

SENIOR CITIZENS HANDBOOK

*Laws and Programs
Affecting Senior Citizens
in Missouri*

Twentieth Edition



Legal Services of Eastern Missouri, Inc.

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ACKNOWLEDGEMENTS

For the 20th Edition

Welcome to the twentieth edition of the Senior Citizens Handbook. The nineteenth edition was distributed to more than 45,000 persons. Legal Services of Eastern Missouri (LSEM) is so grateful to all the contributors for this edition and those who contributed over the years to many prior editions.

The first edition of this book was published in 1977. 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 of Metropolitan St. Louis Young Lawyers Section, subsequently a staff attorney with LSEM, and presently a teacher at Saint 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 Saint 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. We also thank attorneys John Ammann and Mike Ferry for their prior contributions to this book.

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Many individuals contributed to various editions of this handbook. The list is too lengthy to enumerate, but we are grateful to all of them, as their contributions have formed the foundation for this current twentieth edition. We appreciate the past support of numerous organizations.

LSEM also wants to thank expressly the contributors to this newest edition, who built upon the work of many prior editors. Current contributors include: Christine Alsop (Personal Planning/Protection); Susan Alverson (Housing); Julie Berkowitz (Medicaid); Harry Charles (Tax); Dan Claggett (Predatory Lending); Pam Coffin (Private Pensions); John Early (Age Discrimination in Employment); Brigid Fernandez (Veterans' Benefits); Mary Sweet (Insurance); Lakitsa (Pinky) Hunter (Medicare); Philip Senturia; Robert Swearingen (Consumer Guide); Dave Sykora (Information and Referral); Karen Warren (Food Stamps and Medicare); and Michael Weeks (Nursing Homes). We also wish to thank Kathy Case Tahan for her many years of service on this project. We offer a special thank you to Stan Platke, Colleen Landefeld and Karen Shelley, whose extraordinary dedication to this handbook and hard work kept it a viable publication for decades.

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 editors.

Jeanne Philips-Roth & John Early,
General Editors

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 2016, 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.

Online Resources

Social Security has focused many resources on enabling people to transact business over the Internet in recent years. The retiring population is growing as the baby boomers age, and Social Security staffing has remained stagnant. Thus, the Social Security Administration must find new ways to deliver service to people more efficiently.

Social Security's website, www.socialsecurity.gov, has many useful features, including frequently asked questions and complete lists of the rules and regulations covering Social Security's programs.

It is possible to apply for retirement or disability insurance benefits online, file a change of address, get a benefit verification letter, and estimate your retirement benefits. For some functions, an individual must make a "my Social Security" account. Representatives (discussed below) also have specialized access to their clients' appeals files, and certain actions performed by representatives *require* online access.

You can make an account, get information, or explore the new features by going to www.socialsecurity.gov.

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 reach retirement age at 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 up to a quarter of coverage for each three-month calendar quarter in which they worked. 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 2016, for example, a worker receives one credit for each \$1,260 of earnings, up to a maximum of four credits based on annual earnings of \$5,040 or more. This amount can go 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 benefits 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, if the cost of living increased the previous year. The 2012 cost of living adjustment was the first one in three years, and there was no adjustment for 2016.

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 2016, the normal maximum monthly amount of retirement insurance benefits for an individual who reaches full retirement age in 2016 is \$2,639. 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, you can use Social Security's online services. Go to www.socialsecurity.gov and follow the links to get your electronic Social Security statement.

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 (5/9 of 1 percent for the first 36 months and 5/12 of 1 percent for each additional month). For an individual born in 1950, for instance, taking retirement at age 62 instead of age 66 (four years early) would result in a 25 percent reduction of his or her monthly payments on a permanent basis.

Spouses of workers who are insured for retirement benefits can often receive benefits of up to 50 percent of the wage-earner's monthly benefit. If a spouse takes the benefit early, the spouse's benefits are also reduced (by 25/36 of 1 percent per month for the first 36 months and 5/12 of 1 percent for each additional month). Therefore, a spouse born in 1950 who elects to take benefits at age 62 (four years early) would have a permanent 30 percent reduction of his or her benefits.

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 will affect your Social Security benefits.

Workers younger than full retirement age can earn \$15,720 in 2016 (\$1,310 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 \$41,880 (as of 2016) 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 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.

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 either 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 2016, one’s individual “countable” income must be less than \$733 a month. A couple’s countable income cannot be more than \$1,100 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.

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. The asset limits are not subject to automatic increase and have not changed in many years.

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 called “in-kind support and maintenance.” 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 rules 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. The type of appeal will depend on the issue you are appealing. 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.

Forms are available from any Social Security Administration office or on the Internet at 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 or non-attorney representative 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 authorization of the Social Security Administration.

Representative Payee

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 /SUPPLEMENTAL NUTRITION ASSISTANCE PROGRAM (SNAP)

This year's section updated by Karen Warren, co-managing attorney of the Health and Welfare program, working with the Public Benefits program at LSEM.

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 with the exception of certain rules relating to unemployed childless adults; other rules may apply if you are younger than 60 or are an immigrant (non-citizen). All figures are current as of October 2015, 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> 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 a company under contract with the 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, print off and complete an application at <http://www.dss.mo.gov/fsd/fstamp>. You can return the application in person, by mail or by fax. You can locate the FSD office nearest to you and find the address and fax number by visiting <http://dss.mo.gov/offices.htm> and entering your zip code or city.

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, childcare, 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” or “EU” 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 percent of the poverty level. You must show that this 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 or at least one disabled member may have resources up to \$3,250. All other households or eligibility units may have resources up to \$2,250.

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 (one burial plot per member of the eligibility unit is excluded); the cash surrender 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.

Three-Month Time Limit for Able-Bodied Adults Without Dependents (ABAWDS)

Special time limits apply to certain households that may include younger adult family members. Effective January 1, 2016, unemployed Food Stamp recipients who are

between the ages of 18-49 and do not have dependents who are under age 18 are subject to a three-month time limit on benefits if they do not meet specific work requirements or exemption criteria (e.g., pregnancy, unfitness for work, caring for an incapacitated family member, etc.) These unemployed childless adults must meet an exemption, work 80 or more hours per calendar month or participate and comply with the requirements of a qualified training program for 80 hours or more per calendar month or participate in a workfare program or they will be limited to three months of food stamp benefits in a 36-month period. See <http://dss.mo.gov/fsd/fstamp/> for more information about exemptions.

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 officer, contact the FSD office 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 – 2015

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

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

The State of Missouri has continued 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 percent 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, 2015 and either was a Missouri resident for the entire 2015 calendar year. If neither the taxpayer nor their spouse was 65 years or older as of December 31, 2015, 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 2015. The third fallback qualifier allows the PTC if the taxpayer was 60 years of age or older as of December 31, 2015 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 no longer offers free preparation of the Missouri individual income tax return and/or property tax credit by Department of Revenue employees. The Department encourages elderly and low income taxpayers to call 800-906-9887, 888-227-7669 pr 211 (St Louis area) for tax assistance information. They also suggest visiting <http://www.irs.gov/individuals/free-tax-return-preparation-for-you-by-volunteers>.

FINANCIAL ASSISTANCE

INCOME TAXES

Taxable Income

The basic federal rules are as follows. For taxpayers who are single and 65 or older at the end of 2015, they must file a return if their gross income was at least \$11,850. For taxpayers filing as head of household who were 65 or older, the income required for filing is \$14,800. For those filing married jointly, if one is 65 or over, the income required for filing is \$21,850. For married filing

jointly, and both are 65 or over, the income required for filing is \$23,100. For married filing separately at any age, the income required for filing is \$4,000. For qualifying widow(er) with dependent child and 65 or older, the income required for filing is \$17,850.

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 2015. See IRS Pub. 915

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 \$6,300; (2) for married filing jointly or qualifying widow(er) with dependent child, the number is \$12,600; and for (3) head of household, the standard deduction is \$9,250. There are higher standard deductions for taxpayers or their spouses who were born before January 2, 1952 and/or blind. Each condition (age and blindness) increases the deduction. For 2015, the additional standard deduction is \$1,250 for married individuals and \$1,550 for singles and heads of household.

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 2015 or were under 65 but permanently and totally disabled, received taxable disability income in 2015, and as of January 1, 2015 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."

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. Credits are approved on a first-come, first-served basis and will be denied after the \$100,000 limit is met.

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 2015, 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, 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 982 and its instructions set 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 one's 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 one's 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."

Earned Income Tax Credit

For 2015, the maximum earned income tax credit (EITC) for low and moderate income workers and working families increases to \$6,242 and the maximum income limit for the EITC is \$53,267. The amount of the credit will vary according to family size, filing status and other factors. See IRS Pub. 596

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.

Health Care Reform

Under the Affordable Care Act (ACA), taxpayers and their dependents must have health insurance, claim an exemption, or make a payment with their return. The Health Insurance Marketplace sends IRS Form 1095-A to individuals who obtained their coverage through the Marketplace. Health insurers send Form 1095-B to covered individuals. Certain employers send Form 1095-C to covered employees. The deadline for issuing these forms is determined by the IRS and has been extended in 2016. Taxpayers will use Form 1095-A to complete Form 8962 to claim or reconcile the premium tax credit.

FINANCIAL ASSISTANCE

PRIVATE PENSIONS

By Pam Coffin, formerly of Mercer, Inc., a human resource consulting firm. Ms. Coffin, who retired from Mercer in September 2015, specializes in pension work. She is also a long-term participant in the Legal Services of Eastern Missouri, 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 (or age 62, if later) 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 five, 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. If the spouse dies after payment begins and the employee remarries, the new spouse is not entitled to the survivor benefit. 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, although some plans offer annuity payments.

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 (and, in some plans, had been married for at least one year 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.

If the surviving spouse's benefit is valued at more than \$5,000, payment cannot be made prior to the date the employee would have reached the plan's normal retirement age unless the spouse consents to the payment.

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, 75 or 100 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 could be directly rolled over but which the recipient elects to take in cash 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 older than 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 could be directly rolled over but which are taken in cash instead are subject to 20 percent 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. Amounts paid directly to a spouse or former spouse under a qualified domestic relations order are taxed to the spouse or former spouse, not the employee. 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 eligible retirement 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 in writing for a benefit and is denied (or receives less than the applicant believes he 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. 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.

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 a traditional IRA on a tax-deductible basis, even if they are covered under a retirement plan at work. However, the deduction is phased out if income exceeds certain levels. Spouses can also set aside the maximum amount each year, even if they are not working. The annual contribution limit for calendar years 2013 and later is \$5,500. Individuals who are age 50 or older 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 non-deductible contributions to a Roth IRA. People whose income exceeds certain levels cannot contribute to a Roth IRA. Both types of IRA have advantages and disadvantages. Distributions from a traditional IRA are generally fully taxable and must begin after the individual reaches age 70-1/2. Distributions from a Roth IRA 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 "Keogh" 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.

FINANCIAL ASSISTANCE

AGE DISCRIMINATION IN EMPLOYMENT

By: Barbara A. Seely, Regional Attorney of the U.S. Equal Employment Opportunity Commission, St. Louis District Office. Past editions were by Rebecca Stith, a former senior trial attorney with the Equal Employment Opportunity Commission and frequent contributor to this publication. This edition was reviewed by John Early, Attorney, Legal Services of Eastern Missouri.

Introduction

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. An employment policy or practice that applies to everyone, regardless of age, can be illegal if it has a negative impact on applicants or employees age 40 or older unless it is based on a reasonable factor other than age. 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. This should enable the

affected employees to determine whether older employees were impacted by the RIF in greater numbers than younger employees. 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.

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 MCHR) 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 of 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 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 from the date on which you received it. In addition, under 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) 773-3566.

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 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 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 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

This year's edition was updated by Karen Warren, co-managing attorney of LSEM's Health and Welfare program, working with LSEM's Public Benefits program, and Lakitsa (Pinky) Hunter, a Public Benefits Specialist at LSEM. Past editions were by Barbara J. Gilchrist, J.D., Ph.D., a professor at Saint 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 May 2016, but is subject to change at any time. This section does not attempt to deal with any changes which may be caused by the Affordable Care Act. For more detailed information, call the Centers for Medicare and Medicaid Services (1-800-633-4227) and TTY (1-877-486-2048).

What Is Medicare?

Medicare is a health insurance program administered by the Centers for Medicare and Medicaid (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 retirement benefits or Railroad Retirement Board benefits; OR
2. Disabled and have received Social Security disability benefits for two years; OR
3. Have end stage renal disease; OR
4. Have Amyotrophic Lateral Sclerosis (ALS or Lou Gehrig's disease).

Part A is available with no premium for persons with 40 or more quarters for Social Security purposes. Persons with 0-29 quarters for Social Security purposes may receive Part A coverage by paying a monthly premium of \$411. Persons not entitled to Social Security or railroad retirement, but who have at least 30–39 quarters, may pay a premium of \$226.

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 – Outpatient Medical Insurance

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

Eligibility for Part B (outpatient medical insurance) is the same as for Part A, but a monthly premium of \$121.80 (or higher depending on your income) must be

paid. Most people will pay the standard premium amount. However, most people who received Social Security benefits in 2016 will continue to pay the same Part B premium amount (\$104.90) as they paid in 2015. This is because there was not a cost-of-living increase for 2016 Social Security benefits.

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, there will be a penalty added to the monthly premium for each year of the delay.

Some people will automatically get Medicare Parts A and B, while others may have to wait to obtain Parts A and B during a specific period called an enrollment period. Medicare Part B has an annual deductible of \$166 for the year 2016.

PART C – Medicare Advantage Plans

Medicare Advantage Plans refer to private managed care health plans for Medicare recipients. These plans may take the form of HMOs, PPOs, SNPs (special needs plans), MSAs (Medicare Savings Accounts) or Fee-For-Service. All of them restrict the patient's choice of healthcare provider. Most people enrolled in a Medicare Advantage Plan must still pay their Part B premium. Members may also pay an additional monthly premium to the plan.

Medicare Advantage plans provide benefits equivalent to Parts A and B. Some plans offer a range of supplemental benefits to cover out-of-pocket costs such as deductibles and co-insurance. 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 an optional program that helps pay for prescription drugs. Medicare beneficiaries may enroll either with a stand-alone prescription drug plan (PDP) or a Medicare Part C Medicare Advantage plan that offers prescription drug benefits. Monthly premiums will vary among plans. Covered medications will also vary among plans.

For people with limited income and resources, there is a Low-Income Subsidy (LIS) called Extra Help that will pay all or part of the Part D premium. If you meet certain income and resource limits, you may qualify for Extra Help from Medicare to pay the costs of Medicare prescription drug coverage. Eligibility for the LIS is based on income and resources. A single person with income of up to \$18,060 in yearly income (and resources up to \$13,640 single) or a married couple with yearly income up to \$13,640 (and resources up to \$27,250) may qualify.

If you do not qualify for Extra Help, your state may have programs that can help pay your prescription drug costs. Contact your State Medical Assistance (Medicaid) office or your State Health Insurance Assistance Program (SHIP) for more information. Remember, you can reapply for Extra Help at any time if your income and resources change. For more information on Extra Help, visit www.Medicare.gov.

Enrolling in Medicare and Switching From Medicare to Medicare Advantage 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 (AGEP) from October 15 – December 7 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 a doctor determines that the services are medically 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. Medically necessary services and supplies are those that meet accepted medical standards and are necessary for the diagnosis and treatment of a medical condition.

The following skilled nursing facility 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.

Medicare Part A will cover hospice care, but the Medicare recipient must have been diagnosed as terminally ill. Hospice care includes comprehensive care for people who are terminally ill, such as pain management, counseling, respite care, prescription drugs, inpatient care and outpatient care, and services for the terminally ill person's family.

Medicare Part B covers the following services and items: physician services (including Federally Qualified Health Centers-FQHCs); hospital outpatient services and supplies incidental to physician services (such as diagnostic x-ray tests) and other medical and health services (including surgical dressings, splints, and casts; rental or purchase of durable medical equipment; ambulance services and prosthetic devices). Part B also covers costs for mental health, chemotherapy, and dialysis.

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, foot exams, diabetic supplies, sexually transmitted infection screenings, tobacco use cessation counseling, obesity 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.

Medicare Part A and Part B 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 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

Both Parts A and B have initial deductibles that the patient must pay before Medicare pays anything. Both parts also have co-insurance payments. This means that after Medicare has paid all costs up to a certain limit, the patient must pay a certain amount of the remaining costs. Other plans, such as Medigap policies and Medicare Advantage plans can be effective ways to handle those costs not covered by Medicare. Refer to the Health and Life Insurance section of the handbook for a more detailed discussion of Medicare supplement plans.

A new deductible applies for each new benefit period. A benefit period (also known as a spell of illness) begins the first day you enter a hospital or skilled nursing facility (SNF) and ends when you do not receive hospital or skilled care for 60 consecutive days. If you reenter the hospital before the 60 days are complete, then the previous deductible remains in effect. There is no limit to the number of benefit periods you can have.

Part A provides up to 90 days of hospital care for each benefit period. However, there is a deductible charged at the beginning of the hospital stay and co-insurance after 60 days. The hospital deductible is \$1,288 for each benefit period. If you are in the hospital for 61-90 days, the co-insurance amount is \$322 per day.

Recipients also have 60 lifetime “reserve days,” but they do not have to be applied toward the same hospital stay. After 90 days of hospitalization, if you choose to use reserve days, the co-insurance amount is \$644 per day. Medicare will also deduct the number of reserved days used from your lifetime limit. Medicare pays the remainder of all covered expenses.

If you are hospitalized more than 90 days and you choose not to use your lifetime reserve days, you must

put your decision in writing and give it to the hospital within 90 days of leaving the hospital.

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 \$161 per day. For days 101 and beyond, you pay all costs. 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 has a basic payment rule for all charges for covered medical expenses. There is a \$166 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 greater than 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 monthly premiums in addition to your Part B premiums. You may also have an annual deductible, co-payments and/or co-insurance charges depending upon the plan that you select.

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, but are not limited to: custodial care in a nursing home, residential care facility, or in your own home; services not reasonable or necessary, as defined by Medicare; routine dental and eye care; dentures; cosmetic surgery; acupuncture; hearing aids and exams for fitting them; and routine foot care. For questions about coverage of a specific service, visit Medicare.gov. Additionally, services not covered

by Part A or Part B may be covered by supplemental plans (Medigap) or Medicare Advantage.

Qualified Medicare Beneficiary (QMB), Specified Low-Income Medicare Beneficiary (SLM)

QMB is a Medicare Cost Savings Program that assists individuals by paying their Medicare premiums and by making payments to their medical providers for the coinsurance and deductibles for Medicare services. To qualify, an individual's income must be less than \$990 (subject to change annually in April) per month and have assets that do not exceed \$7,280. To qualify as a married couple, combined income must be less than \$1,335 per month and have assets that do not exceed \$10,930 (subject to change annually in April).

SLMB1 is another Medicare Cost Savings Program that assists individuals by paying their Medicare Part B premium. Individuals with income up to \$1,188 per month and couples with income up to \$1,602 may qualify for the SLMB1 program. The SLMB2 program (previously called Qualified Individual (QI-1) program) also pays the Medicare Part B premium for individuals with income up to \$1,337 and couples with income up to \$1,803. For both SLMB1 and SLMB2, assets must not exceed \$7,280 for an individual and \$10,930 for a couple.

The income limits for these programs are subject to change annually in April. The Missouri Family Support Division (FSD) administers the QMB and SLMB Programs and each of these programs has additional eligibility criteria that must be met. Inquiries about each of these programs should be directed 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. Click on the "Claims and Appeals" tab.

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 to www.medicare.gov and click on the "Forms, Help & Resources" tab.

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 cannot present all of the information that may be needed regarding the Medicare program. One resource for more information is Missouri's free state health insurance assistance program, which uses the name CLAIM (Community Leaders Assisting the Insured of Missouri). To reach CLAIM, call 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 2016*. 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

MO HEALTHNET (Medicaid in Missouri)

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Editor's Note: The information in this booklet on MO HealthNet is designed to give a brief description of this program, a description of the benefits, and general rules as to how one qualifies for those benefits. This information is current as of January 2016, 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 Medicaid 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. There are financial need requirements for eligibility for the MO HealthNet program (formerly known as Medicaid).

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. Under what is known as the "Vendor" MO HealthNet program, benefits may also help to cover the expense of skilled nursing home care.

For medical expenses that are not explicitly covered, there is a procedure that allows a MO HealthNet recipient to make a "medical exception" request for MO HealthNet coverage. 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.

Additionally, 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, the individual may appeal the decision. (*See later section for information on 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, the individual has two options: change the health care provider or pay with his or her 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 the two main MO HealthNet programs for elderly and disabled individuals; “*Medical Assistance*” and “*Vendor MO HealthNet*.”

Eligibility for a MO HealthNet Program

In order to qualify for any 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” and must also meet certain financial eligibility requirements.

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 2016.

- An unmarried individual must have monthly income of \$834 or less after allowable deductions.

- A married individual and his or her spouse must have a combined monthly income of \$1,129 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 "spend-down" amount. This is like a monthly deductible. (See "*Spend-down MO HealthNet*").

Asset Limit Requirements

In addition to income limits, MO HealthNet programs also have 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. For the *Medical Assistance* program the asset limits are:

- An unmarried individual must have no more than \$999.99 in non-exempt assets.
- A married individual and his or her spouse must have no more 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 \$552,000) 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.

"Spend-down MO HealthNet"

If an individual's countable income is above the applicable income limit, he or she may still qualify for *Medical Assistance* benefits. In those situations, the individual is responsible for a certain amount of medical expenses each month before MO HealthNet benefits will cover other medical costs. The amount for which the individual is responsible is referred to as his or her "spend-down" amount. An individual's spend-down 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. (For 2016 these amounts are \$834 for a single individual and \$1,129 for a married couple).

The remainder, after all allowable deductions, is the individual's monthly spend-down amount.

An individual can meet his or her spend-down in one of two ways:

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

If the individual chooses the second option, his or her MO HealthNet coverage for each month will become effective the day bills meet or exceed the spend-down amount. (Bills given to the caseworker to meet spend-down will not be paid by MO HealthNet).

If the individual is eligible under the spend-down program, his or her case will stay open whether or not the spend-down is met in any one month. MO HealthNet will send an invoice each month to the individual that he or she can use to pay the spend-down "up-front" for the next month. MO HealthNet sends the invoice for the next month's premium in advance. However, the individual can also pay the premiums retroactively for certain months.

If the individual does not meet the spend-down for six (6) consecutive months, MO HealthNet will no longer send invoices, but the case will still stay open.

MO HealthNet for Nursing Home Care (Vendor MO HealthNet)

The *Vendor* MO HealthNet program will cover some of the cost of nursing home care for those who qualify. 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 benefits. However, as a practical matter, an individual's income must be less than the monthly cost of his or her nursing home care. Otherwise, MO HealthNet benefits are usually not needed.

As a general rule, once an individual is eligible for *Vendor* benefits, the 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. (Special rules apply for the income of certain individuals who are married and whose spouse does not also reside in a nursing home).

Asset Limit Requirements

The following asset limit requirements apply to non-exempt assets. (*For information on what is an exempt asset, see "Exempt vs. Non-Exempt Assets" in prior section*).

- 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 keep a Community Spouse Resource Allowance ("CSRA"). The amount of a spouse's CSRA is not considered in the \$999.99 non-exempt asset limit.

Community Spouse Resource Allowance. The FSD will compute a "Community Spouse Resource Allowance" ("CSRA") for the spouse of a married individual applying for *Vendor* MO HealthNet assistance. The CSRA 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, as of the date the MO HealthNet applicant first became “institutionalized.” The caseworker then adds the value of all of the non-exempt assets and determines the total value. The caseworker then takes the total value, divides it by two (2), and applies a minimum and maximum standard amount.

The CSRA will be 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 one-half total is *less* than the minimum, then the CSRA will be more than one-half, and will equal the minimum standard amount. If the one-half total is *more* than the maximum standard amount, then the CSRA will be less than one-half, and will equal the maximum standard amount.

The minimum and maximum standard amounts are typically increased each year. As of January 2016, the minimum CSRA amount is \$23,844 and the maximum amount is \$119,220.

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

In addition to the CSRA, a spouse of a *Vendor* MO HealthNet recipient (“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 income from his or her spouse in the nursing home, and/or be entitled to an increased CSRA. 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.

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 benefits, 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 1) has no more than \$999.99 in non-exempt assets, 2) is otherwise eligible for benefits, and 3) has applied for MO HealthNet benefits. Essentially, the penalty period will run from the date of application and not the date of transfer, assuming the applicant meets all of the other eligibility requirements at the time of the application.

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 exempt under the law, and are not subject to penalty.

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. In addition, the State is entitled to a lien against the individual's home. However, there are certain exceptions and circumstances in which the State does not have a legal right to such a claim or lien. 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.

Right to an Appeal

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 those 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 individual continues to receive full benefits during the appeal process and loses the appeal, the State can seek repayment from the individual for those expenses.

HEALTH CARE

NURSING HOMES

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Introduction

If you are looking for a nursing home for yourself, a friend or family member, this section will help you choose a long-term care facility that will meet your needs, both 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 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 one unannounced inspection annually and may be subject to other inspections based upon complaints received through the Elder Abuse Hotline (800-392-0210). Residents and families are encouraged to participate in the inspections. A copy of the inspection's survey report must be available for public viewing in the facility.

Levels of Care

There are four levels of long term 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. Commonly referred to as a nursing home, 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 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 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. There are two levels of Assisted Living. Residents of ALF I facilities must be capable of exiting the building with minimal assistance within 5 minutes or less during an emergency. ALF II facilities have the option of caring for someone who is not capable of meeting this Pathway to Safety criteria. Residents in an ALF II may have greater options to age in place.

Independent living facilities usually consist of the resident occupying an apartment and being provided with one or more meals per day, light housekeeping and laundry services. It does not include medical care. However, many places offer some personal aide services. There is very limited financial aid provided for residents in independent living facilities except for some personal aide services for residents who qualify under Medicaid.

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 the needs 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?

Is the facility clean, and does it match the personality of your loved one?

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. Ask what alternative dining options are available. Many facilities provide an a la carte menu or a food service buffet.

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. For example, what is the restraint policy and what is the bed hold policy?

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 or not institutionalized.

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

- The Department of Health and Senior Services, P.O. Box 570, Jefferson City, MO 65102; www.health.mo.gov/seniors/nursinghomes; 573-526-8524
- 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.

Results of the latest facility inspections can be found at www.health.mo.gov/safety/showmelongtermcare. Additionally, www.Medicare.gov/nursinghomecompare provides ratings based on certain criteria. These ratings may be helpful in comparisons but cannot be considered definitive rankings of the quality of care in each facility.

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, attending your care plan meeting, and refusing treatment;
- (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 and receive notification before a room change;
- (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 financial report quarterly and upon request;
- (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 24 hours per day;
- (12) Receive the facility's bed-hold policy in writing when you are hospitalized and return to the first available bed if you choose not to pay for bed-hold; 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. When a grievance is submitted in writing, the home has three days to respond. This response should include a written explanation of findings and proposed remedies, if any, to the complainant.

If the complaint is not resolved to the satisfaction of the resident, there are additional steps a resident can take. The resident may contact 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.

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. The Department also will investigate complaints that are not risking the welfare of the resident although those complaints may not be investigated immediately.

Discharges from a Nursing Home

It is the resident's right to remain in the nursing home for as long as she/he chooses. 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 (but there needs to be some difference between the current facility and the new one that has something additional that makes it a more appropriate placement);
- 2) The resident's health has improved sufficiently so the resident no longer needs the services provided by the facility;
- 3) The health or safety of the other individuals in the facility is endangered;
- 4) After reasonable notice, the resident fails to pay for a stay at the facility; or
- 5) The facility ceases operation.

When the facility discharges a resident, they must provide the resident, any legally authorized representative, and at least one family member with a written notice of their intent to discharge at least 30 days prior to the intended discharge date. In this notice, the facility must give the reason for the discharge, the

effective date of discharge, the resident's right to appeal the discharge, the address for requesting an appeal hearing, the location to which the resident will be discharged, contact information for the regional long term care ombudsman program and the Missouri Protection and Advocacy Agency for residents with developmental disabilities or mental illness. The notice must also state that the resident has the right to remain in the facility while the appeal is pending. The appeal is made to the Administrative Hearings Unit, Division of Legal Services in Jefferson City (phone 573-751-0335). 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. The hearing usually is conducted by phone. 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 its intent not to take the resident back and the reason, and 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 (meaning admission and not just stay for observation), 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 Medigap insurance plan.

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. The maximum available coverage under Medicare is 100 days, but most residents will not receive the full 100 days of coverage because they will not need the skilled level of care for medical reasons. 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 must provide the resident with information on this appeal process.

Medicare Advantage or Medicare Complete Plans: These are private insurance contracts that are a replacement for traditional Medicare. All of these plans have some coverage for skilled nursing stays and require the same three day hospital admission. Each of these plans are different in the amount of copays that are required for each stay, so you need to make sure to check your plan if you have this type of coverage. Medicare Advantage plans also typically have networks of skilled nursing facilities that are more restrictive than traditional Medicare, so choices of homes may be more limited under this type of insurance.

Medicaid/MO HealthNet: 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.

The Medicaid program is called MO HealthNet in Missouri. 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 is financially responsible to the facility for his or her "surplus" amount, as determined by FSD. FSD determines the surplus amount by totaling the resident's monthly income, subtracting any health insurance premiums of the resident, and a personal needs allowance (currently \$50). The remainder is the resident's surplus amount. The amount of this personal needs allowance is set annually by state regulation. Failure to turn the surplus over to the nursing home could result in a discharge letter for non-payment. Moreover, if another individual is keeping the resident's surplus funds which should be given to the facility, that

individual can be charged with the crime of financial exploitation.

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

To qualify for Medicaid payments, you must:

- be a U. S. citizen or "qualified alien," *and* must be a Missouri resident, *and*
- be 65 years or older (elderly), blind or permanently and totally disabled, *and*
- meet the financial eligibility requirements (for more information on the financial eligibility requirements, see the Medicaid/MO Health Net section).

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. For more information on the special rules that apply to married Medicaid applicants, please see the Medicaid/MO Health/Net Section.

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 a licensed residential care 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. Most long-term care insurance plans do not pay for a specified initial period of time which would be stated in the policy, *i.e.*, the first 90 – 100 days.

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

This year's two Housing sections were edited by Susan Alverson, the managing attorney of the LSEM Housing Program in the St. Louis office. This section in the 19th edition was edited by Mary DeVries, a former staff attorney in the Housing Law Program at LSEM. Past editions' Landlord-Tenant section was assisted by John Ammann, who was at that time the director of the Saint Louis University School of Law's Clinical Law Program.

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 out tenant 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

The dwelling you lease may be sold at a foreclosure sale. If this occurs, this does NOT mean you must vacate the dwelling. The new owner may lawfully evict you only by going through the **judicial process** and obtaining an **eviction court order** against you.

You have the right to ask to enter into a new lease with the new owner. Your original lease ended with the foreclosure sale. The new owner does not have to lease to you and has the right to ask you to move. However, the new owner does not have the right to illegally evict you or to use “self-help” eviction actions against you, such as locking you out, etc.

If the new owner does not want to lease to you, and has demanded that you move, the demand must be in writing. And, to legally enforce the demand that you vacate, the new owner must obtain a court order. To obtain this court order, the new owner must file an eviction lawsuit against you. You will know if the lawsuit is filed because you will receive a summons to court. You would receive the summons through the mail, posted on the front door, or hand-delivered to you by a special process server or sheriff.

The prior owner has NO legal right to evict you after a foreclosure sale. The foreclosure sale means that the prior owner has lost ownership and thus has no rights regarding the dwelling. The prior owner, your landlord, has NO right to enter the dwelling after the foreclosure sale. Moreover, you have the right to the return of the security deposit you gave your original landlord. The security deposit will NOT be transferred to the new owner after a foreclosure sale. If the prior owner or your landlord fails to return the security deposit, you have the right to file a lawsuit against the prior owner. You may bring this claim in the small claims court of the county in which the dwelling is located.

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 landlord cannot get a judgment for eviction, but may be able to get a money judgment for any other amounts owed. 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 merely wait 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

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 8 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.

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

This year's section was updated by Robert Swearingen, a staff attorney in the Consumer Law Program at LSEM. Updates of past editions were assisted by Daniel Claggett, managing attorney of the Consumer Law Program at LSEM, and written by Michael Ferry, currently the executive director of Gateway Legal Services, Inc., and previously a long-time attorney with LSEM.

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, radio or the internet. 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. You should always compare prices, research, and never be in a hurry to make a purchase. If a merchant tells you the price is only good today, you should walk away. 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 NOT sign a contract with an arbitration clause.

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 refinancing, 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 (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 do 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.

Never pay the contractor the full price until the job is completed to your satisfaction.

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 does 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.

Used Car Purchases

If you are buying a used car from a dealership, you should follow these steps BEFORE signing the contract.

1. Never purchase the car on the first visit.
2. Ask to see the title to the vehicle so you can see if the car was previously a salvage or a lease vehicle.
3. Ask questions about the history of the car. Ask the dealer to provide you with a Carfax.
4. Make sure the car has passed safety and emissions inspection prior to purchase.
5. Write down the make, model and year along with the mileage and find out the purchase price.
6. Research the market value of the car by going to Bluebook.com, NADA.com or Edmunds.com and obtain the fair market value of the car.
7. Print out the fair market value and take it back to the dealership and negotiate a fair price with the dealer.
8. Take the car to a mechanic and have the car looked over prior to purchase. If the dealer will not let you take the car to a mechanic to be inspected, go to another dealer.
9. Do not purchase the car until you are satisfied that the car is in good mechanical condition and you have negotiated a fair price for the car.

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). 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 \$5,000 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 \$5,000 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 \$5,000 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 \$5,000, 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.

Most time share properties do not appreciate in value. More often than not, you will not be able to resell your time share property. Never pay money in advance to any company that promises to resell you time share property.

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). 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

This year's section was updated by Mary Sweet, an Affordable Care Act Specialist at LSEM. Past editions' Insurance section was written by Michael Ferry, currently the executive director of Gateway Legal Services, Inc. and previously a long-time attorney with LSEM.

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 too much nor too little.

Life insurance. For most people, life insurance provides financial security to your 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 important to know the basics 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. The policy has no cash value and the coverage ends at the end of the specified time or term. For example, if someone has a term life insurance policy that covers the policyholder until he/she reaches age 65, once he or she reaches 65

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 last?
2. If I die, 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 goal for getting 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?

Keep 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 getting a policy’s cash 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. The policy will not actually terminate until the cash value is \$0.

Borrowing against a policy will continue the coverage, but the policyholder can get a loan, usually at a low interest rate. Note 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 Affordable Care Act (ACA) requires that most people have health insurance or pay a fee on their taxes. 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.

If you do not have insurance through Medicaid or an employer, you may have other health insurance options through the Health Insurance Marketplace (Marketplace) or Medicare.

Health Insurance Marketplace

The ACA created new options in the private health insurance market. If you retired early, and your former employer does not offer group coverage, or the coverage that is offered is not affordable, you may be able to purchase health insurance through the Health Insurance Marketplace (Marketplace), otherwise known as “Obamacare.”

Adults under 65 who do not have other affordable coverage can purchase a health insurance plan through the Marketplace. This includes adults under 65 who are eligible for the Medicaid Spenddown program but cannot afford to pay their monthly spenddown. Adults who are eligible for Medicare are not eligible to purchase a plan through the Marketplace.

Depending on your household income, you may qualify for financial help to lower the cost of your coverage.

Premium Tax Credits: Premium tax credits (PTCs) can lower the monthly cost, or premium, of your Marketplace plan. The amount of your PTC is based on your income and household size. Individuals and families with household income between 100 – 400 percent of the Federal Poverty Level (FPL) may qualify for PTCs.

Family Size	100% FPL (2016)	400% FPL (2016)
1	\$11,770	\$29,425
4	\$24,250	\$97,000

Cost Sharing Reductions: Cost Sharing Reductions (CSRs) lower the plan’s out-of-pocket costs, like deductibles, co-pays, and co-insurance. The level of CSRs that you qualify for are also based on income and household size. Individuals and families with household income between 100 – 250 percent FPL may qualify for CSRs.

Family Size	100% FPL (2016)	250% FPL (2016)
1	\$11,770	\$47,080
4	\$24,250	\$60,625

For more information on health insurance and financial help through the Marketplace, go to covermissouri.org to find assisters who offer in-person, one-on-one help in your area.

Medicare

As described earlier in this Handbook, Medicare is a health insurance program designed to help meet the medical costs of senior citizens (age 65 or older) and some disabled persons under age 65. While Medicare covers many of the costs of medical care, it does not cover them all.

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 only cover Medicare deductibles and co-insurance costs. They exclude the same services that Medicare excludes.

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 what you are charged. The plan only pays 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 doctor 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: You get a doctor’s bill for \$600. The Medicare-approved charges for the doctor’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 you must 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 \$1,288) 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 \$322) 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 \$644) 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 \$161) 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 \$166) 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 useful. In most cases, you 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 beneficiaries that have been available since 1997. Medicare Advantage plans provide

all the same benefits as Medicare, but are also similar to Medigap policies. 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 beneficiaries. To qualify for QMB, your household income must be under 100 percent FPL plus \$20. In Missouri, the QMB program is handled through the Missouri Department of Social Services, Family Support Division (FSD). The State pays the Part A and Part B Medicare premiums, deductibles, and co-insurance charges for those who qualify. Those currently receiving Medicaid may also be eligible for QMB benefits. To find out if you qualify, contact your local FSD office.

CONSUMER INFORMATION

PREDATORY LENDING

This year's section was updated by Daniel Claggett, the managing attorney of the Consumer Law Program at LSEM. Past editions' sections were written by Kerry Kaufmann, the administrator of Normandy Nursing Center and previously with the St. Louis Long Term Care Ombudsman Program (now VOYCE).

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, you may wish to contact a housing counselor certified by the United States Department of Housing and Urban Development ("HUD") about seeking a loan modification that will lower your interest rate and lower your monthly payment. There is no charge for the housing counselors' services. HUD maintains a list of these counselors on its website at <http://www.hud.gov/offices/hsg/sfh/hcc/fc>. You can also call HUD at 1-800-569-4287 to find the name of the closest HUD certified counselor. Beware that there are many con artists who promise homeowners that they can secure a loan modification on their behalf, collect a fee upfront for their services, and then disappear with the money. There is no need to pay for loan modification assistance since the HUD-certified counselor will provide assistance for free.

If your lender is demanding monies that you contend you do not owe, or you feel that you were tricked into entering into the loan, then you should also contact an attorney.

Also beware of a lender or third party who offers to purchase your home in foreclosure for a small percentage of what the home is actually worth with the promise that you can remain in the home as a tenant and purchase the home back at a later date when your credit score improves. Generally, 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 may instead be a higher interest rate, overpriced costs, and little or no cash for the homeowner.

Sometimes, unsuspecting homeowners are 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.

Reverse mortgages, which allow homeowners 62 and older to borrow money against the value of their homes

and not pay it back until they move out or die, are another area of abuse. Used correctly, reverse mortgages can be a valuable tool for seniors to stay in their homes and gain access to money needed for retirement. However, some lenders are aggressively pitching the loans to seniors who cannot afford the fees associated with them. Other lenders are inducing seniors to enter into reverse mortgages with promises that the loans are free money that can be used to finance a long coveted vacation without clearly explaining the risks. Some widows are at risk of losing their homes because they were pressured to keep the loan solely in their husband’s name without being told that upon their husband’s death the full amount of the loan would come due. Other seniors are promised that the reverse mortgage will enable them to fund repairs to their homes. Then, they are swindled by contractors, introduced by the lender or broker, who do shoddy workmanship or charge exorbitant fees.

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);
- (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

By Christine A. Alsop, The Elder & Disability Advocacy Firm of Christine A. Alsop, LLC. Ms. Alsop concentrates her practice on elder law and estate planning in the St. Louis area.

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 OR ELDER LAW 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.

When dealing with the assets of a deceased person, one of the most important issues in determining the manner in which the asset will transfer at death is consideration of the way in which the asset was titled. This means that the way in which the asset was held at death will determine how the asset will be distributed at death.

Options for arranging transfer of assets after death can be summed up in five categories:

- (1) doing nothing;
- (2) executing a Last Will and Testament;
- (3) executing a living trust;
- (4) providing for non-probate transfers; 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. If the person does not plan and the assets are held in the name of the deceased person alone, the assets must be handled through the probate court. The probate court will determine the distribution of those assets

through the guidance of the probate statutes in effect in the state of residence of the decedent. These statutes, which are called 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 the assets 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. 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. When working with an estate planning attorney, the intent and concerns of the client are reflected in the documents. Particular attention must be paid when a second marriage and/or blended family are involved or when property is not being divided equally among heirs. Family disputes and other misunderstandings are common after the death of a loved one.

(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, beneficiary designations or the use of a trust – is in place. Moreover, a will does not avoid probate. Instead, the will directs the probate estate by providing the intent of the decedent.

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 by the decedent alone 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 non-probate 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 includes 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 at the death of decedent when administration of the will is sought. 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 and legitimate 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. Family members can be disinherited or treated differently. However, there are two classes of people who cannot be disinherited: a surviving spouse and dependent children. For instance, a surviving spouse can choose to either receive the distribution provided 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. This is referred to as a "spousal election against the will." A prenuptial agreement is sometimes used to overcome this default rule.

Types of Probate

There are various procedures available to distribute an estate. The choice of probate 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 execution 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 the creator of the trust 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. The use of online "forms" can cause expensive problems for families and should be avoided. In Missouri, a trust is notarized generally and financial institutions often will not accept trusts without a notary's signature. In order for the trust to be valid, the trustor must have capacity.

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. So, as an example, assume that Robert Smith creates a revocable living trust. He would retitle his bank account to reflect that the "Robert Smith Revocable Living Trust" is the owner, with Robert Smith as trustee. The bank account would no longer be in the individual name of Robert Smith. The living trust only affects assets to which title has been transferred to the trust. Assets that are not titled in the name of the trust or only have the name of the decedent on title 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 transferred into a trust by the use of a "pour-over" will still have to be administered 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 the beneficiaries 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 boats, 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 oftentimes 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 through the court 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 state 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 are 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. The State of Missouri does not currently impose an estate tax.

Most relatively simple estates (cash, publicly traded securities, small amounts of other easily valued assets, and no special deductions or elections, or jointly held property) do not require the filing of an estate tax return. A filing is required for estates with combined gross assets and prior taxable gifts exceeding \$1,500,000 in 2004 - 2005; \$2,000,000 in 2006 - 2008; \$3,500,000 for decedents dying in 2009; and \$5,000,000 or more for decedents dying in 2010 and 2011 (note: there are special rules for decedents dying in 2010); \$5,120,000 in 2012, \$5,250,000 in 2013, \$5,340,000 in 2014, \$5,430,000 in 2015, and \$5,450,000 in 2016. Most estates are not taxed because they do not exceed the exemption amount.

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 an original 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 the 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. This is in large part due to the inherent risks of adding another individual's circumstances to one's own.

Real Estate Transfers

Many senior citizens attempt to sell or give away their property either to avoid probate or in the hope of making 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 deeds his or her house to someone, there could be significant tax consequences that could be avoided if the conveyance occurred at death.
- 3) 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."
- 4) 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.
- 5) 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.
- 6) In Missouri, a married person cannot deed away his or her interest in real estate without the spouse's signature as well.
- 7) Lifetime transfers may have adverse effects on capital gains taxation.
- 8) Medicaid and other government benefits qualification can be adversely affected through real estate transfers of these types.

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

PERSONAL PLANNING/PROTECTION

POWER OF ATTORNEY, PERSONAL CUSTODIAN AND GUARDIANSHIP

By Christine A. Alsop, of the Elder & Disability Advocacy Firm of Christine A. Alsop. Ms. Alsop concentrates on the areas of estate planning, elder law and helping those who are disabled in the greater St. Louis area.

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" or "agent") 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 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 loses the capacity to conduct his or her affairs, the attorney-in-fact likewise becomes unable to act. The power of attorney thus ends with either the incapacity 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 the principle becomes 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 is incapacitated 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. The filing of the power of attorney is only mandatory, however, where the agent is handling a real estate transaction.

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. It must be noted that 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 property in 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 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. No attorney-in-fact may require the principal, against his or her will, to take any action or to refrain from taking any action or to carry out any actions specifically forbidden by the principal while not under any disability or incapacity.

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. You are not required to testify and you cannot be forced to testify during any part of the proceeding. The court-appointed lawyer will make a report to the court regarding whether the guardianship or conservatorship are warranted.

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. However, the conservator must obtain court approval before taking any action with the ward'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, such as the right to vote or operate a vehicle. 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 guardian or conservator. You may specify in your will, power of attorney, 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 ask the court's approval prior to taking any action with the ward's assets. 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 Christine A. Alsop, The Elder & Disability Advocacy Firm of Christine A. Alsop, LLC. Ms. Alsop concentrates her practice on elder law and estate planning in the St. Louis area.

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 1-800-735-2466 (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 and bullying.

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 Christine A. Alsop, The Elder & Disability Advocacy Firm of Christine A. Alsop, LLC. Ms. Alsop concentrates her practice on elder law and estate planning in the St. Louis area.

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 Missouri statute authorizing the creation of living wills specifies that the statement or declaration be in substantially the following form: “I have the primary right to make my own decisions concerning treatment that might unduly prolong the dying process. By this declaration I express to my physician, family and friends my intent. If I should have a terminal condition, it is my desire that my dying not be prolonged by administration of death-prolonging procedures. If my condition is terminal and I am unable to participate in decisions regarding my medical treatment, I direct my attending physician to withhold or withdraw medical procedures that merely prolong the dying process and are not necessary to my comfort or to alleviate pain. It is not my intent to authorize affirmative or deliberate acts or omissions to shorten my life, rather only to permit the natural process of dying.”

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.

The living will 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 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.

The Missouri statute uses the terms “death prolonging procedure” and “terminal condition” to specify the circumstances to which a living will applies. The statute defines both of those terms as relating to a condition where death will occur within a short period of time,

regardless of whether certain treatment is provided. In other words, the patient will die shortly with or without artificial resuscitation, use of a ventilator, artificially supplied nutrition and hydration, or other invasive surgical procedures. Living wills and other advance directives by definition, only avoid treatment when death is imminent and the treatment is ineffective to avoid or significantly delay death. Furthermore, the statute prohibits a living will from withholding or withdrawing artificially supplied nutrition and hydration, which is sustenance supplied through a feeding tube or IV.

For patients who desire to give instructions for their health care that exceed the limitations of the living will statute, there is an alternative, commonly referred to as "advance directives." An advance directive is an instruction by a patient as to the withholding or withdrawing of certain medical treatment in advance of the patient suffering a condition rendering the patient unable to refuse such treatment. A competent patient always has the right to refuse treatment for himself or herself or direct that such treatment be discontinued. Without an advance directive, once a patient becomes incapacitated he or she may well lose that right. A living will is simply one type of advance directive. Recent court cases have made it clear that people have the right to make other types of advance directives that exceed the limitations of the living will statute. Those directives

need to be "clear and convincing," and may include instructions to withhold or withdraw artificially supplied nutrition and hydration or other treatment or machinery which may maintain a patient in a persistent vegetative state. These expanded advance directives can be tailored to meet the needs and desires of each individual patient, and need not be in any standard form. For example, they can specify that certain procedures are to be used for a reasonable period of time and then discontinued if they do not prove to be effective. Generally, additional advance directives should be signed, dated and witnessed in the same manner as living wills.

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 it upon request.

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 Christine A. Alsop, The Elder & Disability Advocacy Firm of Christine A. Alsop, LLC. Ms. Alsop concentrates her practice on elder law and estate planning in the St. Louis area.

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 as well as a HIPAA privacy authorization form that is valid in Missouri. Single copies of the forms are available at no charge by sending a written request to:

Health Care Proxy Form
HIPAA Privacy Authorization 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.

PERSONAL PLANNING/PROTECTION

PATIENT SELF-DETERMINATION ACT

By Christine A. Alsop, The Elder & Disability Advocacy Firm of Christine A. Alsop, LLC. Ms. Alsop concentrates her practice on elder law and estate planning in the St. Louis area.

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 PENSION

By M. Brigid Fernandez, JD, LCSW, CELA. Ms. Fernandez is an elder law attorney with Fernandez Elder Law, LLC and assists older adults, their families and persons with disabilities with living, financial, health and long term care planning. Ms. Fernandez is a Certified Elder Law Attorney and a VA accredited attorney. *Certified as an Elder Law Attorney by the National Elder Law Foundation. Neither the Supreme Court of Missouri nor The Missouri Bar reviews or approves certifying organizations or specialist designations. Thanks also to Mary R. McCormick, J.D., LL.M., CELA.* for her personal work on this section in prior editions.*

Editor's Note: This information on veterans benefits gives a brief description of the Aid and Attendance program. The information is current as of January 2016, but is subject to change at any time. For more detailed information, or for information about the Missouri Veterans Commission nursing homes, you may wish to visit their website (<http://mvc.dps.mo.gov>).

Introduction

Many veterans know of benefits available from the U.S. Department of Veterans Affairs (VA) medical system, but few veterans know of the special monthly pension programs designed to assist wartime veterans and their surviving spouses by providing a pension to assist with the cost of long term care. One particular program, the Aid and Attendance program, is addressed in this article. This article provides an overview of the eligibility criteria for this non-service connected pension program. Additional information may be found on the VA's website at <http://www.benefits.va.gov/PENSION>.

Veteran, Widowed Spouse, or Disabled Adult Child May Be A Claimant

- Veteran must have served at least 90 consecutive days on active duty and one day during a war time period.
- Veteran must have a discharge that was other than dishonorable.
- Claimant must be declared by his/her physician to be permanently and totally disabled or housebound or in need of assistance from another person, which may include skilled nursing facility care, assisted living, or home healthcare; or the claimant must be over 65, blind; or reside in a skilled nursing facility.

- Claimant must have limited income and insufficient net worth to provide for either the veteran or the surviving spouse's maintenance for the remainder of their lifetime.
- Claimant's countable income must fall below the maximum annual pension rate (MAPR).
- Claimant's net worth is considered and the VA evaluates whether the claimant's income, with their net worth, is being used for their care.
- Income is reduced by amount of allowable unreimbursed, recurring medical expenses.
- A surviving spouse must have been married to the veteran at the time of the veteran's death, or have had children by the veteran (minor or disabled children may qualify for benefits on their own).
- Surviving spouse must have been living with the veteran at the time of the veteran's death, unless the separation was due to medical reasons. Other exceptions related to separation exist.

If Under Age 65

Claimant must prove disability under the VA's disability rating system if under the age of 65. Veterans over the age of 65 are presumed to meet the disability criteria.

Applicable Periods of Wartime Service

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 veteran 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 Aid and Attendance Pension Rates*

Single veteran \$21,466 annually

Married veteran or
veteran and dependent \$25,448 annually

Widowed spouse \$13,794 annually

*The MAPR increases with additional dependents or when two veterans are claimants and is subject to an annual cost of living increase.

Proposed Changes Regarding Eligibility

The VA has proposed changes to the eligibility criteria for the non-service connected benefits – specifically to the net worth, asset transfer and income for this needs based benefit.

As of 1/31/2016, the proposed changes have been made, the comment period has expired but no changes to the Code of Federal Regulations have been finalized.

The rules propose to establish a new combined net worth and income limit of \$119,220. This figure is based on Medicaid laws. In addition, the rules propose to impose a 36-month look back period on asset transfers. A penalty will be assessed the first day of the month after the last asset transfer and the penalty divisor is the maximum annual pension rate in effect as of the date of the claim. The maximum penalty period proposed is 10 years.

Veterans or their surviving spouses who are interested in the Aid and Attendance special monthly pension should be cautious when advised to make gifts or transfers or to purchase annuities as they could result in a period of ineligibility. A veteran or surviving spouse should consult with a VA-accredited attorney or Veterans Service officer prior to applying for VA Aid and Attendance benefits. To find an accredited attorney in your area, search the VA's accreditation webpage at <http://www.va.gov/ogc/apps/accreditation/index.asp>.

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 (as of 2/2016). 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 the Community Action Agency (CAA) nearest you. Persons in St. Louis County may also 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., P.O. Box 1078
Warrensburg, MO 64093
(660) 747-3107
(800) 748-7826
E-mail: information@goaging.org

Northwest Area Agency on Aging

504 E. Highway 136, P.O. Box 265
Albany, MO 64402
(660) 726-3800
(888) 844-5626
E-mail: nwmoaaa@nwmoaaa.org

Central Missouri Area Agency on Aging

1121 Business Loop 70 East
Columbia, MO 65201
(573) 443-5823
(800) 369-5211
E-mail: mbrown@marc.org

St. Louis Area Agency on Aging

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

Mid-America Regional Council

600 Broadway, Suite 200
Kansas City, MO 64105
(816) 474-4240
(800) 593-7948

Southeast Area Agency on Aging

1078 Wolverine Ln., Ste. J
Cape Girardeau, MO 63701
(573) 335-3331
(800) 392-8771

Mid-East Area Agency on Aging

14535 Manchester
Manchester, MO 63011
(636) 207-1323
(800) 243-6060

Southwest Area Agency on Aging

1735 South Fort
Springfield, MO 65807
(417) 862-0762
(800) 497-0822
Website: swmoa.com

Northeast Area Agency on Aging

815 N. Osteopathy
Kirksville, MO 63501
(660) 665-4682
(800) 664-6338
(800) 664-6338
E-mail: nemoaaa@sbcglobal.net

Region X Area Agency on Aging

531 East 15th Street
Joplin, MO 64804
(417) 781-7562
E-mail: aaax@aaaregionx.org

MISSOURI COMMUNITY ACTION AGENCIES

Central Missouri Community Action

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

Community Services, Inc. of Northwest Missouri

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

Delta Area Economic Opportunity Corporation

99 Skyview Road
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

East Missouri Action Agency

403 Parkway Dr., P.O. Box 308
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. Odell
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

Community Action Partnership of St. Joseph

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

Community Action Agency of St. Louis County, Inc.

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

South Central Missouri Community Action Agency

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

Greater Community Services of Kansas City

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

West Central Missouri Community Action Agency

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

SOCIAL SERVICES, INCOME AND FAMILY MAINTENANCE

The Missouri Department of Health & Senior Services and the 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 Department of Health & Senior Services (DHSS) – The basic services available through the DHSS offices include protective services, 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 between the ages of 18 and 59 with a physical or mental disability or 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.

The division 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 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 (855) 373-4636.

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 and St. Louis, call: (877) 772-5772

In St. Louis: Young Federal Bldg., 1222 Spruce, Room 7303, St. Louis, MO 63103

In Kansas City: 601 East 12th Street, Room 113, Kansas City, MO 64106

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 (no St. Louis office).
Farmington, MO (573) 756-6488

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. The toll-free number is: 1-800-333-4636.

CONSUMER

Better Business Bureau of Kansas City

8080 Ward Parkway, Suite 401
Kansas City, MO 64114
(816) 421-7800, a 24-hour automated phone line

Consumer Protection Division of the Attorney General's Office

Jefferson City, MO 65102
1-800-392-8222, Hotline Phone Number

or

815 Olive St., Suite 200
St. Louis, MO 63101
(314) 340-6815

In Kansas City:

615 East 13th Street, Suite 401
Kansas City, MO 64106
(816) 889-5000

In Springfield:

149 Park Central Square, Suite 1017
Springfield, MO 65806
(417) 895-6567

Jefferson City:

207 West High Street
PO BOX 899
Jefferson City, MO 65102

Missouri State Department of Insurance

301 West High Street, Room 530
Jefferson City, MO 65101
1-800-726-7390

Better Business Bureau of St. Louis

211 North Broadway, Suite 2060
St. Louis, MO 63102
(314) 645-3300

EMPLOYMENT

For information on the American Association of 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 (disconnected)

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.

(Serves 21 counties in eastern Missouri)
4232 Forest Park Avenue
St. Louis, MO 63108
(314) 534-4200
(800) 444-0514 toll free

Mid-Missouri Legal Services Corporation

205 E. Forest Street
Columbia, MO 65203
(573) 442-0116
(800) 568-4931 toll free (9-11 a.m.)

Legal Services of Southern Missouri

2872 South Meadowbrook
Springfield, MO 65807
(417) 881-1397 or
(800) 444-4863 toll free

Rolla Office:

1412 Highway 72 East
P.O. Box 135
Rolla, MO 65402
(573) 341-3655
(800) 999-0249 toll free

Charleston Office:

P.O. Box 349
116 North Main
Charleston, MO 63834
(573) 683-3783
(800) 748-7456 toll free

If a legal aid office cannot handle your case, contact your local office of the Area Agency on Aging (listing at the front of this section) for further information.

Missouri Bar LawyerSearch

Use The Missouri Bar's [LawyerSearch](#) tool to find a lawyer currently accepting new clients. You can search by areas of practice and location (city or county). This free feature will help you find a list of lawyers who have indicated that they are accepting new clients in various areas of the law. Visit <http://missourilawyershelp.org/find-lawyer/>

TRANSPORTATION

OATS, INC. – Senior citizens should contact the regional office of OATS, Inc. for details about how OATS buses operate in your county.

East:

Catz Transportation
186 North West Industrial Court
Bridgeton, MO 63044
(800) 201- 6287
(314) 894-1701

Northeast:

3006 Jims Rd.
Macon, MO 63552
(660) 395-3041; (660) 395-3045 Fax
(800) 654-6287

Northwest:

St. Joseph, MO 64507
(816) 279-3131
(800) 831-9219

West:

107 W. Pacific
Sedalia, MO 65301
(660) 827-2611
(800) 276-6287

Southwest:

3259 E. Sunshine, Suite T
 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:

2501 Maguire Blvd. Suite 103
 Columbia, MO 65201
 (573) 449-3789
 (800) 269-6287

For 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 & 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:

Elder Care Locator

(800) 677-1116

Center for Practical Bioethics

111 Main St., Suite 500
 Kansas City, MO 64105
 (816) 221-1100
 (800) 344-3829

The Family Conservancy

444 Minnesota Ave., Suite 200
 Kansas City, KS 66101
 (913) 342-1110

Local Investment Commission

Aging Committee
 3100 Broadway, Suite 1100
 Kansas City, MO 64111
 (816) 889-5050

Metropolitan Lutheran Ministries

3031 Holmes
 Kansas City, MO 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 Family Services
5801 West 115th Street, Suite 103
Overland Park, KS 66211
(913) 327-8250

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

A clearinghouse of resources and information. For healthcare information related to seniors, please call the Area Agency on Aging in your area.

