will not be able to pay rent for a particular month, one should contact the landlord and let him or her know about the problem and attempt to work together on a payment arrangement. While the landlord is not obligated to accept payments of less than what was originally agreed, notifying the landlord in advance may help avoid problems.

When the tenant fails to pay the rent for any month, the landlord can sue the tenant in a **rent and possession** lawsuit. The tenant will receive a summons notifying him or her that a lawsuit has been filed. The summons will indicate when and where the tenant must appear in court to respond to the lawsuit. Upon receiving the summons, the tenant should contact a lawyer immediately. Do not ignore the summons. If a tenant has been properly served the summons and fails to appear in court when the case is scheduled, the landlord may obtain a judgment for rent and possession by default.

If there is rent due and the tenant pays it, along with court costs, on or before the day of trial, the case will be dismissed. If the court decides in favor of the landlord, the court may order the tenant to pay back rent plus costs and to move out of the apartment (this is an eviction order). The sheriff may forcibly remove a tenant still in possession, usually as soon as 10 days after the eviction order. The court may also order the tenant's wages garnished to satisfy a money judgment in favor of the landlord. **Remember:** the landlord cannot legally evict or lock out a tenant without a court order.

### **Unlawful Detainer**

If a landlord wants a tenant to move out for some reason other than non-payment of rent, the landlord may be able to force the tenant to move from the property. If there is no long-term lease, the landlord does not need a reason to end the tenancy but must give adequate notice that the tenancy is to be ended (30 days written notice for a month-to-month tenancy). If there is a long-term lease, it will state how much notice must be given, but by law it can be no less than 10 days' notice. The lease will also state what things constitute sufficient reason for the landlord to terminate tenancy (i.e., tenant-caused damage to premises, pets in apartment, etc.). If the tenant does not move out when the tenancy is ended, the landlord can file an **unlawful detainer** lawsuit to have the tenant evicted. The tenant receives a summons, much as in a rent and possession action, and there is a court

hearing or trial (Do not ignore the summons – contact an attorney immediately).

After a trial, the judge decides whether the landlord properly ended the tenancy. If the landlord acted properly, the court orders the tenant to move and may also issue a money judgment. If the tenant does not move within 10 days, or other court-ordered period of time, the sheriff may forcibly remove the tenant. If the landlord did not properly end the tenancy, the tenant can stay in the property. PLEASE NOTE: If the tenant stays in the property after the tenancy is ended — an action called “holding over” — the landlord may be entitled to **double rent** for each day the tenant holds over if the landlord is successful in the unlawful detainer action.

### **Security Deposits**

A landlord can charge no more than two months’ rent as a security deposit. After a tenant moves, the landlord can keep and apply the deposit to unpaid rent or other amounts owed or for costs of repair and cleaning after the tenant moves. The landlord cannot charge the tenant for repairing ordinary wear and tear to the premises. It is a good idea to take photographs of the apartment when you move in to document the condition of the apartment and to take photographs of the apartment before one moves out to show that no damage was done to the apartment.

The landlord must allow the tenant to attend a move-out inspection and either return the full security deposit or provide a written list of the reasons that all or part of the security deposit is being withheld. This must be done within 30 days of the end of tenancy. If the landlord does not do so, or wrongfully withholds any part of the security deposit, the tenant can sue and recover up to two times the amount that the landlord wrongfully withheld.

### **Repairs**

The landlord does not always have to pay for repairs, especially tenant-caused damage. Before a tenant does them or hires someone else to do them under assumption that the landlord will reimburse, have the landlord agree in writing to pay for the repairs.

If an apartment is found to be or suspected of being substandard (in violation of housing codes), a tenant should:

- Call the landlord and ask for repairs.
- Make a written request of the landlord for repairs.
- Call the health department or building inspector if the landlord does nothing.
- Contact a lawyer. (One may be able to withhold rent in some situations, but it would be prudent, if not essential, to obtain the advice of counsel first).

In some cases, the tenant has the right to repair and deduct from the rent the cost of the repair. The tenant has this right when the defective condition is a violation of a local municipal housing or building code and the cost of the repair is less than \$300, or one-half the monthly rent, whichever is greater, provided the amount may not exceed one month's rent. The tenant must also have lived in the unit for at least six months, be current on rent and other charges, and have cured any other lease violations for which the tenant has received written notice. To exercise this right, the tenant must put the landlord on notice of the tenant’s intention to repair. The landlord must then fail to respond to tenant’s notice within 14 days after being notified by the tenant (if the repair is for an emergency, the tenant must wait merely a reasonable period). If the landlord disputes the necessity for the repair, the tenant must obtain a written certification from the local building or health departments that the condition violates a local or municipal housing or building code.

## **HOUSING**

### **RENTAL ASSISTANCE PROGRAMS**

*By Mary Devries. Mary DeVries is a staff attorney with the Housing Unit of Legal Services of Eastern Missouri, Inc.*

#### **Public Housing**

Public housing is rental housing owned and operated by local public housing authorities using subsidies from

the U.S. Department of Housing and Urban Development (HUD). Residents pay approximately 30 percent of their income for rent. Most housing

authorities operate public housing specifically designated for senior citizens. Many senior citizen public housing developments provide services such as meals, transportation and social events.

**Eligibility:** Only low-income families, the elderly or disabled are eligible for public housing. Some housing authorities give waiting list preferences to seniors. In many parts of the state, there is an ample supply of public housing for the elderly. Seniors should apply for housing with the housing authority in their city if the municipality has its own agency, and at the county housing authority, which may also operate public housing in areas where the person is willing to reside. If you do not qualify for public housing, the housing authority must notify you in writing, tell you its reason for denial, and give you an opportunity for an informal meeting to discuss and review the denial.

### **Section Eight Housing Choice Voucher**

HUD funds a rental subsidy program known as the Section 8 voucher program. The program is administered locally by housing authorities or community action corporations.

This program helps low-income families and individuals pay their rent. Once a family obtains a Section 8 voucher, the family takes the voucher to any willing landlord. If the landlord agrees to participate in the program, the landlord will sign a contract with the housing authority. Under the program, the housing authority pays the owner the difference between the rent tenants pay (approximately 30 percent of their adjusted gross income) and the market rent of the units.

**Eligibility:** In order to apply for a Section 8 voucher, you must complete an application at the housing authority. Based on your application, the housing authority will determine if you are eligible. Only low-income families, the elderly or disabled are eligible for vouchers.

If the housing authority determines that you are eligible, the housing authority may put your name on a

waiting list if there are no available vouchers. The housing authority has discretion to open or close its waiting lists as needed. If you do not qualify for a Section 8 voucher, the housing authority must notify you in writing, tell you its reason for denial, and give you an opportunity for an informal hearing.

### **Project-Based Housing**

Through this program, HUD provides funds to privately-owned apartment owners who lower the rent they charge low-income families, elderly and disabled. The HUD rent subsidy is tied to the unit. Some units have low fixed rental amounts while the rent portion for other units changes when your income changes. Under the project-based Section 8 program, your rental portion is approximately 30 percent of your monthly adjusted gross income. The apartment owner has a contract with HUD through which HUD pays the owner the difference between the contract rent and your portion. If you move, you cannot apply the rent subsidy to a new unit. To locate project-based housing in your area, you can search by zip code at [www.hud.gov/apps/section8](http://www.hud.gov/apps/section8).

**Eligibility:** In order to apply, you need to visit the management office for the apartment complex that interests you. Based on your application, the owner will determine if you are eligible. If you do not qualify for project-based housing, the owner must notify you in writing, tell you its reason for denial, and give you an opportunity for a meeting to review its decision.

### **Low-Income Housing Tax Credit (LIHTC)**

The owner receives federal tax credits in return for preserving and renting a certain percentage of the apartments to low-income tenants. The amount of rent you pay is fixed and does not change just because your income changes. Rent increases must be approved by the Missouri Housing Development Commission (MHDC).

**Eligibility:** In order to apply, you need to visit the management office for the apartment complex that interests you. The owner will determine whether you qualify.

## **CONSUMER INFORMATION**

### **CONSUMER GUIDE**

*By Michael Ferry and Daniel Claggett. Michael serves on the Board of Directors of the National Consumer Law Center (where he received NCLC's highest honor for "outstanding efforts to strengthen and affirm the rights of low-income Americans through the practice of consumer law") and is the first St. Louis lawyer to be elected to the American College of Consumer Financial Services Lawyers. He has served on the Consumer Advisory Council of the Board of Governors for the Federal Reserve System and as a*

consumer fellow of the Uniform Commercial Code Committee of the Business Law Section of the American Bar Association. Michael is the executive director of Gateway Legal Services, Inc.(314-534-0404) – a not-for-profit legal aid program that represents individuals in Social Security and Disability matters. Before Michael helped found Gateway Legal Services he was a long time attorney with Legal Services of Eastern Missouri (“LSEM”). Daniel Claggett, manager of the Consumer Unit at LSEM, reviewed this section for the current 18th edition.

### Introduction

Consumers of all ages are vulnerable to the fast pitch and hard sell of professional sales people, whether door-to-door or on television or radio. Even prudent consumers, in the face of attractive product claims, need to remember the old saying: "If it's too good to be true, it probably is."

Even though consumer protection legislation and favorable court decisions help the consumer, your best protection is to be a well-informed, careful buyer. Smart consumers know their legal rights, look carefully at product claims, and demand satisfaction from their purchases.

This section will help make you a more alert consumer. Toward this end, this section describes general information helpful in your consumer purchases, specific facts you should know about particular types of purchases, plus legal and informal remedies that you can use if you are dissatisfied with a purchase.

### Contracts and Credit Buying

Almost all major and even routine purchases that you make as a consumer involve a contract between you (the buyer) and a merchant (the seller). If you have ever purchased a car, hired a person to do repair work, or bought a pair of shoes with or without a credit card, you have made a contract with a seller.

Often a consumer contract involves a credit purchase and repayment over a period of time. This arrangement is commonly known as "buying on time" or "buying on credit." In effect, the store, dealer or company from which you are buying lends you the amount needed to purchase the desired item or service. You, in turn, agree to pay back the money, plus a finance charge of some kind.

*Note: Some banks, usually those charging a membership fee for charge cards issued by them, will not impose finance charges on credit purchases if you pay your balance in full each month.*

Whenever you buy on time, be sure you know how much your total cost will be. Make a budget examining your monthly income and expenses (monthly debt payments greater than 20 percent of your monthly income may lead to trouble) and future plans (for example, you may need to replace a roof in several months) before you make a credit purchase.

### Key Terms to Understand

The following is a glossary of credit buying terms with which you should be familiar:

**Cash Price:** This tells you what an item or service would cost if you paid for it completely in cash at the time you bought it.

**Finance Charge:** This is the cost of credit. It is the price you pay for the privilege of paying over time. It is added to the cash price.

**Annual Percentage Rate (APR):** This is the cost of your credit expressed as a rate. *The lower the APR, the cheaper the credit. The higher the APR, the more expensive the credit.*

The **Federal Truth-in-Lending Act** requires persons and businesses that regularly extend credit to tell consumers what that credit will cost in the long run. When you buy on credit, you must be told, among other things, the finance charge and the annual percentage rate on the purchase you wish to make. If you have a credit card or account, these disclosures may be made on or before your first use of the card or account. Otherwise the terms of the credit purchase must be disclosed with each purchase. Lenders that fail to make these disclosures may be sued by their customers for twice the amount of the finance charge, plus court costs and attorney's fees. If a security interest was taken in the customer's home, the customer may also be able to undo the contract.

### Key Questions To Ask Yourself

Before signing any sales contract, ask yourself these questions:

- (1) Do I know what I am buying?
- (2) Do I really understand the terms of the contract and my obligations under the contract?
- (3) Am I making the common mistake of looking only at the size of the monthly payment, or did I also look at the APR?
- (4) Can I buy a similar item elsewhere at a lower price?
- (5) Am I satisfied with the cost of credit charged on my purchase?
- (6) What kind of protection do I have in the way of guarantees and warranties? (Buying something "as is" means no warranties.)

### **Basic Contract Do's and Don'ts**

DO insist that the salesperson let you take home a copy of the contract before you sign it.

DO NOT deal with a salesperson who refuses to let you take home, prior to signing, a contract with the sales price, cost of credit, etc., filled in.

DO NOT pay 100 percent for items or services you have not yet received.

DO show the contract to a friend or a lawyer if you have any questions about its provisions.

DO NOT sign anything unless you have had time to read it carefully (or have it read to you) and you fully understand what it says.

DO insist that all promises (guarantees and warranties) be put in writing.

DO NOT sign a contract with blank spaces that are to be filled in later by a salesperson.

DO keep copies of all contracts, payment records, and complaint letters in a safe place.

### **Watch Out for Predatory Loans**

Loans that are unreasonably expensive, charge overly high or unnecessary fees, or are otherwise unfair or fraudulent in some way, are often called “predatory” loans.

Perhaps the worst predatory loans are those associated with refinancing of your house. This is because the consequences – loss of your equity, perhaps loss of the house itself – can be so extreme.

Predatory practices come in many forms, but some of the more common include:

- Multiple refinancings, each one with more fees added on.
- Very high interest rates.
- Very high fees.
- Fees for charges supposedly paid to third parties that were actually never paid.
- Padded fees for charges paid to third parties.
- Kickbacks paid by lenders to mortgage brokers for getting you to agree to an interest rate that is higher than the rate the lender would have been willing to give you.
- Requiring credit insurance.
- Falsifying loan applications.
- Knowingly making loans on terms the borrower cannot afford.

- Presenting different terms at closing from those the borrower had been led to expect.
- Creating a payment schedule with a “balloon” payment (a larger-than-normal payment) at the end, without the borrower being aware of it.

Before you refinance your house, there are many questions you should ask the person arranging the loan. The Bar Association of Metropolitan St. Louis has a “Before You Make the Loan” checklist that you may find very useful. You can get a copy of the checklist by going to the association’s web site at [www.bamsl.org](http://www.bamsl.org) (go to the “For the Public” section), or by calling the association at (314) 421-4134.

Be sure to carefully read the “Good Faith Estimate” (“GFE”), which your lender is required to give you no later than three business days after the lender receives your loan application for a mortgage loan. The GFE will contain important information about your loan, such as your interest rate, whether the interest rate can change, and whether your loan has a balloon payment. The GFE will also itemize and explain settlement charges for your new loan. Federal law limits the circumstances and amount by which the lender can change certain of these settlement charges at the time of the loan closing.

Other high-cost loans include “payday” loans, “title” loans, and “tax refund anticipation” loans. It is not unusual for such loans to have annual percentage rates of more than 100 percent, and sometimes 300 percent or higher. Such loans can be very profitable for the lender, and very expensive for you.

### **Door-to-Door Sales**

Even the most strong-willed consumer occasionally buys an unwanted item from an enterprising door-to-door salesperson. If you change your mind after he or she leaves with your money or a sales contract, however, you can do something about it.

Both a Missouri law and a Federal Trade Commission (FTC) rule allow you a three-day “cooling off” period during which you can decide whether to cancel the sale or rescind the contract. You must do so by sending written notice to the company or business before midnight of the third business day after the date of the transaction. Keep a copy for your records.

Missouri law does not require you to follow any particular format in sending your notice to cancel, but the FTC rule involves a **Notice of Cancellation** form which you should receive from the salesperson along with copies of the sales contract or receipt of sale. You merely sign and date one copy of the Notice of Cancellation and send

or deliver it to the company or business within three business days from the date of the transaction. If possible, send this notice or a written letter of cancellation by certified mail with a return receipt request.

Once the merchant receives the notice or letter of cancellation, he or she has 10 days to refund any money received, return any documents that you have signed, return any goods or property that you've traded in, and inform you whether they will pick up or let you keep any items that were left with you. If anything was left with you, you must return it in its original condition. It is not your responsibility to ship the items; the seller must pay postage. Otherwise, the seller must pick up the items.

*Note: The FTC rule and Missouri law does not cover purchases under \$25.*

### **Consumers and Home Repairs**

Whenever you hire someone to make repairs on your home, use caution and shop around. Get two or three estimates to see who is offering the best bargain. Also, check references before you hire. There are a lot of "fly-by-night" operators. Also, check with the Better Business Bureau to see if the contractor has unresolved complaints outstanding.

After you decide upon a contractor, ask that your agreement be written down. This can avoid a lot of trouble later on. Items such as price and guarantees should be in writing to avoid arguments after the work is completed.

If the contractor or a loan company is going to finance your home repairs and takes a **deed of trust** on your home as collateral for this loan, remember three things: (1) the contractor or loan company financing the repairs must inform you that your house is collateral for the work and that you have a right to cancel the loan without cost within a specified period; (2) you usually have three business days after you enter into the loan in which to cancel it (during which time the contractor is not supposed to begin work); and (3) *if you get behind on your payments, you may lose your home to the contractor or loan company.*

### **Mechanic's Liens**

A **contractor** (the person with whom you, the homeowner, have contracted to perform home repairs) may file a mechanic's lien against your house if you fail to pay for materials and/or labor for home repairs.

However, **subcontractors** and **suppliers** must have your written consent before they can file mechanic's liens against your house. They will usually ask the homeowner to give written consent before they do any work or supply any materials.

The written consent must be printed in 10-point bold type, must be signed by you, and must say:

### **CONSENT OF OWNER**

**CONSENT IS HEREBY GIVEN FOR FILING OF MECHANIC'S LIENS BY ANY PERSON WHO SUPPLIES MATERIALS OR SERVICES FOR THE WORK DESCRIBED IN THIS CONTRACT ON THE PROPERTY ON WHICH IT IS LOCATED IF HE IS NOT PAID.**

Be **very** careful about signing a form like this.

In order to collect any money from you on those liens, the contractor, subcontractors, or suppliers who have not been paid must file a lawsuit against you.

In the court action, the contractor has to prove it is entitled to the money. Once the lawsuit is filed, you will receive a summons that usually tells you to appear in court on a certain date and at a set time. **DO NOT** ignore the summons. If you or your attorney do not appear in court at the appropriate time, a default judgment could be taken against you. If you have paid the general contractor in full and you have not given your written consent for a subcontractor and/or supplier to file a lien, then you are not liable to the subcontractors and suppliers – but you still need to appear in court if you are sued.

### **Collection Activities and Garnishment**

If you are paying for a product or service over time and you fall behind on the payments, the loan company or bank may turn the debt over to a collection agency. Remember that a collection agency **cannot** use harassment to get the money. If you are called by an agency late at night or if your friends are being bothered, report the company to the Missouri Department of Finance (573-751-3242) and call an attorney. Federal law protects consumers against some abusive tactics by debt collectors.

When loan companies, banks or collection agencies obtain court judgments on debts you owe, they may garnish up to 25 percent (10 percent if you are head of the household) of your wages after taxes. Furthermore, these creditors may attempt to take away your house, car, or household furnishings. Some of this property is exempt, but you should contact an attorney immediately if you face garnishment of your property. You should also quickly file your request for any exemptions to which you may be entitled with the sheriff who served the garnishment. Social Security benefits and most pension benefits cannot usually be garnished.

## Consumer Remedies

When something goes wrong with a product you have purchased, or if a repair job that you contracted to have completed (for example, on your car or house) was poorly done, you can seek satisfaction in a number of ways short of a lawsuit. A thoughtfully prepared complaint made either in person or in writing can be an extremely effective way of getting a consumer problem solved, especially when that complaint is made to the proper authority. A consumer can file a complaint with the Missouri Attorney General's office by phone (800-392-8222) or online ([www.ago.mo.gov](http://www.ago.mo.gov)). Many problems can be handled successfully through the use of this method. The use of laws that give consumers the ability to cancel certain types of sales contracts is another remedy you have at your disposal. Small claims court is also available to consumers who believe that they have been treated unfairly; the amount in dispute must be \$3,000 or less. Better Business Bureau arbitration can also be helpful (see below).

### Complaints

Complaints are most effective when they are accompanied by receipts and other documents that help explain your case. If you contact the store or business by mail, send your complaint letter by registered mail and keep a copy for your records. **Never send originals** of any receipt, contract or document. If you are making your complaint in person, try to remain calm, but firm. Make sure that what you are told makes sense to you.

If taking your complaint directly to the store or business does not produce the satisfaction that you are seeking, then bring the matter to the attention of the Better Business Bureau in your community or contact the Missouri Attorney General's Office.

### Consumer Arbitration

The Better Business Bureau (314-645-3300) offers a free service, called arbitration, to settle disputes between consumers and businesses. When all informal attempts to settle a dispute fail, you or the business may enlist the aid of an arbitrator to resolve your differences. Both you and the business must agree to this process, and any decision of the arbitrator is legally binding upon the parties. Because the arbitration hearing is informal, you don't need the services of an attorney, but you may have one represent you. Contact the Better Business Bureau in your area for more details about consumer arbitration.

Beware of contracts that let the creditor force you to take any disputes to arbitration. Such contracts can cost you the right to jury trial and many important procedural rights. Arbitration can also be more expensive than court. Arbitrators are not required to follow the law, and your right to appeal an arbitrator's decision is very limited. You

have the right to request that the arbitration clause be stricken or removed from the contract. If the creditor refuses, then you should carefully weigh the risks and benefits of entering into such a contract vs. walking away and searching for a creditor selling the same service or product who will not insist upon the arbitration of disputes.

### Small Claims Court

Missouri consumers who have not received satisfactory responses to their inquiries and complaints about defective products and poor service may seek relief in small claims court when their dispute involves \$3,000 or less. The small claims court is a valuable tool to the consumer because: (1) the court costs are minimal; (2) the procedure is informal; and (3) you do not need an attorney to represent you (though you or the opposing party may have one).

Before you decide to use the small claims court (or any court for that matter), make certain there is no other way of settling your dispute, short of a lawsuit. You may save yourself a lot of time, effort and potential difficulties in litigation if you can solve your grievance satisfactorily out of court. However, if you feel that you have tried all other available avenues in your attempt to resolve your differences and \$3,000 or less is in dispute, take advantage of the small claims court.

To file a lawsuit, go to the Associate Circuit Court clerk in the county where you live. If the person or business you are suing resides in another county or if the purchase of the product or service was made in another county, you should file your lawsuit in that county.

The clerk will give you a form to fill out and file, and will assist you if you need help. The clerk will also answer any questions that you may have about court procedures. However, it is not the clerk's duty to help you decide the amount for which you are going to sue.

You (the plaintiff) should have with you the exact name and address of the person or business you are suing (the defendant) when you fill out the form to file your case. You pay a filing fee and you also pay the cost of mailing the summons by registered mail or of service on the defendant by the sheriff.

When you leave the courthouse, check to see that you know the docket number of your case, the time and date that your case is to be heard, and the location of the courtroom where you are to appear.

Here are some important points to remember when preparing your lawsuit:



- (1) Organize important materials (bills, receipts, letters, etc.) so that you can make a complete and orderly presentation of your case at the hearing.
- (2) Think over and make some notes on what you want to say so that you can make a full but brief statement of the facts in your case.
- (3) Decide what witnesses, if any, you want to appear at the hearing. Witnesses may be subpoenaed (compelled) if they are reluctant to appear voluntarily and if they are important to the case.
- (4) Check with the court before the hearing to find out whether the defendant has been served with the summons. If service has not been made, the clerk can tell you about your options.
- (5) It is very important that you appear in court at the scheduled time and place for your hearing. Failure to do so may result in your lawsuit being dismissed by the court.

When you appear in court, do not be disturbed if the business or person you are suing is represented by an attorney. The judge has a responsibility to ensure that the proceedings remain informal, so your lack of legal knowledge will not work against you.

Either side in a small claims case may request a new trial in response to an unfavorable ruling. If you are dissatisfied with the decision and want a new trial, you must act promptly. Requests for new trials must be filed within 10 days. You may need the help of an attorney.

If you win damages, you face the task of getting the defendant to pay. The defendant may voluntarily agree to pay you in a certain way — all at once or in installments. Occasionally, a defendant who has lost in court will not pay the judgment. When this happens, the court clerk can help you complete the forms to garnish the wages or bank account of the defendant. Other court procedures may be available to collect a judgment, but they are difficult to pursue without the help of an attorney.

If you have a chance to settle the suit before the court hearing, try to do so. Inform the court if this occurs and be ready to have the case heard in the event the settlement negotiations fall through.

When all other remedies fail or if small claims court is not available to you because the amount in controversy is more than \$3,000, you may want to pursue your case in a more formal court setting. If you decide to do that, you should discuss the situation with an attorney. For legal assistance information, see the reference section in the back of this book.

## **Time Share Property**

Senior citizens are frequently contacted by real estate developers and resort communities offering time share plans for sale. In a "time share plan," you buy an ownership interest in, or the right to use, real estate or property for a certain period of time, usually for vacations or other short periods of time, up to one year in length for any given year. The real estate or property typically consists of condominiums, apartments, lodges, cabins or hotel rooms.

Missouri has a statute protecting the rights of buyers of time share plans. First, the buyer has five days after the purchase of a time share arrangement to cancel the purchase. The cancellation should be given in writing on a form that the seller must provide at the time of the time share purchase.

Secondly, when the seller uses free offers, gifts, drawings or other promotions as a method of soliciting you to buy a time share plan, the seller must deliver any promised gifts or an acceptable substitute gift or cash in an amount equal to the retail value of the gift offered within 10 days of when promised. The seller must also maintain a list of the names and addresses of all winners, which must be made available to the public.

If the seller fails to provide the buyer with the promised gift or cash, the buyer can sue and collect up to five times the value of the most expensive gift offered, not to exceed \$1,000 in addition to other actual damages.

If the time share plan involves an exchange program in which time share buyers may assign or exchange their property with other time share owners, the seller must notify the buyer in writing of all information relevant to the exchange program, including whether the exchange program is voluntary or mandatory, the procedures for qualifying and doing exchanges, and the names and addresses of all other time share programs participating in the exchange program.

If you have questions about any time share program or feel you have been cheated by a time share seller, contact the Consumer Protection Division of the Missouri Attorney General's Office.

## **Summary**

If you are dissatisfied with a service, a product or work done for you, the first thing you should do is to notify the company, in writing, of your complaints. If they do not satisfy your complaint, you may want to contact a lawyer. Do not assume you can stop paying just because you are dissatisfied. Get the advice of a lawyer first. A lawyer may be able to help you overcome the effects of a bad bargain.

### Missouri No Call Law

Missouri has a law that prohibits telemarketers from contacting residents at home. In order to be protected by the law, you can register your household with the Missouri Attorney General's office by phone (866-662-2551) or online ([www.ago.mo.gov](http://www.ago.mo.gov)). It is only necessary to register your household once, but you must make sure to include all of your home numbers if you have more than one line.

The Attorney General's office submits names every three months, so it may take up to three months for your name to get on the telemarketer's No Call list. If a telemarketer violates the No Call law by contacting you after your registration is complete, you can report the telemarketer by phone or electronically to the Missouri Attorney General's office. A telemarketer who violates the law faces a civil penalty of up to \$5,000.

## CONSUMER INFORMATION

### HEALTH AND LIFE INSURANCE

*Michael Ferry is executive director of Gateway Legal Services, Inc., and previously a long time attorney with Legal Services of Eastern Missouri, Inc. Gateway Legal Services, Inc. (314-534-0404) is a not-for-profit legal aid program that represents individuals in Social Security Disability and SSI matters as well as various consumer law matters.*

#### Introduction

As one approaches retirement, insurance needs change. Additional health insurance coverage may be needed or life insurance needs may decrease. Choosing new insurance or deciding whether to continue a current policy is an important decision. The best protection is to be well informed so that insurance coverage is neither excessive nor inadequate.

#### Life Insurance

For most people, life insurance assures the financial security of dependents. It may also act as an investment. For someone who already owns insurance and is wondering whether to continue the coverage or for someone who wants to purchase a new policy, it is essential to know the basic elements of life insurance.

**Term insurance** refers to a policy under which one receives a certain amount of life insurance coverage for a specified period of time — or term. There is no cash value for the policy and the coverage ends at the end of the specified term. For example, if someone has a term life insurance policy that covers the policyholder until he/she reaches age 65, once that age is reached the policy terminates and the policyholder will no longer have coverage under that policy.

**Whole-life insurance** (also called straight-life or ordinary life) provides life insurance coverage for the entire life of the policyholder. These types of policies have a cash value that the policyholder may receive if he/she decides to terminate the policy. The cash value

will increase the longer one holds the policy. Typically, whole-life policies are more expensive than term insurance.

Some questions that one should ask when determining life insurance needs include:

1. Do others depend on me for their financial support? If so, for how long will this dependence be true?
2. In the case of my death, will there be expenses that someone will need to pay? If so, are there more economical arrangements that could be made rather than purchasing a life insurance policy?
3. Is my primary objective for obtaining a life insurance policy to leave money to someone? If so, would my money be better spent by placing it in a bank account or investments rather than used toward payment of insurance premiums?

It should be kept in mind that the need for life insurance decreases over time as children become independent. In addition, the cash value of the insurance policy is usually quite low when compared to the amount of premiums paid.

**Face value** refers to the amount of coverage one has under a policy. For example, if a policy has a face value of \$5,000, the policy's beneficiary will be paid \$5,000 if the policyholder dies while the policy is still in force. Under some policies, additional coverage, often double the face value, may be provided if the policyholder dies as a result of an accident. The benefits of the policy will

be reduced by the amount of any loans outstanding against the policy.

**Cash value** refers to the amount of money one may receive by terminating or borrowing against a whole-life insurance policy. Typically, unless the policy is fairly old, the cash value of a policy will be less than its face value. Each of the two methods of obtaining a policy's face value — terminating or borrowing against it — has its own advantages.

Terminating the policy allows one to receive the cash value, but ends the coverage of the policy. If a policyholder chooses to terminate coverage, the insurance company should be notified immediately. Otherwise, if a policyholder simply stops paying premiums, the insurance company will continue the coverage and deduct the premiums from the remaining cash value and not actually terminate coverage until the cash value is depleted.

Borrowing against a policy will continue the coverage, but allow the policyholder to obtain a loan, usually at a low interest rate. It should be noted that any outstanding loans at the time of death of the policyholder will reduce the amount of insurance payment to the beneficiary.

### **Health Insurance**

The proper choice of health insurance involves careful consideration of the costs and benefits. If you are currently receiving or are eligible for Medicaid, you may not need to purchase additional health insurance. Similarly, if you have insurance through a group plan from a former employer, you may have all the coverage you need. Most people who are covered by Medicare at most need supplemental health coverage to help pay for costs that Medicare does not cover, such as deductibles and co-insurance amounts. Many private insurance companies offer supplemental (Medigap) policies, but such plans can be confusing and also vary widely in value.

Most supplemental policies are designed to only cover Medicare deductibles and co-insurance costs. They exclude the same types of coverage that are excluded by Medicare. Terms or phrases in a health insurance policy such as “medically necessary” or “customary charge” mean that the policy does not pay the actual difference between what Medicare pays and you are charged, but only the deductibles and co-insurance based on what Medicare determines it will pay. This is most important for Part B, doctor and outpatient costs, because hospitals generally cannot charge the patient more than what Medicare pays. Also keep in mind that a physician who

accepts “assignment” has agreed not to charge patients more than what Medicare determines should be charged, but the patient is still responsible for 20 percent of the charge.

Example: A doctor's bill is received for \$600. The Medicare-approved charges for the physician's services are \$450. Medicare Part B will pay 80 percent of the Medicare approved charge (80 percent of \$450 = \$360). A supplemental insurance policy will pay the balance (or 20 percent) of the Medicare approved charge. Therefore, the supplemental insurance would cover \$90 (20 percent of \$450), but the patient would have to pay \$150, the difference between the actual charge and the Medicare-approved charge (unless the doctor accepts assignment).

These questions may be helpful when comparing available supplemental policies:

1. Does the supplemental policy cover the deductible (currently \$1,132) that must be met before Medicare will kick in for the first 60 days of a hospital stay?
2. Does the policy cover the amount per day (currently \$283) that Medicare will not cover if the hospital stay lasts between 61 and 90 days?
3. Does the policy pay the amount per day (currently \$563) that Medicare will not pay if a hospital stay is more than 90 days, which requires the policyholder to use some of the lifetime reserve days?
4. Does the policy cover medical and hospital costs if the policyholder is hospitalized more than 150 days, under which circumstance the policyholder can no longer receive Medicare?
5. Does the policy pay the amount per day (currently \$141.50) that Medicare will not pay for a stay in a skilled nursing facility that is between 21 and 100 days?
6. Does the policy cover the costs of staying in a skilled nursing facility for more than 100 days, under which circumstance a Medicare recipient can no longer receive Medicare?
7. Does the policy pay the annual deductible (currently \$162) that must be met under Medicare Part B?
8. Does the policy cover the full 20 percent of reasonable (or covered or necessary) charges that are not covered under Medicare Part B?
9. Does the policy cover costs that Medicare may not consider to be reasonable and necessary?
10. Does the policy cover costs that are not currently covered under Medicare, such as prescription drugs and medicines, hearing aids, dental care, routine exams, or custodial care in a nursing home?

Remember, it is Medicare Part B costs that need to be supplemented. Policies that offer amounts up to

\$50,000 (or more) in hospital protection are often not advantageous. In most cases, one would have to be hospitalized for “medically necessary” services for more than six months in order to actually benefit from the stated offer in the policy.

**Medicare Advantage** refers to private managed care health plans for Medicare recipients that have been available since 1997. Medicare Advantage plans provide all the same benefits as Medicare, but are also similar to Medigap policies in that they offer a range of supplemental benefits to cover out-of-pocket costs, such as deductibles and co-insurance, as well as coverage for those Medicare beneficiaries who exhaust their hospital inpatient benefits. Some plans also offer coverage for other benefits not covered by Medicare, such as prescription drugs, routine eye exams, annual physicals, hearing exams, eyeglasses, or hearing aids. It should be noted that most Medicare Advantage plans have reduced

these supplemental benefits in the past year. In addition, many companies are withdrawing from the Medicare Advantage program, which means that many members will have to return to regular Medicare and may need a Medigap policy.

**Qualified Medicare Beneficiary (QMB)** is a program under which Medicaid acts as a supplemental (Medigap) policy for Medicare recipients whose income is higher than that allowed for Medicaid eligibility, but below the federal poverty level plus \$20. In Missouri, the QMB program is handled through the Missouri Department of Social Services, Family Support Division (FSD) and the state pays the Part A and Part B Medicare premiums, deductibles, and co-insurance charges for eligible recipients. Those currently receiving Medicaid may also be eligible for QMB benefits; inquiries should be made to the local FSD office.

## PREDATORY LENDING

*By Kerry Kaufmann, who is administrator of Normandy Nursing Center, a position she has held for 14 years. Prior to that, Ms. Kaufmann was the assistant director of the St. Louis Long Term Care Ombudsman Program, and she has sat on various boards and committees concerning the elderly. Kerry has been involved with various projects with Legal Services of Eastern Missouri since serving a paralegal internship there in 1987.*

Today’s financial environment has caused homeowners to consider refinancing their homes to cover day to day living expenses or, in extreme cases, working with lenders to save their homes from foreclosure. Be alert and be aware!

Always work with a reputable lender. Contact an attorney, financial planner or a bank officer before considering refinancing.

If foreclosure is the issue, first consult the primary lender and ask about the options available. Some lenders may consider working with the homeowner by reducing interest rates or by making other arrangements that would allow the homeowner to keep the home. If this is not an option, contact an attorney.

Recently there have been lenders offering to purchase homes in foreclosure from the homeowner for a small percentage of what the home is actually worth. These lenders promise to allow the homeowners to either purchase the home back at a lower interest rate or rent the home back at a low rental fee.

Once a home is transferred, there is no responsibility for the new owner to provide for the previous owner. Therefore, these schemes do nothing but entice desperate homeowners to sell their homes for pennies on the dollar and broken promises.

Predatory lending means imposing unfair and/or abusive loan terms on borrowers, often through aggressive sales tactics, deception, or taking advantage of a borrower’s lack of understanding. In the case of the elderly, this practice is more common with those who are refinancing their homes.

Predatory lending usually includes one or more of the following: an excessively high interest rate, a large number of “points,” a large “balloon” payment after two or three years, prepaid life insurance, unnecessary closing costs, and “loan flipping.” Unnecessary closing costs can include processing fees, underwriting fees, broker fees, documentation preparation fees, and administrative fees. Loan flipping is when the loan is refinanced several times with the promise of cash or reduced payments each time by the broker or lender,

when in fact the individual is not benefiting and the equity is being significantly reduced.

These practices are commonly seen in situations where the elderly have a large amount of equity built up in their homes and are faced with unexpected home repairs or medical bills. Lenders or brokers persuade the elderly to refinance their home to “consolidate” these bills. This often leads to the repeated refinancing of mortgages, which in many instances serves no purpose other than to generate higher fees for the brokers and/or lenders.

The broker or lender will make promises to the homeowner that, by refinancing the mortgage, various bills will be paid off and/or that their monthly payments will drop significantly. However, the outcome is usually a higher interest rate, overpriced costs, and little or no cash for the homeowner.

Sometimes, unsuspecting homeowners are often offered what appears at first to be lower monthly payments. However, these payments do not include escrows for taxes and homeowners’ insurance, which the current payment does include. In addition, there may be significant prepayment penalties, which are not disclosed. All of these add-ons can decrease the homeowner’s equity and increase their debt ratio.

Telemarketers are infamous for trying to convince older homeowners that they need to refinance. These telemarketers purchase lists of homeowners in the area

who have recently refinanced their homes or have liens or second and third mortgages on their homes. Such homeowners may be particularly vulnerable to promises of loans that sound too good to be true.

To guard against predatory lending, the homeowner is advised to:

- (1) Always have an attorney, financial planner, or trusted advisor review any documents associated with refinancing;
- (2) Make sure that you are on the Missouri No Call list by phone (866-NOCALL1) or online ([www.ago.mo.gov](http://www.ago.mo.gov));
- (3) Do not give financial power of attorney to anyone without your attorney’s advice;
- (4) Do not sign any contract with financing provisions without having an attorney review it; and
- (5) Make sure that your total monthly payments do not exceed your disposable income. A good rule of thumb is that your housing expense should not exceed approximately one-third of your total income.

If you suspect that you have been a victim of predatory lending, contact an attorney. There may be some matters he/she can help you with to save your home, including filing complaints under the Elder Abuse Act with the appropriate agencies.

## PERSONAL PLANNING/PROTECTION

### TRANSFERS UPON DEATH

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**NOTICE: THIS RENDERING IS INTENDED AS A SERVICE TO PROVIDE GENERAL INFORMATION TO THE PUBLIC AND TO PROVIDE SUGGESTIONS ABOUT APPROPRIATE APPROACHES TO ACHIEVE DIFFERENT ESTATE PLANNING GOALS. IT IS NOT INTENDED TO REPLACE OR SUBSTITUTE FOR THE ADVICE OF A QUALIFIED ESTATE PLANNING ATTORNEY FAMILIAR WITH THE SPECIFIC SITUATION AND OBJECTIVES OF THE READER AND RETAINED TO ADVISE ABOUT ESTATE PLANNING AND ADMINISTRATION OF A PARTICULAR ESTATE. THE AUTHOR SHALL NOT HAVE ANY LIABILITY OR RESPONSIBILITY WHATSOEVER FOR ANY LOSS OR DAMAGE ALLEGED AS A RESULT OF RELIANCE ON THE INFORMATION CONTAINED IN THIS RENDERING.**

## Introduction

This section primarily outlines the options and tools for transferring property to heirs and beneficiaries after death and outlines advantages and pitfalls of each. It covers what will happen if you fail to plan and includes a discussion of probate for decedent's estates. Covered in a different section are the various ways that property of an incapacitated or disabled person can be managed during his or her lifetime. Options for arranging transfer of assets after death can be summed up into five categories:

- (1) doing nothing;
- (2) making a will;
- (3) doing a living trust;
- (4) doing a non-probate transfer; and
- (5) making someone else a joint owner with right of survivorship.

As a practical matter, a person may die having used any or all of these methods for various assets.

### (1) Doing Nothing

The option of doing nothing is selected by many people, either through ignorance, procrastination, or design. The result is that, at death, the person's assets will pass to their next of kin as defined in the statutes in effect in the state of residence. These statutes, which lawyers call the rules of intestate succession or the rules of descent and distribution, originated in the English Common Law. They provide a complex formula for dividing first among surviving spouse and children, if any, and if none survive then to other relatives based upon degree of relatedness by blood or adoption. Except in the case of a surviving spouse and children, assets are never divided among people who do not bear the same relationship to the decedent so that, for instance, if a single childless person is survived by a mother and three siblings, the mother would inherit the entire estate. Missouri's rules of intestate succession are set out at Section 474.010 of the Missouri Revised Statutes and amplifying sections which follow. Ironically, this legislative scheme, while sensible and comprehensive, is rarely, if ever, as good as an individual plan could be when worked out with the assistance of an experienced estate planning attorney.

### (2) Intro to Wills

A last will and testament is used to designate a guardian for minor children, to name someone as personal representative (once called the executor) to administer your estate after you die, and to designate who is to inherit from you after your death. A will does not go into effect until death and is therefore of no value in providing for management of your affairs before you

die. A will is generally effective to transfer only assets for which no other plan of inheritance (such as joint ownership) is in place. Moreover, a will does not avoid probate.

### Some Basic Facts About Wills

A carefully drafted will allows one to control the disposition of one's property after death. A probate estate is all property that passes pursuant to the provisions of a will and consists of all property and cash assets owned at the time of death, including bank accounts, land, furniture, buildings, cars, stocks and bonds, proceeds of life insurance, pension plans, and retirement accounts payable to the estate. Property that is titled with a joint tenant or has nonprobate transfer designation is not part of the probate estate. Also, any property that has a beneficiary designation (other than to the estate) is not part of the probate estate. This type of property often would include insurance policies, annuities and retirement accounts.

A will can help assure that one's property transfers to a spouse, children or relatives. In addition, provisions of a will can ease the estate tax burdens that may accompany the transfer of an estate to the individuals chosen. A will provides the probate court with guidance regarding the distribution of the decedent's property and the payment of debts.

In Missouri, a valid will must comply with these requirements:

- 1) The maker (called the testator if a man, or testatrix if a woman) must be at least 18 years of age, except for a minor emancipated by adjudication, marriage, or entry into active military service;
- 2) The maker must be of "sound mind" at the time the will is prepared;
- 3) The will must be in writing and signed by the maker; and
- 4) The will must be witnessed by at least two people who do not receive any property under the will. The witnesses must sign their names at the end of the will in the presence of the testator.

A notary is not required to create a valid will. However, a notary is needed to create a **self-proving will**. A "self-proving will" is one in which the two witnesses have sworn that they have signed the will in compliance with the requirements for a valid will. This eliminates the need for the witnesses to personally appear in court before the Probate Division to prove their signatures. A self-proving will is advisable because witnesses may predecease the maker of the will or be difficult to locate.

A will names a personal representative (formerly called the executor) to administer the probate estate, usually one or more persons who have attained the age of 18 or older, or an institution such as a bank or a trust company. A personal representative need not be a resident of Missouri; however, it is often prudent to choose a representative who lives close enough to oversee your estate conveniently.

The administration of the probate estate involves paying outstanding debts and taxes from the estate, as well as distributing the estate according to the provisions of the will or by intestate succession. The personal representative is responsible for proper management of the estate, but is not personally liable for the debts and taxes of the deceased individual. If the personal representative is unable to carry out his or her duties, the court will appoint someone else to fulfill the personal representative's task. However, the situation is avoidable if the maker of the will names a successor personal representative in the will to replace the first choice.

### **Restrictions on Distributing Property by Will**

Missouri law gives a person broad freedom to distribute the estate as desired. However, a surviving spouse can choose to either receive by the will or ask the Probate Division by petition for one-third of the estate if there are children or one-half of the estate if there are no children.

### **Types of Probate**

There are various procedures available to distribute an estate. The choice of procedures depends primarily upon the value of the estate. Although complexity varies, virtually all probate proceedings require use of an attorney.

When a will is involved, the court first calls in the witnesses to the will, who testify to the validity of the will. (If the will is self-proving, which means that the witnesses signatures are notarized, this step is eliminated.) After that is done, or if there is no will, the court moves directly to the next step, which is called **administration**.

When the value of the probate estate is less than the exemptions allowed to the surviving spouse and minor children (which includes a maximum \$7,500 homestead allowance and a reasonable living expenses maintenance allowance for one year), the court may allow immediate distribution if the spouse requests a **refusal of letters**. This also is allowed when there is no surviving spouse, the estate is less than \$5,000, and a creditor has a claim against the estate. A friend or relative may be able to use this procedure to be repaid for funeral bills.

If the value of the entire probate estate, including real property, is worth less than \$40,000, then the estate is considered a **small estate**, and the court will allow distribution without lengthy proceedings after a simple document is filed.

If an estate cannot be administered by a refusal of letters, or as a small estate, it must go through a full administration. The court supervises this administration unless either the deceased in the will specifically authorized an **independent administration** or all the heirs agree to independent administration. Independent administration means that the personal representative may distribute the entire estate with the help of an attorney without having a court order. The personal representative is required to only make a final report to the court.

An estate, whether administered independently or supervised, must remain open for at least six months to allow creditors to file claims and to give individuals the opportunity to challenge the will.

Both full administration and independent administration of an estate normally take at least nine months to complete, but can take longer if more complicated property is involved or claims are filed against the estate.

### **Costs of Probate**

Missouri law prescribes a minimum compensation for the personal representative's services. It must be remembered that this fee schedule applies only to estates with more than \$40,000 of property in the estate. This compensation, paid out of the estate, is a percentage of the value of the estate.

- On the first \$5,000 – 5 percent
- On the next \$20,000 – 4 percent
- On the next \$75,000 – 3 percent
- On the next \$300,000 – 2¾ percent
- On the next \$600,000 – 2½ percent
- On all over \$1,000,000 – 2 percent

**The personal representative may waive this compensation. Because the personal representative's fees are taxable, many personal representatives waive the fee if they are beneficiaries of the will or trust.**

The attorney who performs services for the estate is also entitled to at least the compensation listed above. The court can allow additional compensation if such is reasonable. A family can also negotiate a fee with the lawyer that is different from above.

### **(3) Living Trusts Avoid Probate**

The generally preferred method by which one can avoid probate while retaining control and use of the property during one's lifetime is thru the creation of a living trust. Living trusts are revocable, which allows one to change the trust's provisions or to revoke the trust. A living trust is created by a trustor (grantor or settlor) and the assets of the trust are managed by a trustee for the benefit of the beneficiary. A trustor may serve as both the trustee and beneficiary of the trust during his or her lifetime, and he or she should choose the successor trustees and beneficiaries. A married couple may also create a joint trust that often makes trust administration easier, and of course a trust can have multiple trustees and beneficiaries. A living trust must be in writing and in today's complex society should be prepared by an experienced estate planning attorney. Financial institutions often do not accept trusts without a notary's signature.

One of the principal advantages of a living trust is that it avoids probate. The probate procedure can interrupt control of assets and the flow of income to one's spouse or other family members. In addition, the costs and fees of administration, such as court costs, attorney fees and personal representative fees, reduce the net value of the devise or bequest to the individual heirs. Another advantage of a living trust is that a living trust can help with the property management during an individual's lifetime in the event one should become incapacitated. Finally, a properly drafted living trust can also help reduce estate taxes, particularly for married couples.

To be effective, a living trust must be funded. Funding is simply the process of changing title of assets to the living trust. The living trust only affects assets to which title has been transferred to the trust. Assets can also be transferred to the trust upon the death of the trust maker by the use of a "pour-over" will. Assets that are put into a trust by the use of a "pour-over" will have to go through probate because the title still has to be changed by the court into the name of the trust. The reason a "pour over" will is used is to make sure that the assets are dealt with as the trust maker desires.

The trust document sets out the powers and duties of the trustee and not only designates the beneficiaries but how and when they are to receive their benefits. All kinds of future problems can be anticipated with alternative instructions. A living trust generally becomes irrevocable once the trustor dies or becomes incapacitated.

All trusts in Missouri are governed by the Missouri Uniform Trust Code (MUTC). This code provides a series of default provisions in case the trust is silent on a particular issue. Many of the provisions of the MUTC can

be overridden by the trust maker. The MUTC sets forth the trustee powers and duties that are not specifically provided for in the trust.

### **(4) Non-Probate Transfers**

Non-probate transfers are of three basic types: (1) beneficiary designation on certain financial arrangements such as IRAs, life insurance and annuities; (2) pay on death [POD] on assets denominated in dollars, such as bank accounts and promissory notes; and (3) transfer on death [TOD] for assets not denominated in dollars, such as titles to real estate, motor vehicles, and corporate stocks or brokerage accounts. All are revocable so long as the transferor is competent, does not pass any interest to the beneficiary during the transferor's lifetime, and assuming that the beneficiary survives the transferor and is legally competent, they avoid probate when the transferor dies. A non-probate transfer can designate one or more alternative beneficiaries in the event of death of the primary beneficiary or other contingency. A trust can be a beneficiary of a non-probate transfer. People who rely on non-probate transfers often encounter problems they did not anticipate – for instance, the transferor becomes incapacitated and there is no mechanism set up to manage the property before the transferor dies; or the value of the asset shrinks or grows in relationship to the transferor's other assets, distorting the balance among all the various beneficiaries of the estate. If the beneficiary predeceases the grantor or is incapacitated or is on government benefits such as SSI or Medicaid or is in legal proceedings such as a divorce, bankruptcy, or creditor problems when the transferor dies, the non-probate transferor plan may be inadequate.

Non-probate transfer of real estate is accomplished by a beneficiary deed.

### **Wills and Life Insurance**

Life insurance policies do not take the place of a will. If the policy benefits are payable to the estate after death, the proceeds will be probated and distributed according to the will. If the policy benefits are payable to a beneficiary other than the estate, such as a spouse or other relative, the will has no effect on the distribution and the named beneficiary will receive the proceeds.

### **Estate Taxes**

An estate tax is a tax imposed by the federal and Missouri governments. The gross estate for estate tax purposes is all property owned at death, certain property transferred during one's lifetime in which an interest was retained, and property transferred in contemplation of death. Included in the gross estate is joint property, life insurance and retirement benefits. The tax is then imposed



on the taxable estate after deductions and exemptions. The federal estate tax liability is reduced by estate tax paid to the State of Missouri.

Most estates are not taxed because they do not exceed the exemption amount. A table of exemptions, based upon current law, follows; however, those exemptions are likely to change with new legislation:

<b>Date of Death</b>	<b>Exemption Amount</b>
2008	\$2 million
2009	\$ 3.5 million
2010	Unlimited
2011 and thereafter	\$1 million

### **What to Do When Someone Dies**

The death of an individual may create a wide variety of legal and financial issues. Regardless of whether there is a will or assets to be probated, it is wise for family members or others most close to the decedent to contact an attorney familiar with handling estates. If there is a will, Missouri law requires that it be promptly filed with the probate court, even if it appears that there are no assets to be probated, and even if the validity of the document is questioned or disputed.

The decedent's expenses of last illness and funeral, as well as tax liability and other debts, must be resolved. Sometimes it is necessary to pay those out of jointly held or non-probate transfer assets. Delays in addressing these issues may only add to the difficulty and expense of settling the estate. All this must be done before any heirs or beneficiaries can rest assured of their rights to the decedent's property.

If an individual dies leaving property that is not transferred by other means (joint ownership with right of survivorship, trust, etc.), it must go through probate court proceedings. When there is a valid will, the personal representative named should be contacted (if he or she is not already aware of the individual's death). The personal representative should contact a lawyer (who is familiar with estate and probate law).

### **Changing Your Will or Living Trust**

A will or living trust that meets all of the specifications described earlier is valid until changed or revoked.

A will or living trust validly executed in another state where one then resided is also valid in Missouri. However, when changing states of residence, one should consult with a local attorney to have the will or living trust reviewed. If one changes one's mind about something in her will or trust, or if circumstances force a modification, one can

execute a codicil (a document stating alterations or changes to the original will) or a trust amendment to change a living trust. The codicil or trust amendment must be executed and witnessed, just as with the original will or living trust. While a codicil or trust amendment is a convenient method for making minor changes to a will or living trust, modifications may require a redrafting of the original document and should always be done by an attorney.

A person should never write on a will or living trust after it is executed. Such writing is not effective and may invalidate the entire document. Always consult an attorney concerning how to change a will or living trust.

### **(5) Joint Ownership As a Will Replacement**

Joint property – property owned by two or more persons with a right of survivorship – is not distributed by will when one owner dies. Property jointly owned bypasses probate and automatically passes to the surviving joint owner(s). Joint tenancy between husband and wife in Missouri is called "tenancy by the entireties."

Joint ownership *may* simplify distribution of a deceased individual's property after death. However, in many circumstances joint tenancy can cause difficulty if the property was intended to be shared among heirs or if there is a disagreement between the remaining joint tenants. Also, joint tenancy can complicate affairs while one is still living. An individual's control over jointly-held property is limited because the property is also owned by, and thus subject to the control of, a joint owner(s). Depending on the situation, creditors of the joint owner may also seize the property. In some circumstances, it may also make qualifying for government benefits more difficult. And if a joint owner becomes mentally incompetent, the property can be subject to probate guardianship and conservatorship.

With the various methods of avoiding probate, estate planning attorneys rarely recommend joint ownership of property as a method of avoiding probate.

### **Real Estate Transfers**

Many senior citizens attempt to sell or give away their property either to avoid probate or in the hope to make it easier on family members when they are gone. Any individual planning a property transfer or a change in title (for example, adding a name to a deed) should consider the following points before acting.

- 1) If a property owner deeds his or her house to someone without keeping his or her name on the deed, the new person on the deed can force the original owner to move out of the house and can sell the house whether the original homeowner wants them to or not.

- 2) If a property owner wants to add a person to the deed as a joint tenant (a person with an equal property share and a right of survivorship), the deed must say "as joint tenants with right of survivorship."
- 3) If a property owner adds another to the deed as a joint tenant, a property owner cannot sell the property later without the joint owner's consent. Also, upon death, the property will automatically belong to the other person if that person has survived.
- 4) If a property owner wants to sell his or her property, the deed must reflect the name of the present owner. If the property has someone else's name on it (such as that of a deceased family member), the name of the

deceased family member must be removed from the title. Contact an attorney to find out what must be done.

- 5) In Missouri, a married person cannot deed away his or her interest in real estate without the spouse's signature as well.
- 6) Lifetime transfers may have adverse effects on capital gains taxation.

There are many alternatives to adding someone's name to a deed. Other options would include a beneficiary deed or the use of a living trust.

## PERSONAL PLANNING/PROTECTION

### POWER OF ATTORNEY, PERSONAL CUSTODIAN AND GUARDIANSHIP

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#### Power of Attorney

If illness or disability confines an individual to home or a hospital, they may find it hard to take care of personal business. One solution to this problem is to create a **power of attorney**. A power of attorney is created when one person (the "principal") gives someone else (the "attorney in fact") written authority to act in the principal's name. Normally, the attorney in fact is not a lawyer, but rather a friend or relative. Because the power of attorney may be used to the principal's disadvantage, the principal must be very careful in choosing an attorney in fact.

A power of attorney is created by a written document stating the names of both the principal and the attorney in fact, along with the specific powers given to the attorney in fact.

Example: Mr. A broke his hip and therefore cannot visit his bank for several months. His Social Security check is directly deposited in his bank account, and he needs cash for his groceries. Mr. A can give a neighbor or relative a power of attorney to make cash withdrawals from his bank account. Because Mr. A can manage the rest of his personal business himself, he does not have to give his attorney in fact any additional powers. However, he may give them the additional powers if he has decided that it is in his best interest to do so.

#### Durable Power of Attorney

One problem with the power of attorney is that the principal may give away only the powers he or she actually possesses. If the principal later becomes incompetent to conduct his or her affairs, the attorney in fact likewise becomes unable to act. The power of attorney thus ends with either the incompetence or death of the principal. A Missouri law, the **Durable Power of Attorney Act**, provides a solution to this problem. A power of attorney will continue after you become incompetent if:

(1) The power of attorney is entitled a "Durable Power of Attorney";

(2) The document states that the power is "durable" and includes a provision specifying that the power of attorney will not terminate in case of disability or incapacity; and

(3) The document is signed by the principal, dated and notarized. The Durable Power of Attorney need not be filed with the local Recorder of Deeds to be valid unless real estate transactions are involved. A Durable Power of Attorney may have "springing powers." This means that the powers conferred to the attorney in fact are only effective when the principal becomes incompetent and is unable to conduct his or her affairs. This type of Durable

Power of Attorney will require that one or two physicians certify that the principal is incompetent.

The power of attorney may be cancelled or modified in one of several ways. One can stipulate a date for the power of attorney to expire in the initial agreement. Changes can also be made simply by notifying the attorney in fact by oral or written communication. However, whenever possible, oral communication should be avoided in favor of written notification. The power of attorney may also be modified or terminated by filing a written notice in the office of the Recorder of Deeds in the city or county of the principal's residence.

*Note: The Recorder of Deeds does charge for recording or revoking the power of attorney.*

A Durable Power of Attorney will be revoked automatically if the attorney in fact is no longer qualified to act. If the attorney in fact is a spouse and a divorce occurs, the power of attorney automatically ends. The Durable Power of Attorney will also automatically terminate at the time of death. One may provide for a successor or contingent attorney in fact, or you may establish a procedure to select a successor in the event that the attorney in fact is unwilling or unable to act. An attorney in fact with general powers also has all the rights, powers or purposes that are conferred in the Durable Power of Attorney. Missouri law requires that a Durable Power of Attorney specifically grant authority for the attorney in fact to have the power to carry out any of the following actions:

- (1) To execute, amend, or revoke any trust agreement;
- (2) To fund with principal's assets any trust not created by the principal;
- (3) To make or revoke a gift of the principal's property in trust or otherwise;
- (4) To disclaim a gift or devise of property to or for the benefit of the principal; and
- (5) To create or change (in some circumstances) survivorship interests in the principal's property or in property which the principal may have an interest;
- (6) To designate or change the designation of beneficiaries to receive any property, benefit or contract right on the principal's death;
- (7) To give or withhold consent to an autopsy or postmortem examination;
- (8) To make a gift of, or decline to make a gift of, the principal's body parts under the Uniform Anatomical Gift Act;
- (9) To nominate a guardian or conservator for the principal, and if so stated in the power of attorney, the attorney in fact may nominate himself as such;

- (10) To give consent to or prohibit any type of health care, medical care, treatment or procedure;
- (11) To designate one or more substitute or successor or additional attorneys in fact.

Missouri law prohibits the attorney in fact from making or revoking a will for the principal or from making or revoking a living will (Health Care Directive) for the principal.

### **Adult Personal Custodian Law**

Another method of allowing another person to conduct business for you is to appoint them as **personal custodian** under the Missouri Personal Custodian Law. Under this law, you can transfer some or all of your property, both personal property and real estate, to another person to hold for you as custodian of the property. Title to the property remains with you. The custodian holds, manages and invests the property for your benefit and in the way you direct. The custodian is a property manager only.

To transfer the property to the custodian, you must execute a written document describing which property is being transferred and, if the property is real estate, you need to execute a deed transferring the property to the custodian. *The written documents should always state that the person receiving the property is a personal custodian acting for you under the Missouri Personal Custodian Law.*

Similar to a Durable Power of Attorney, a personal custodianship may be effective even after you become incompetent. The custodian administers the property for your benefit as you directed before you became incompetent or as the custodian deems advisable if you did not so direct.

You may revoke the personal custodianship during your lifetime unless you are not competent or have stated in writing that the custodianship is irrevocable. The custodian must transfer the property back to you if you revoke the custodianship and are competent to receive the property.

The personal custodianship may be a beneficial tool for you in managing your affairs. It provides an alternative method for older persons to avoid the necessity of a conservatorship as well as transferring property into joint tenancy or outright to another person. Discuss your situation thoroughly with an attorney before you decide to institute a personal custodianship.

### **Guardianship and Conservatorship**

**A guardian is a person appointed by the court to have care and custody of a person (the "ward") who is unable to**

care for him or herself. A **conservator** is a person appointed by the court to manage the financial resources of a person (the "protectee") who is unable to manage his or her own financial resources.

Guardianships and conservatorships may have far-reaching implications for all persons involved. Before an individual begins guardianship or conservatorship proceedings, they should be certain that such steps are absolutely necessary. Consider whether the proposed ward or protectee is able to make decisions concerning his or her personal or business affairs.

Because guardianships and conservatorships have such serious consequences, the law provides special protection for the person over whom a guardianship or conservatorship is sought. If you are that person, you must receive notice of the impending proceedings. If you object to the proceedings, you have the right to challenge the guardianship or conservatorship in court. You have the right to a court-appointed lawyer (if you cannot afford a private lawyer) and to a hearing. This hearing will determine whether a guardianship or conservatorship is necessary. You may bring your personal doctor or other witnesses to testify on your behalf. In addition, your attorney can question the witnesses appearing against you. The court-appointed lawyer will make a report to the court regarding the condition of the potential ward.

If the court finds that you need a guardian, the court will appoint someone to so act. The guardian must provide for the ward's basic needs: food, shelter and medical care. The guardian must not impose excessive restraints upon the ward's freedom, limiting only those acts necessary to ensure safety. Each year the guardian must prepare a report for the court on the personal status of the ward.

If the court finds that you need a conservator, the court will also appoint someone to so act. The conservator may or may not be the same person who is appointed as your guardian. The conservator must skillfully and prudently manage the protectee's financial resources. The conservator may pay bills, receive public benefits, sell and buy real estate and personal possessions, and otherwise control the protectee's assets. The conservator must file with the court an annual report describing all transactions made in the protectee's name. In addition, the conservator must deposit with the court an amount of money, called a bond, to ensure honest and prudent management of the protectee's estate. This bond is purchased from an insurance company with money from the protectee's estate.

Sometimes a person suffers from only a mild disability or partial incapacity. In such a circumstance, the court may appoint a "limited" guardian or conservator. This appointment can preserve many of the person's legal rights. A person retains power over those affairs he or she is capable of managing. The guardian or conservator manages the rest. The use of a living trust and durable powers of attorney can help avoid this procedure.

### Procedure

The procedure for appointing a guardian or conservator is as follows:

- (1) A petition must be filed with the probate court.
- (2) The person for whom a guardian or conservator is sought must receive notice of the filing and be informed of his or her rights to have an attorney and a hearing. The court will appoint a lawyer to represent the potential protectee. If only a conservatorship is sought and the person agrees to appointment of a conservator, the court may make such appointment without further notice or hearing.
- (3) In all other cases, the probate court will hold a hearing on whether a guardian or conservator is required. Before the court will appoint a guardian or conservator, a finding must be made that the person is incapacitated or disabled. Evidence usually involves testimony by a doctor, either in person or in writing. The attorney representing the person may contest this evidence and offer alternative medical evidence.
- (4) If incapacity or disability is proven, the court will appoint a guardian, conservator, or both. If the ward or protectee is able to communicate his or her choice for the individual to serve as guardian or conservator, the court will give strong consideration to that choice. If no such choice is communicated, the court may review an individual's estate planning documents to see if the potential ward has indicated a choice of guardians or conservator. You may specify in your will or other advance directive the individual that you want to be your guardian or conservator. Employees of nursing homes, the Department of Mental Health, and the Department of Social Services may not serve as guardians or conservators unless they are related to the ward or protectee.

If you wish to become a guardian or conservator, remember that you may need to post a bond. You will also need an attorney. Once appointed, you assume responsibility for the ward and may use the ward's assets only for maintenance and valid expenses. You must keep accurate records for use in making your annual reports to the court.

A guardianship or conservatorship can be terminated in several ways. A guardianship ends with the death of the ward. If the protectee's property is exhausted, the court may order the conservatorship ended. Also, a ward can request that the court review his or her capacity. A new hearing will be held and additional evidence will be considered. If the court finds that the ward or protectee has

regained capacity or ability, the guardianship or conservatorship will be modified or ended.

If there is no one to act as a guardian or conservator for a person who needs help, contact the Office of the Public Administrator for the county in which the person lives. They may be able to institute the proper proceedings and act as guardian and/or conservator.

## PERSONAL PLANNING/PROTECTION

### PROTECTIVE SERVICES AND **ADULT ABUSE**

*By David S. Purcell, J.D., an attorney with the law firm of Purcell & Amen, L.L.C., where he concentrates in estate planning and taxation. The firm's website at [yourestatematters.com](http://yourestatematters.com) has additional information on estate planning, elder law, Medicaid planning and taxation.*

#### **Protective Services**

The term "protective services" may be used in several ways. In its broadest sense, it describes a network of public and private social services agencies available to assist individuals with their personal or financial affairs. Typically, these agencies aid mentally or physically frail persons who live alone and have become unable to care for themselves. For persons unable to make necessary decisions, long-term assistance may come through the appointment of a guardian. (See Guardianship section.)

Missouri has two protective services laws. The **Adult Abuse Law** protects adults of all ages, including senior citizens, from physical harm from a present or former household member. The **Elderly Abuse Law** specifically protects senior citizens against financial and physical abuse, as well as general neglect.

#### **Elderly Abuse Law**

The Elderly Abuse Law directs the Missouri Department of Health and Senior Services to establish an intervention program to respond to reports of alleged elder abuse, neglect and exploitation, and to work with older and handicapped adults in resolving the situations. The program is based on an individual's right to self-determination; no decisions are made about a competent adult without his or her involvement and consent. Every effort is made to keep an individual in his or her own home.

Missouri's law provides that people – who in good faith report suspected abuse or cooperate with an investigation – will be immune from criminal or civil liability. It further provides that the identity of the reporter shall not be disclosed except with the permission of the

reporter or by order of a court. Anonymous reports are also accepted.

**To report suspected abuse in Missouri, please call 1-800-392-0210 or 1-800-392-8819 (TDD).** Callers should be prepared to give the alleged victim's name and address, an account of what has occurred, where and when it happened, and who the suspected abuser might be.

*Note: Abuse is defined as the infliction of physical, sexual or emotional injury or harm, including financial exploitation by any person, firm or corporation.*

After the Department of Health and Senior Services receives a report, it conducts an investigation to determine whether the elderly person is facing a likelihood of serious physical harm and is in need of protective services. If protective services are necessary, the department will review and evaluate the needs of the person. With the consent of the elderly person, the department can provide casework, counseling and, if necessary, assistance in locating alternative living arrangements.

If the person in need of protective services is unable to consent to these services, then the director of the Department of Social Services can initiate court proceedings to obtain a guardian for the person. (See Guardianship section.)

#### **Adult Abuse Law**

In contrast to the Elderly Abuse Law, the Missouri Adult Abuse Law applies to anyone 18 years of age or older who is in danger of suffering physical injury from a present or former household member.

The abused adult may file a complaint (called the "petition") in court, and, if good cause is shown, immediately can obtain an ***ex parte* order of protection** that day. This order can prevent the abusive person from entering the complainant's home and generally can restrain the person from abusing, threatening, molesting, or disturbing the complainant. This *ex parte* order is served on the abuser by a sheriff and lasts for 15 days. There is also a procedure for filing for an order of protection during non-business hours – check with your local court.

Within 15 days after the filing of the petition, a hearing is held and the complainant must prove the accusations stated in the petition. The respondent (the accused abuser) receives notice of the hearing. If such proof is shown, the judge can issue or continue a protective order for up to 180 days. The protective order may be renewed, after a hearing, for a second 180-day period. The abusive party must comply with the order or face arrest.

If you desire protection under the Missouri Adult Abuse Law, contact your county circuit court clerk. If the petitioner does not have counsel, the clerks of the court are required to provide guidance in filing the petition. You may also want to contact an attorney to assist you.

### **Offenses Against A Person**

**Elder abuse is a crime in Missouri, and an individual may be charged in connection with an act or acts that cause harm to a person 60 years of age or older.**

The provisions of the Elderly Abuse Law describe elder abuse in the first, second and third degrees. While first and second degree abuse involve physical harm, third degree elder abuse can involve “grave emotional distress” as well as threats and intimidation.

Missouri law states that any person who knowingly abuses or neglects a resident of a long-term care facility shall be guilty of a class “D” felony.

## **PERSONAL PLANNING/PROTECTION**

### **STATUTORY LIVING WILL (HEALTH CARE DIRECTIVE)**

*By David S. Purcell, J.D., an attorney with the law firm of Purcell & Amen, L.L.C., where he concentrates in estate planning and taxation. The firm's website at [yourestatematters.com](http://yourestatematters.com) has additional information on estate planning, elder law, Medicaid planning and taxation.*

#### **Introduction**

Missouri's Living Will Law allows a person (the declarant) to direct his or her doctor and medical facility to withhold or withdraw medical procedures that merely prolong the dying process.

The **living will** must be in writing, dated, and signed by the declarant or by a person other than the declarant at the declarant's express direction. If the living will is not in the declarant's handwriting, two persons must witness it. The witnesses must be at least 18 years of age. Anyone making a living will should always keep the original and give copies to his/her doctor, hospital (for inclusion in medical files) and family members. If the living will is intended to include denial or withdrawal of artificial (intravenous or tube) nutrition and hydration, or breathing, the intention must be specifically stated. Similar desires can also be expressed in a health care directive. The Missouri Bar has created a Durable Power of Attorney for

Health Care Directive in a document available from them upon request.

The living will or health care directive can be **revoked in any manner** by which the declarant can show he or she wants to revoke it.

#### **When Does The Living Will Become Effective?**

The living will or health care directive becomes effective only when the declarant, suffering from a terminal condition, is no longer able to make and communicate treatment decisions. It is important to remember that so long as the declarant is able to make and communicate treatment decisions, those decisions control, and the living will is not effective.

### **What The Living Will Does and Does Not Do**

The living will or health care directive directs the doctor and hospital not to perform any medical procedures that merely keep the declarant alive. The living will also prevents any health care professional or medical care facility that acts pursuant to a living will from being subject to civil or criminal liability. The living will does not authorize mercy killing or any affirmative act to shorten life. It also does not prevent administration of medication or any medical procedure necessary to provide comfort or to reduce pain.

### **Dealing With Your Physician and Hospital**

Some doctors and health care facilities do not recognize the living will as a means for a patient to control his/her own medical treatment. These doctors and facilities are required to take all reasonable steps to transfer the patient to a doctor and facility that will honor the living will. To prevent any complications in honoring your living will, it is very important that you discuss your wishes with your doctor before you sign one.

## **PERSONAL PLANNING/PROTECTION**

### **DURABLE POWER OF ATTORNEY FOR HEALTH CARE**

*By David S. Purcell, J.D., an attorney with the law firm of Purcell & Amen, L.L.C., where he concentrates in estate planning and taxation. The firm's website at [yourestatematters.com](http://yourestatematters.com) has additional information on estate planning, elder law, Medicaid planning and taxation.*

#### **Introduction**

Missouri has enacted legislation providing citizens with a statutory right to designate another person to make health care decisions for them if they become incapacitated. The law allows what is known as a "durable power of attorney for health care." The person who executes such a document is called the "principal." The person who is designated to act is called an "attorney in fact." The attorney in fact may be any adult you trust to make important decisions for you, other than an attending physician or the owner, operator or employee of a health care facility where the person is a resident.

The durable power of attorney for health care must be in writing, signed by the principal and notarized. It comes into effect only upon a certification of incapacity by two licensed physicians, unless the document provides for a different number. In any event, certification by at least one physician is required.

A competent patient may revoke the durable power of attorney for health care at any time and in any manner by which the patient can show that he or she wants to revoke it. The revocation is effective upon it being communicated by the principal to the attorney in fact or the attending doctor.

No doctor or treatment facility can require a patient to execute a durable power of attorney for health care as a condition of treatment. Also, no insurance company can require an insured to execute a power of attorney for health

care as a condition for receiving benefits. Any third party acting in good faith may rely on the instructions of and dealings with an attorney in fact pursuant to the authority granted in a power of attorney for health care without liability.

#### **What the Durable Power of Attorney for Health Care Does and Does Not Do**

Under the durable power of attorney for health care, your attorney in fact may make every possible decision regarding health care. This includes decisions to enter a hospital, to undergo an operation, and even to terminate life-support systems. If you want to enable your attorney in fact to authorize the withdrawing or withholding of food and water, however, the document must provide a specific grant of authority to do so.

#### **How Does a Durable Power of Attorney For Health Care Differ From a Living Will?**

A living will is merely a statement saying that the person signing the document does not want any extraordinary procedures that simply keep the declarant alive. A living will does not authorize anyone else to make health care decisions for you, whereas a durable power of attorney does.

#### **Do I Need Both a Living Will and a Durable Power of Attorney for Health Care?**

If you decide that you want someone to speak for you concerning all of your future health care, including the removal of life-support systems, you will need to complete



a durable power of attorney for health care. A living will merely helps make clear that you do not want certain life-prolonging medical procedures or treatments under specific conditions. A living will provides doctors and others with evidence concerning your wishes. It may also serve as a guide to your attorney in fact. The prudent course of action would be to have both a living will and a durable power of attorney for health care.

#### **Information**

The Missouri Bar has created a health care directive and durable power of attorney for health care form that is

valid in Missouri. Single copies of the form are available at no charge by sending a written request to:

Health Care Proxy Form  
The Missouri Bar  
P.O. Box 119  
Jefferson City, MO 65101

or call The Missouri Bar at 573-635-4128. You can also find a copy of this document on The Missouri Bar website at [www.mobar.org](http://www.mobar.org).

## **PERSONAL PLANNING/PROTECTION**

### **PATIENT SELF-DETERMINATION ACT**

*By David S. Purcell, J.D., an attorney with the Law Firm of Purcell & Amen, L.L.C., where he concentrates in estate planning and taxation. The firm's website at [yourestatematters.com](http://yourestatematters.com) has additional information on estate planning, elder law, Medicaid planning and taxation.*

#### **Introduction**

An important federal disclosure law went into effect on December 1, 1991. The law, known as the Patient Self-Determination Act (the act), is an amendment to the Medicare and Medicaid provisions of the Social Security Act.

#### **Who the Act Affects**

The act affects all Medicare and Medicaid provider organizations. These organizations include hospitals, skilled nursing facilities, home health agencies, hospices, and pre-paid health care organizations. In general, the act requires these organizations to provide written information to patients about their rights under state law to make their own medical care decisions. These rights include the patient's right to refuse medical treatment and formulate advance directives.

Advance directives are written instructions authorized by the patient concerning the patient's health care in the event the patient is incapacitated. Living wills and durable powers of attorney for health care are two forms of advance directives that are legal in Missouri. Both living wills and durable powers of attorney for health care are covered elsewhere in this chapter.

#### **How the Act Applies to the Patient**

To illustrate, if you are entering the hospital for surgery, the act would affect you. Upon your admission to the hospital, a hospital representative must provide you with written information about your health care rights under state law. This information should include information about living wills and health care powers of attorney. If you have a living will and a health care power of attorney, you should make them part of your hospital

records at that time if you have not done so previously. The hospital representative should provide you with a written copy of the policy regarding your health care rights. At that time, the hospital representative documents in your medical record whether or not you have a living will and/or health care power of attorney.

Finally, the act specifically states that your care cannot be contingent upon whether or not you have an advance directive. The act exists to inform you of your rights. Therefore, those organizations affected by the act may not discriminate against you because you do or do not have an advance directive.

Of course, the time to make health care decisions is not at the time of admission to a hospital or other health care facility. You should make these decisions while you are healthy and not under any pressure. In addition, you should discuss your health care wishes with close family members, your doctor, clergy, and close friends in order to alleviate any future confusion or misunderstanding.



# **VETERANS' BENEFITS THAT INCREASE INCOME TO PAY FOR LONG TERM CARE Non-Service Connected "Aid and Attendance"**

*By Mary R. McCormick, J.D., LL.M., CELA. Ms. McCormick recently completed her 23rd year as a Navy Reserve lawyer. In her civilian capacity, she assists older adults and their caregivers throughout western Missouri, with an emphasis on obtaining the highest quality long term care. Her elder law firm located in the Kansas City area focuses on estate planning, Medicaid and veterans' benefits, and all probate matters, including guardianships and conservatorships.*

*Editors Note: This information on veterans' benefits is designed to give a brief description of the Aid and Attendance program. The information is current as of November, 2010, but is subject to change at any time. For more detailed information, or for information about Missouri's nursing homes for veterans and other benefits, you may wish to visit the Missouri Veterans Commission website (<http://mvc.dps.mo.gov>)*

Many veterans know of benefits available from the Veterans Administration's medical system, but few veterans are aware of the VA's special pension programs designed to assist wartime veterans, and their surviving spouses, with funds to help offset the cost of long term care. The most generous of these programs is "Aid and Attendance." This article provides a brief overview of the eligibility criteria for this important, but underutilized, program.

### **Veteran, Widowed Spouse, or Disabled Adult Child (Any May be a Claimant)**

- Veteran must have served at least 90 consecutive days on active duty, one day of which was during a war-time period
- Veteran must have a discharge that was other than dishonorable
- Claimant's physician must declare him/her as housebound or in need of assistance from another individual, which may include services offered by home health care, assisted living, or nursing home care
- Claimant must have less than \$75,000 in assets, excluding home, car, and personal belongings
- Must meet income requirements (and family income is reduced by amount of family medical expenses)
- Widowed spouse must have been married to the veteran at the time of the veteran's death, or have had children by the veteran and never remarried (minor or disabled children may qualify for benefits on their own)
- Widowed spouse must have been living with the veteran at the time of the veteran's death, unless the separation was due to medical reasons (there may be some exceptions related to separations due to abuse)

### **If Under Age 65**

Claimant must prove disability if under the age of 65. The two ways to prove disability include:

1. A single permanent disability rated as 100 percent disabling under the VA schedule, and confined to the dwelling; or,
2. A 100 percent disability with another 60 percent disability, regardless of whether or not the person is confined to the dwelling.

Veterans over the age of 65 are presumed to meet the disability criteria.

### **Periods of Wartime Service**

WWI:	April 6, 1917 to November 11, 1918
WWII:	December 7, 1941 to December 31, 1946
Korean War:	June 27, 1950 to January 31, 1955
Vietnam War:	August 5, 1964 (February 28, 1961, for veterans who served "in country" before August 5, 1964), through May 7, 1975
Gulf War:	August 2, 1990, through a date yet to be set

## Maximum Pension Rates 2009

	<b>Aid and Attendance</b>	<b>Homebound Only</b>
Single Veteran	\$1,644 per month	\$1,204 per month
Married Veteran or With Dependent	\$1,949 per month	\$1,510 per month
Widowed Spouse	\$1,056 per month	\$ 808 per month

### Other, Related Benefits

Once awarded Aid and Attendance, a veteran may obtain free medications, medical equipment, incontinence supplies, glasses, and hearing aides from the VA hospital/clinic via U.S. Mail without going to the VA.

## INFORMATION AND REFERRAL FOR SENIORS AND PERSONS WITH DISABILITIES

*By David P. Sykora, Executive Director of the St. Louis Area Agency on Aging, and his staff.*

*Editor's Note: The following is a partial listing of the many agencies and organizations in Missouri that aid senior citizens. Most of the individual agencies listed can better inform you of the spectrum of services offered in Missouri.*

### AREA AGENCIES ON AGING (AAA)

For information on programs available in your area which benefit senior citizens and persons with disabilities, contact the Area Agency on Aging (AAA) in your community or go to [www.MoAging.com](http://www.MoAging.com). Additional information is available at the Community Action Agency (CAA) nearest you. Persons in St. Louis County may contact the St. Louis County Office of Family and Community Services, County Older Resident Program (CORP), 121 South Meramec, Clayton, MO 63105, (314) 615-4516, TTY (314) 615-4425.

#### **Care Connection for Aging Services**

106 West Young St.  
Warrensburg, MO 64093  
(660) 747-3107  
(800) 886-4699

#### **Central Missouri Area Agency on Aging**

1121 Business Loop 70 East, Suite 2A  
Columbia, MO 65201  
(573) 443-5823  
(800) 369-5211

#### **Mid-America Regional Council**

600 Broadway, Suite 300  
Kansas City, MO 64105-9990  
(816) 474-4240  
(800) 593-7948

#### **Northwest Area Agency on Aging**

211 S. Polk  
Albany, MO 64402  
(660) 726-3800  
(888) 844-5626

#### **St. Louis Area Agency on Aging**

1520 Market, Suite 4086  
St. Louis, MO 63103  
(314) 612-5918  
(877) 612-5918

#### **Southeast Area Agency on Aging**

1219 North Kingshighway, Suite 100  
Cape Girardeau, MO 63701  
(573) 335-3331  
(800) 392-8771

**Mid-East Area Agency on Aging**

14535 Manchester  
 Manchester, MO 63011-3690  
 (636) 207-0847  
 (800) 243-6060

**Southwest Area Agency on Aging**

1735 South Fort  
 Springfield, MO 65807  
 (417) 862-0762  
 (800) 497-0822

**Northeast Area Agency on Aging**

815 N. Osteopathy  
 Kirksville, MO 63501-4682  
 (660) 665-4682  
 (800) 664-6338

**Region X Area Agency on Aging**

531 E.15th St.  
 Joplin, MO 64803  
 (417) 781-7562

## MISSOURI COMMUNITY ACTION AGENCIES

**Central Missouri Counties****Human Development Corporation**

807B N. Providence  
 Columbia, MO 65203  
 (573) 443-8706  
 (800) 706-1742

**Community Services, Inc. of Northwest Missouri**

1212 South Main  
 P.O. Box 328  
 Maryville, MO 64468-2604  
 (660) 582-3113

**Delta Area Economic Opportunity Corporation**

99 Skyview Drive  
 Portageville, MO 63873  
 (573) 379-3851  
 (800) 748-8320

**Green Hills Community Action Agency**

1506 Oklahoma Avenue  
 P.O. Box 278  
 Trenton, MO 64683  
 (660) 359-3907

**Human Development Corporation of Metro St. Louis**

929 North Spring  
 St. Louis, MO 63108  
 (314) 613-2200

**East Missouri Action Agency**

107 Industrial Drive, P.O. Box N  
 Park Hills, MO 63601  
 (573) 431-5191  
 (800) 392-8663

**Missouri Ozarks Community Action, Inc.**

Box 69, 306 S. Pine  
 Richland, MO 65556  
 (573) 765-3263  
 (800) 876-3264

**Missouri Valley Human Resource Community Action Agency**

1415 S. Odel  
 Marshall, MO 65340  
 (660) 886-7476

**Northeast Community Action Corp. (Central Office)**

16 North Court Street  
 Bowling Green, MO 63334  
 (573) 324-2231

**Ozarks Area Community Action Corporation**

215 South Barnes  
 Springfield, MO 65802  
 (417) 862-4314

**Economic Opportunity of Greater St. Joseph Community Action and Partnership**

817 Monterey  
 St. Joseph, MO 64503  
 (816) 233-8281  
 (866) 664-0432

**Economic Security Corp. of Southwest Area**

302 South Joplin  
 Joplin, MO 64801  
 (417) 781-0352

**Ozark Action, Inc.**

710 East Main St.  
 West Plains, MO 65775  
 (417) 256-6147

**Jefferson-Franklin Community Action Corp.**

#2 Merchant Dr.  
Hillsboro, MO 63050  
(636) 789-2686

**Greater Community Services of Kansas City**

6323 Manchester Avenue  
Kansas City, MO 64133-4717  
(816) 358-6868

**Community Action Agency of St. Louis County, Inc.**

2709 Woodson Road  
St. Louis, MO 63114  
(314) 863-0015

**West Central Missouri Community Action Agency**

106 West 4th St.  
Appleton City, MO 64724  
(660) 476-2185  
(800) 293-3532

**South Central Missouri Community Action Agency**

P.O. Box 6, Old Alton Road  
Winona, MO 65588  
(573) 325-4255

## **SOCIAL SERVICES, INCOME AND FAMILY MAINTENANCE**

The Missouri Department of Health & Senior Services and the Missouri Department of Social Service/ Division of Family Services have offices located throughout the state to assist older persons in maintaining an adequate standard of living. Consult your telephone directory for the nearest office. Look under the major heading of "Missouri-State of" and find either "Department of Health & Senior Services" or "Division of Family Services."

**The MO Department of Health and Senior Services (DHSS)** – The basic services available through the DHSS offices include placement, counseling, information and referral, and in-home (homemaker) services. For information, write to the Department of Health and Senior Services, P.O. Box 570, Jefferson City, Missouri 65102 or call (573) 751-6400 or (800) 835-5465.

**The Department of Health and Senior Services also coordinates a protective services program for Missourians 60 years of age and older. To aid in identifying elderly persons who are in need of protective services, the Department of Health & Senior Services has a 24-hour toll-free hotline. This hotline will speed investigations and assistance to anyone needing immediate services. The hotline number is 1-800-392-0210.**

**DHSS also strives to maintain a high standard of living for individuals residing in long-term care facilities in Missouri through inspection, certification, and licensure.**

**The MO Department of Social Services / Division of Family Services** – Can help eligible individuals with income maintenance, medical assistance, food stamps, and other financial assistance. For the office in your area, consult the white or blue government pages of the telephone directory under the major listing "Government Offices-State of Missouri," and find "Family Services" or call (800) 735-2466.

**Medicare Hotline** – Call 1-800-633-4227 for questions concerning Medicare.

**Social Security Administration** – Offices are located throughout the state. Consult the blue pages of the telephone directory for the office nearest to you. Call toll-free 1-800-772-1213.

**Veterans' Administration** – Consult the blue pages of the telephone directory for the office nearest you or call toll-free 1-800-827-1000.

**Railroad Retirement Board** – Two Missouri offices provide assistance for railroad employees and their families.

In Kansas City, call: (816) 426-5884 or (800) 808-0772  
In St. Louis, call: (314) 539-6220

**Rural Development** – This agency provides housing loans and a limited number of grants to individuals or families in order to provide decent, safe, and adequate housing. The number of the Missouri office, located in Columbia, is (573) 876-0976. The number of the St. Louis office is (636) 789-2441.

**St. Louis Housing Authority** – In Missouri there are two centers for this agency. HUD provides housing subsidy programs to individuals who qualify.

In St. Louis County, call: (314) 428-3200

In St. Louis City, call: (314) 531-4770

### **Additional Federal Government Programs**

The federal government maintains a Federal Information Center telephone service for answering and referring calls on federal programs. These numbers are toll-free. All other areas call 1-800-333-4636.

## **CONSUMER**

### **Better Business Bureau of Kansas City**

8080 Ward Parkway, Suite 401

Kansas City, MO 64114

(816) 421-7800

### **Missouri State Department of Insurance**

301 West High Street, Room 530

Jefferson City, MO 65101

1-800-726-7390

### **Consumer Protection Division of the Attorney General's Office**

Jefferson City, MO 65102

1-800-392-8222

or

815 Olive St., Suite 200

St. Louis, MO 63101

(314) 340-6815

### **In Kansas City:**

(816) 889-5000

### **In Springfield:**

(417) 895-6567

### **Better Business Bureau**

15 Sunnen Dr., Suite 107

St. Louis, MO 63143

(314) 645-3300

## EMPLOYMENT

For information on the Association on Aging Retired Persons (AARP) employment program, if you live in the City of St. Louis please call (314) 918-7563. If you live in St. Louis County, please call (314) 830-3600. If you live in Madison County, IL, please call (618) 876-5258. If you live in St. Clair County, IL, please call (618) 397-5445.

Missouri Division of Employment Security **Job Service Offices** are located throughout the state of Missouri. Consult the yellow pages under "Employment Agencies" and look for "Job Service." You may also look under the major listing "Missouri-State of" in the blue pages and find "Division of Employment Security."

In St. Louis, the **Federal Job Information Center** number is (314) 539-2285

For **employment discrimination** problems, contact the U.S Government Wage and Hour Division, U.S. Department of Labor:

Kansas City – call (913) 551-5721 or (866) 487-9243

St. Louis – call (314) 539-7800 or (800) 669-4000

## LEGAL SERVICES

When you are in need of legal assistance, contact the free legal service organizations listed below or consult your local telephone directory for branch offices.

### **Legal Aid of Western Missouri, Inc.**

1125 Grand Avenue, Suite 1900

Kansas City, MO 64106

(660) 747-7101

### **Legal Services of Eastern Missouri, Inc.**

4232 Forest Park Avenue

St. Louis, MO 63108

(314) 534-4200

1-800-444-0514 toll free

### **Lasting Solutions Project**

Domestic Violence and Abuse

4232 Forest Park Avenue

St. Louis, MO 63108

(314) 534-4200, Ext. 1244

(800) 444-0514

### **Hannibal Office:**

The Federal Building

801 Broadway P.O. Box 1276

Hannibal, MO 63401

(573) 248-1111

1-800-767-2018 toll free

### **Mid Missouri Legal Services Corporation**

205 E. Forest Street

Columbia, MO 65203

(573) 442-0116

1-800-568-4931 toll free (9-11am)

### **Legal Services of Southern Missouri**

2872 South Meadowbrook

Springfield, MO 65807

(417) 881-1397 or

1-800-444-4863 toll free

### **Legal Services of Southern Missouri**

#### **Rolla Office:**

1412 Highway 72 East

P.O. Box 135

Rolla, MO 65402

(573) 341-3655

1-800-999-0249 toll free

#### **Charleston Office:**

P.O. Box 349

116 North Main

Charleston, MO 63834

(573) 683-3783

1-800-748-7456 toll free

If a legal aid office cannot handle your case, check the sources listed below for referral to the private bar in your community or contact your local office of the Area Agency on Aging (listing at the front of this section) for further information.

**Missouri Lawyer Referral Service**  
P.O. Box 110  
Jefferson City, MO 65102  
(573) 636-3635

**Lawyer Referral Service of Bar Association of  
Metropolitan St. Louis**  
(314) 621-6681  
Hours: 8:30 a.m. - 3:00 p.m.  
Monday - Friday

**NO WALK-INS, TELEPHONE CALLS ONLY**

## **TRANSPORTATION**

Senior Citizens should contact the Area Agency on Aging in their area (see above) for transportation information.

Senior citizens can also contact the regional office of **OATS, Inc.** for details about how OATS buses operate in your county.

**East:**  
2572 Lemay Ferry Road  
St. Louis, MO 63125  
(314) 894-1701

**Northwest:**  
2921 N. Belt Highway  
St. Joseph, MO 64508  
(816) 279-3131  
(800) 831-9219

**Northeast:**  
401 West Elm, P.O. Box 613  
Shelbina, MO 63468  
(573) 588-2103  
(800) 654-6287

**West:**  
2501 West Main  
Sedalia, MO 65301-2572  
(660) 827-2611  
(800) 276-6287

**Southwest:**  
3259 E. Sunshine, Suite L  
Springfield, MO 65804  
(417) 887-9272  
(800) 770-6287

**Administrative Offices:**  
OATS, Inc.  
2501 Maguire Blvd., Ste 101  
Columbia, MO 65201  
(573) 443-4516  
(888) 875-6287

**Mid-Missouri:**  
601 Business Loop 70W, Suite 216A  
**Columbia, MO 65203**  
(573) 449-3789  
(800) 269-6287

### **For specific transportation information in other areas:**

#### **St. Louis City**

Senior citizens and persons with disabilities should contact the St. Louis Area Agency on Aging, at (314) 612-5918 or (877) 612-5918. A caregiver transportation program that reimburses caregivers in part for some of their transportation expenses is also available.

#### **St. Louis County**

The St. Louis County Office of Family and Community Services, County Older Resident Programs (CORP) has a transportation program, 121 South Meramec, Clayton, MO 63105, (314) 615-4516.

#### **Kansas City Area**

Share-A-Fare: (816) 842-9070. Door-to-door transportation for elderly persons or persons with a disability. Once the application is turned in, there is a 21-day wait before services will begin.

## **Southeast Missouri**

Senior citizens in the southeast part of Missouri should contact the Southeast Missouri Transportation Services (SMTS) at 1-800-392-0754. Call the Department of Health and Senior Services or the Division of Family Services office nearest you for more information.

## **HEALTH CARE INFORMATION**

*Caregiving in America, Kansas City's Resource Guide to the Most Important Health Care Issue of the 21st Century* available from:

### **Alliance on Aging**

6025 Martway, Suite 101  
Mission, Kansas 66202  
(913) 236-8700

### **Center for Practical Bioethics**

111 Main St.  
Kansas City, Missouri 64105  
(816) 221-1100  
(800) 344-3829

### **The Family Conservancy**

626 Minnesota  
Kansas City, KS 66101  
(913) 342-1110

### **Local Investment Commission**

Aging Committee  
3100 Broadway, Suite 226  
Kansas City, Missouri 64111  
(816) 889-5050

### **Metropolitan Lutheran Ministries**

3031 Holmes  
Kansas City, Missouri 64109  
(816) 931-0027

Offers emergency assistance for utilities and medicine; a Senior Companion Program; a food pantry/commodity foods program; case management; a Phone Friends program; and a Friendly Visitor Program

### **Jewish Senior Network**

c/o Jewish Foundation of Greater Kansas City  
5801 West 115th Street, Suite 201  
Overland Park, Kansas 66211  
(913) 327-4677

Offers information and referral services for all persons. For people of the Jewish faith only: needs assessment, case management, and financial subsidies for goods and services as needed.

### **KC Connect Senior Info-Line**

600 Broadway, Suite 200  
Kansas City, MO 64105  
(816) 421-4980  
(800) 593-7948

**For additional healthcare information related to seniors, please call the Area Agency on Aging in your area (locations listed on page 55).**



