Thank you to these legal professionals for volunteering their time and knowledge to author and edit this fantastic resource for the older citizens of our state:

Claire E. Lewis, Editor
Indianapolis
Vicki L. Anderson
Indianapolis
Samuel L. Bolinger
Fort Wayne
Brian K. Carroll
Evansville
Ron Flickinger
Indianapolis
Crystal Francis
Indianapolis
Dennis K. Frick
Indianapolis
Christopher J. Holly
Bloomington
Jennifer L. VanderVeen
Greenwood

Special thanks to Maryann Williams, Susan Ferrer and the Indiana State Bar Association for assistance in coordinating and funding this publication:
Elder Law Section • Family & Juvenile Law Section • General Practice, Solo and Small Firm Section
Probate, Trust and Real Property Section

Very special thanks to the Ruth Lilly Philanthropic Foundation for a grant without which this project would not have been possible.

The Indiana Bar Foundation and the lawyers of Indiana are pleased to provide this publication to Indiana citizens. If you wish to make a tax-deductible contribution in support of this publication at the Indiana Bar Foundation, send your donation to:

Indiana Bar Foundation
250 East Ohio Street, Suite 400
Indianapolis, IN 46204
(800) 279-6772
www.inbf.org

© 2009 by Indiana Bar Foundation, Inc.
All rights reserved.
**Chapter 1 – Legal Services**

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Planning for Long Term Healthcare Needs</td>
<td>29</td>
</tr>
<tr>
<td>Medicare</td>
<td>29</td>
</tr>
<tr>
<td>Medicaid</td>
<td>36</td>
</tr>
<tr>
<td>Supplemental and Long Term Healthcare Insurance</td>
<td>42</td>
</tr>
<tr>
<td>Treatment Decisions</td>
<td>44</td>
</tr>
<tr>
<td>Mental Health Services</td>
<td>46</td>
</tr>
<tr>
<td>Civil Commitment</td>
<td>46</td>
</tr>
</tbody>
</table>

**Chapter 2 – Income**

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Social Security</td>
<td>5</td>
</tr>
<tr>
<td>Supplemental Security Income (SSI)</td>
<td>12</td>
</tr>
<tr>
<td>Food Stamps</td>
<td>15</td>
</tr>
<tr>
<td>Township Trustee Benefits</td>
<td>18</td>
</tr>
<tr>
<td>Private Pensions</td>
<td>19</td>
</tr>
<tr>
<td>Public Pensions</td>
<td>25</td>
</tr>
<tr>
<td>Veterans’ Benefits</td>
<td>26</td>
</tr>
</tbody>
</table>

**Chapter 3 – Healthcare**

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Planning for Long Term Healthcare Needs</td>
<td>29</td>
</tr>
<tr>
<td>Medicare</td>
<td>29</td>
</tr>
<tr>
<td>Medicaid</td>
<td>36</td>
</tr>
<tr>
<td>Supplemental and Long Term Healthcare Insurance</td>
<td>42</td>
</tr>
<tr>
<td>Treatment Decisions</td>
<td>44</td>
</tr>
<tr>
<td>Mental Health Services</td>
<td>46</td>
</tr>
<tr>
<td>Civil Commitment</td>
<td>46</td>
</tr>
</tbody>
</table>

**Chapter 4 – Long Term Care Alternatives**

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Home Healthcare</td>
<td>49</td>
</tr>
<tr>
<td>In-Home Support Services</td>
<td>50</td>
</tr>
<tr>
<td>Healthcare Facilities</td>
<td>51</td>
</tr>
</tbody>
</table>

**Chapter 5 – Housing**

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Subsidized Housing</td>
<td>61</td>
</tr>
<tr>
<td>Landlord-Tenant Issues</td>
<td>62</td>
</tr>
<tr>
<td>Home Ownership Issues</td>
<td>63</td>
</tr>
<tr>
<td>Utilities/Weatherization</td>
<td>65</td>
</tr>
<tr>
<td>Home Sharing</td>
<td>67</td>
</tr>
<tr>
<td>Home Equity Conversion</td>
<td>68</td>
</tr>
</tbody>
</table>

**Chapter 6 – Managing Your Affairs and Planning for Your Future**

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Planning for Your future</td>
<td>71</td>
</tr>
</tbody>
</table>

**Chapter 7 – Guardianship**

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Planning for Your future</td>
<td>77</td>
</tr>
</tbody>
</table>

**Chapter 8 – Planning for Death**

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Estate Planning</td>
<td>81</td>
</tr>
<tr>
<td>Wills</td>
<td>81</td>
</tr>
<tr>
<td>Probate and Estate Administration</td>
<td>83</td>
</tr>
<tr>
<td>Joint Ownership of Property</td>
<td>84</td>
</tr>
<tr>
<td>Life Insurance</td>
<td>86</td>
</tr>
<tr>
<td>Anatomical Gifts</td>
<td>86</td>
</tr>
<tr>
<td>Funeral and Burial Planning</td>
<td>87</td>
</tr>
<tr>
<td>When Someone Dies</td>
<td>88</td>
</tr>
</tbody>
</table>

**Chapter 9 – Elder Abuse, Neglect, and Exploitation**

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
</table>

**Chapter 10 – Age Discrimination**

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age Discrimination in Employment</td>
<td>93</td>
</tr>
<tr>
<td>Age Discrimination in Housing</td>
<td>95</td>
</tr>
</tbody>
</table>

**Chapter 11 – Consumer Protection**

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
</table>

**Chapter 12 – Grandparents’ Rights**

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Grandparent Visitation</td>
<td>103</td>
</tr>
<tr>
<td>Grandparents Raising Grandchildren</td>
<td>103</td>
</tr>
</tbody>
</table>

**Chapter 13 – Programs and Services for Older Hoosiers**

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Identification Card</td>
<td>105</td>
</tr>
<tr>
<td>Work Programs</td>
<td>105</td>
</tr>
<tr>
<td>Discounts</td>
<td>106</td>
</tr>
<tr>
<td>Parking for the Handicapped</td>
<td>106</td>
</tr>
</tbody>
</table>

**Chapter 14 – Resource Guide**

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Indiana Legal Services Officers</td>
<td>107</td>
</tr>
<tr>
<td>Adult Protective Services</td>
<td>108</td>
</tr>
<tr>
<td>Ombudsman &amp; Area Agencies on Aging</td>
<td>110</td>
</tr>
<tr>
<td>Indiana Pro Bono Districts</td>
<td>112</td>
</tr>
<tr>
<td>Lawyer Referral Services</td>
<td>114</td>
</tr>
<tr>
<td>Veterans’ Resources</td>
<td>115</td>
</tr>
</tbody>
</table>

---

**Legal Services**

Older adults are likely to need a lawyer at one time or another. This discussion explains briefly:

- when to seek a lawyer’s help
- how to find a lawyer
- how to get help if you cannot afford to hire a lawyer
- help available for older adults
- court appointed legal assistance
- what to expect in dealing with a lawyer

When to Seek a Lawyer’s Help

Throughout this book there are suggestions that you consult a lawyer for particular problems. A lawyer can explain complicated laws, including Social Security, Medicare, Medicaid and pensions. A lawyer can help you cut through the maze of government bureaucracy to get answers about government benefits.

Lawyers have the expertise to draft contracts, powers of attorney, trusts, and other legal documents. A lawyer can help you arrange your finances and property to meet your needs and minimize taxes. He or she can help you plan for the possibility of future disability or long-term care. A lawyer can write your will and make other arrangements so that after your death your survivors are protected and your property is distributed according to your wishes.

A lawyer can help with problems of divorce, child custody, landlord-tenant relations, credit sales, property transactions and represent you in negotiations with persons with whom you have a dispute.

You should consult a lawyer if you plan to sue or if someone is suing you in any court except small claims court. Most small claims courts can resolve disputes where the amount in controversy is $6,000 or less; however, the amount varies depending on the county in which the claim is brought.

If more is involved, you will need a lawyer to represent you in the proper court. These are only a few of the services that a good lawyer can provide.

How to Find a Lawyer

If you do not have a family lawyer and do not know whom to consult, ask your friends for recommendations. Some non-profit public interest organizations can suggest attorneys in special subject areas. (See Chapter 14.)

You may also contact the Indiana State Bar Association to get the name of a bar official in your area who can help you find a lawyer. Write or call:

**Indiana State Bar Association**
One Indiana Square, Suite 530
Indianapolis, IN 46204
317-639-5465 or 1-800-266-2581
[www.inbar.org](http://www.inbar.org)

Also, your local Area Agency on Aging might be able to refer you to a lawyer and your local Social Security office can help you find a lawyer for Social Security matters.

If you qualify as low-income or are on a fixed income and cannot afford to pay a private lawyer, you may qualify for help from Indiana Legal Services or at a local legal aid office.

If You Cannot Afford a Lawyer

Do not hesitate to ask a lawyer ahead of time how much she or he charges. Such questions are not considered rude, and you have the right to know. You may want to shop around to get a good lawyer at a price you can afford.

Some lawyers and law firms work for a reduced fee or for free if the client cannot afford to pay regular rates. Ask before you hire the lawyer. If other people share your legal problem, perhaps all of you could consult a lawyer together and share the legal fees.

Indiana has several legal services and legal aid offices that provide free legal advice and representation to persons whose income and assets qualify them for these services. If you are eligible, you pay no lawyer’s fee; however, you may have to pay court filing fees and other costs of the case.
HELP AVAILABLE FOR OLDER ADULTS

There is help from legal service providers, which are funded by the Older Americans Act and coordinated by Area Agencies on Aging, providing free legal assistance to older adults age 60 and older. There are no income or asset eligibility requirements. However, the type of services available varies from area to area.

COURT APPOINTED LEGAL ASSISTANCE

None of these legal services offices or providers handles criminal cases. If you are a defendant in a criminal case, including traffic offenses, and you cannot afford to pay a lawyer, you have the right to have a lawyer appointed for you free. The first time you are in court, tell the judge that you cannot afford a lawyer. Ask about getting the free services of a public defender.

WHAT TO EXPECT

Once you have a lawyer, he or she will probably want to get as much information from you as possible. Typically you will meet in person and bring any relevant papers to be reviewed.

It is very important that you be completely honest with your lawyer. Do not withhold information or misrepresent facts. Only if the lawyer knows all the facts can he or she advise or represent you well. With very rare exceptions, what you tell a lawyer is confidential information. It is a lawyer’s ethical obligation to keep your secrets.

Some legal problems can be handled quickly; others take a long time. The lawyer should keep you informed about the progress of your case. Although it is the lawyer’s job to know the law and to give you advice, you should make the important decisions about how to proceed. Once you have decided, the lawyer’s job is to try to put your wishes into effect.

If you have a complaint about a lawyer, you should fill out a grievance form, which you can get from: Indiana Supreme Court Disciplinary Commission 115 W. Washington Street, Suite 1165 Indianapolis, IN 46204 (317) 232-1807 http://www.in.gov/judiciary/discipline/

SOCIAL SECURITY

President Franklin D. Roosevelt signed the Social Security Act into law on August 14, 1935, in the midst of the Great Depression. It created a national safety net with programs like public assistance, unemployment, and retirement benefits. Congress has changed and added to the act many times since then, adding Medicare, Medicaid, Unemployment Insurance and others. This section concerns the Social Security program itself.

Social Security is a social insurance program for workers and their families, not a savings plan. Workers and their employers fund Social Security through a payroll tax which goes into the Social Security trust fund. The trust fund pays benefits to current Social Security beneficiaries. The program is run by the Social Security Administration (SSA), an independent agency of the federal government.

As the Baby Boomer generation retires, many fear Social Security will run out of money. While action should be taken to build up Social Security’s trust fund, funding will last until 2041 even if nothing is done in the meantime. Even then, future workers will be paying enough into the fund to pay roughly 78% of promised benefits. Social Security tax revenue will fall below pay out starting in 2017, although interest on the trust fund will keep the fund growing until 2027. Correction could be as simple as increasing the Social Security payroll tax from 12.4% to 14.1% to balance the fund for the next 75 years or to 15.6% to balance it indefinitely.

In 2008, nearly 51 million people received Social Security benefits. About 80% are age 62 or older. Twenty percent of older couples and 41% of older individuals rely on Social Security for at least 90% of their income. Social Security provides benefits to three categories of persons:

1. Retired workers and their dependents.
2. Survivors of deceased workers.
3. Disabled workers and their dependents.

Income

The Social Security Administration also runs a program called Supplemental Security Income (SSI) that provides income for the needy who are aged or disabled. You can get both Social Security and SSI if you are eligible for both.

Health insurance coverage under Medicare comes with Social Security eligibility. You are automatically eligible for Medicare if you are 65 or over and eligible for Social Security or if you are under 65 and have received Social Security benefits based on a disability for at least two years or are on kidney dialysis or have Lou Gehrig’s disease (amyotrophic lateral sclerosis). (See the Medicare section later in this chapter.)

Social Security is a complex and changing program. This chapter is only an overview. For more information, check with your local Social Security office. You can contact SSA through its toll-free number, (800) 772-1213, its deaf or hearing impaired line (TTY), (800) 325-0778 or online at www.ssa.gov. The Online Social Security Handbook is a very good reference tool as well, www.ssa.gov/OP_Home/handbook/handbook.html.

ELIGIBILITY

To qualify for Social Security benefits for yourself or your family, you must be insured. You become insured by working in jobs covered by Social Security. These days very few workers are not covered; however, certain farm and household workers, federal employees hired before 1984, and employees of state and local governments who do not participate in Social Security are not covered.

As you work in a covered job, you earn credits. You need a certain number of credits to be insured. In 2009, you earn a credit for every $1,090 you receive in employment income. This figure changes every year. You can earn a maximum of four credits per year. Credits used to be called “quarters of coverage” because you had to earn the minimum amount in each calendar quarter to get a credit. Since 1978, total earnings for the entire year are used to calculate the
number of credits earned for that year. Most workers born after January 1, 1929, need 40 credits to be insured for retirement benefits. To be insured for disability benefits, a worker must have 20 credits in the 10 years before disability began. Workers disabled before age 51 need fewer credits. Some dependents of a worker can receive benefits based on the worker’s earnings record. The circumstances under which spouses, divorced spouses, children, and sometimes parents can receive benefits are described generally later in this chapter. There is an important gap in Social Security benefits for dependents. A person under age 60 when his or her spouse dies and whose children are older than 16 will receive nothing. If the surviving spouse is disabled, he or she can get widow(er)’s benefits as early as age 50. In addition, benefits can be reduced as much as 28.5% for widowed spouses or surviving divorced spouses who begin drawing benefits before age 65. Therefore, life insurance may be desirable to protect a younger spouse in the event of the death of the worker.

Sometimes one person is entitled to two different benefits. For example, a wife may be eligible for retirement benefits on her own work record and also on her husband’s record. Or a worker may be both retired and disabled. Whenever that happens, the person cannot receive both, but would get the higher of the two.

Retirement Benefits
To qualify for retirement benefits, you must be at least age 62 and have the required number of credits, usually 40. However, your benefits will be permanently reduced if you start drawing before your full retirement age (FRA). If you turned 65 before 2003, the full retirement age is 65. For workers who reach age 65 after the year 2002, the full retirement age will gradually increase to age 67. If you turn 65 in 2009, your FRA is age 66. If you retire at that age, you will receive full monthly benefits. The earliest age a worker can begin to receive retirement benefits is 62. If you were to start receiving benefits at 62 before reaching FRA, your monthly check would only be 70% to 80% of the amount you would have drawn at your FRA. If you work past your full retirement age and don’t draw retirement benefits, you get a bonus for delaying retirement. For retirees born after 1942, the credit is 8% for each year of delayed retirement up to age 70. Because retirement benefits are intended to partly replace earnings, you cannot always have both retirement benefits and substantial earnings. Social Security’s “retirement test,” also called the Earned Income Deduction, limits the income a retired worker can earn and still receive full Social Security benefits. For 2009, these limits are:

- Retired worker under full retirement age – $14,160 per year
- In year retired worker reaches full retirement age – $37,680
- Retired worker at, or beyond, full retirement age – No Limit

Also, there is a special monthly limit used in a “grace year”, usually the year of retirement. In the grace year, you can still receive full benefits for any month in which you earn less than one-twelfth (1/12) of the annual limit, even though your total earnings for the year may be over the annual limit. These limits increase every year. Social Security has online calculators at www.socialsecurity.gov/planners/benefitcalculators.htm. If you earn more than the limit, your Social Security benefits are reduced. From age 62 through full retirement age, they are reduced $1 for every $2 earned over the limit. In the year you reach your FRA, there is a reduction of $1 in Social Security benefits for every $3 earned over the limit. Starting with the month you reach your FRA, there is no reduction for earnings. However, part of your Social Security will still be taxed if you earn enough, e.g., if your total income plus half of your Social Security benefits exceeds $25,000 for singles or $32,000 for couples filing jointly.

Dependents and survivors benefits are also reduced if they earn over certain amounts. They may also be reduced if the retiree whose account they are paid from earns too much.

If you have earnings and receive Social Security benefits in a given year, you must usually report your earnings to Social Security by April 15 of the next year. There is a fine if you miss this deadline. You can get an extension to avoid the fine if you have a good reason; however, you must ask for the extension before the due date. You must report your actual earnings for the prior year and estimate your earnings for the current year. It is important to make an accurate estimate to avoid being paid too much or too little by Social Security. If you are paid too much, you will be asked to pay it back. If your earnings change after you make the report, you should notify Social Security. Always make these reports in writing and keep copies for your records. Usually an IRS Form W-2 from the employer will suffice.

Benefits for Dependents of a Retired Worker
The following dependents of a retired worker are also eligible for benefits if the worker is insured.

- Spouse. You must be at least age 62 or caring for the worker’s child who is under 16 or disabled before 22. Also, you must either have been married to the worker at least one year, had a child with the worker, or been entitled, or potentially entitled, to certain Social Security benefits in the month before marrying the worker.
- Divorced Spouse. You must be at least age 62, have been married to the worker at least 10 years, and not currently remarried. If your ex-spouse is not yet receiving retirement benefits, but is 62 and fully insured, you can still draw benefits if you have been divorced at least 2 years.
- Unmarried Child. You must be under age 18, or 18 to 19 and a full-time high school student, or 18 or older and disabled before 22. You must also meet certain dependency requirements.

Death and Survivors Benefits
When an insured worker dies, a surviving spouse or child may receive a one-time death benefit of $255. This death benefit is paid only:

- To the surviving spouse who was living with the worker at the time of his/her death.
- To the surviving spouse not living with the worker, but eligible for monthly survivor benefits on the deceased worker’s record.
- If there is no eligible surviving spouse, to surviving children eligible for monthly survivor benefits on the worker’s record.

The death benefit cannot be paid to a funeral home or a divorced spouse. Additionally, when an insured worker dies, certain survivors can receive monthly benefits.

- Spouse. You must be at least age 60, or at least age 50 if disabled; or if younger, caring for the worker’s child who is under 16 or disabled before 22. You must be unmarried or remarried after turning 60, or at least 50 if disabled. Also you must have either been married to the worker usually at least nine months just before he or she died, had a child with the worker, adopted the worker’s child, adopted a child with the worker, had your child adopted by the worker, or been entitled, or potentially entitled, to certain Social Security benefits in the month before marrying the worker. Sometimes the nine month marriage requirement can be waived.
- Divorced Spouse. You must be at least age 60 or at least age 50 if disabled. You must have been married to the worker at least 10 years. You must be unmarried, or remarried after turning 60, or at least 50 if disabled. If you do not qualify based on these criteria, you may still be able to draw benefits if you are caring for the worker’s child under 16 or disabled before 22. The child must also be your natural or adopted child and entitled to benefits on the deceased ex-spouse’s earnings record. Also you must have either been married to the worker usually at least nine months just before he/she died, had a child with the worker, adopted the worker’s child, adopted a child with the worker, had your child adopted by the worker, or been entitled, or potentially entitled, to certain Social Security benefits in the month before marrying the worker. Sometimes the nine month marriage requirement can be waived.
- Unmarried Child. You must be under age 18, or 18 to 19 and a full-time high school student, or 18 or older and disabled before 22. You must also meet certain dependency requirements.

Parents. You must be at least age 62 and have received at least half of your support from your deceased child. You must prove dependency within two years of your child’s death, even if you are not yet eligible for a parent’s benefit at the time.

Disability Benefits
A blind or disabled worker may be eligible for monthly Social Security benefits. There is no age
requirement, but the worker must have the required work credits to be insured, i.e. having worked 5 of the prior 10 years.

If you become disabled, you should apply as soon as possible. There is a five month waiting period for which you do not receive benefits. If you delay applying for disability benefits, Social Security can go back no more than 12 months before the date you apply.

When you apply, take the names and addresses of doctors and hospitals that have treated you recently to the Social Security office. The Social Security Administration (SSA) will send for medical reports and may require you to undergo additional examinations by its doctors. Your own doctor's report should be as thorough as possible. It should include your doctor's opinion as to the nature and effects of your condition; how long it will last; the chances of improvement; the extent of your pain; medications you take and their effects; and the effect of your condition and your medications on your ability to sit, stand, walk, lift, carry, and work. If your illness has mental or psychological effects, your doctor should explain how they prevent work.

The state disability determination office will decide whether you are disabled. The worker must show one of these two conditions:

1. Blindness: vision no better than 20/200 even with corrective lenses or a field of vision of 20 degrees or less.
2. Disability: a medically provable physical or mental condition that has lasted 12 months, is expected to last 12 months, or result in death, and that keeps you from working for 12 months.

Usually, it is not enough that you cannot do your old job. If there are a significant number of other jobs you could do, you are not considered disabled.

Your age, experience, education, and training are considered. Jobs you could do, you are not considered disabled. If you work despite your disability, earnings over $980 per month after a nine month trial work period will usually make you ineligible. This figure increases every year.

Dependents are also eligible when the worker is disabled. Benefits are the same as for dependents of a retired worker.

**APPLYING FOR BENEFITS**

Contact your Social Security office shortly before you plan to retire. For better preparation, plan ahead and meet with Social Security about a year before you intend to retire to learn about your retirement options. Contact Social Security about three months before your 65th birthday, whether you plan to retire at 65 or not, so you can sign up for Medicare without losing any coverage. Apply for disability benefits as soon as you become disabled and cannot work.

You may apply online, in person, or over the phone. Social Security has a toll-free number, (800) 772-1213, which you can call for information as well as for an application. Applying by phone can save you time and energy. SSA will complete the forms and then send them to you to sign. You can send necessary proofs with your application. SSA will copy them and return them to you. If you cannot apply yourself, someone else can sometimes apply for you. You can also apply through Social Security's website, www.ssa.gov/onlineservices.

If you think you are eligible for benefits, insist on filling out a written application. Then, if SSA wrongly denies you benefits, you can appeal.

When you apply, SSA will assign you a claim number. Use it in all communications with SSA. When you apply, take your Social Security card or the card or number of the person on whose work record you are claiming benefits.

Take with you documents that prove your eligibility. For example, to prove your age, you should take a birth certificate. If that is not available, take a baptismal certificate. If these documents are not available, take some other proof of your age, such as school records, family bible, insurance policy, marriage license, etc. The best proof is a document made before you were 5 years old. You may need other documents to prove marriage, divorce, parenthood, dependency, disability, or earnings. Do not wait to collect all these documents before you apply. There will be time to continue collecting documents while SSA is working on your claim. To avoid delays, however, you should contact SSA before you file your claim. SSA can tell you ahead of time what papers you will need to submit and how to get evidence you do not have. SSA may also help you get the necessary papers.

If SSA decides that you are eligible for retirement benefits, you should receive your first check or notice of award in about three to six weeks. There are occasional delays and snags in any government program as big as Social Security. If you have not received a response from SSA after six weeks, call them.

**BENEFIT PAYMENT**

Your benefits should arrive about the same time every month. If you filed your claim before May 1997, then you normally receive your benefits on the third day of each month, unless it is a holiday. If you retired in May 1997 or later, then your benefits usually arrive on the second, third, or fourth Wednesday of the month, depending on the birth date of the worker on whose record you are drawing. Social Security pays you benefits in the month after they are due. For example, benefits due for January are paid in February. If your check does not arrive on its usual day, wait three business days and then call Social Security for help.

The amount you receive depends on the worker's earnings, years worked, and age of retirement, among other factors. Dependents drawing on a worker's record are paid a percentage of the benefit paid to the insured worker. There is a maximum family benefit which may limit payments to dependents to a smaller amount in some cases.

Social Security encourages you to have your benefits direct deposited to your bank account. This can be convenient and secure. Ask your bank for the necessary form, fill it out, and have the bank send it to the Social Security office. If you do not have a bank account or prefer not to use direct deposit, then you can still receive a monthly check.

If you get a check that is not yours, send it back and notify Social Security. If you receive too much, notify Social Security. If you keep an incorrect payment, you may later be forced to repay the money. (See the Overpayments section later in this chapter.)

**REPRESENTATIVE PAYEESHIP**

What is a representative payee? Social Security andSSI benefits are usually paid directly to the beneficiary, the person entitled to receive the benefits. However, sometimes SSA may appoint another person or organization to receive and manage a beneficiary's Social Security or SSI payments. This person or organization is called a representative payee.

When will SSA appoint a payee? SSA can appoint a payee if it decides it is in a person's best interests. If a person is too young or is physically or mentally unable to take care of his or her own benefits, SSA will appoint a payee. SSA will consider court decisions, doctor reports, and statements from others who know the beneficiary.

Who may serve as a payee? SSA must pick a person or organization who can best serve the beneficiary's interests. Usually, that will be a guardian or other legal representative, a spouse, a relative, or a friend. It can also be an agency or institution that cares for the person, such as a nursing home or mental health center. In some cases, a volunteer might be appointed. SSA must investigate a person or organization before it appoints them as a representative payee. Certain people may not be allowed to serve as payee. A person to whom a beneficiary owes money or who has misused funds in the past usually can't be a payee.

With SSA's approval, certain non-profit agencies can charge a beneficiary for acting as his payee. The fee is usually limited to $30 or 10% of the person's monthly benefit, whichever is less. No one else can charge a fee for serving as representative payee.

What are a payee's responsibilities? A payee is responsible for taking care of Social Security or SSI payments for a beneficiary. The payee has no authority over any other funds or income the beneficiary has. A payee must use a beneficiary's Social Security or SSI
payment for the beneficiary’s best interest. Above all, the payment must be used to meet the beneficiary's current needs for food, clothing, shelter, medical care, and personal comfort. Once those needs are met, the payment may be used to support the beneficiary's legal dependents. A payee may not pay off the beneficiary’s debts unless the current and foreseeable needs have been met first. Social Security and SSI benefits cannot usually be attached to satisfy a debt.

Any leftover funds must be invested wisely. SSA prefers savings bonds or interest-bearing, government- insured banks, savings & loans, credit unions, etc. Any account must clearly show that the funds are invested for the beneficiary by the representative payee. A payee is responsible for reporting changes which might affect the beneficiary’s eligibility for SSI or Social Security benefits. This can include changes in the beneficiary’s income, assets, address, roommates, and marital status; medical improvement; return to work; and admission to hospital or nursing home. A payee must also tell SSA if he or she becomes unable to act as payee. The payee must show how funds have been spent if SSA requires it. It is important to keep good records and a separate checking account for this purpose. It should be titled in the payee’s name for the beneficiary, i.e., Peter Payee, representative payee for Bill Beneficiary.

Can a payee be liable? If a payee fails to use Social Security or SSI payments in the beneficiary’s interest, the payee can be criminally prosecuted. If a beneficiary is overpaid benefits and the payee agreed, you can appeal. If you object to the person you need a representative payee, it must tell you in writing. If you object to the person who will provide the benefits for the beneficiary, i.e., Peter Payee, representative payee for Bill Beneficiary, SSA has wrongly denied, reduced, or stopped your benefits. You have the right to appeal when you think that SSA has wrongly denied, reduced, or stopped your benefits. In the written notice of its decision, SSA should tell you exactly how to appeal. Be sure to meet all deadlines. If you miss a deadline, you may get an extension if you had a good reason for missing the deadline. Sometimes, Social Security will reopen a decision that you failed to appeal. It is often better to ask for an extension or reopening than to reapply and start over because you may lose benefits by reapplying. To begin the appeals process:

1. Request a reconsideration of the decision. Do this on SSA’s form within 60 days of receiving notice of the action with which you disagree. State your reasons for disagreement and attach any additional evidence you have. SSA will reexamine your case and send you notice of its decision. 2. If you still disagree, request a hearing. Make the written request within 60 days of SSA’s decision on reconsideration.

a. At the hearing, an administrative law judge from SSA will hear your case. You may be represented at the hearing by a friend, relative, lawyer, or other person. At the hearing, you can present evidence, testify and have other witnesses testify for you, and cross-examine the government’s witnesses.

b. A lawyer or trained paralegal can be especially helpful at the hearing stage of your appeal. Studies have shown that chances of winning are greater when you are represented. If you do not have a lawyer for your hearing, here is some advice:

i. Submit as much evidence as possible to SSA before the hearing.
ii. You have the right to look at your government file before the hearing. You should check it to be sure that SSA’s information is correct, complete, and current.
iii. Make sure your witnesses show up at the hearing. To be sure, you can ask the administrative law judge ahead of time to subpoena any witness, that is, to order the witness to appear and testify at the hearing.
iv. If the hearing involves the question whether you are disabled, get a complete medical report from your doctor. This report should discuss all problems resulting from your condition, including psychological problems. Your doctor may also attend and testify at the hearing.

3. If you disagree with the judge’s decision after the hearing, you can appeal within 60 days to the Appeals Council.
4. If you still disagree, you can appeal to a federal court. At this stage, if not before, you should seek the assistance of a lawyer. This procedure can take a long time. During the appeal, you might go without benefits. But if you eventually win, you may receive back benefits to cover the time during which you were appealing.

You have the right to be represented by a friend, relative, lawyer, or anyone else you choose. A lawyer can be a great help in a Social Security appeal. If you cannot afford representation, you may qualify for free help from a legal services or legal aid office. SSA will set the lawyer’s fee and will usually approve a fee of up to 25% of your back award or $5,300, whichever is less. It will usually pay the lawyer directly out of your back award. Most lawyers handle these cases on a contingency fee basis. This means you pay the lawyer only if you win your appeal.

OVERPAYMENTS
Social Security is a complex program. Changes in earnings, age, and other factors can affect the amount of benefits you are due. When SSA pays you too much, it expects you to refund the overpayment. If SSA thinks that you have been overpaid, it must send you a written notice. You may need to ask for a more detailed explanation. Unless you act promptly, SSA will keep your benefits until the overpayment is repaid. You can request reconsideration and/or waiver as explained later in this chapter. You should do this within 30 days of receiving the notice to avoid an interruption in benefits.

If you think you have not been overpaid, you should request reconsideration. (See the Appeals section earlier in this chapter.) You can appeal a decision that you were overpaid just like any other decision made by SSA.

If you accept that you were overpaid but don’t think it was your fault, you should request a waiver of the overpayment. You will need to show it was not your fault. You will also need to show that you cannot afford to repay it. If your income does not exceed your expenses by more than $25 and your assets are under $3,000, more if you have dependents, SSA will generally consider that you cannot afford to repay. Under some circumstances you will not be required to pay back the overpayment even when you can afford to, if it would be “against equity and good conscience”. Also, if you are not at fault and the overpayment is not over $1,000, SSA usually waives the overpayment if you ask.

After you request a waiver, SSA will contact you to schedule a meeting to consider your request, unless it decides a waiver can be granted without the meeting. You will be given an opportunity to look at your claims file and to explain why you are not at fault. SSA must consider your physical, mental, educational, and language limitations, if any. If the waiver is denied, you may then appeal. (See the Appeals section earlier in this chapter.)

You may request reconsideration, a waiver or both. While you may request both at the same time, it is usually better to request reconsideration first. Then, if reconsideration is denied, you can request a hearing on that issue and a waiver. This delays recovery of the overpayment as long as possible. SSA will not start recouping from your benefits while you wait for a decision on reconsideration or waiver.

When SSA intends to collect an overpayment, it will set the lawyer’s fee and will usually approve a fee of up to 25% of your back award or $5,300, whichever is less. It will usually pay the lawyer directly out of your back award. Most lawyers handle these cases on a contingency fee basis. This means you pay the lawyer only if you win your appeal.

OVERPAYMENTS
Social Security is a complex program. Changes in earnings, age, and other factors can affect the amount of benefits you are due. When SSA pays you too much, it expects you to refund the overpayment. If SSA thinks that you have been overpaid, it must send you a written notice. You may need to ask for a more detailed explanation. Unless you act promptly, SSA will keep your benefits until the overpayment is repaid. You can request reconsideration and/or waiver as explained later in this chapter. You should do this within 30 days of receiving the notice to avoid an interruption in benefits.

If you think you have not been overpaid, you should request reconsideration. (See the Appeals section earlier in this chapter.) You can appeal a decision that you were overpaid just like any other decision made by SSA.

If you accept that you were overpaid but don’t think it was your fault, you should request a waiver of the overpayment. You will need to show it was not your fault. You will also need to show that you cannot afford to repay it. If your income does not exceed your expenses by more than $25 and your assets are under $3,000, more if you have dependents, SSA will generally consider that you cannot afford to repay. Under some circumstances you will not be required to pay back the overpayment even when you can afford to, if it would be “against equity and good conscience”. Also, if you are not at fault and the overpayment is not over $1,000, SSA usually waives the overpayment if you ask.

After you request a waiver, SSA will contact you to schedule a meeting to consider your request, unless it decides a waiver can be granted without the meeting. You will be given an opportunity to look at your claims file and to explain why you are not at fault. SSA must consider your physical, mental, educational, and language limitations, if any. If the waiver is denied, you may then appeal. (See the Appeals section earlier in this chapter.)

You may request reconsideration, a waiver or both. While you may request both at the same time, it is usually better to request reconsideration first. Then, if reconsideration is denied, you can request a hearing on that issue and a waiver. This delays recovery of the overpayment as long as possible. SSA will not start recouping from your benefits while you wait for a decision on reconsideration or waiver.

When SSA intends to collect an overpayment, it offers a choice of paying the entire amount at once or having your benefit checks withheld until it is
3. You must have a low income and limited assets.
4. SSA may require you to apply for other benefits for which you might be eligible, including: Social Security, Veterans benefits, Workers Compensation, Railroad Retirement pensions, private pensions, or unemployment compensation.

You do not have to sell your home to get SSI benefits. The government gets no lien on your property and no claim against your estate for SSI benefits it has given you. (See the Overpayments section earlier in this chapter.) If you give away money or property before or after applying for SSI, it can make you ineligible for SSI in some cases. You should seek advice from a lawyer or legal assistance program if you are in this situation.

The government may change the way eligibility is calculated, so be sure to ask for current information at your local Social Security office.

INCOME TEST
You are not eligible for SSI if your income is too high. Income includes cash and checks you or your spouse receives plus the value of food and housing from friends, relatives, or others. Some income, for example, tax refunds and income from volunteer work in an ACTION program, is not counted at all. After all your other income is added together, SSA subtracts certain amounts, including:

• $20 a month for any income, except Veterans’ benefits.
• $65 a month of earned gross income, earnings from a job or self-employment.
• Half of the rest of your earned income for the month.

If your monthly income after deductions is below the SSI monthly benefit level, you meet the income test. For an individual, that amount in 2009 is $674; for a couple, both spouses must be age 65 or over, blind, or disabled and it is $1,011. These amounts change nearly every year on January 1 as the cost of living goes up.

ASSET TEST
Your assets are the property and possessions you own. A single individual cannot receive SSI if his/her countable assets are worth more than $2,000. A couple cannot receive SSI benefits if their assets are worth more than $3,000.

In adding up the value of your assets, SSA will not count the value of your house if you live there. SSA will also generally not count the value of your personal effects, i.e. personal jewelry, personal care items, prosthetic devices, books, musical instruments, cultural or religious items; and household goods, i.e. furniture, appliances, personal computers, televisions, radios, carpets, cooking and eating utensils, and dishes. However, if such items are held for investment value, they will be counted as a resource. For example, wedding or engagement rings will be exempt, but a collection of valuable jewelry purchased as an investment and kept in a safe deposit box will be counted.

Starting March 9, 2005, SSA no longer counts one car as a resource, regardless of its value, as long as it is used to transport the individual or a member of his/her family. Other vehicles will count as resources up to their equity value, fair market value minus outstanding loans. A life insurance policy does not count as an asset if the face value is less than $1,500. However, if the face value is more than $1,500, the cash surrender value is counted as income.

Even if your resources are worth more than the maximum allowed, you might still be eligible for SSI if you agree to sell the excess assets. You must then sell the assets within the time allowed, which is nine months for land or a house and three months for other property. You will have to pay back the SSI benefits you received during this time. If it takes more than nine months to sell real estate, you can usually still receive SSI while you try to sell; however, only have to pay back the SSI received during the first nine months.

WHERE YOU LIVE
When you live in a medical treatment facility for less than one full calendar month, your SSI benefits should not be affected. When you live in a private facility, i.e. hospital, convalescent center, nursing home, etc., for a full calendar month and Medicaid pays more than half your bill, your SSI benefits are reduced to only $30 a month. Indiana Medicaid should pay you an additional $22 per month also. If your stay is expected to last no more than 90 days and you want to keep your home or apartment, you can continue receiving your full SSI check. However, you must tell Social Security shortly after you enter the nursing home or other facility. If Medicaid does not pay for your care in the facility, you should receive full SSI benefits. You are not eligible for SSI at all when you are in a public institution such as a veterans’ hospital, state hospital, etc., for a full calendar month; however, there are a few exceptions.

If you receive food or shelter from another person, SSA will count what you receive as in-kind income and will reduce your SSI check. If you live in someone else’s household and receive both food and shelter from that person, your SSI check will be reduced by $224.67 as an individual, or $337 if you are married, regardless of the value of the food and shelter you receive. These figures go up whenever the SSI benefit goes up. If you receive in-kind income under different circumstances, for example, you live with a friend rent-free but buy your own food, SSA will assume that the food or shelter you receive is worth $244.67, or $357 if you are married and will reduce your SSI check by that amount less $20. However, if you show SSA that it is worth less than this amount, they will use the actual value.

The simplest way to prevent your benefits from being reduced for in-kind income is to pay your “pro rata” share of food and shelter expenses, including rent, mortgage, property taxes, heating fuel, gas, electricity, water, sewage, and garbage collection. Your pro rata share is the average monthly cost of these items divided by the number of people living in the household. If the value of the shelter you receive is high, you might instead enter into a business arrangement with the person who owns the housing so that you pay monthly rent equal to $244.67, or $357 if you are married. If you live in Indiana and pay that amount, you will not have in-kind income from shelter that someone provides you, even if it could be worth more than that.

These rules are complex. If your SSI has been reduced because of in-kind income, consult with an experienced lawyer or legal assistance program.

HOW TO APPLY
Apply for SSI benefits at your local Social Security office. You have the right to file a written application if you think that you might be eligible. If you prefer, you can call SSA and make an appointment for an office or telephone interview, (800) 772-1213 or TTY (800) 325-0778.

When you apply, you should take records and documents that will show you are eligible. For example,
to prove your age, unless you are already receiving Social Security, you should take a birth certificate. If you cannot take a birth certificate, take some other proof of age. (See the Social Security section earlier in this chapter.) You must also show your Social Security card.

To show your income, you should take W-2 forms or a copy of your federal income tax return and recent check stubs. You should also take a list of the persons who help to support you and how much each provides. To show ownership of real property, you should take your latest tax bill or an assessment notice and the deed. Also, take documents that show your assets. For example, your bank book and bank statements, motor vehicle registration or title, stock certificates, and bonds. If you are blind or disabled, take the names of doctors and hospitals that have treated you. SSA might help pay your expenses for gathering these necessary documents.

Having this information with you will speed up processing of your claim. However, it is more important to file your application at the earliest possible date. SSA benefits can be paid no earlier than the month after you apply. So if you cannot find all the documents right away, go ahead and apply anyway. A simple phone call asking about your eligibility for SSI and requesting an application should establish your application date.

**BENEFITS**

In 2009, an eligible individual with no countable income receives $674 a month from SSI. An eligible couple with no countable income receives $1,011 a month. If you live in a nursing home and Medicaid pays most of the bill, your SSI benefit will be only $30 per month unless your stay is expected to last less than 90 days. (See the section Where You Live previously in this chapter.) These are the maximum SSI benefits; benefits are smaller for persons who have countable income. Some states supplement these basic amounts from the federal government; however, Indiana does not unless you are on Medicaid in a nursing home. These amounts usually increase in January each year, except for the $30 benefit.

**PAYMENTS**

Once you have applied, you might not receive your first check for 60 to 90 days. If you are found eligible, however, you will receive benefits that go back to the first month after the month you applied. In some cases, you can receive benefits immediately. If you need money desperately and can show that you are probably eligible for SSI, you should ask for an emergency advance of up to the full SSI benefit level. Also, if you are obviously disabled, you can get full benefits immediately for up to six months.

The effect of income on SSI benefits can be confusing. SSI benefits are reduced by the amount of income you have that SSA counts. However, your SSI benefits are not adjusted until two months after you actually receive the income. For example, if you receive $100 in March, it won’t affect your SSI benefit until May.

**OVERPAYMENT**

An overpayment occurs when you receive more SSI money than you should. If SSA thinks that you have been overpaid, they must write you. SSA may then try to get the money back by reducing your SSI checks for subsequent months. If you disagree with this decision, you should appeal. (See the Overpayments section earlier in this chapter.)

SSA cannot take more than 10% of the SSI benefit level to collect an overpayment and you can request that they take less. If you become ineligible for SSI benefits, the SSI overpayment can be collected from Social Security benefits you receive. An overpayment can also be collected from an IRS tax refund or from certain other federal payments you might receive.

**APPEAL RIGHTS**

You have the right to appeal any decision or action that affects your SSI benefits. The appeals process for SSI is the same as that for Social Security. (See the Appeals section earlier in this chapter.)

If SSA proposes to stop or reduce your SSI check, you may continue to receive the same benefit amount if you appeal within 10 days of receiving the notice. However, if you lose the appeal, SSA may ask you to repay benefits that you were not entitled to. You may request a waiver of this overpayment. (See the Overpayments section earlier in this chapter.) Or, you may have small amounts withheld from your SSI check until it is paid back. To avoid a possible overpayment, you may waive your right to continue being paid during your appeal, but it may take weeks before your appeal is decided.

Normally you cannot receive benefits after losing the first stage of the appeal, unless you are appealing a decision that your disability has ended. If you have questions about the appeals procedure, ask at your local Social Security office. It is also very helpful to get a lawyer. If you are represented by a lawyer and you win, SSA must approve the lawyer’s fee. Attorneys with legal services organizations, however, do not usually charge a fee for this assistance.

**REPRESENTATIVE PAYEESHIP**

If SSA decides that you cannot manage your SSI checks, it may appoint a representative payee to receive your checks for you. (See the Representative Payeeship section earlier in this chapter.)

**CHANGED CIRCUMSTANCES**

SSA should review your case every year to make sure that you are still eligible, unfortunately, they often don’t.

Be sure to notify SSA within 10 days if there are changes in your circumstances that may affect your SSI eligibility or benefits. Otherwise, you could end up overpaying. You may even be penalized for failure to report these changes. Report changes in writing and keep a copy for yourself. SSA is notorious for not keeping records of oral reports. If you do not use SSA forms, be sure to include in your report:

- Your name and address.
- Your Social Security claim number.
- An explanation of the change in circumstances.
- Date the change occurred.
- Your signature.

Examples of changes that must be reported to Social Security include:

- Change of address
- Entering/leaving a hospital, nursing home, or other institution
- Plans to leave the United States for at least 30 days
- Separation from your spouse or a change in marital status
- Someone joining or leaving your household
- Buying, selling, giving or receiving an item of property

Income changes, other than general increases in Social Security benefits
- Major changes in physical condition if you are receiving SSI benefits because you are blind or disabled
- Death

**OTHER HELP**

If you are eligible for SSI, you might also be eligible for help with medical bills under Indiana’s Medicaid program. (See the Medicaid section in Chapter 3.) You might also be eligible for such social services as help with chores at home and rehabilitation. For more information, contact your county’s office of Family and Social Services Administration, http://www.in.gov/fssa/dfr/2999.htm, and Area Agency on Aging.

**FOR MORE INFORMATION**

If you have questions about the SSI program, ask at your local Social Security office. Look in the telephone book under offices of the U.S. government, Social Security Administration. You can also go to the SSI home page at http://www.ssa.gov/ssi/index.htm.

**FOOD STAMPS**

The food stamp program is a federally funded program which helps low-income households buy the food they need for good health. There are no age requirements to receive food stamps. Eligibility is determined for a given length of time called a certification period. Because recipients no longer receive stamps or coupons, the federal government now calls the program the Supplemental Nutrition Assistance Program, or SNAP. In Indiana, the program is still referred to as food stamps.

**USE**

Food stamps are like a credit card that you spend like money to buy food and plants and seeds to grow food. Food stamp benefits are accessed with a plastic Hoosier Works Card, like an ATM card. You cannot use food stamps to buy alcoholic beverages, tobacco or cigarettes, household supplies, soap and paper products, medicine, hot foods that are ready to eat, pet foods or other non-food items.
You can use food stamps at any grocery or other store that has been approved to accept them. You can also use the program to pay for meals on wheels, group meals for the elderly, and restaurant meals if the organization giving the meals has been approved.

**ELIGIBILITY AND BENEFITS**

Eligibility is determined by household. Each separate household must be certified separately for food stamps. A household is:

1. A person, or group of persons, living alone.
2. A person or, group of persons, living with others but usually purchasing and preparing meals separately
3. A group of individuals who live together and customarily purchase food and prepare meals together.

If parents live with their children, the parents and children are not considered separate households unless at least one parent is age 60 or older, or defined as disabled for food stamp purposes, and each household usually buys and prepares food separately. A spouse of a household member cannot be a separate household. A boarder, someone who lives with a household and pays a reasonable compensation to the household for room and meals, is only eligible for food stamps if the household is eligible and wants the boarder to be considered part of the household.

If you live in an institution that provides most of your meals, you may not be eligible for food stamps. Residents of subsidized housing for the elderly, however, may be eligible.

If your household meets the eligibility requirements, you will receive food stamp benefits. You do not have to pay for the benefits. The amount that each household gets each month depends on the size and income of that household.

The financial eligibility requirements include an income test and a resources test. There are also non-financial eligibility requirements, such as registering for work if not exempted and providing a Social Security number.

**INCOME TEST**

The amount of income that you can have and still be eligible for food stamp benefits depends on the size of your household. These amounts are adjusted annually on October 1. You need to check with your local food stamp office to determine the current allowable income for your household. Indiana’s food stamp program can be accessed online at [www.in.gov/2691.htm](http://www.in.gov/2691.htm).

Eligibility of most households is now based on gross income. If, however, the household contains a member who is age 60 or older, or who fits the given definition of disabled, that household’s eligibility is based only on net income. Net income is first figured by adding all of the countable income of all household members together. This includes most types of income including most government benefits. After adding together all countable income, $144 is automatically subtracted unless the household is more than four persons, then the deduction is more. More may also be deducted for care of a dependent and for shelter expenses including utility expenses. Persons who are over age 60, receive SSI benefits, or who fit the program’s definition of disabled also receive an extra deduction for medical expenses that exceed $35 per month. The amount of stamps is then based on the net income and the size of the household.

**RESOURCES TEST**

Resources include cash, bank accounts, stocks, bonds, vehicles, and property that you own. Usually, a household is not eligible for food stamps if it has accessible resources worth more than $2,000. If at least one person in your household is age 60 or over or is disabled, your household can have up to $3,000 in resources. Some resources are counted and others are not. Your house, surrounding lot, household goods, personal belongings, and life insurance policies are not counted. All vehicles used for household transportation are exempt as well. Only recreational vehicles and those not used for household transportation will have their equity value counted as a resource.

**WORK REQUIREMENT**

The food stamp office may require members of your household to register for work and/or accept a job. Persons do not have to work, however, if they are age 60 or older, younger than 16, physically or mentally unfit to work, taking care of a child under age six or an incapacitated person, receiving unemployment compensation, or already employed.

**APPLYING FOR BENEFITS**

The first step is to apply for food stamps at your local food stamp office. To find out where that office is, you can:

1. Call your local Area Agency of Aging.
2. Call your county office of the Division of Family Resources, formerly known as the County Welfare Department.
3. Go to [www.in.gov/2407.htm](http://www.in.gov/2407.htm) and click on Food Stamps.

If all members of your household receive SSI benefits, you may apply for food stamps at the Social Security office.

You can ask for the food stamp application form in person, over the phone, or by mail, or you can send someone else to get it for you. The office must accept your application form on the day you turn it in. If you are not a food stamp worker, you cannot interview you that same day. It is important to apply as soon as possible. Food stamps are paid only for days beginning with the day you apply.

If you have signed and turned in your application form, a worker will conduct a confidential interview with you or another member of your household. If you are not a food stamp office, you do not have to go to the food stamp office for an additional interview. If no one in your household can go to the food stamp office for an interview, you may send an adult friend or relative to be interviewed for you. This person must know your household’s circumstances and finances. If you cannot get to the food stamp office and cannot send someone, especially if you are age 65 or older or handicapped, you should ask the food stamp office to interview you at your home or over the telephone.

Do not hold back information. Tell the food stamp worker all relevant information and let the worker decide whether you are eligible.

The food stamp office must tell you whether you need to do anything more, such as submit documents. The office will then notify you whether you are eligible, how long your certification period is, and the monthly amount of stamps that you will receive. You may be able to get food stamps within five days if you let the food stamp worker know of your immediate need. Emergency food stamps are available only to persons who have very low income and few resources. There are special rules for migrant farm workers. Otherwise, if you are eligible, you will receive an identification card and a notice of eligibility, and may participate in the program within 30 days from the date you first applied.

Once approved, you will be given a Hoosier Works Card, which you will use with the grocer or other provider. Once a month your allotment will be electronically added to your account, and you will then be able to access your benefits.

If you receive notice that you are not eligible, the notice should explain why your application has been denied. If you think that your application has been wrongly denied or that you have not received the right amount of food stamps, you should discuss the matter with someone at the food stamp office. If you still disagree, you can ask for a fair hearing at which your disagreement will be considered.

**RIGHTS**

Under the food stamp program you have the right to:

- Receive and submit a written application the same day you ask for it.
- Have an adult friend or relative apply for you if you cannot get to the food stamp office yourself.
- Have an interview at your home or by phone if you are age 65 or older or handicapped and cannot get to the food stamp office or send someone in your place.
- Get your food stamps within 30 days after you apply, if you are eligible and have done all that is required of you.
- Receive advance notice if your benefits are going to be reduced or stopped within the certification period.
- See your own case file and a copy of the rules of the food stamp program. You should make advance arrangements to do this.
- Have a fair hearing if you disagree with any action or decision on your case.
- Whenever you disagree with a decision, you can ask in writing, in person, or over the phone for a fair hearing. You should make this request within 90 days of the action you are complaining about or anytime during that certification period. If you are already
The law requires the trustee to help needy persons to pay for other basic needs, including:

- Food, clothing, shelter, electricity, water
- Fuel for heating and cooking
- Necessary household supplies, including first aid and medical supplies for minor injuries and illnesses
- Necessary household furnishings, including basic furniture, utensils, and heating and cooking stoves
- Necessary household appliances
- Transportation required to find a job

You are eligible for help from your township trustee if you are in need. The law requires the trustee to have written standards to tell you who is eligible, what benefits are provided if you are eligible, and how to apply. If the standards are so strict that you are denied help that you really need for basic needs of life, you should challenge the trustee’s standards by appealing. (See later in this section for how to appeal.)

The trustee may investigate your financial circumstances and approach your relatives who live in the township and ask them to assist you. The trustee can also require you to try to find ways to meet your needs, for example, by applying for food stamps, Medicaid, Social Security, or SSI. The trustee cannot ask you to promise to repay any aid that you receive unless you receive “jump sum” retroactive Supplemental Security Income (SSI) benefits, although the trustee can file a claim against your estate when you die. The trustee may ask you or a member of your family to work in a local government office or non-profit agency in order to work off your benefits at the federal minimum wage. You cannot be required to work if:
1. You are 65 years old or older
2. You are a minor
3. You already have a full-time job
4. You are not physically able to do the work
5. You are needed to care for someone else
6. There is no work available

You do not need to have lived in the township for any given length of time in order to be eligible for benefits. If your home is in the township, it is illegal for the trustee to deny you assistance based on how long you have lived there.

The law does not limit this assistance to emergencies. If you continue to need assistance and continue to be eligible, the trustee should not refuse to continue giving you assistance. The trustee may, however, ask you to re-apply periodically.

To apply for trustee benefits, you should go to your township trustee’s office and apply in writing. Your township trustee should be listed in the telephone book under the name of your township. You may also find a directory online, http://indianatownshipas-soc.org/component?option=com_mtree/itemid,76/.

If you do not know which township you live in, you may contact your county auditor’s office to find out. You have a right to fill out a written application. The trustee must give you a prompt decision within three working days. The decision must be in writing and provide the reasons if you are denied any of the assistance you have requested. If you are already receiving benefits and the trustee decides to stop or reduce your benefits, the trustee must send you written notice at least 10 days before benefits are stopped or reduced. The notice must give the reasons for the change.

If you disagree with the trustee’s decision, you can appeal to your County Commissioner’s office. The trustee’s notice should tell you how to appeal. Generally, you will have 15 days to request an appeal. However, if you have been receiving benefits which the trustee wishes to reduce or stop, you must request an appeal hearing within 10 days in order to continue those benefits until the appeal has been decided. The Commissioners must decide your appeal within 10 working days and must give you notice of their decision within five working days of the decision. If you want to appeal the decision of the County Commissioners, you can go to court. You should see a lawyer before appealing to a court.

PRIVATE PENSIONS

Many employees of private companies will receive pension plan benefits upon retirement. Such plans generally allow you to defer compensation while you work, and until you retire. During the worker’s working years, the worker, the employer, a union or any combination of these contributes to the plan. Workers then are entitled to draw benefits when they retire, or, in some cases, when they become disabled.

Some pension plans are called qualified retirement plans because they qualify for special tax treatment under the rules of the Internal Revenue Code. An employer is allocated a current deduction for its contributions to the plan. Also, contributions workers make, and any growth in the plan, are not taxed until the benefits are paid to the workers. Most retirement plans will pay benefits to the dependents or beneficiaries of the worker if the worker dies or becomes disabled before retirement.

TYPES OF PENSION PLANS

There are two major categories of pension or retirement plans.

Defined Benefit Plan. The defined benefit plan is the traditional pension plan. The employer promises you a specific benefit at retirement and for your remaining life based on a formula. The employer makes contributions to the plan in an amount that is determined to provide that promised benefit to you. Because the benefits are defined in the plan, most defined benefit plans do not permit you to make contributions. Here is an example of how the benefit might be determined:

Example: A plan provides that the employee will receive a pension equal to 1% of his compensation for each year of service. If the employee works for 25 years by retirement age and his compensation was $50,000, the pension provided by the plan would be $12,500 per year ($50,000 x 25 years x 1%).

Under a defined benefit plan, the employer retains an actuary to compute the amount of annual contributions needed to fund the benefits that will be paid to you under the plan. You are guaranteed to receive the stated pension and a federal agency insures the pension amount. (See the section The Law later in this chapter.) Any investment risk falls on the employer.

Defined Contribution Plan. Defined contribution plans have become the more popular type of retirement plan. An individual account is established for you, and money is contributed to that account each year. The plan has a stated or defined, contribution limit each year. Once the employer makes the contribution to your account, the employer has fulfilled its promise, and there is no continuing obligation to contribute additional funds. Often the employer con-
tributes a set percentage each year, and you are able to contribute additional funds to the account. Upon retirement, death or disability, the benefits paid out will be based on the amount in your account. These defined contribution plans are not insured, and any risk of loss in the investment is on you.

The most popular defined contribution plans include profit sharing plans, money purchase plans and employee stock ownership plans.

**Profit Sharing Plans.** A profit sharing plan generally provides for an employer contribution each year that may not necessarily be based on the employer's profits. The employer retains the right to increase or decrease the contribution amount each year, or to decide to make no contribution in a particular year. An arrangement known as a 401(k) plan often is tied to the typical profit sharing plan and permits employees to contribute to the plan from their own compensation on a pre-tax basis.

**Money Purchase Plan.** A money purchase plan is a defined contribution plan under which the employer is obligated to contribute a stated percentage of the employee's compensation to the plan each year. The money purchase plan differs from a profit sharing plan only in the fixed nature of the employer's annual funding requirement.

**Employee Stock Ownership Plan.** An employee stock ownership plan (ESOP) is a tax qualified retirement plan that is designed to invest primarily in the stock of the employer.

**OTHER EMPLOYEE BENEFIT PLANS**

If you are self-employed without a company sponsored retirement plan, you can obtain some of the benefits of a plan with one of the following:

**Keogh plan.** Keogh Plans cover self-employed persons and their employees under prior law. Contributions these individuals make to the plan, and the employer can make tax deductible contributions to the employee's IRA each year up to the lesser of $49,000 (as of 2009) or 25% of the employee’s compensation.

**SIMPLE Plan.** The SIMPLE plan is available to employers of 100 or fewer employees. Contributions of up to $11,500 (as of 2009), plus $2,500 more for those age 50 or older are made to a special IRA account for each employee based on salary deferral elections by the employee. The employer's contribution generally is matched by an employer contribution of up to three percent of the employee's compensation.

**Individual Retirement Arrangement (IRA).** IRAs have become increasingly popular. Traditional IRAs, like qualified plans, let you postpone income tax on your earnings. You can set aside money in your working years and may be able to postpone tax on that money until you withdraw money for retirement. At that time, you probably will be in a lower income tax bracket, so your tax on the money will be less than if it had been taxed in the years earned.

The Roth IRA became available in 1998 and contributions you make to a Roth are not deductible for income tax purposes, but the Roth grows tax-free and you pay no income tax on withdrawals. The annual contribution limits for traditional and Roth IRAs are the same. However, unlike a traditional IRA, you may continue to contribute to a Roth after age 70 1/2, and you are not required to take any distributions from the Roth before death.

If you also have a qualified retirement plan, any worker, full-time or part-time, can set up an IRA, subject to income limitations. Also, a married worker can contribute to an IRA for a non-working spouse. The main advantages are postponement of income tax, on a traditional IRA, and a savings source for retirement. The disadvantage is that money you put in an IRA will be tied up until you reach age 59 1/2. Tax law changes in 2001 increased the limits for contributions to IRAs. Working individuals over age 50 can make even greater contributions each year. The limits are as follows:

<table>
<thead>
<tr>
<th>Year</th>
<th>Individuals under 50</th>
<th>Individuals 50 – 70</th>
</tr>
</thead>
<tbody>
<tr>
<td>2008</td>
<td>$5,000</td>
<td>$6,000</td>
</tr>
<tr>
<td>2009</td>
<td>$5,000</td>
<td>$6,000</td>
</tr>
</tbody>
</table>

You may start withdrawing from your IRA without penalty at age 59 1/2. If you withdraw money before age 59 1/2, you pay not only the income tax due on the withdrawal if the IRA is a non-Roth, but also a 10% premature withdrawal penalty.

For more information about Kegoths, SEP SIMPLE plans, or IRAs, consult your tax advisor, a lawyer, or the Internal Revenue Service. Many financial institutions offer IRAs and can also give you information. Do shop around. Most banks offer basic IRAs, for example, but they differ as to interest rates, minimum deposits, and investment risks. An expert knows your specific financial history is in the best position to advise you on these specific matters.

**THE LAW**

Complex federal laws, including numerous sections of the Internal Revenue Code, regulate retirement plans, including pensions, and IRAs.

**ERISA.** The Employment Retirement Income Security Act of 1974 (ERISA) sets minimum standards for qualified plans relating to reporting and disclosure, funding and the maximum contribution and benefit limits. ERISA covers most company sponsored plans, including most defined benefit plans and defined contribution plans. ERISA does not cover plans sponsored by the government, churches or the military. ERISA is an extremely complex law, and it has exceptions for almost every rule. It applies only to people who have retired or become disabled after January 1, 1976.

**PBGC.** Defined benefit plans also are covered by the Pension Benefit Guarantee Corporation (PBGC) Termination Insurance under Title IV of ERISA. Defined Benefit Plans are not covered.

TRA 97. The Tax Relief Act of 1997 added the Roth IRA and also permits a spouse of an individual participating in a qualified plan to make contributions to a traditional or Roth IRA, if certain income levels apply.

**IRC 401(a).** Section 401(a) of the Internal Revenue Code sets out the minimum distribution rules relating to distributions of benefits at retirement and following death from all qualified plans, qualified annuities and the several forms of IRAs.

Employers and IRA providers are permitted to offer fewer than all of the distribution choices contained in the 401(a) rules. So, it is important for you to obtain a copy of your plan or IRA agreement in order to find out specifically the rules that apply to your situation.

**PPA.** The Pension Protection Act of 2006 permitted non-spousal rollovers of employee retirement plans to inherited IRAs following the employee’s death. The PPA also permitted rollovers from a qualified plan directly into a Roth IRA by the employee or heirs.

**YOUR RIGHTS UNDER FEDERAL LAW**

ERISA gives you important rights to information concerning your pension or other qualified retirement plan. However, it is important to remember that not every employee is covered by a plan. The law does not require an employer to have a plan for its employees or to continue a plan once it is begun. If the employer does have a plan, however, that plan must meet the following requirements of federal law.

Your employer must furnish to you automatically and for free:

- A summary plan description. A booklet summarizing the plan rules and explaining your benefits.
- A financial summary that provides you with a summary of the pension plan’s annual report.
- Upon termination of your employment, or upon a break in service, a statement explaining the amount of your vested benefits.
- Upon written request, an individual benefit statement that sets out the total benefits accrued to date and whether they are vested. You have the right to demand this benefit statement once every 12 months, and it must be furnished to you within 30 days of your written request.
CONDITIONS FOR QUALIFICATION
In exchange for offering the tax benefits attributable to pensions and qualified retirement plans, the Internal Revenue Code requires that every plan satisfy a series of complex conditions and restrictions. The employer must assure that these requirements are satisfied or the plan will lose its tax qualification, which could have adverse tax consequences for you, as well as for the employer. The most important of these requirements are discussed in the following sections.

ELIGIBILITY AND PARTICIPATION
Eligibility and participation requirements include the following:
1. All employees who work more than 1,000 hours during a year must be eligible to participate in a plan, if the employer has a plan.
2. Part-time employees may be excluded unless that part-time worker has worked 1,000 hours.
3. An employee who satisfies the eligibility requirements must become a participant no later than six months after reaching age 21 or after completion of one year of service.
A year is defined by ERISA to mean a 12 month period in which the worker has worked at least 1,000 hours.
4. A plan may require two years of service as a condition for participation if the plan also provides full and immediate vesting.

VESTING
Generally, a plan must meet the following vesting requirements which were shortened by the 2001 Tax Relief Act:
1. An employee must be 100% vested in the accrued benefit under a plan after three years of plan participation.
2. Alternatively, a plan may provide for six-year graded vesting, that is, a vesting schedule that provides at least 20% vesting after two years, increasing by 20% per year thereafter.
3. If a plan is “top-heavy,” i.e. 60% of the plan’s balances benefit the key employees, the vesting schedule must be shortened based on alternative schedules.

NONDISCRIMINATORY COVERAGE
Because a pension plan may be designed to exclude a portion of an employer’s workforce, the Internal Revenue Code provides a series of tests to ensure that the effect of a plan’s coverage provisions do not result in prohibited discrimination. The tests are purely mathematical and involve an analysis of the percentage of highly compensated employees who are covered by the plan as compared to the percentage of non-highly compensated employees who are covered. Additionally, the code requires that a plan cover the lesser of 50 employees or 40% or more of all employees of the employer if a plan is offered.

CLAIMS AND APPEALS
ERISA requires all pension plans to have procedures for submitting claims and for appealing decisions. When you claim benefits, you have a right to:
• A decision within a reasonable time.
• Written notice if your claim is denied, including specific reasons.
• A reasonable opportunity for a full and fair review of the decision.
You have at least 60 days to appeal the decision in writing. To prepare for the appeal, you have the right to submit written material to support your claim and to see the relevant documents that the plan administrators have. You do not necessarily have the right to argue in person at a formal hearing. You are entitled to a written decision on your appeal within 60 days of your request for appeal.
If you still are not satisfied with the decision, you can appeal to a court. A lawyer can help you with these procedures.

OTHER PROTECTIONS
ERISA also protects a worker from loss of benefits due to the employer’s going out of business, acquisition of the employer’s company by a new employer, or amendment or termination of the pension plan. In addition, ERISA imposes new duties on administrators of pension plans to make sure that pension funds are properly managed.
A pension plan should not discriminate against older workers or prevent them from participation. (See the Age Discrimination in Employment section in Chapter 10.) There is one exception. If a worker begins work within five years of the normal retirement age, and if the pension plan is a defined benefit plan, then the employer can limit the new worker’s participation in the plan.

RECEIVING BENEFITS DURING LIFE FROM DEFINED BENEFIT PLANS (PENSIONS)
If you meet all the requirements discussed above, you can begin to receive your pension benefits from defined benefit plans when you reach your plan’s retirement age. Some plans provide for early retirement but require the early retiree to take a lower benefit. Some plans also start paying benefits when you become disabled. A very few plans pay the employee a lump sum when the employee leaves the job at any age, but only if a small amount of money is involved.
Benefits are usually paid monthly, although some plans pay in a lump sum and some provide for increases in benefits to reflect the cost of living. The law does not require a pension to provide any specific amounts.
Even though your pension plan states a normal retirement age, most employers cannot force you to retire. (See the Age Discrimination in Employment section in Chapter 10.) Most pension plans let you work full-time or part-time and still receive pension benefits. Some, however, suspend payment if you return to work for your former employer or in the same industry, trade, or geographic area. You also can receive both Social Security and pension benefits. In some cases, your pension benefit will be affected by the amount of Social Security you receive.
Also, when there is a divorce, a spouse can share in pension rights if those rights are vested. The spouse must obtain a court order at the time of the divorce to protect his or her interest in the worker’s pension benefits. For more information, consult a lawyer.

RECEIVING BENEFITS FROM OTHER QUALIFIED PLANS AND IRAS
The Internal Revenue Service issued final regulations effective in 2003 that address when and how you and your beneficiary must withdraw retirement money from retirement plans, such as 401(k) plans, 403(b) plans, and IRAs. The rules allow several options, but you must check your own plan or IRA agreement to determine whether it permits all the distribution choices to you. Plans are permitted to be more restrictive than the rules.

DISTRIBUTIONS BEFORE AGE 59 1/2
A distribution to you from your qualified plan or traditional IRA before the age of 59 ½ is a premature distribution subject to a penalty of 10%. The penalty is designed to discourage the use of a retirement vehicle as a short-term deferral device rather than as a long-term retirement savings.
There are exceptions to the penalty. Some exceptions apply only to IRAs, and others are available only for employer-sponsored retirement plans. Most of the exceptions are triggered only by particular hardships, such as death, disability or unemployment, or depend on a particular use of the funds distributed, such as college tuition, health insurance premiums, or a first-time home purchase. See your attorney if you require a premature distribution.

DISTRIBUTIONS BETWEEN 59 1/2 AND 70 1/2
There are no penalties for distributions to you from your IRA or qualified plan after you reach age 59 ½. You may take a small or a large distribution, or no distribution at all, without penalty. A primary consideration when evaluating whether or not to take distributions before age 70 ½ is the resulting income tax impact. The increased income may throw you into a higher tax bracket, or may contribute to a phase-out of personal exemptions or a reduction of itemized deductions.

MINIMUM REQUIRED DISTRIBUTIONS AT AROUND AGE 70 1/2
To encourage the use of IRAs and qualified plans as retirement devices, federal regulations impose a substantial penalty if an individual fails to begin taking retirement plan distributions at the required beginning date (RBD). For most people in most plans and all traditional IRAs, the RBD is April 1 following the year in which you reach age 70 ½.
At your RBD, distributions from an IRA and, in most cases, from a qualified plan, must begin, with the exception of those who work past 70 ½ and are not a 5% owner, and whose plans allow deferral of
the distribution. Failure to take the required distributions and to subject the required amount of deferred income to income tax invokes a hefty 50% penalty on the amount that should have been taken but was not. You determine your distribution for each year after your RBD by dividing your retirement account balance, as of December 31 of the prior year, by a life expectancy factor that is set forth in the table.

Uniform Table

<table>
<thead>
<tr>
<th>Age</th>
<th>Factor</th>
<th>Age</th>
<th>Factor</th>
</tr>
</thead>
<tbody>
<tr>
<td>70</td>
<td>27.4</td>
<td>73</td>
<td>24.7</td>
</tr>
<tr>
<td>71</td>
<td>26.5</td>
<td>74</td>
<td>23.8</td>
</tr>
<tr>
<td>72</td>
<td>25.6</td>
<td>75</td>
<td>22.9</td>
</tr>
<tr>
<td>73</td>
<td>24.7</td>
<td>76</td>
<td>22.0</td>
</tr>
<tr>
<td>74</td>
<td>23.8</td>
<td>77</td>
<td>22.1</td>
</tr>
<tr>
<td>75</td>
<td>22.9</td>
<td>78</td>
<td>20.3</td>
</tr>
<tr>
<td>76</td>
<td>22.0</td>
<td>79</td>
<td>19.5</td>
</tr>
<tr>
<td>77</td>
<td>21.2</td>
<td>80</td>
<td>18.7</td>
</tr>
<tr>
<td>78</td>
<td>20.3</td>
<td>81</td>
<td>17.9</td>
</tr>
<tr>
<td>79</td>
<td>19.5</td>
<td>82</td>
<td>17.1</td>
</tr>
<tr>
<td>80</td>
<td>18.7</td>
<td>83</td>
<td>16.3</td>
</tr>
<tr>
<td>81</td>
<td>17.9</td>
<td>84</td>
<td>15.5</td>
</tr>
<tr>
<td>82</td>
<td>17.1</td>
<td>85</td>
<td>14.8</td>
</tr>
<tr>
<td>83</td>
<td>16.3</td>
<td>86</td>
<td>14.1</td>
</tr>
<tr>
<td>84</td>
<td>15.5</td>
<td>87</td>
<td>13.4</td>
</tr>
<tr>
<td>85</td>
<td>14.8</td>
<td>88</td>
<td>12.7</td>
</tr>
<tr>
<td>86</td>
<td>14.1</td>
<td>89</td>
<td>12.0</td>
</tr>
<tr>
<td>87</td>
<td>13.4</td>
<td>90</td>
<td>11.4</td>
</tr>
<tr>
<td>88</td>
<td>12.7</td>
<td>91</td>
<td>10.8</td>
</tr>
<tr>
<td>89</td>
<td>12.0</td>
<td>92</td>
<td>10.2</td>
</tr>
</tbody>
</table>

The Uniform Table and simple calculation method apply in nearly every situation for life-time distributions. The only exception is if you are married to someone more than 10 years younger. If so, you must use a different table to calculate your yearly required distribution. You may contact the IRS or your attorney to obtain a copy of that table.

DEATH DISTRIBUTIONS WHEN THE WORKER DIES (PENSIONS)

Most monthly benefit pension plans must provide at least half of the benefits the worker would have received upon retirement to the spouse of a deceased worker. This arrangement is sometimes called a joint and survivor annuity. Under the joint and survivor annuity plan, the worker's monthly benefit is reduced to leave something for the spouse. For pensions beginning on or after January 1, 1985, survivor benefits are payable unless the spouse gave written consent to waive those benefits. The worker cannot waive survivor benefits for the spouse. If survivor benefits are waived, the worker will receive a higher pension, but then the spouse is not protected if the worker dies before the spouse.

If the worker dies before retirement, the rules are more complicated, but in many cases, the surviving spouse can receive benefits. For more information about the protection that your pension plan gives to spouses after a worker's death, read the pension agreement and consult with the plan administrator.

WHEN THE WORKER DIES (QUALIFIED PLANS AND IRAS)

Required distributions of your qualified retirement plans and IRAs to your beneficiaries after your death are based on the life expectancy of those beneficiaries. The actual beneficiary of a plan is not determined until September 30 of the calendar year following the year of your death. So, opportunity exists for some post-death planning.

For example, a spouse who would inherit an IRA may disclaim, allowing a younger generation to inherit. The payments then would be stretched out over the longer lives of those children, permitting more deferred income tax growth. This post-death planning only works, though, if you have designated a primary and a contingent beneficiary of your retirement account.

COMPUTING DISTRIBUTIONS IN THE EVENT OF DEATH BEFORE RBD

If you die before your RBD, April 1 of the year following the year you turned age 70 ½, the beneficiaries you designate receive distributions, as follows:

Surviving Spouse. If the beneficiary is your spouse, he/she may choose one of the following options, if the qualified plan or IRA agreement so permits:

• Rollover the benefits into your spouse's own IRA.
• Take distributions over 5 years.
• Receive distributions over your spouse's life expectancy, recalculated annually. If your spouse chooses this option, he/she must begin receiving the distributions no later than December 31 of the year you would have reached 70 ½.

Individual Beneficiary. If the beneficiary is a non-spouse individual such as a child, the child can:

• Take distributions over 5 years.
• Receive distributions over the child's fixed life expectancy, beginning no later than December 31 of the year following the year of your death. If you name multiple beneficiaries, the distributions are made over the life expectancy of the oldest of the group.

Non-Individual Beneficiary. If a beneficiary is a non-individual, such as a charity, estate, or corporation, all death distributions are made under the five-year rule.

COMPUTING DISTRIBUTIONS (DEATH AFTER RBD)

If you die on or after your RBD, the IRS rules require that in the year of death, the minimum required distribution must be paid from your retirement account, still using the Uniform Table. After the year of death, distributions are paid to beneficiaries, as follows:

Surviving Spouse. If the beneficiary is the participant's surviving spouse, the spouse can:

• Rollover the benefits into his/her own IRA.
• Receive distributions over his/her life expectancy, recalculated annually. If the spouse dies before the benefits are all paid, any benefits remaining will be paid out over the remaining, fixed, life expectancy of the surviving spouse, computed as of the age of his/her birthday in the year of his/her death.

Individual Beneficiary. If the beneficiary is a non-spouse individual, the beneficiary can take the benefits over the beneficiary's fixed life expectancy. If there are multiple beneficiaries and they are all individuals, they take the required distributions over the oldest beneficiary's fixed life expectancy, unless separate accounts are created.

Non-Individual Beneficiaries. If a beneficiary is a non-individual, such as an estate, charity, or corporation, the participant is treated as having no designated beneficiary. In this case, the applicable distribution period is the remaining years of the worker's life expectancy, determined using the IRS' single, fixed, life expectancy table.

A WORD ABOUT ROTH IRAS

A Roth IRA owner is not required to receive any distributions, minimum or otherwise, from the Roth IRA during life. However, the owner can withdraw his own contributions to the Roth IRA at any time tax-free. All distributions, even from earnings on the contributions, are tax-free after the owner reaches age 59 ½ and once the Roth has been open for five years.

After the death of the Roth IRA owner, distributions are made over the life expectancy of the named beneficiary.

PUBLIC PENSIONS

STATE EMPLOYMENT BENEFITS

If you worked for the state government in Indiana, you may be eligible for retirement or disability benefits under the state's program. For information, contact:

Public Employees' Retirement Fund
143 W. Market St., Suite 800
Indianapolis, IN 46204
(317) 233-4162, or (888) 526-1687
www.in.gov/perf/

RAILROAD RETIREMENT BENEFITS

The Railroad Retirement program offers benefits to former railroad employees and their dependents. These benefits are very similar to Social Security benefits, and eligibility is determined in a similar way.
(See the Social Security section earlier in this chapter.) If you are eligible to receive both railroad benefits and Social Security, your total benefits will be determined by a formula calculation and paid by the Railroad Retirement Board.

Eligibility for benefits is based on years of service. Your years of service need not have been consecutive, and in some cases, your military service may be counted as railroad service. If you have at least 10 years of covered railroad work or five years performed after 1995, you can get full retirement benefits starting at age 62. For some Social Security programs, you can start getting benefits between ages 62 and 65, but your benefits will be permanently fixed at less than the full amount. If you have 30 or more years of covered railroad employment, you may retire at age 60 or 61 and receive a reduced benefit or may wait until age 62 and retire on a full, unreduced benefit.

Some retirees are eligible for an extra sum of money under the Supplemental Annuity System. You are eligible at age 60 if you have at least 30 years of railroad service, or at age 65 if you have 25 to 29 years of service.

There are two kinds of benefits for disabled railroad workers depending upon whether the disability is total or merely occupational. In addition, some relatives of railroad workers are also eligible for benefits when the worker retires, becomes disabled or dies. This information is very general and does not cover exceptions or special cases. For specific and current information, contact:

U.S. Railroad Retirement Board
50 S. Meridian St., Suite 303
Indianapolis, IN 46204
(317) 226-6111, or (800) 888-0772
www.rrb.gov

FEDERAL EMPLOYMENT BENEFITS

Employees of the federal government have their own public pension program. If you worked for the federal government prior to 1987, you might be eligible for Civil Service Retirement (CSR) benefits. These benefits replace Social Security and have multiple levels of benefits depending upon the timing and circumstances of your retirement, including benefits for disability.

This program’s test for disability is different from Social Security’s test. You are disabled for purposes of this program if your federal employer cannot place you in another job that you can perform and if the Office of Personnel Management approves your disability claim.

For federal employees who entered service after 1987, retirement benefits are provided through the Federal Employees Retirement System (FERS). FERS has three components. First, employees covered by FERS pay into and are covered by the Social Security System under normal Social Security benefits. Employees also have accounts through the Thrift Savings Plan (TSP) which includes both employee and voluntary employee contributions and is tax-deferred. Finally, FERS provides additional retirement annuity payments based upon the length of service and salary of the employee.

When a former federal employee dies, his/her surviving spouse and dependent children might be eligible for survivors’ benefits. Civil Service Retirement benefits and procedures are very similar to those of Social Security. To find out more about Civil Service Retirement benefits, write or call:

U.S. Office of Personnel Management
Attn: Retirement Division
1900 E Street N.W.
Washington, DC 20415
(202) 606-1800 or TTY (202) 606-2532
www.opm.gov/reitre/

VETERANS BENEFITS

FEDERAL

The federal government offers many kinds of benefits to veterans, including medical care, disability compensation for service-connected disabilities, pensions, treatment for alcoholism and drug addiction, loans, insurance, education, and burial payments. The Veterans Administration (VA) operates 137 VA nursing homes and also has a community nursing home program. The extensive medical care available includes priority treatment for disabled veterans who are age 65 or older or disabled due to non-service-related causes.

Pension benefits are based on need and are available to wartime veterans who are permanently disabled and whose family income falls within the program’s income limits. The disability does not have to be service-connected. A veteran who is age 65 or older is considered disabled and need only meet the income requirement. The amount of the pension depends on the veteran’s other income.

The VA Aid and Attendance Pension program is designed to assist wartime veterans whose medical expenses, including nursing home costs and some assisted living costs, exceed their income. Veterans must show that their income is less than their cost of care and that their assets are below the standard set by the VA. The VA may pay up to $1,300 per month for nursing home expenses or for the expenses of a caretaker if the relative is helpless.

STATE

The State of Indiana also offers benefits for honorably discharged veterans:

Burial Allowances. County governments pay up to $100 for burial costs for veterans or their spouses and up to $100 for the setting of a government headstone in the county of burial. Applications must be filed with the auditor of the county of residence of the veteran or spouse at the time of death.
• License Plates. Distinctive license plates are available to veterans who are totally disabled, who have a service-connected disability that results in difficulty walking, who are ex-PW’s or who have received the Purple Heart. Contact your local license branch.

• Indiana Soldiers and Sailors Children’s Home. Located in Knightstown, the home provides for the care, training and education of children of indigent veterans. Contact the superintendent at (765) 345-5141, or online, www.in.gov/isdh/23517.htm, for further information.

• Indiana Veterans Home. Nursing or domiciliary care will be provided to any person with 90 days or more military service during wartime. The veteran’s spouse is also eligible. Contact the Indiana Veterans Home at (765) 463-1502 or www.in.gov/dva/2380.htm.

• Tax Exemptions. Several kinds of property tax exemptions are available to certain disabled veterans. Contact your county auditor.

• Remission of Fees. Children of a veteran who was killed or disabled in wartime are eligible to attend state universities at a reduced rate. Also, children of those classified as POW or MIA after January 1, 1960, may attend free of charge.

• Indiana Veterans Memorial Cemetery. Located in Madison, any Hoosier veteran eligible to be buried in a national cemetery will be eligible for burial in the cemetery. Contact the cemetery superintendent, (812) 273-9220, or download an application form at www.in.gov/dva/files/cemetery_burial_form.pdf.

Veterans’ service officers are located in each county to assist veterans in completing applications for benefits. Look for the telephone number in the county government section of your local telephone book. The Indiana Department of Veterans’ Affairs can also assist in filing claims. For information or assistance, contact: Indiana Department of Veterans’ Affairs 320 W. Washington Street, Room E120 Indianapolis, IN 46204 (317) 232-3910 www.in.gov/dva/

When Alzheimer’s disease touches your life, turn to us.
For over 25 years, the Alzheimer’s Association has been the leader in Alzheimer’s research and support. Our programs and services assist people impacted by Alzheimer’s disease.

• A Toll-free Helpline at 1-800-272-3900
• Education Programs offered for families and professionals
• Support Groups for caregivers
• Care Consultation to provide a map in the journey of Alzheimer’s disease

Contact us at 800.272.3900
www.alz.org/indiana

Healthcare

PLANNING FOR LONG TERM HEALTHCARE NEEDS

The catastrophic cost of long term care is the greatest threat to the financial security of most older adults. Medicare does not cover long term care in a nursing home, and Medicare’s coverage of home care is limited. The vast majority of Medicare supplement, Medigap, insurance policies offer little or no long term coverage. In fact, less than 3% of the costs of nursing home care in this country are paid by either Medicare or private insurance. The result is that most families pay this cost out of their savings until they reach poverty level and then turn to the Medicaid program for assistance. Planning ahead can help alleviate these harsh results.

The first step in planning ahead is to assess what coverage you have. If you have health or long term insurance, find out what it will cover. It is also useful to consider what steps you would need to take to qualify for Medicaid to cover nursing home costs. Now that Medicaid has rules to help protect a community spouse, Medicaid may be a viable option where one spouse enters a nursing home and one spouse remains at home.

It is also important to assess what you wish to accomplish. If it is important to you to preserve assets to pass along to your heirs, then you will want to make certain that you are protected against the cost of long term care. You may wish to purchase long term care insurance or seek legal advice concerning how you may be able to protect assets. If it is unimportant to you whether there are assets left to pass to heirs, then you may be content with simply relying on Medicaid once your assets are reduced sufficiently so that you are eligible for Medicaid.

MEDICARE

Medicare is a federal health insurance program that helps persons 65 or older and some disabled persons pay for medical care. Your eligibility for Medicare does not depend on your financial situation. Medicare has four parts. Part A, called Hospital Insurance, can help you pay for in-patient care in a hospital and for limited care in a nursing home, hospice, or at home.

Part B, called Medical Insurance, can help you pay for doctors’ services, outpatient hospital services, and some other medical services and supplies. Not all medical expenses are covered by Medicare, and Medicare does not always pay the full cost of covered services. You should read the following explanation carefully to understand what Medicare does not cover. Because of the gaps in Medicare, you may want to supplement your Medicare program with other health insurance. (See Supplemental & Long Term Healthcare Insurance)

Part C, called Medicare Advantage, includes health plan options, such as HMOs or PPOs, approved by Medicare and run by private companies. For a person choosing this type of plan, the plan takes the place of the traditional Medicare Parts A and B.

Part D is Prescription Drug Coverage covered later in this chapter.

If you have very low income, you may want to apply for Medicaid, another federal program that helps pay medical expenses for elderly or disabled persons with low income. (See Medicaid)

Medicare is a federal program run by the Center for Medicare and Medicaid Services. You apply for Medicare at your local Social Security office. The government also has entered into contracts with private insurance companies who administer the Medicare payments. In Indiana, Medicare payments are handled by AdminStar Federal. AdminStar Federal is called an “intermediary” when it handles claims from hospitals, nursing homes and home health agencies under Part A. AdminStar Federal is called a “carrier” when it handles claims from doctors and other providers of medical services under Part B. The involvement of these different organizations is sometimes confusing to Medicare recipients. On matters of application or eligibility, you will usually deal with a
Social Security office. On matters of claims, coverage, and payment, you will often deal with AdminStar Federal. For general information about the Medicare program, contact your local Social Security office.

WHO IS ELIGIBLE AND HOW DO YOU APPLY

Part "A" benefits. You should apply when you become eligible. Do not wait for illness or injury. Four categories of persons are eligible for Part A benefits:

1. You are automatically eligible for Part A benefits if you are 65 or older and are eligible for either Social Security retirement, survivor’s benefits or Railroad Retirement benefits. (See Social Security) You should apply for these benefits about three months before your 65th birthday. If you started receiving Social Security or Railroad Retirement benefits before age 65, you should receive your Medicare card automatically when you reach age 65.

2. You are eligible for Part A if you are younger than 65, are disabled and have been eligible for Social Security disability, Social Security retirement, survivor’s benefits or Railroad Retirement disability benefits for at least two years. If you are getting disability benefits, you should receive your Medicare card automatically after two years. (See Social Security’s definition of disability)

3. If you have chronic kidney disease at any age and are eligible for Social Security or Railroad Retirement disability benefits, you are eligible for Part A without waiting for two years.

4. If you are 65 or older but not otherwise eligible, you may choose to enroll in Part A. Persons who have retired from work in the federal government are usually not eligible. If you choose to enroll, you must pay a monthly premium ($443 in 2009, but only $244 if you have 30 quarters of coverage) and must enroll in Medicare Part B. The premium for Part B is higher for every year you wait to apply beyond age 65, unless you qualify for Medicaid, Medicaid may pay your premium for Part B.

You are eligible for Part B if you are eligible for Part A benefits. If you are enrolled for Part A benefits, you will also be automatically signed up for Part B. You can opt to decline Part B coverage, but you should keep Part B coverage unless you are absolutely certain that you have other insurance coverage for those items covered under Part B. Although you can later sign up for Part B, in many cases you would not be required to pay a higher Part B premium for the rest of your life.

YOUR MEDICARE CARD

If you are covered by Medicare, you will be given a Medicare card. If you and your spouse are both covered, you should have separate cards with separate claim numbers. You should show your card whenever you receive services that Medicare will pay for. Put your full claim number, including the letter, on all claims and correspondence about Medicare. Carry your official card with you when you are away from home. If you lose your card, call Social Security to get a replacement.

COVERED

Generally, Medicare will not pay for:

1. Services by healthcare organizations and professionals who are not licensed under state or local health laws.

2. Care by a hospital, nursing home or home health agency that is not approved to participate in the Medicare program. Be sure to check that organizations are approved for Medicare.

3. Custodial care, which is help that does not require professional skills or training; for example, help in eating, walking, dressing, bathing and taking medicine.

4. Care that is not reasonable and necessary.

If you have received care reasonably believing that Medicare would cover the expense, you will not be held responsible for paying for that care even if it turns out that the care is not covered because it is custodial or not reasonable or necessary. This rule, called “waiver of liability,” applies to Part A benefits, but only applies to Part B benefits if the doctor or supplier agreed to accept an assignment. (See Part A coverage) Even if your doctor did not accept assignment, you will not be responsible to pay your doctor for services Medicare found not to be reasonable or necessary. This does not apply if either your doctor could not reasonably have been expected to know that Medicare would not pay for the services, or if the doctor informed you in advance that he or she believed Medicare was likely to deny payment for that service. If you disagree with Medicare’s decision about such services, you can appeal that decision. A nursing home should notify you within three days of admittance if your care there is not covered by Medicare.

PART A COVERAGE


Medicare can help pay for only a limited number of days in a hospital or nursing home in each benefit period. A benefit period starts when you first enter the hospital and ends when you have been out of the hospital or entered a skilled nursing home for 60 days in a row. There is no limit to the number of benefit periods you can have, but there are limits to Medicare payments within each benefit period. Also, Medicare will not pay for every expense in a hospital or nursing home.

When you are in the hospital, Medicare will pay for in-patient hospital expenses only if a doctor prescribes hospital care the care can only be provided in the hospital, the hospital participates in Medicare, there are some exceptions, and a hospital committee agrees that you need the care.

Part A Hospital Insurance does not cover:

1. Doctor’s services while you are in the hospital. Part B might cover this.

2. Personal convenience items you request such as TV, radio, telephone, etc.

3. Private duty nurses.

4. Extra charge for a private room, unless it is medically necessary.

5. Fees for the first three pints of blood per year that you do not replace.

Other expenses, such as a semi-private room, regular nursing services, meals, therapy, medical supplies, drugs and wheelchairs and walkers are usually covered.

In special circumstances, Part A might help pay for hospital care in a foreign hospital, in a Christian Science sanatorium or in a hospital that does not participate in Medicare. Part A can also help pay for a lifetime total of up to 190 days in a psychiatric hospital. For information about these special cases, call your Social Security office.

Medicare limits the amount of covered expenses it will pay in each benefit period. From day number 1 through day number 60 in each benefit period, Part A pays for all covered expenses except the first $1,068. The first $1,068 is your deductible and you must pay it. From day number 61 through day number 90, Part A pays for all covered expenses except $267 a day, which you must pay yourself. If you need more than 90 days of care in a hospital, you can use up to 60 additional days. During these reserve days, Part A pays all but $534 a day, which you must pay yourself.

These amounts change annually.

NOTE: You only get 60 reserve days in your lifetime. Once you have used them, they are gone. They will not be available again in the next benefit period. You can decide yourself whether and when to use these reserve days. You may choose to use private insurance or other funds to pay hospital expenses after day number 90 and save your reserve days. If so, you should notify the hospital in writing ahead of time.

The following examples might help explain Part A hospital coverage.

Example #1: Mrs. A enters the hospital on June 1. On June 12, she goes home. Mrs. A must pay the $1,068 deductible, and Medicare Part A will pay the rest of her covered hospital expenses.

Example #2: Mrs. B enters the hospital on June 1 and does not go home until August 15. For the first 60 days, Mrs. B must pay the $1,068 deductible, and Part A will pay the rest of her covered hospital expenses. After day number 60, Mrs. B must pay $267 a day, and Part A will pay the rest.

Example #3: Mr. C is in the hospital for 55 days. He must pay the $1,068 deductible, and Medicare Part A will pay the rest of his covered expenses. After he
has been home for 20 days, he is readmitted to the hospital for the same condition. Because he has been home less than 60 days, the second hospital stay is in the same benefit period. So the day he is admitted is considered day number 56, and he does not have to pay the deductible again. After 5 days, however, he will have to start paying $267 a day.

Example #4: Mr. D is in the hospital for 7 days. He pays the $1,068 deductible, and Medicare Part A pays the rest of his covered hospital expenses. After he has been home for 90 days, he returns to the hospital. Because he has been home longer than 60 days, a new benefit period will begin when he re-enters the hospital. His first day after readmission will be day number 1, and he must pay the $1,068 deductible again.

NOTE: The amounts that you pay change each year, so check with your Social Security office.

When you are in a nursing home. Part A can help pay for care in a skilled nursing home facility after you have been in a hospital. Many nursing homes do not provide the level of care necessary to make that home a skilled nursing facility, so be sure to check before you assume that Medicare will help pay for that facility’s care. To be covered, the nursing home must be certified for Medicare, and also you must meet all the following requirements:

1. You have been in a hospital at least three days in a row, not counting the day you were discharged.
2. You need follow-up care in a skilled nursing facility for the same condition that was treated in the hospital.
3. You enter the facility soon, usually within 30 days, after you leave the hospital.
4. A doctor certifies that you need daily skilled nursing or rehabilitation care, not just custodial care or periodic nursing care.
5. The facility’s review board agrees that you need this type care.
6. The facility, including the wing or part where you stay, provides skilled nursing care.

If your stay in the nursing home is covered, Part A will help pay for up to 100 days of care in each benefit period so long as you continue to need skilled nursing care. If you leave the facility before you have used your 100 days and you are readmitted within 30 days, you may be able to use the rest of your 100 days even though you do not have a new three day stay in the hospital.

In each benefit period, Part A will pay the following amounts:
1. From day number 1 through day number 20, Part A will pay for all covered expenses.
2. From day number 21 through day number 100, you must pay $133.50 a day (this amount changes each year), and Part A will pay the rest of covered expenses.
3. After day number 100, you must pay all expenses.

Notice that if you are in a nursing home very long, Medicare will run out. As a practical matter, you may not get Medicare payments even for the full 100 days as Medicare may decide you no longer need daily skilled services. The average number of nursing home days for which Medicare actually pays is much less than 100. This means that you should not count on Medicare for substantial payment of nursing home expenses. (See Supplemental & Long Term Healthcare Insurance)

Covered services in a skilled nursing facility include:
1. A semi-private room
2. Meals, including special diets
3. Regular nursing services
4. Drugs furnished by the facility
5. Medical supplies
6. Use of wheelchairs
7. Rehabilitation services

Part A cannot pay for:
1. Your doctor’s services while you are in the facility, although Part B may help pay for these services. (See Part B coverage)
2. Private nurses.
3. Extra charges for a private room, unless the room is medically necessary.
4. Personal convenience items such as TV, radio, or telephone in your room.
5. Fees for the first three pints of blood per year that you receive and do not replace.

PART B COVERAGE
Medicare Part B can help pay for doctor’s services, outpatient therapy, outpatient hospital care, home healthcare and other services and supplies not covered by Part A.

Part B covers a doctor’s services you receive in the doctor’s office, in a hospital, in a skilled nursing facility, in your home or anywhere else in the United States. Sometimes, especially if your doctor recommends surgery, you may want a second opinion. Part B helps pay for a second opinion.

Part B also typically helps pay for:
1. Medical and surgical services
2. Outpatient hospital care, including emergency room services
3. Diagnostic tests and procedures
4. X-rays
5. Drugs that cannot be self-administered
6. Medical supplies
7. Outpatient rehabilitation
8. Reasonable charges for radiology and pathology services while you are in a hospital
9. Outpatient treatment for mental illness, but only 62.5% of charges are covered
10. Services of a licensed podiatrist, but not for routine foot care
11. Independent laboratory services, if the laboratory is certified by Medicare
12. Necessary ambulance transportation by an ambulance service approved by Medicare, not used merely to get to the doctor’s office
13. Prosthetic devices, such as heart pacemaker, corrective lenses after a cataract operation, breast prosthesis after a mastectomy, colostomy bags, etc.
14. Artificial limbs and braces
15. Oxygen equipment
16. Wheelchairs
17. Home dialysis equipment
18. Various screening tests, including mammograms, pap smears, bone mass measurement, diabetes screening, cardiovascular screening, prostate cancer screenings, glaucoma tests, and colorectal exams
19. Medical nutritional therapy for persons with diabetes or renal disease
20. Flu and pneumonia shots
21. Smoking cessation

Under Part B, payments are based on the calendar year rather than the benefit period used for Part A. You must pay the first $135 of all Part B expenses in each year. This is your deductible. After you have paid the first $135 of expenses, Part B will pay 80% of the remaining reasonable charges for the year. You must pay the other 20%.

NOTE: Medicare Part B only counts reasonable charges for medical services which Medicare uses a formula to determine what a reasonable charge for each service is and will pay only 80% of this reasonable charge. What Medicare calls a reasonable charge for a service is often less than what the doctor or other provider actually charges. As a result, you may have to pay the difference between what Medicare considers a reasonable charge and what the doctor or other supplier actually charges you. So it is important to ask whether your doctor or other supplier will accept an assignment. A doctor who accepts assignment cannot bill you for this difference. Even if the doctor does not accept assignment, there are limits on what the doctor can charge you, as discussed below.

HOME HEALTHCARE UNDER BOTH PART A AND PART B
Medicare pays for some part-time skilled health services if you are confined to your home because of illness or injury. The agency that provides the care must be certified by Medicare.

Medicare cannot pay for:
1. Full-time nursing care at home
2. Drugs or medicines, with some exceptions
3. Meals delivered to your home
4. Help with dressing, bathing, or meeting personal needs such as shopping services
5. Homemaker services
6. Medical supplies
7. Outpatient therapy, outpatient hospital care, home healthcare and other services and supplies not covered by Part A.

There are no longer limits on the number of home health visits you can have, although you must only need part-time or intermittent services. Full-time services, up to eight hours per day, can be covered for a temporary period not over 21 days.

To find out what home health services are available in your area, contact your Area Agency on Aging as listed in Chapter 14.

HOSPICE CARE
Medicare Part A can pay for hospice care for persons with a terminal illness where death is expected within six months. The hospice must be certified by Medicare. Medicare pays for two 90 day periods, one 30 day period of hospice benefits, and a final period
of unlimited duration. During a period, Medicare will pay the full cost of medical and support services, including physician and nursing services, medical appliances and supplies, short-term inpatient care, therapy counseling, and home health and homemaker services. By agreeing to hospice care, you agree to receive care related to your terminal illness only from the hospice program, and you give up the right to receive Medicare services from other providers.

**PRESCRIPTION DRUG COVERAGE**

Persons with Medicare A and B can sign up for a Part D Prescription Drug Plan for a monthly premium that varies depending on the plan selected. There are also opportunities to sign up for Medicare managed care plans that may include prescription drug coverage. Medicare contracts with several private companies to provide this benefit, so the plans have various options, with different covered prescriptions at different costs.

For prescriptions available under a standard plan, a beneficiary will be responsible for a part of the annual cost of the prescriptions, as follows:

1. Must pay the first $295, the deductible;
2. Must pay 25% of the costs between $295 and $2,700;
3. Must pay all of the costs between $2,700 and $6,153.75;
4. Costs above $6,153.75, must pay $2.40 for generics, $6 for brand drugs, or a 5% copayment, whichever is highest.

The requirement that beneficiaries pay all of the costs between $2,700 and $6,153.75 has been referred to as the “coverage gap” or “doughnut hole”, due to the lack of coverage for prescriptions falling within the hole. The amounts listed are indexed to rise with the growth in per capita Part D spending. There are specific provisions designed to assist low income persons. Persons eligible for both Medicare and Medicaid, so some Medicaid recipients may be disadvantaged.

There is assistance available for low income persons who do not qualify for full Medicaid benefits. Persons with incomes below 135% of poverty level and assets under $6,000 for a single person or $9,000 for a couple receive a premium subsidy, are not responsible for a deductible and pay copayments ranging from $2.40 to $6 per prescription. Persons with incomes below 150% of poverty level and with assets under $10,000 for a single person or $20,000 for a married couple receive premium subsidies on a sliding scale, have a deductible reduced to $20, pay 15% copayments for prescriptions and after that, pay copayments of $2.40 to $6 per prescription.

**HOW PAYMENTS ARE MADE**

**Part A.** You do not have to send in any claims or bills for care received from a hospital, skilled nursing facility or home health agency under Part A. These agencies file your claim for you, and Medicare then pays them directly. You will get a notice that explains what Medicare covers. The hospital, nursing home or home health agency cannot bill you for any additional amount for covered services other than the deductible amounts discussed above.

If you have questions about what Medicare has paid, you should contact your local Social Security office.

**Part B.** Part B payments may be made in either of two ways:

1. The doctor or other supplier may accept an assignment.

   a. When choosing to accept an assignment, the doctor or supplier agrees not to charge you more than what Part B considers a reasonable charge. The doctor will file the claim with Medicare and collect payment directly from Medicare. You can then be billed only for the part of the yearly $135 deductible that you have not yet met and 20% of the remaining reasonable charge. You can, of course, also be charged for any services that Medicare does not cover. You cannot be charged for the difference between the doctor or supplier’s fee and what Medicare determines to be a reasonable charge.

   b. A doctor who accepts an assignment is agreeing to charge no more than the amount Medicare approves. You should ask your doctor or other supplier to accept an assignment of your claim against Medicare. You are probably better off if the doctor or supplier agrees to this method of claiming medical payments. Some doctors and suppliers accept assignments on all Medicare claims. Directories listing these doctors and suppliers can be obtained from a Social Security office or purchased from Medicare.

2. If the doctor or supplier does not accept an assignment, Medicare will pay 65% of the approved charge, minus any part of the $135 deductible you have not yet met for the year.

   a. Under this method of payment, the doctor or supplier may bill you for the amount that he charges over and above what Medicare considers a reasonable charge. So you may have to pay more under this method of payment. But there are still limits on how much a doctor can charge you. A doctor cannot charge more than 115% of the Medicare approved amount.

   b. Also when a doctor performs elective surgery on an unassigned basis and charges $500 or more, the doctor cannot charge more than Medicare’s reasonable charge unless the doctor disclosed in advance in writing his or her fee, the estimated Medicare payment and what the patient will need to pay.

   c. Even if your doctor or supplier does not accept assignment, he or she must still submit a Medicare claim for you. No fee can be charged for submitting a claim. Medicare will send you a check for the amount it covers, and you are responsible for paying the entire bill of the doctor or supplier, subject to the limits discussed above.

Medicare may take up to six months to process a claim. They will not begin any payments until you have submitted bills that add up to your $135 deductible for the year.

**IF YOU DISAGREE WITH A DECISION BY MEDICARE**

**Part A.** An initial coverage determination is made by Medicare based upon a claim submitted by the healthcare provider. The provider initially decides whether the care is covered by Medicare. If you are notified by a provider that care is not covered under Medicare, you can then appeal the claim to Medicare. A claim cannot be submitted unless services are actually provided. For example, a skilled nursing home may notify you that your care is not covered by Medicare. If you go home, you cannot file a claim and pursue an appeal for skilled nursing home services. Unless you request that the provider submit the claim to Medicare, there will be no official determination which you can appeal.

If you only have a denial from the provider but you believe the care ought to be covered by Medicare, the first step is to request the provider to submit the claim to Medicare. Nursing homes must notify you of the right to request that a claim be submitted. If you request the nursing home to submit the bill to Medicare, the nursing home cannot bill you until Medicare decides whether the bill is covered. Likewise, you can request that a home health agency submit a claim for home healthcare. However, the claim cannot be submitted unless the services are provided, and the agency can require you to pay for the care in the meantime.

If Medicare denies the claim, it will mail a notice which should explain the reason for its decision. If you disagree with the decision, you have 120 days to request that Medicare redetermine its decision. The form to request redetermination is available at your local Social Security Office.

If you disagree with the redetermination, you have 180 days to ask Medicare for reconsideration. Maximus, a contractor, will issue a new decision within 60 days after reviewing the file.

If, after a review, you still disagree with the decision and more than $120 is at issue, you have 60 days to request a hearing before a Medicare Administrative Law Judge. You can then eventually appeal to federal court if at least $1,180 is at issue.

**Part A Hospital Coverage.** There is a special expeditious review process if you think you are being asked to leave a hospital too soon. If the hospital determines that you no longer need hospital care, it will issue a Notice of Non-Coverage. If you do not request a review, the hospital can bill you for all the costs of your stay beginning with the third day after you receive the Notice of Non-Coverage.

The hospital cannot charge you unless it gives you a Notice of Non-Coverage. If the Notice states that your doctor agrees with the hospital’s decision, you can request that the Quality Improvement Organization (QIO) review the decision. The QIO for Indiana is Health Care Excel, Inc., you can contact at (800) 288-1499, or (317) 243-1499. You must make your request for review by noon of the first work day after you receive the Notice of Non-Coverage. The QIO will ask for your views before making its decision. You will not be responsible for the cost of hospital care before you receive the QIO’s decision.
If the QIO agrees with the hospital, then you can be billed for all costs beginning at noon of the day after you received the QIO's decision. If the Notice of Non-Coverage states that the QIO agrees with the hospital's decision, then you should request review immediately, because the hospital can begin billing you beginning with the third calendar day after you received your Notice of Non-Coverage, even if the QIO has not completed its review.

Review by an Administrative Law Judge of the QIO's decision is available if at least $200 is in controversy, and review in federal court is eventually available if at least $2,000 is at issue.

Part B. After a claim has been submitted under either Part A or Part B, Medicare should send you a notice that explains what Medicare decided on your claim and what services Medicare will pay for. Examine the notice carefully. If you do not understand it or if you disagree with the decision, contact Medicare. If you disagree with Medicare's decision, you have the right to ask for a review of the decision. Someone at the Social Security office can help you make the request for review. You must request the review within 120 days after you receive the notice of decision on your claim. The notice you receive from Medicare should tell you exactly what steps you can take to appeal.

If you disagree with the redetermination, you have 180 days to request reconsideration of the decision. The reconsideration should be complete within 60 days. If, after reconsideration, you still disagree with Medicare's decision, and if the disputed amount is at least $120, you have 60 days to ask for a hearing by a Medicare Administrative Law Judge. To reach the $120 amount under Part B, you can combine several smaller bills, but the programs are very different. Medicare is available without regard to your financial situation. You can receive Medicaid in most cases only if you have a low income and few assets. Medicare is a federal program run locally by Social Security offices. Medicaid is a cooperative federal-state program, and the Family and Social Services Administration (FSSA) is the agency which is ultimately responsible for the program in Indiana. The Office of Medicaid Policy and Planning (OMPP), a division of FSSA, is designated as the "single state agency" for administering Indiana's Medicaid program.

Medicare is basically the same throughout the United States. Medicaid programs vary from state to state and pay for more kinds of services than Medicare. In fact, Medicaid can pay for some of the gaps in Medicare coverage. You can participate in both Medicare and Medicaid if you are eligible for both programs. (See Medicare)

**MEDICAID**

Medicaid is a government program that pays necessary medical expenses for many needy persons, including the elderly, blind and disabled. Medicaid pays directly to the provider, that is, to the doctor, hospital, nursing home, pharmacist or other provider of medical services. Both the federal and the state government pay for Medicaid and set rules for the program.

**MEDICAID AND MEDICARE**

Medicaid and Medicare both help pay medical bills, but the programs are very different. Medicaid is available without regard to your financial situation. You can receive Medicaid in most cases only if you have a low income and few assets. Medicare is a federal program run locally by Social Security offices. Medicaid is a cooperative federal-state program, and the Family and Social Services Administration (FSSA) is the agency which is ultimately responsible for the program in Indiana. The Office of Medicaid Policy and Planning (OMPP), a division of FSSA, is designated as the "single state agency" for administering Indiana's Medicaid program.

Medicare is basically the same throughout the United States. Medicaid programs vary from state to state and pay for more kinds of services than Medicare. In fact, Medicaid can pay for some of the gaps in Medicare coverage. You can participate in both Medicare and Medicaid if you are eligible for both programs. (See Medicare)

**PRIVATIZATION OF THE MEDICAID PROGRAM**

FSSA and OMPP contract with private entities to perform various functions. In 2006, Governor Mitch Daniels signed a 10-year, $1.16 billion contract with the IBM Coalition for it to "modernize" and privatize the eligibility determination and review process. The Coalition will replace most of the functions now performed by caseworkers in the county Division of Family Resources (DFR) offices, though the county offices will remain in place with a reduced staff to provide some assistance to persons who prefer to walk into a local office. There will be two major service centers: one in the City of Marion and the other in Lake County. These centers will serve as call centers for the entire state and handle various other tasks. There will also be minor service centers located in South Bend, Fort Wayne, Indianapolis, Terre Haute, New Albany and Evansville. Fifty-nine counties have transitioned to the new system as of the writing of this reference guide, and FSSA goal is for all counties to be on the new system as soon as some of the problems in the new system have been corrected. Cases in the 59 counties which have rolled out the new system are processed through the service centers.

There is a new application process for all counties in the modernized system. An applicant can apply online or obtain an application form online at www.in.gov/fssa, by telephoning the Service Center at (800) 403-0864 or by going to a local DFR office and using the computer at the local office. An online application can be signed electronically and filed online. Alternatively, an application can be completed online, saved, printed and signed by the applicant. The signature pages must then be mailed or faxed to a service center in order to make the application official and fix the application date.

If an applicant telephones the service center to start the application process, the service center will obtain information and then mail a bar coded application form to the caller. The caller will then sign the form and mail or fax it to the service center. The date of application is not the date of the initial call but the date that the service center receives the signed signature page, either by mail or by fax.

Applicants, and recipients, do not have an assigned caseworker under the modernized system. Instead, the case is processed by multiple staff. Applicants can orally communicate with the service center, which is staffed from 7 a.m. to 7 p.m. Monday through Friday. Service center staff have access to information in an electronic file. Documents are scanned in and saved with the electronic file, so there is no hard file. The applicant can telephone the call center to confirm that the documents have been received and processed.

**ELIGIBILITY**

To be eligible for Medicaid, you must first be in one of several categories of eligible persons. The categories that may apply to older adults are:

1. Age 65 or older
2. Blind with vision no better than 20/200 in the better eye with the use of a corrective lens or a visual field restriction of 20 degrees or less
3. Disabled because of a physical or mental impairment, disease or loss which appears reasonably certain to result in death or that has lasted, or appears reasonably certain to last, for a continuous period of at least one year without significant improvement and that substantially impairs your ability to work. This is very similar to the test used for Social Security and SSI.

Certain working individuals with disabilities are eligible to buy Medicaid coverage. This coverage was authorized by the federal Ticket to Work and Work Incentives Improvement Act of 1999.

To be eligible, an individual must:

1. Have a severe medically determinable impairment;
2. Be at least 16 years of age but no more than 64 years of age;
3. Be engaged in a substantial and reasonable work effort;
4. Not have countable resources above those allowed for SSI, $2,000 for a single individual or $3,000 for a married couple;
5. Have countable income at or below 350% of the federal poverty level for an individual but excluding a spouse's income.

There is also a special category of benefits to assist women with breast or cervical cancer. This category provides that a woman under age 65 who does not qualify for Medicaid under any other category, who does not have other credible health insurance coverage and who needs treatment for breast or cervical cancer will qualify for Medicaid if the family income is less than 200% of poverty level. Eligibility lasts as long as treatment is needed. The Indiana Breast and Cervical Cancer Program can be contacted at (317) 233-7633, or (800) 433-0746.

There are other categories which deal with the eligibility of persons such as pregnant women, children.
and certain recipients of other public assistance programs which are not discussed in this section.

You must be a U.S. citizen or a lawfully admitted alien. You do not have to have lived in Indiana for any minimum length of time to be eligible for Medicaid. If you have moved to Indiana with the intention of making this your home, the Division of Family Resources shall deny you Medicaid benefits just because you have not lived here for a particular length of time; however, there are a few exceptions. If Medicaid denies your application because you have not lived here long enough, you can request a fair hearing to challenge that decision. (See Appeals) You also must meet an income test and a resources test to be eligible for Medicaid.

**INCOME STANDARD**

In 2009, if you live at home, your income standard is $674 if you are not married. If you are married, the income standard is $1,011 regardless of whether one or both of you should apply for Medicaid. The applicant’s SSI payments are not counted toward these maximum amounts and $15.50 of the applicant’s income is not counted.

You can have income greater than these standards and still be eligible for Medicaid to cover some of your medical bills. You will be subject to an “income spend down” equal to the amount by which your countable income exceeds the income standard.

**Example**

Mr. A, who is single, has income which exceeds the monthly income standard by $46. His monthly medical expenses, however, are $150. Mr. A qualifies for Medicaid assistance with an income spend down of $46. Once Mr. A incurs $46 worth of medical bills, Medicaid will cover his additional medical expenses.

Medicaid may take into consideration the income of your spouse, but not the incomes of your children or other persons, unless those incomes are actually available to you.

If you are in a nursing home, you are eligible if you do not have enough income to pay for the nursing home’s private pay rate. You will pay all of your income to the nursing home except for $52 which you are allowed to keep for your personal needs and an amount equal to the cost of your healthcare insurance premium. You may also be entitled to keep more of your income to pay additional expenses such as old medical bills and guardian’s fees.

If you are in a nursing home and have a spouse at home whose income is less than $1,023, effective through 2009, then you can give your spouse enough money each month to raise her or his income to $1,023. This figure changes every year in July. Your spouse may also be entitled to an “excess shelter allowance” if he or she has high shelter expenses such as mortgage, rent, utilities, taxes, insurance, etc. Dependent family members may be able to keep some of your income. The spouse at home always has a fair claim to a third of your income. You can keep $52 of your income per month for your personal needs and an amount equal to the cost of your healthcare insurance premium.

**RESOURCES TEST**

Your resources are the money, property and possessions you own. Some resources are countable, or “non-exempt,” while some resources are “exempt” and do not count toward the resource limits set by Medicaid. A single person can have resources worth up to $1,500 and still be eligible for Medicaid. A couple can have resources worth up to $2,250. Special rules apply to couples in situations in which one spouse lives at home and the other lives in a nursing home.

There is no limit to the amount of real estate you can own as a Medicaid applicant or recipient. If the real estate does not fall into one of the exempt categories of property, then you must offer it for sale or rent in order for it to be exempt.

Your home is not counted as a resource as long as you live in it or intend to live in it. If you are single and living in a nursing home, and there is an apparent contradiction between your intent and your ability to return home, Medicaid will ask you to submit a doctor's statement indicating that it may be possible for you to return home. Your home also is exempt if your spouse, your disabled child or your dependent minor child lives or intends to live there.

Income-producing real estate and property owned jointly with rights of survivorship with another person or persons are not counted toward the resource limit.

Irrevocable funeral trusts and life insurance policies which are irrevocably assigned for payment of funeral and burial expenses are exempt resources. Certain life insurance policies may be exempt, but, generally, the cash surrender value of your life insurance policies will count toward your resource limit. However, in order for an insurance policy or irrevocable funeral trust to be exempt, you must designate your estate or state Medicaid to receive any excess amounts after payment of funeral and burial expenses for reimbursement of Medicaid benefits provided to you after age 55 for services received after October 1, 1993 and after age 65 for services received before October 1, 1993. You can have any amount of private health insurance, though, and still be eligible for Medicaid.

One car or any value is exempt if the vehicle is needed for medical care or employment or if it has been modified for use by a handicapped person. If no car is exempt for one of these three reasons, then up to $4,500 of the current market value of your car is exempt. The equity value of additional vehicles counts toward your resource limit.

There are several other types of exempt or non-countable resources. You can check with an elder law attorney on the effect of the gift or an estate to which you are entitled, you should consult with an elder law attorney on the effect of the gift or disclaimer on your Medicaid eligibility. As of the writing of this book, Medicaid can look back from three to five years to determine if transfers in violation of these rules have occurred. By November 1, 2014, Medicaid will be able to look back five years from the date of application in all cases in which gifts have been made.

The Medicaid office can file a lien against your real estate, but only if you are institutionalized in a nursing home, intermediate care facility for the mentally retarded or a hospital, and Medicaid determines that you cannot reasonably be expected to be discharged and return home. If Medicaid determines that you will be unable to return home to live, then it may file a lien against your interest in any real estate. It cannot obtain a lien against the home, however, if any one of the following persons is living there:

- Your spouse
- Your child under age 21
- Your child who is disabled as defined by SSI
- Your parent
- Your sibling who has an ownership interest in the home and who has lived in the home continuously beginning at least one year before you were admitted to the medical institution.

The lien law is complex and contains many exceptions to Medicaid’s ability not only to file a lien, but also to enforce it. If this is an issue for you, please consult an elder law attorney who is expert in Medicaid law for further advice.

Medicaid has a “preferred claim” on your estate after your death for the amount of benefits it has paid out for you after age 55 for services received after October 1, 1993 and after age 65 for services received before October 1, 1993. Your estate includes assets that pass by will when you die and also some assets that do not, such as assets transferred into a revocable living trust after April 30, 2002. Your estate also includes property held jointly with rights of survivorship with another person but only if the joint ownership was created after June 30, 2002. Whether your home will be part of your estate at death and subject to this claim depends on how the property is titled. In any event, if your spouse, dependent or disabled child continues to live in your home after your death, Medicaid cannot make a claim against the home.

**Special rules for nursing home residents with spouses at home:**

If you entered an institution, a nursing home or hospital, on or after September 30, 1989 and you have a spouse at home, your spouse is allowed to keep a “spousal resource allowance” of one half of the resources up to $109,560 that you and your spouse owned at the time you were institutionalized. If your combined resources are $21,912 or less, your spouse can keep all of the resources. The $109,560 and $21,912 standards are 2009 figures. These numbers increase in January of each year. The chart below illustrates how these rules work in 2009:

<table>
<thead>
<tr>
<th>If the resources are:</th>
<th>The spousal share is:</th>
</tr>
</thead>
<tbody>
<tr>
<td>$219,120 or greater</td>
<td>$109,560</td>
</tr>
<tr>
<td>$100,000</td>
<td>$50,000</td>
</tr>
<tr>
<td>$50,000</td>
<td>$25,000</td>
</tr>
<tr>
<td>From $21,912 to $43,824</td>
<td>$21,912</td>
</tr>
<tr>
<td>$21,912 or less</td>
<td>All of the resources</td>
</tr>
</tbody>
</table>
In addition, you, as the institutionalized spouse, are allowed to keep up to $1,500 in resources. Any countable resources you own in excess of your $1,500 resource allowance plus your spouse's resource allowance must be spent or invested in non-countable resources. The planning process for couples in these situations can be quite complex. You should consult a lawyer who is an expert in Medicaid law for assistance.

Different rules apply if you have been institutionalized since before September 30, 1989 and have a spouse at home. You can, however, qualify under the special rules outlined previously if you entered a nursing home before September 30, 1989, and you leave the nursing home for a minimum period of thirty days, re-entering at any time on or after September 30, 1989. Otherwise, you cannot qualify for Medicaid unless you and your spouse's resources are less than $2,250.

**APPLYING**

You apply for Medicaid at your county Division of Family Resources if your county is not one that has already been rolled out into the privatized system. To locate this office, look in the telephone book under the name of your county. If you cannot go to the office yourself, you can send someone to apply for you, ask the office to mail the application or send a caseworker to your home.

If you live in one of the currently 59 counties which are in full privatized mode, see the previous section Privatization of the Medicaid Program for more details on the new online process for applying.

If you are not physically or mentally able to complete the application, the application may be completed by your spouse, guardian or other person interested in your welfare. The state will take care of applications for persons in public psychiatric facilities or public intermediate care facilities for the mentally retarded.

The law requires Medicaid to act on your application within 45 days, or, if you are applying because of disability, within 90 days of the date you signed the application. If the office is late, you can ask for a hearing.

If Medicaid notifies you that you are not eligible, it must tell you why. If you disagree, you have the right to appeal. If you are found eligible, you will receive a Medicaid card. This card is renewed every month so long as you remain eligible for Medicaid. Show this card to the provider, doctor, hospital, pharmacist, etc., every time you request a covered medical service. Medicaid can pay for necessary medical care as far back as three months before the month of application if you were eligible during those three months.

The Medicaid office will check at least once a year to make sure that you continue to be eligible. In addition, Medicaid may check on your eligibility when it learns that your circumstances have changed. You have a duty to tell the caseworker immediately, within 10 days, when there is a change in your circumstances that may affect your eligibility for Medicaid.

**COVERAGE**

Medicaid coverage is broad. In Indiana, Medicaid will usually pay for the medical services listed below and for some services not mentioned on this list. Some items require prior approval by the Division of Family Resources. The provider will take care of asking for the prior approval. Medical services included:

- **Physician services**
- **In-patient and outpatient hospital care**
- **Laboratory and X-ray services**
- **Nursing home services**
- **Intermediate care facilities for persons with mental retardation**
- **Assisted living facilities, with a waiver**
- **Home health services and other non-medical personal care (See Medicaid Waiver Services)**
- **Prescription drugs**
- **Medical supplies and equipment**
- **Outpatient mental health services**
- **In-patient psychiatric care for persons under age 21 or over age 65**
- **Dental services with a $600 limit per year on most services**
- **Optometric services, including eyeglasses**
- **Physical and occupational therapies**
- **Speech pathology, audiology, and related supplies**
- **Respirators, therapy, and related supplies**
- **Private duty nursing**
- **Chiropractic services**
- **Podiatric services**
- **Transportation for Medicaid-covered services**
- **Burial assistance**

Some of these services are optional services, meaning that the federal government does not require Indiana to provide the service. As a result, a service listed may be “on the chopping block” as Indiana strives to contain Medicaid costs in the coming years.

You may choose the doctor, pharmacist, hospital, nursing home or other provider who will care for you as long as that provider is certified by Medicaid. You do not have to go to the least expensive doctor. To make sure that the provider is certified by Medicaid, show your Medicaid card to the provider before you receive services. You can also ask Medicaid for a list of providers in your area who are certified. If you receive services from a provider who does not participate in Medicaid, you will have to pay the cost yourself.

**QUALIFIED MEDICARE BENEFICIARY (QMB), SPECIAL LOW INCOME MEDICARE BENEFICIARY (SLMB), QUALIFIED INDIVIDUAL (QI), AND QUALIFIED DISABLED WORKER (QDW)**

Some people who are ineligible for regular Medicaid may qualify for special Medicaid benefits called Qualified Medicare Beneficiary (QMB), Special Low Income Medicare Beneficiary (SLMB), Qualified Individual (QI), and Qualified Disabled Worker (QDW).

**APPEALS**

If Medicaid denies your application, it must notify you in writing. Also, if you are already receiving benefits and Medicaid plans to reduce or limit your benefits, it must usually give you at least a 10 day notice. The notice must contain the reasons for the change. If you disagree with a decision or action by Medicaid, you have the right to appeal. For example, you can appeal:

- **The denial of eligibility**
- **The termination of eligibility**
- **The violation of your civil rights**
- **The lack of timeliness of the Medicaid decision, e.g., award of eligibility, a limit on payments for particular services or the amount of income Medicaid says you must contribute toward your own medical care.**

To appeal, you must notify the county or state office in writing within 10 days of the effective date of the action you want to dispute. If you appeal in time, the law gives you the right to a fair hearing. If you request this hearing before the effective date of Medicaid’s proposed action, your former benefits should continue until a decision is reached after the hearing. Before the hearing, you have the right to see the file on your case. If needed, a medical examination to help prove your disability, the government will pay for that examination. A lawyer can be very helpful at this
stage. If you cannot afford a lawyer, you might get help at a legal services program office. (See Legal Services) If you cannot afford a lawyer, you might get help at a legal services program office. (See Legal Services)

At the hearing, you may be represented or assisted by a friend, lawyer, or other person. The hearing will be like an informal trial. An administrative law judge hears the case. You have the right to testify, have others testify for you, and cross-examine Medicaid’s witnesses. You should bring to the hearing all papers that relate to your case, and you should be ready to explain your reason for appealing.

Medicaid must notify you in writing of its decision within 90 days of the day you requested the hearing. The notice should tell you how to appeal further if you are still not satisfied with the decision. You can appeal if you do so within 10 days of receiving the decision from the hearing. If you still disagree, you may be able to appeal to a court. At that stage, you will need a lawyer.

**SUPPLEMENTAL AND LONG TERM HEALTHCARE INSURANCE**

**MEDICARE SUPPLEMENTAL INSURANCE**

Many older persons purchase private health insurance as protection against illness or injury. Even if you have Medicare, you may want to supplement your Medicare coverage with private health insurance. If you read carefully the section on Medicare, you will see that there are many medical expenses not covered by that program. Medicaid was not designed to meet all the medical needs of older persons.

If you buy health insurance to supplement Medicare, you should read the policy carefully. You want coverage that fills the gaps in Medicare that are important to you but does not duplicate Medicare’s coverage. Many insurance companies sell insurance, called Medicare Supplements, specifically designed to fill the gaps in Medicare. These gaps include:

- Full-time nursing care at home
- The deductibles and copayments that you must pay under Medicare

**For a stay in a hospital in 2009, Medicare has these “gaps”:**
- Days 1-60, you pay the first $1,068.
- Days 61-90, you pay $267 a day.
- Days 91-150, you pay $534 (reserve days).
- After Day 150, you pay the entire cost.
- You also pay for the first three pints of blood.

**For a stay in a nursing home in 2009, Medicare has these gaps:**
- Any care that is less than skilled nursing care, e.g., custodial in nature.
- Days 21-100, you pay $133.50 a day.
- After Day 100, you pay the entire cost.
- You also pay for the first three pints of blood.

Some Medicare Supplement policies cover nursing home expenses only after Medicare benefits are exhausted. Yet Medicaid makes it difficult to “use up” all your Medicare coverage. As a result, you may be left with a useless insurance policy that never takes effect.

**For bills from a doctor or other supplier in 2009:**
- You pay the first $135 a year. This amount increases periodically.
- You pay 20% of the rest of covered expenses.
- You pay the difference between what the doctor or supplier charges and what Medicare allows.

For more details concerning gaps in Medicare, see the Medicare section. All these dollar amounts are subject to change. For current information, ask at your local Social Security office.

**FEDERAL LAW PROTECTS CONSUMERS**

Federal law helps to protect consumers. Companies are required to issue standardized policies so that it is easier to compare policies issued by different companies. There will be only 10 different types of policies which can be issued. Insurance companies are required to use the same format to describe their plans, again making it easier to compare policies.

Insurance companies must warn consumers that persons normally do not need more than one supplemental policy. Consumers should normally not purchase more than one policy because in most situations, one policy will provide the benefits anyway.

An insurance company cannot discriminate or refuse to sell a supplemental policy during the first six months after a person age 65 or older first enrolls for benefits under Medicare Part B. The policy can provide a waiting period of up to six months for pre-existing conditions for which the person received treatment six months before the policy became effective. If you replace one supplemental policy with another, you cannot be forced to go through a new six month period for pre-existing conditions.

All Medicare supplemental policies will be guaranteed renewable, and an insurance company cannot cancel your policy due to your health. A policy can be cancelled only for nonpayment of premiums or material misrepresentation. If a policy is terminated for all policyholders by the group policyholder and not replaced, the insurer must offer the policyholders an individual policy that provides for the continuation of benefits.

**LONG TERM HEALTHCARE INSURANCE**

Many insurance companies are now offering long term care or nursing home policies. Be careful in buying this type of policy. Many such policies do not provide the protection you are most likely to need. For example, many persons are in nursing homes because they need help with daily living, yet many policies are limited to care that is medically necessary. Pay special attention to the definition of medically necessary in the insurance contract. Also, many policies limit coverage to skilled care and would not cover custodial care.

In shopping for long term care policies, find out whether a given policy guarantees renewability; a policy that can be cancelled by the insurance company after a need arises may be worthless. Indiana law now provides that a long term healthcare insurance policy cannot be cancelled or terminated on the grounds of age or a decline in health. Find out also whether the company limits rate increases, some companies attract you with low rates but then raise rates dramatically later. Find out about the company policy on pre-existing conditions. Be aware of the maximum number of days covered. A policy that pays for 365 days of continuous stay will not be renewable after one year of stay in a nursing home.

The state Medicaid office offers a program that allows you to keep more assets and still receive Medicaid if your long term care insurance policy pays toward the costs of your long term care. For every dollar of benefits paid out under an individual’s long term care policy for Medicaid-eligible long term services, that person’s asset limit increases by the same amount. So, for example, for a policy that pays out $50,000 in benefits, $50,000 will be added to the Medicaid resource limit for that individual.

A person who purchases a qualified policy meeting the maximum benefit criteria will have no asset limit once the policy has paid out the maximum benefit amount. This means, for example, that when the policy has paid the maximum benefit, an individual with $500,000 in the bank could immediately qualify for Medicaid. Furthermore, Medicaid will have no claim on the assets when that individual is deceased. The maximum benefit amount required to obtain total asset disregard is:

- 2009.....................$239,447
- 2010.....................$251,419

Further information is available from the Indiana Long Term Care Program office at (317) 233-1470 or on its web site at www.in.gov/issa/ltc. The website lists the insurance companies which offer qualified policies and the insurance agents who have completed the required training course and who are marketing qualified policies. For more information on general insurance issues, contact the Indiana Department of Insurance at (800) 452-4800.

**GENERAL TIPS ON SHOPPING FOR HEALTH INSURANCE**

Whatever type of health insurance you want, you should shop carefully and compare the policies of different companies. Consider, for example, how quickly the insurance company pays a claim. Also consider whether the company gives you individual attention and helps you answer questions about your policy. Here are some general tips for buying health insurance:

---

42 INDIANA LAWS OF AGING

---
1. It is not usually advantageous for an older person to drop the insurance he already has in force in order to buy a new policy. Consider the matter carefully.

2. Do you really need additional health insurance? Consider the alternatives and do not buy insurance that duplicates protection you already have. For example, if you have a low income and are eligible for Medicaid, that program will pay most of your medical bills. Even if you do not qualify for full Medicaid benefits, you may qualify for Medicaid as a Qualified Medicare Beneficiary which functions like a Medicare supplemental insurance policy. (See Medicaid) If you belong to a Health Maintenance Organization (HMO), you probably already have substantial coverage for health expenses. An HMO provides insurance in a sense. You pay a premium or membership fee to join an HMO. You then receive health services directly from the doctors and other providers who participate in the HMO.

3. Check the waiting period to see how soon the policy will cover an illness that began before the effective date of the policy. At the time you get the insurance you may already have a condition that will later require medical attention, and you probably want to be covered for related expenses as soon as possible.

4. Watch out for policies that pay fixed amounts for certain expenses. These policies may sound attractively cheap, but this type of policy rapidly will later require medical attention, and you probably want to be covered for related expenses as soon as possible.

5. Be suspicious of policies that let the insurance company refuse to renew your policy on an individual basis.

6. Neither the state nor the federal government by the government, or that he represents any government agency, do not buy from him and report him to the state insurance department.

7. Purchase of more than one Medicare Supplement policy is usually a poor buy.

8. Do not let a salesperson frighten you into buying any insurance policy. Think calmly about whether you need the coverage that is offered.

9. Indiana law protects you against pushy insurance salespeople. Even if you have already signed an application, you may cancel a health insurance policy within 10 days of receiving the policy. You simply mail the policy back to the insurance company’s home office and ask for a refund of any premium you paid.

10. You should pay premiums by check, payable to the insurance company. Do not pay with cash and do not make the check payable to the agent.

11. You should keep a copy of your completed application so that you will know what you have bought. You should also get a receipt for any thing including money, an insurance policy, etc. you gave to the insurance agent. The receipt should contain the agent’s name, company address and company telephone number.

If you have questions about health insurance or if you have complaints about your insurance company or agent, you can get help from:

Consumer Services Division
Indiana Department of Insurance
311 W. Washington St., Suite 300
Indianapolis, IN 46204
(317) 232-2945 (Indianapolis)
(800) 622-4461 (toll-free number)

You can also obtain from this office booklets of advice concerning various aspects of health insurance.

---

**TREATMENT DECISIONS**

**RIGHT TO TREATMENT**

In this country, you generally do not have a right to receive medical treatment. There are limited exceptions. For example, if you have been committed to a psychiatric facility against your will, you have the right to receive appropriate treatment there. If you are eligible for certain medical programs of the government, for example, hospital care for certain veterans, then in some sense you have a “right” to some kinds of medical care. But, as a general rule, you do not have a legally enforceable right to receive medical treatment.

**RIGHT TO PARTICIPATE IN TREATMENT DECISIONS**

If you are being treated, however, you have the right to participate in decisions about your medical treatment. You must give informed consent to that treatment. Your consent is informed if the doctor tells you the important facts about your condition, the options for treatment and the significant advantages and risks of each option. If the doctor proceeds to treat you before you have given informed consent, his actions might be an illegal battery.

If a voluntary patient makes the request, the treatment must stop. An involuntary patient may ask a court to order the end of treatment. The treatment must then stop until the court makes a decision.

1. Sue Ann Lawrence was a young woman left in a persistent vegetative state as the result of an accident. Because she had suffered brain damage as a child, she was never able to express her wishes regarding life prolonging medical care. The Indiana Supreme Court was asked to decide whether Sue Ann’s parents had authority to request withdrawal of the feeding tube which kept her alive.

2. In 1991, the Court decided that the Indiana Health Care Consent Act applies when the family of a never- competent person in a persistent vegetative state seeks to withdraw medical care. If the patient was committed to a psychiatric facility against his will, the Court specifically determined that the term medical treatment includes artificially delivered nutrition and hydration.

3. The court went on to say that a family is not required to go to court for permission to withhold or withdraw healthcare. According to the Court, courts should become involved only when no one is available to make decisions or when there are disagreements concerning the care.

Since the Indiana Health Care Consent Act allows several different categories of people to consent to your healthcare and does not give priority to any of the persons who can consent, problems often occur when there are several family members in disagreement over how decisions should be made. Despite the court decision in the Lawrence case, advance written instructions or “directives” are still necessary to ensure that your wishes will be respected.

**RIGHT TO GOOD TREATMENT**

A doctor who treats you has the legal duty to apply reasonable knowledge and skill and to use reasonable care in treating you. If you are dissatisfied with your doctor’s treatment, you can simply change doctors. If your complaint is serious, you should notify the Attorney General’s Office, 302 W. Washington St., 5th Floor, Indianapolis, IN 46204, (317) 232-6330. If injury results, you can sue the doctor for malpractice.

Similarly, a hospital, nursing home or other health facility has the duty to use reasonable care in treating and caring for you. See Healthcare Facilities’ Complaints about your treatment in these facilities should first be discussed with the facility’s administrator. You can also make complaints regarding long term care facilities to the Division of Long Term Care, Indiana State Department of Health, 2 North Meridian Street, Section 4B, Indianapolis, Indiana 46204, (800) 246-8909.
If you have a complaint about a nursing home, you also can contact your local ombudsman program, listed in Chapter 14. In extreme cases, you can sue the facility.

MENTAL HEALTH SERVICES

Mental health is important at all ages, but some people find that growing older brings additional losses, pressure and loneliness. Sometimes you can find help for these problems by talking with a friend, relative, doctor or clergyperson. Other times you should consult a psychiatrist or go to a counseling or mental health center. You should get professional help when:

1. Mental or emotional problems become too big to handle by yourself.
2. You are overwhelmed by depression, anxiety, or anger or loneliness.
3. You are dependent on alcohol or drugs.

To find a psychiatrist or other trained mental health professional, call a county medical society or mental health association. Your Area Agency on Aging can also refer you to a counseling center.

You can also get help at your local mental health center. Indiana has 30 community mental health centers. To locate one in your area, look in the phone book under mental health, social services or counseling. At each center a professional staff provides a variety of services for all ages and special programs for older adults. It is illegal for a mental health center to discriminate against you because of your age, color, race, national origin, religion, sex or handicap.

Fees are based on ability to pay. You will not be turned away because you cannot pay. For further information, contact the Indiana Division of Mental Health and Addiction at (800) 901-1133.

CIVIL COMMITMENT

Psychological problems and mental illness may appear at any age. Many persons with these problems can find help from a clergyperson, doctor, counselor, psychiatrist, social worker, relative or close friend. An accurate diagnosis of the problem is extremely important for older persons. Many treatable disorders, such as anemia, drug reaction, depression or even a virus, can cause symptoms that resemble mental illness or "senility." Signs of mental impairment should be checked with a doctor who specializes in treating older persons if possible. In addition, community mental health centers can help with many mental problems. (See Mental Health Services) But when a person develops a psychiatric disorder that seriously affects his thinking, feeling or behavior and impairs his ability to function, civil commitment to a psychiatric facility may be necessary. (See Adult Protective Services)

Civil commitment results in significant loss of liberty, so Indiana requires that all commitments be supervised by the courts. Indiana laws are very specific to protect the constitutional rights of the person whose commitment is being considered. This discussion is merely a summary of those laws. If you are considering committing yourself or someone else for treatment, you should consult a lawyer for specific advice.

VOLUNTARY COMMITMENT

In Indiana, you can voluntarily commit yourself if you believe that you are mentally ill and need psychiatric help. You do this by applying for admission to a psychiatric hospital, community health center or other approved institution. A family doctor or someone at a mental health facility can explain the procedures for voluntary commitment.

Even if you sign yourself in, you may not be free to leave when you want. You must first submit to the superintendent or attending doctor a written request to leave. The institution then has 24 hours, not counting weekends and holidays, to decide whether to let you go. If your request is denied, you have the right to a court hearing and you then have all rights of a person who has been involuntarily committed. You may be kept in the institution until the court decides your case. A voluntarily committed patient has the absolute right to refuse unwanted treatment.

IN Voluntary COMMITMENT

Involuntary commitment is commitment to which you either do not or cannot consent. You can be committed against your will only if a court decides that both these requirements are met:

1. You are mentally ill. That is, you have a psychiatric disorder that substantially disturbs your thinking, feeling, or behavior and impairs your ability to function.
2. You are gravely disabled or dangerous. You are gravely disabled if you are in danger of coming to harm, either because you cannot provide for your food, clothing, shelter or other essential human needs or because a serious impairment or obvious deterioration of your judgment, reasoning or behavior results in your inability to function independently. You are dangerous if your mental illness presents a substantial risk that you will harm yourself or others.

Old age alone is not a reason to commit anyone. It is against the law for you to be committed if you are not dangerous and are capable of surviving safely in freedom by yourself or with the help of willing and responsible family members or friends.

If you have been declared incompetent and the court has appointed a guardian of your person (See Guardianship), then your guardian may apply for your admission to a psychiatric hospital. You cannot be committed simply because you have a guardian. Also, even if your guardian petitions for your commitment, you cannot be committed against your will unless a court finds that the requirements listed above are met. Furthermore, if you are committed, you are not necessarily legally incompetent, and you are not necessarily required to have a guardian appointed for you.

COMMITMENT PROCEDURES

Indiana has several procedures for involuntary commitment:

1. Immediate Detention, which can last no more than 24 hours. A law enforcement officer may take a person to a psychiatric facility if the officer has reasonable grounds to believe that the person is mentally ill, dangerous to self or others and in immediate need of hospitalization and treatment.
2. Emergency Detention, which can last no more than three working days. To order emergency detention, a court must find that the person is mentally ill and dangerous and in need of immediate restraint. The petition for emergency detention must include a doctor's statement that the person is mentally ill and dangerous.
3. Temporary Commitment, which can last no more than 90 days unless it is renewed for one additional 90-day period.
4. Regular Commitment, which is appropriate when the person appears to be suffering from a chronic mental illness which is expected to require custody, care or treatment in a mental health facility for more than 90 days or indefinitely.

Each of these procedures is different, so you should get legal advice on your particular situation. If you face temporary or regular commitment as outlined, the following procedure should protect your constitutional rights:

1. Any person, such as a relative, friend, guardian, health or police officer, can file a written petition with the court. The petition must include a doctor's written statement that says the doctor has examined you within the past 30 days and believes that you are mentally ill and either dangerous or gravely disabled, and that you need care or treatment.
2. The court sets a date for the hearing.
3. You must get a copy of the petition and adequate notice of the hearing so that you and your lawyer can prepare for the hearing.
4. You have a right to be present at the hearing unless you are disruptive or your presence would harm yourself. Do not sign any papers to waive this right unless you are sure you should not be present.
5. You have a right to have a lawyer represent you at the hearing. If you cannot afford a lawyer, ask the court to appoint one for you.
6. You have the right to testify at the hearing, to present your own witnesses and to cross-examine other witnesses.
7. The court may commit you to a psychiatric hospital, a nursing home, a local mental health center or the care of another mental health program. You have the right to be committed to the least restrictive alternative suitable for your treatment. This means that the court must assign you to the place and the program that least interferes with your liberty and personal life while providing the treatment you need. In some circumstances, you may be placed on outpatient status, which means that you could live outside the psychiatric facility and receive treatment as an outpatient.

8. You have the right to appeal the court’s decision.

**AFTER COMMITMENT**

Once you are committed, you lose many important rights. Because civil commitment leads to such a drastic loss of liberty, consult a lawyer if someone is trying to commit you against your will. (See Legal Services)

After you are committed, you still have some basic rights. You have the right to receive professional services appropriate to your needs. You have the right to ask a court for a hearing to determine whether you should be released. You have the right to humane care and protection from harm. You have the right to practice your religion. You have the right to consult your attorney.

You also have certain “conditional rights” that are subject to reasonable restrictions. These include the right to keep and wear your own clothes, to keep personal possessions, to have access to individual storage space for your own private use and to keep and spend a reasonable amount of your own money. You have the right to reasonable means of communication with persons outside the facility, including visits at reasonable times. You have the right to send and receive mail unopened and to place and receive telephone calls.

You have the right to be told the nature of the treatment program, including medication, proposed for you, the known effects of this treatment and of non-treatment and the alternatives, if any. You have the right to refuse to submit to the proposed treatment and to petition a court for consideration of that treatment. The court should decide to respect your refusal, unless the state makes a strong showing that:

1. The treating psychiatrist believes that the proposed treatment will be of substantial benefit in treating your condition, not just in controlling your behavior.
2. The probable benefits from the proposed treatment outweigh your concerns and the risk of harm to you.
3. After an evaluation of every alternative form of treatment, it is plain that the proposed treatment is reasonable and is the least restrictive of your liberty. Anti-psychotic drugs should not be continued for a long time against your will if you do not substantially benefit from them.

**PAYING FOR HOSPITALIZATION**

In Indiana, you or your spouse, guardian or, in some cases, the township trustee must pay the cost of psychiatric hospitalization. The Indiana Division of Mental Health may, however, waive those costs upon request.

**FOR FURTHER INFORMATION**

For information about state mental health institutions, call the Indiana Division of Mental Health and Addiction at (800) 901-1133.

---

**CHAPTER FOUR**

### Long Term Care Alternatives

There are many kinds of home and community services that promote independent living for older adults aimed specifically at keeping older adults in their own homes. Some of these programs are privately funded; others are sponsored by the government. If your needs can be met by one or more of these programs, you might be able to get along better in your own home and avoid the need for a nursing facility. The services available vary from one part of Indiana to another so you will need to investigate what services are available in your area. To receive an assessment of what services you need and to find out which are available in your area, ask your Area Agency on Aging. Inquire carefully into the quality of service provided. You might also consider whether your needs could be met by sharing a home with someone else. (See Home Sharing)

---

**HOME HEALTHCARE**

Home health agencies provide nursing care, physical therapy and other healthcare in your home. Make sure that the agency is licensed by the state and inquire about the quality of care offered. In addition, some communities have nursing homes or other centers that provide day care and treatment for older adults. Besides helping other persons receive care and attention without institutionalization, these centers can also provide respite for family members who need a break from full-time care of an older relative.

Home healthcare can be covered under Medicare Part A or Part B. It will be considered to be covered under Part A unless the patient is only covered under Part B. Even then, the home healthcare coverage under Part B is identical to coverage under Part A. There is no deductible or copayment required for the patient for home health services. If the service is covered by Medicare, Medicare is responsible for the full cost. You can only be charged for services that Medicare does not cover.

Home health services are covered if the following are true:

1. You are homebound. You may leave the home if absences are brief, infrequent or for medical purposes.
2. You are under the care of a doctor who certifies the need for home care and sets up a plan.
3. You need intermittent or part-time skilled nursing services or physical, speech, or occupational therapy. Full time services (eight hours a day) can be covered for a temporary period not exceeding 21 days.
4. The services are provided by a home health agency certified by Medicare.
5. The services are reasonable and necessary to the treatment of an illness or injury.

If these requirements are met, Medicare can also pay for part time or intermittent services of home health aids, medical social services, medical supplies, and 80% of the approved cost of durable medical equipment. Thus, if you need skilled home health services, Medicare can also pay for the services of a home health aide. But if you need a home health aide, and do not need any skilled services, Medicare will not provide any coverage.

The home health agency makes the initial Medicare coverage decision. If it decides that the services are not covered by Medicare, you can request that a claim be submitted to the intermediary for an official decision which can then be appealed. However, you must be receiving the services for a claim to be submitted. Thus, unless the agency is willing to wait for payment until the Medicare claim is acted upon, you will likely need to arrange to privately pay for the services and then later get a refund if the claim is approved. (See Medicare for more information on the appeal process).

Medicaid also covers home health agency services for those persons receiving Medicaid. Coverage is available for services provided by an RN, LPN, home
health aide, renal dialysis aide, physical therapist, occupational therapist or respiratory therapist. Prior approval must be obtained from Medicaid before services are provided, except that prior approval is not required for Medicaid to pay for the first 15 days after release from a hospital where your doctor ordered the services before your release. The coverage criteria are similar to Medicare. You must be medically confined to your home, the services must be prescribed by your doctor and the services must be intermittent or part time and medically reasonable and necessary. One requirement not contained in Medicare is that the services must be less expensive than any alternate types of care.

IN-HOME SUPPORT SERVICES

MEALS
Every county in Indiana offers a meal program for people over 60. Monday through Friday, older adults gather together for a well balanced meal. There is no specific charge for the meal, but you are encouraged to donate whatever you can afford. You can use food stamps for your donation. No one will ask you questions about your income. Also, Area Agencies on Aging and Meals on Wheels deliver meals to persons who are unable to fix their own meals. Volunteers deliver nutritional meals from Monday through Friday. Often special diets can be accommodated. You can pay for these meals. However, if you cannot afford to pay the full cost, arrangements can sometimes be made to receive the meals on a donation basis.

For more information about meal programs, contact your Area Agency on Aging.

TELEPHONE
Telephone service is vital to many older persons. If you have difficulty using a telephone, ask your telephone company about ways to adapt the telephone for your disability. Telephone companies offer a variety of special devices to permit persons with hearing, sight or motion impairments to use the telephone. Many companies also do not charge you for directory assistance if you cannot use a telephone directory because of a vision or motion impairment; call the telephone company to get an application form for this exemption.

Some organizations offer telephone reassignment programs, which arrange for someone to call you every day to make sure that you are all right. Ask your Area Agency on Aging if such a service is available in your area.

Your telephone company may offer assistance to reduce the price of service for low income customers who receive subsidized housing, food stamps, SSI, Medicaid or energy assistance. Contact your telephone company for information and to apply.

TRANSPORTATION
Many bus and taxi companies offer discounts for senior citizens and special transportation arrangements for the disabled. If you are eligible for Medicaid, that program pays for transportation to and from a doctor or medical facility and, if necessary, the cost of someone going with you. Ask your Area Agency on Aging whether there are any other transportation or escort services in your area.

MEDICAID WAIVER SERVICES
Persons eligible for Medicaid can also potentially receive not only medical services, but also some non-medical services known as “waiver services.” They are referred to as waiver services because Indiana had to obtain a waiver from the federal government to provide them. Waiver services include:
1. Home delivered meals
2. Home modification. Up to $5,000 of modifications to clients who own their homes. Includes ramps, railings, bathroom adjustments, etc. General repairs are not included.
3. Adaptive aids or devices. Examples include emergency response systems, electronic speech devices, meal preparation devices, etc.
4. Adult day care
5. Personal/attendant care
6. Homemaker
7. Respite care
8. Case management services
9. Assisted living
10. Adult foster care
11. Community transition funds. Up to $1,000 to pay one-time expenses to move from an institution to the community.

To qualify for these services a person must qualify for nursing home placement. Your Area Agency on Aging can assess your eligibility for this program and tell you about the current availability of these services in your area. Waiting lists for this program have been eliminated.

COMMUNITY AND HOME OPTIONS TO INSTITUTIONAL CARE FOR THE ELDERLY AND DISABLED (CHOICE)
The CHOICE program provides a variety of in-home services to persons age 60 or over and to the disabled who are at risk of institutionalization. Services include attendant care, homemaker services, respite care and other services for primary or family caregivers, adult day care, home health services and supplies, home delivered meals, transportation and other services necessary to prevent institutionalization.

Your local Area Agency on Aging assesses you and determines what services you need to stay at home. The program is designed to fill gaps not covered by your family, insurance, Medicare or Medicaid. The Agency also assesses what share, if any, of the cost of services for which you should be responsible. Waiting lists may be lengthy. You should contact your local Area Agency on Aging to see if you qualify.

OTHER SERVICES
A wide variety of other services are available in different communities, including:
1. Homemaker services — help with light housecleaning, preparing meals, laundry, washing dishes and seasonal cleaning
2. Handyman services — help taking care of your yard, minor repairs
3. Counseling — legal, financial, tax, employment, pre-retirement
4. Friendly visitor services — someone to visit you regularly, read and write letters, etc.
5. Services for the blind — to help you adjust to loss of sight
6. Recreation and social activities
7. Day care for older adults
8. Continuing education
9. Information, referral and case management
10. Respite care for Alzheimer patients

Many of these services are free to older persons with low income. Ask your local Area Agency on Aging about these and other services that might meet your needs and help you remain living at home.

HEALTHCARE FACILITIES

Some older persons need the special care that a nursing home provides. This discussion gives some information about:

• Types of nursing home care available
• Sources of help for paying nursing home costs
• Legal standards that nursing homes should meet
• How to enforce residents rights
• Choosing a good nursing home

The term nursing home or nursing facility can refer to different types of facilities. Indiana’s law calls nursing homes healthcare facilities and classifies them into these categories, according to level of care:

Residential Care Facility. A residential care facility provides room, meals, laundry and occasional help with dressing, personal care, medications and diets. Nursing care is provided only in emergencies.

Comprehensive Nursing Care Facility. This type of facility provides more than room, meals and laundry. It also provides, under doctor’s orders, nursing care, special diets, administration of medications, general medical supervision and, in some cases, rehabilitation and restorative therapy. Legislative changes did away with the skilled nursing facility (SNF) and intermediate care facility (ICF) distinction for Medicaid certified facilities. Nursing Facilities (NF) are now held to the same standard of care. Medicare certified facilities will continue to have skilled Medicare beds.

RESIDENTIAL CARE
Residential care facilities that house three or fewer residents, or related residents, are not licensed or registered anywhere in the state. Residential facilities that have four or more unrelated residents and that provide residential nursing care must have a license from the Indiana State Department of Health (ISDH). Licensed residential facilities must meet the standards outlined in the Indiana Administrative Code. The ISDH conducts an annual survey of residential facilities and maintains public information files on

50 INDIANA LAWS OF AGING

INDIANA LAWS OF AGING 51
every licensed residential facility.

Before entering a residential facility, you should review the public files at the ISDH for every licensed facility you are considering. The ISDH is charged with investigating complaints against residential facilities. (See Enforcing Your Rights) Results of any complaint investigation are also included in the public files.

Residential Care Assistance Program (RCAP)

Residential Care Assistance may be available to help pay for care in a licensed boarding or residential home. You must be over age 65 or disabled or blind, and you must have low income. Your disability does not have to be permanent. Apply for RCAP at the Division of Family Resources for the county where the home is located.

Comprehensive Care Facilities (Nursing Homes)

Nursing facilities are held to a high standard of care that focuses on the residents’ “highest practicable physical, mental and psychosocial well-being.” Nursing facilities are directed to recognize “individual needs and preferences” to the enhancement of the quality of life of each resident. This standard is dictated by the Nursing Home Reform Amendments to the Omnibus Budget Reconciliation Act (OBRA) of 1987 and subsequent technical amendments. Indiana Health Facility Rules have been revised in order to comply with the Reform Law.

Quality of Life

OBRA mandates that residents be allowed to choose activities, schedules and healthcare consistent with interests, assessments and plans of care and make choices about aspects of his/her life in the home that are significant to the resident. OBRA has eliminated minimum standards of care. The new standard is the “highest practicable physical, mental and psychosocial well-being.” Facilities must ensure that the resident’s abilities “do not diminish unless circumstances of the individual’s clinical condition demonstrate that diminution was unavoidable” in the 12 care areas listed below:

- Activities of daily living
- Range of motion
- Vision and hearing
- Pressure sores
- Urinary incontinence
- Nutrition
- Activities of daily living
- Catabolic physical, mental and psychosocial well-being.

Residents must demonstrate that diminution was unavoidable. Facilities must provide:

- Make your own decisions about medical treatment.
- Be free of physical, mental and sexual abuse.
- Enter into contracts.
- Practice your religion.
- Speak freely.
- Right to information. Nursing facilities must inform residents of their rights at admission and upon request. Facilities must provide:
  - A copy of the latest survey (inspection) results and any plan of correction in a public area.
  - Advance notice of changes in their room or roommate.
• A written copy of the legal rights, including personal funds, the right to file a complaint and how to contact the ombudsman and the state survey agency.
• Written information about services covered under the basic rate and extra charges.
• Written and oral information concerning Medicaid.
• Notification of nurse staffing waivers.

2. Self determination. Nursing facilities must respond to residents’ needs and concerns, as expressed by residents, or their legal representative. Residents have the right to:
• Choose their personal physician.
• Receive full information, in advance, and participate in their care plan and treatment.
• Receive reasonable accommodation for individual needs and preferences.
• Voice grievances without reprisal and receive a prompt response.
• Organize and participate in resident groups.

3. Personal and privacy rights. Residents have the right to:
• Participate in social, religious and community activities as they choose.
• Be provided privacy during medical treatment, personal visits, written and telephone communications.
• Have confidentiality of all records protected.

4. Involuntary transfer and discharge rights. Residents may only be transferred under the following conditions:
• Facility is unable to meet the medical needs of the resident.
• Resident’s health has improved so that nursing care is no longer needed.
• Health or safety of other residents is endangered.
• Resident has failed, after reasonable notice, to pay for his/her care.
• The facility closes. Notice of Relocation must be given on the form specified by the state (OBRA and the state rules mandate the assessment and care planning process be the basis for care that helps residents “attain or maintain the highest practicable physical, mental and psychosocial wellbeing.”

Assessment. Each resident entering a facility must be assessed within 14 days of admission. The assessment shall be the basis for the plan of care. The assessment must be reviewed quarterly and redone annually or earlier when there is a significant change in the resident’s mental or physical condition. The assessment is to be coordinated by an RN, with participation by appropriate health professionals.

Care plan meetings. The information gathered from the assessment will be used as the basis for the plan of care the facility has for the resident. Care plan meetings will be held periodically to update information and reevaluate goals and approaches. Residents, families and representatives are allowed to participate and should be encouraged to do so.

5. Visitation rights. Residents have the right to receive visitors:
• Immediate access by personal physician and representatives from state and federal agencies, including the ombudsman program.
• Immediate access by relatives, if resident consents.
• Immediate access by others with “reasonable” restrictions.
• Reasonable visits by groups, subject to resident’s consent.

6. Protection against Medicaid discrimination. Discrimination in treatment of residents is prohibited and applicants for admission are protected from fraudulent activities. Facilities must:
• Have identical policies regardless of source of payment.
• Provide information on how to apply for Medicaid.
• Not request, require or encourage residents to waive rights concerning Medicaid.
• Not transfer or discharge solely because payment source has changed from private to Medicaid.
• Not charge for service or items covered by Medicaid.
• Not transfer or discharge solely because payment source has changed from Medicaid.
• Not request, require or encourage residents to waive rights concerning Medicaid.
• Not transfer or discharge solely because payment source has changed from private to Medicaid.
• Not charge for service or items covered by Medicaid.
• Not transfer or discharge solely because payment source has changed from Medicaid.
• Not request, require or encourage residents to waive rights concerning Medicaid.
• Not transfer or discharge solely because payment source has changed from private to Medicaid.
• Not charge for service or items covered by Medicaid.

7. Protection of personal funds. If a resident requests the facility to manage his/her funds, the facility must:
• Keep funds over $50 in an interest bearing account.
• Keep resident and facility funds separate.
• Keep and provide to the resident complete and accurate accountings, with a written record.
• Not charge for service or items covered by Medicaid.
• Upon a resident’s death, turn funds over to the administrator of the estate.
• Purchase a surety bond or provide other assurance of security.

8. Rights against restraint and abuse. Residents are protected from physical, mental and sexual abuse and the inappropriate use of physical and chemical restraints, including freedom from:
• Physical or mental abuse, corporal punishment or involuntary seclusion.
• Restraints used for discipline or convenience of staff.
• Restraints used without a physician’s written orders to treat medical symptoms.
• Drugs used to control mood, mental status or behavior without a written physician’s order in the plan of care for a specific medical symptom and an annual review for appropriateness by an independent, external expert.

9. Rights of incompetent residents. The law states specifically that when a resident has been found by a court to be incompetent under the laws of the state, the rights of the resident “shall devolve upon, and, to the extent judged necessary by the court of competent jurisdiction, be exercised by the person appointed under state law to act on the resident’s behalf.”

LEAVING THE NURSING FACILITY
You can leave a nursing facility for the day, overnight or permanently (unless you have a guardian), and the staff may not prevent you from leaving. Remember, however, that the facility is responsible for your care and safety and may have set up procedures for pre-arranging a leave or discharge. If you sign a release of responsibility, the nursing home is no longer responsible for you when you are gone.

If you are gone overnight, you may have to pay a fee to hold your bed while you are gone. Check your home’s policy on leaves. Medicare will not pay to hold your place if you are gone overnight. Medicaid will pay to hold your bed for a limited number of days only if your overnight leave of absence is considered therapeutic, is approved by your doctor, and the facility has at least 90% occupancy.

CARE PLAN DEVELOPMENT
OBRA and the state rules mandate the assessment and care planning process be the basis for care that helps residents “attain or maintain the highest practicable physical, mental and psychosocial wellbeing.”
If your rights are being violated, or you have a complaint, you should contact the facility's administrator. Follow the facility's grievance procedure and if the facility does not respond, you can get outside help from other sources.

1. **Indiana State Department of Health (ISDH).** The ISDH will conduct an annual standard survey in each facility. Extended surveys will be conducted if the standard survey indicates substandard care. ISDH is also responsible for investigating complaints filed with the office. The survey focuses on resident outcome but this does not mean surveys must wait until the resident suffers a negative outcome before citing a deficiency.

2. **Nursing Home Ombudsman Program.** The ISDH can rescind waivers if the quality of care has declined, or if the facility has not continued diligent efforts to recruit staff.

ENFORCING YOUR RIGHTS

If your rights are being violated, or you have a complaint, you should contact the facility's administrator. Follow the facility's grievance procedure and if the facility does not respond, you can get outside help from other sources.

1. **Indiana State Department of Health (ISDH).** The ISDH will conduct an annual standard survey in each facility. Extended surveys will be conducted if the standard survey indicates substandard care. ISDH is also responsible for investigating complaints filed with the office. The survey focuses on resident outcome but this does not mean surveys must wait until the resident suffers a negative outcome before citing a deficiency.

Local Ombudsmen will also be participating in the survey process. The surveys will contact the ombudsman during the survey to inform the ombudsman of the survey and invite the ombudsman to the Resident Council Meeting, with resident approval, and the Exit Conference. The ombudsman can share complaints with the survey team. Complaints can be filed with:

**Health Facilities Division**
Indiana State Department of Health
2 N. Meridian Street
Indianapolis, IN 46204
(317) 233-7442, (800) 246-8999
Written complaints are best, but telephone complaints will be accepted.

2. **Nursing Home Ombudsman Program.** Ombudsman is a Swedish word that means citizen representative. A nursing home ombudsman is a representative for residents and can do the following:

- Investigate and seek to resolve complaints about nursing home care that affects the health, welfare or quality of life of a nursing home resident.
- Protect the rights of residents.
- Assist residents to assert their rights.
- Work to insure quality care and treatment of residents.
- Aanwer questions and provide information about nursing home care and related services.
- Educate residents, families, staff and community about nursing home resident rights.

Anyone can contact the ombudsman program for assistance; however, the resident will be consulted and direct the actions of the ombudsman. You can contact the State Ombudsman program:

**State Ombudsman Program**
Indiana Family & Social Services Administration
Division of Aging & Rehabilitative Services
P.O. Box 7083
Indianapolis, IN 46207-7083
(317) 232-7134, (800) 622-4484

3. A lawyer can help you enforce your rights. A lawyer can give you advice and, if necessary, help you in a lawsuit. (See Legal Services)

4. The Medicaid Fraud Control Unit in the Attorney General's office investigates complaints in Medicaid certified facilities. The complaint does not have to involve a Medicaid resident.

**Medicaid Fraud Control Unit**
Indiana Attorney General's Office
219 State House
Indianapolis, IN 46204
(317) 232-6520, or (800) 382-1039

5. If you are in a home that receives Medicaid, consult the Medicaid Caseworker at the county Division of Family Resources. Look in the telephone book under County Government Offices.

6. If the Veterans Administration placed you in the home, or if you receive Veteran Benefits, contact Social Services at the nearest VA hospital.

7. To report criminal conduct (cruelty, fraud, etc.), notify the County Prosecutor's Office. Look in the telephone book under County Government Offices.

When you consult these sources for help for yourself or someone you know, you may want to ask them about confidentiality and how your problem will be handled. The Department of Health, the Ombudsman, and lawyers all are required to treat your inquiry or complaint with confidentiality if you wish. If you fear retaliation for making a complaint, you should discuss this with them and they can advise you about ways your problem can be handled while protecting you from any retaliation.

MAKING THE DECISION

If you are considering nursing home care for yourself or someone else, you should first ask: is a nursing home the best alternative? What home services are available in the community? Which services are paid for in part or in full by Medicare, Medicaid or another program? If your community offers good home services and/or day care for older persons, you might prefer to maintain independent living. Your Area Agency on Aging can tell you what services are available. (See In-Home Support Services) The pre-admission screening program helps determine who needs nursing home care and who does not.

You should consult past years' surveys for the nursing homes you are considering. These reports are public records. All nursing homes are required to have available in a public area copies of the ISDH survey and plan of correction. If the home's administrator is reluctant to discuss these reports with you, be suspicious. Comparative information can also be found at www.indiana.gov under Nursing Home Compare and on the health department's website, www.indiana.gov/isdh/reports/QAMIS/ltc/repcard/rptcrd1.htm.

When considering a particular facility, ask to see a current Indiana license for both the home and its administrator. Make sure they are current. If you need Medicare and Medicaid, find out if the home is certified for these programs. Ask to see any contract or other document you will have to sign. Be sure that you understand all the terms. A lawyer can explain parts you do not understand. If someone from the home makes a promise or representation, get it in writing and have it made a part of the written contract. Be sure you understand exactly what services the home provides and what all your costs will be. The home cannot require Medicaid patients to pay a deposit before entering the home.

Be especially careful about Life Care Contracts. These contracts typically require you to turn over your home or possessions to the nursing home in return for the facility's promise to care for you for the rest of your life. You should definitely consult a lawyer before signing this type of contract.

Make full inquiry before you decide. After all, the facility you choose will be your home, at least for a while. Ask questions of the staff, residents and family and friends of residents. And do visit the facility in person. A tour with a staff member can be helpful. It can also be informative to visit the home unannounced. You may want to visit during the evening or on a weekend. Here are some questions to help you decide. These questions do not all raise legal points, but they suggest information that might be helpful.

- Is the home certified for Medicare and/or Medicaid, if you need these programs’ help?
- What do past years survey reports indicate about the home's compliance with the law?
- What does the plan of correction say the facility is doing to address the problem? Look around, is this being done?
- Are all financial agreements in writing?
- What services are included in the price? What services are not included?

**INDIANA LAWS OF AGING**

56

57
• Will you receive a refund of advance payments if you leave the facility?

• Ask to see a copy of the residents’ rights. Do staff members know about these rights?

• Is regular medical attention assured?

• Are doctors and nurses available other than in emergencies? What arrangements are there for hospitalization if it becomes necessary?

• Can each resident choose his own doctor and pharmacist?

• Are drugs carefully labeled?

• Who dispenses drugs?

• Where is the isolation room required for residents with contagious diseases?

• What arrangements are there for therapy?

• What arrangements are there for mental health services?

• Does the staff seem cheerful and helpful?

• Is there a call light for each bed and for the bathrooms?

• During your visit, how long does it take staff to respond to call lights?

• What is the turnover rate for employees?

• Do aids knock or speak before entering rooms?

• Does staff know and use residents names?

• Does staff seem cheerful and helpful?

• What do the grounds look like?

• Are doors locked from the inside?

• When was the last fire drill?

• Are exits clearly marked and unobstructed?

• Are there ramps where needed?

• Is there room for wheelchairs to maneuver?

• Are there ramps where needed?

• Are there non-slip surfaces in the bathroom?

• Are there handrails and grab-bars where necessary in the hallways and bathrooms?

• Is the place free of hazards underfoot and generally designed to minimize accidents?

• Are the chairs comfortable and not easily tipped? Are they designed to meet each resident’s individual needs?

• Are exits clearly marked and unobstructed?

• When was the last fire drill?

• Are doors locked from the inside?

• Are you allowed to look in every section of the home?

• Can you talk freely with residents? Or is there a staff person at your elbow?

• Is there a dietitian associated with the facility?

• Are special diets available?

• Are meals served at regular times?

• Are there 14 hours or less between the evening meal and the next day’s breakfast? Is a bedtime snack offered?

• Do those who need help eating get it and while the food is still warm?

• Does the food look appetizing? Are substitutes offered?

• Do lots of trays return with uneaten food?

• Ask for a tray. How does the food look, smell, and taste?

• Do the menus correspond with the meals actually served?

• Do the menus correspond with the meals actually served?

• Is the food preparation area separate from the garbage?

• Is there fresh water by each bed?

• May residents keep their own possessions and furnishings?

• May residents decorate their own rooms?

• What arrangements are there for grooming?

• Are there screens, curtains, etc., to guard privacy for personal care? Are they in good repair and functioning? Does staff use them?

• How much attention is given to matching roommates?

• Does the daily schedule seem to be set up for the convenience of residents?

• Are there convenient visiting hours?

• Are there regularly scheduled activities? Are there evening and weekend activities? This is an important question for facilities where the residents are capable of such activities.

• Are the facilities adequate for social and recreational activities? Are activities offered for every level of resident ability?

• Are arrangements made for religious services?

• What is the home’s policy on leaves of absence? When can a resident leave and for how long?

• Talk to residents and friends of residents. Are they pleased with the home? What services does the social services department offer?

• What are the qualifications of the staff in the social services department?

• How many residents are physically restrained?

• What type of security system does the facility have?

• Is there a safe area for residents who wander?

SPECIAL CARE UNITS

Special care units are sometimes used to meet the needs of specific groups of residents, such as Alzheimer’s patients. If you are looking at a special care unit it is important to compare services offered to meet the special needs of the target population. Examples would be specialized activities and therapies along with environmental adaptations. You should also ask for staff qualifications. Has the staff received special ongoing training to better work with the population?

All facilities that have special care units must file a disclosure form with the State Ombudsman. This form identifies services provided, admission requirements and other information that help you compare facilities. These forms can be reviewed by contacting the nursing home ombudsman in your area.

PERSONAL HYGIENE ITEMS

Nursing home residents whose care is paid for by Medicaid or residents who are in a Medicare skilled bed with Medicare paying for their care, should not be charged for the following personal hygiene items:

• Shampoo, comb, brush

• Bath or disinfecting soaps

• Razors, shaving cream

• Toothbrush, toothpaste, floss

• Denture adhesive, cleanser

• Moisturizing lotion

• Tissues, cotton balls, swabs

• Deodorant

• Incontinence supplies and care

• Sanitary napkins, related supplies

• Towels, washcloths

• Hospital gowns

• Over the counter drugs

• Hair and nail hygiene services

• Bathing assistance or supplies

• Basic personal laundry

If a resident would like a specific brand item other than that which is provided by the facility, the resident pays the difference between the cost of the facility provided brand and the brand that the resident is requesting.

58 INDIANA LAWS OF AGING
Discover

AMERICAN SENIOR COMMUNITIES

At a time when home and health services are seen as fragmented and, consequently, frustrating, where can today’s senior adults find a housing community to call home? That was our challenge, and the reason we created American Senior Communities. We've created communities specifically designed to serve today's seniors by providing a multitude of lifestyle choices with integrated services and amenities. With our full continuum of care, we provide a home that remains home for as long as you like.

Our Services

Garden Homes
Independent and/or Assisted Living Apartments
New Energy Wellness
Moving Forward Rehabilitation
Auguste’s Cottage Memory Care
Skilled Nursing Services Long Term Care Hospice Care Respite Care

With 43 locations throughout Indiana there’s a location near you!
For more information, visit our website at www.AmericanSrCommunities.com.

ASK ABOUT OUR MOVE IN SPECIALS!

Located in Anderson, Bedford, Beech Grove, Brownsburg, Clarksville, Elkhart, Evansville, Fort Wayne, Franklin, Greensburg, Indianapolis, Kokomo, Lafayette, Markle, Monticello, Mooresville, Noblesville, South Bend, Valparaiso, Westfield, and Zionsville.

CHAPTER FIVE

Housing

SUBSIDIZED HOUSING

If you cannot find a decent, affordable place to live, you might consider the following government programs. Keep in mind that these programs do not provide emergency housing. In fact, they often have long waiting lists.

PUBLIC HOUSING

Public housing is owned and operated by local housing authorities. The purpose of public housing programs is to provide safe, decent and sanitary housing for persons with low income. Public housing programs in Indiana often give priority to the elderly and the disabled. The programs are different in different parts of the state, as they are operated by local housing authorities.

You may be eligible if your income is below a certain amount. The amount varies from community to community. Application procedures also vary slightly but usually require a personal or telephone interview. If you live in public housing, you will pay only up to about 30% of your income for rent. Tenants in public housing have special rights and the usual responsibilities. They cannot be evicted without good cause or without a court proceeding. The Housing Authority must provide a grievance procedure that tenants can use to make complaints. There must be a written lease.

To find out if public housing is available in your area and how you qualify, or to get more information about public housing, contact your local Housing Authority.

FEDERALLY SUBSIDIZED HOUSING

Inexpensive housing may also be available to low-income elderly persons through federally subsidized private housing. Many subsidized apartment buildings are specifically designed for older residents. The federal government controls the rent in these apartments. Also, many tenants in this type of housing are eligible for Section 8 rent subsidies (see below).

To get a list of the privately owned, federally subsidized apartment complexes for the elderly in Indiana, call or write:

Department of Housing and Urban Development Loan Management Branch 151 North Delaware Indianapolis, Indiana 46204 (317) 226-7739

To apply, contact someone at the particular apartment complex in which you are interested.

SECTION 8 RENT SUBSIDIES

The federal government also has a program of rent subsidies (called Section 8 rent subsidies) for elderly persons with low or moderate income who live in privately owned housing. Under this program, a tenant may pay only up to about 30% of his income in rent. The federal government pays the difference. The advantage of this program is that an elderly tenant can choose his own apartment or house and may even be able to get help paying for the place where he already lives, if the landlord is willing to accept Section 8.

Apply for this program through your local Housing Authority. If the agency decides that you are not eligible for Section 8 housing, it should send you a written notice. You can then ask for an informal hearing to discuss the matter. If the agency decides that you are eligible, you will receive a certificate of eligibility. You then select an apartment, house or trailer. The housing chosen must pass an inspection and the lease must contain special protections for the tenants. For example, a tenant can generally only be evicted for good cause.

If you are interested in this program, contact your local housing authority or, if there is none in your area call (800) 382-9895.
LATE RENT PAYMENTS

If a tenant cannot pay the rent, he or she should ask the landlord for an extension of time. A needy tenant might qualify for help from his or her township trustee. (See Township Trustee Benefits) A landlord has the right to evict a tenant, that is, order him or her out, if the tenant is late with the rent. The landlord does not usually need to give the tenant any warning or extension of time. But if the landlord cannot evict the tenant peacefully, the landlord must go to court and let the legal system handle the matter.

The landlord cannot keep the tenant’s possessions in order to force the tenant to pay the rent. A mobile home park, however, can prevent a tenant from removing the mobile home if the tenant is behind on rent. Also, once a landlord sues and the court orders the tenant evicted, the landlord can put the tenant’s property in storage with a storage company if the tenant does not remove the property by the date listed in the court order. If the landlord improperly keeps the tenant’s property, the tenant can sue the landlord in Small Claims Court. The tenant’s lawsuit is called a replevin action, which means that the tenant is asking the court to order the landlord to return his or her possessions. The tenant can bring this lawsuit with or without a lawyer.

If a tenant is often late with the rent and the landlord accepts these late payments, then it is not fair for the landlord to suddenly decide to evict the tenant for paying late. The law requires the landlord to first warn the tenant that payments must start arriving on time.

ENDING THE LEASE

Usually, either the landlord or the tenant must give notice before ending the lease early. If the lease does not say how much notice is required, there must be at least as much notice as the length of a payment period. For example, one week’s notice if the tenant pays by the week, one month’s notice if the tenant pays by the month. If a tenant fails to give the required notice, he or she can be required to keep paying rent. If a landlord fails to give the required notice and tries to evict the tenant, the tenant should tell the court about the lack of proper notice.

Even where the lease is for a specific time, for example, one year, the tenant should not assume that the lease will end automatically on the last day of the term stated in the lease. Leases very often contain a “renewal clause” which states that the lease will be automatically renewed for a second term unless the tenant gives the landlord notice a certain number of days before the end of the lease term. If the tenant fails to give notice, he or she will owe rent for the second term. So the tenant needs to understand every term in the lease and give the appropriate notice to end the lease.

The landlord cannot shut off utilities, change the locks or remove the door in order to make the tenant’s property available to inspect the property in the presence of the tenant immediately after the tenant moves out. If the landlord is not present, the tenant should take pictures of all of the rooms. The tenant should have someone else present when the pictures are taken.

Indiana law requires a landlord to return the tenant’s security deposit within 45 days of termination of the tenancy and/or provide the tenant with an itemized list of damages, back rent and utility charges applied against the security deposit. The tenant must first give the landlord written notice of the tenant’s new address. If the landlord fails to provide the tenant with the notice of damages, the law presumes no damages have occurred, and the landlord must return the entire security deposit. The tenant can sue the landlord for the return of the security deposit and may be entitled to reasonable attorney fees incurred.

HOME OWNERSHIP ISSUES

REFINANCING A HOME MORTGAGE

Your house is a substantial asset. Be cautious about refinancing your home mortgage or taking out a new mortgage in retirement.

When circumstances result in missed mortgage payments, you risk losing your home, not just your investment. It is important to avoid creating a lien on your home unless absolutely necessary. Consider the following when determining if it is really necessary to refinance your home.

1. People often refinance to pay for large repairs to their homes, such as a roof or a furnace. These are normal, reoccurring homeowner expenses. Ideally, you should set aside savings specifically for such repairs. If you cannot afford home repairs, think about downsizing your home.

2. Some people refinance to pay for the unexpected funeral costs of a family member. Purchasing life insurance is a better way to cover this type of expense.

3. People refinance to pay off credit card debts, medical bills or judgments. This may seem attractive because the interest rates for a mortgage are lower than credit card rates and because there is a federal tax deduction for the annual interest paid on a home mortgage. However, these “advantages” should be weighed against the risk of losing the house due to a mortgage foreclosure. Failing to pay a credit card debt could result in a judgment against you, but failing to pay your mortgage could cause the loss of your home. Financial counseling can help determine if this or some other option is the best way to deal with debts.

Before refinancing your home, think about whether you can afford a new or higher house payment. Consider if you can re-pay the loan if you become unable to work or if your spouse dies. Make a plan for what you will do when you can no longer work or if a source of income ends, i.e. your spouse dies. Consider also whether you will be able to pay off the mortgage if you sell your house.

If you decide to refinance your home, look at your other expenses to decide how much you can afford for a monthly mortgage payment. A mortgage payment that consumes more than one-third of your income is likely to result in a financial crisis. You need to be able to meet your regular monthly living expenses and to have enough leftover money to save for emergencies.

Retirement is a time to look at whether you can afford to remain in your home. Medical expenses may significantly increase as you age. Home maintenance costs increase as your house ages. At a time when income is decreasing, it can be difficult to meet rising
expenses. The practical solution may be to change your living situation to reduce expenses. This might mean selling your home and moving to a condominium or an apartment.

**Predatory Lending**

Predatory lending practices tend to target elderly and minority homeowners who want to refinance an existing mortgage. To avoid predatory lenders, shop for the best rates and terms. Talk to your bank or existing mortgage lender. Consider if you really need to refinance. Look at the estimated costs of the loan to see if you are truly receiving a benefit from the loan.

Predatory loans are characterized by high interest rates, prepayment penalties, high closing costs, balloon payments (a very large payment due at the end of the loan) and other unscrupulous practices, such as over-valuing your home, lying about your financial circumstances on the loan application and disregarding your ability to re-pay the loan.

The goal of the lender in predatory lending is to take as much of your home equity from you as possible, usually accomplished through high closing costs at the beginning of the loan. The result is that you may be trapped by a loan that exceeds the actual value of your home and is more expensive that you can comfortably afford. Such loans can be impossible to refinance or even pay off by selling the house. Always consider having a trusted advisor review loan documents before you sign them. Small print coupled with pages and pages of legal wording can make it difficult to be sure you understand the terms and conditions of the loan.

**When Loans Go Bad: The Indiana Home Loan Protection Act**

In response to some of the unfair and abusive acts mentioned above, Indiana enacted a new law, effective January 1, 2005, to protect consumers from some of the most harmful lending practices. The Indiana Home Loan Protection Act (HLPA) prohibits many loan practices which have been used by loan brokers and lenders.

Most importantly, the HLPA prohibits brokers and lenders from misrepresenting or concealing important facts about your loan. The HLPA also prohibits many other practices, such as:

- Financing costly insurance often sold to many other practices, such as:
  - Predator Lending
  - Conventional closed ended loans but are really
  - Selling loans to consumers which look like
  - Engaging in deceptive acts regarding a home loan.
  - Harassing anyone attempting to assert his or her

The HLPA also limits the amount of fees and costs that may be charged before a loan will be considered a high cost loan. High cost loans are subject to additional prohibitions and consumers must receive a written notice that the loan is a high cost loan. Violations of the HLPA are subject to a variety of legal remedies including damages, statutory damages of twice the finance charge, costs and attorney fees. Consumers who think they may have been a victim of an unfair loan practice, should consult their attorney or legal advisor or file a written complaint with the Indiana Attorney General’s Office.

**Utilities/Weatherization**

The Indiana Utility Regulatory Commission has rules about your treatment by gas, electric and water utility companies. These rules do not apply to municipal utilities which make their own rules. Detailed information can be obtained for free from the utility itself. The utility must provide its customers with a handbook discussing the customer’s rights and responsibilities.

**Shut-Offs**

You must get notice in writing mailed at least two weeks before the utility shuts off service, one week for water. The notice should be mailed to you or delivered to a responsible person in your family. The notice must say:

- Obtain a claim against mortgage insurance, if there is mortgage insurance, to bring the account current.
- Agree to accept a reduced pay-off amount if you are selling your house to avoid foreclosure.
- Allow a qualified buyer to assume the mortgage.
- Agree to accept a deed in lieu of foreclosure, which means that you sign over ownership of the house to the mortgage company in exchange for cancellation of your debt.
- Each option has conditions that you must meet to use the option. Your mortgage company may be willing to consider other options. The important thing is to contact the mortgage company as soon as you know that you are in trouble. Waiting to discuss the options may make it impossible to avoid foreclosure.
- A credit counseling agency can you look at your bills and analyze whether a workable budget can help. Such an agency may be able to negotiate with some of your creditors to accept lower payments while you try to catch up on your bills. A lawyer can advise you about bankruptcy and other legal strategies that may help you save your home.

Due to the current serious economic crisis, Congress has enacted legislation to encourage lenders to modify high cost loans. Check with your lender or with legal counsel to see if you may qualify for a loan modification.

**Extension for Medical Hardship**

If you get an unusually big bill because the meter broke or it was wrongly read or it has not been read for more than two months, then you can avoid a shut-off by paying a part of the bill, equal to the average bill for the preceding 12 months, and promising to pay the rest in installments. No late fee should be charged.

**Extension for Financial Hardship**

If you fall behind in making your mortgage payments, get advice as soon as possible. Do not let fear or embarrassment cause you to fall deeper into debt. Talk to your mortgage company’s loss mitigation department. Talk to a credit counseling agency about your situation. Consider getting legal advice.

Your mortgage company has programs for helping people who are behind on their mortgages. Among the options available, the mortgage company can:

- Suspend or lower your payments temporarily.
- Set up a repayment plan to allow time to bring your account current.
- Modify your loan to change the interest, to extend the length of the loan or to allow missed payments to be added to the end of the loan.

**Utilities/Weatherization**

The Indiana Utility Regulatory Commission has rules about your treatment by gas, electric and water utility companies. These rules do not apply to municipal utilities which make their own rules. Detailed information can be obtained for free from the utility itself. The utility must provide its customers with a handbook discussing the customer’s rights and responsibilities.

**Shut-Offs**

You must get notice in writing mailed at least two weeks before the utility shuts off service, one week for water. The notice should be mailed to you or delivered to a responsible person in your family. The notice must say:

- When service will be shut off
- Why
- What telephone number to call to get information or dispute the shut-off.

**Extension for Medical Hardship**

If you do not have the money to pay your bill, or if you have another good reason for not paying, you can avoid a shut-off by agreeing with the utility, in writing, to pay $10 or one-tenth of the bill that you owe, whichever is less. You must, however, promise to pay the rest of that bill within three months and to continue to pay other undisputed bills as they are due. The utility can charge a late fee.

**Extension for Financial Hardship**

If you get an unusually big bill because the electric or water bills, the utility can shut off service without notifying you. You can still avoid the shut-off by paying the average bill for the preceding 12 months, and promising to pay the rest in installments. No late fee should be charged.

**Shut-Offs**

Shut-offs must occur between 8 a.m. and 3 p.m. on a day that the utility company’s office is open. No shut-off can occur after noon if the utility office will not be open the next day. When someone comes to shut off service, you can still avoid the shut-off by giving him reliable evidence that you have already paid the bill or are already disputing it. You cannot, however, avoid a shut-off by paying the person who comes to shut off the service.

If you rent your home and the landlord pays utility bills, the utility can shut off service without notifying you. You must then work out the problem with your landlord.

Some utility companies have a budget plan or make special arrangements for older adults. In any case, if you cannot pay a bill, you should explain to someone at the utility company before the bill is due. Utility companies might be willing to grant you an extension for good cause. If you have applied for Energy Assistance Program (see below) and are eligible, the utility cannot shut off service between December 1 and March 15.
DEPOSITS

The utility company can usually require you to pay a deposit. If, however, you have been a customer for any utility in the past two years, you do not have to pay a deposit if:

• You do not owe bills to another utility, and
• You have not been late with payments more than twice in the last year and
• You have not had a shut-off for non-payment in the last year.

If you have not been a customer of any utility in the past two years, you can still avoid paying a deposit if you meet two of the following three requirements:

1. You have worked for the same employer for two years, or you have not had more than two employers in two years.
2. You own or are buying your home or have lived in your rented home for more than two years.
3. You can show that you have a good credit rating on charge accounts, credit cards, etc. You can also be asked for a deposit if:
   • Service is shut off for non-payments.
   • You get two shut-off notices in a row.
   • You get three shut-off notices in twelve months.
   The utility must tell you in writing why it is requiring the deposit.

A deposit to a water or electric company should not be greater than one-sixth of your estimated annual billing. A deposit to a gas company should not be greater than one-third of your estimated annual billing (one-sixth if you are on a budget plan). If any deposit is more than $70, a new customer should be allowed to pay it in installments over a 60-day period (one-sixth if you are on a budget plan).

The gas company must refund your deposit after you have paid your bills on time for 12 months in a row or two billing cycles. The water or electric company must refund your deposit if you have paid your bills on time for nine months in a row or 10 out of 12 months.

HELP FOR PAYING UTILITY BILLS

Your township trustee can help with utility bills if you are needy. (See Township Trustee Benefits) The following programs might also help.

Energy Assistance Program. If you have low income, the Energy Assistance Program can help you pay heating bills. You are eligible if your household's income is at or below the income cut-off for your size household. These income guidelines change every year. If you receive SSI, your household is probably eligible. You do not have to pay back benefits received under this program, and no one gets a lien on your house. You are eligible even if you pay rent, and the rent covers the heat.

If you are eligible, no money will come to you directly. Instead, you will get a deduction from your fuel and electric bills. The Energy Assistance Program does not pay your whole bill but helps with part of the bill. The amount of benefits depends on your location in Indiana, the type of heating fuel you use and your household's income.

If you heat with natural gas, apply at your natural gas utility. If you heat with any other fuel, contact your electric utility. You can also get an application form and help filing it out at your Area Agency on Aging, a Community Action Agency and other senior citizen's centers. If you cannot apply in person, send someone at least 18 years old to apply for you. For further information about the Energy Assistance Program, call (800) 382-9895.

Weatherization Program. Indiana has a Weatherization Program run by the Division of Family Resources. If your income is low, you can get help with small projects to weatherize your house to prevent heat loss in the winter. The program might, for example, replace broken glass, caulk windows, weatherstrip, install insulation or do minor repair work. To apply or to get information, contact your local Community Action Agency or Area Agency on Aging.

HOME SHARING

“Home sharing” refers to a housing arrangement in which two or more persons decide to live together. They may choose this arrangement for companionship, for mutual help or to save money. These persons may be related, for example, an older mother living with her son or daughter, or two sisters living together. Or the sharers may be unrelated, for example, a group of older persons sharing a house, or an older person living with an unrelated younger person.

Shared housing can allow persons to pool their resources in order to live in a secure, affordable home in the community of their choice. If you are considering a home sharing arrangement, you should carefully analyze the advantages against some of the possible legal obstacles discussed below.

EFFECT ON GOVERNMENT BENEFITS

If an older person in the shared home is needy and receiving government benefits, that person's benefits may be reduced as a direct result of the housing arrangement. Social Security benefits and Medicare are not affected by home sharing, but SSI, Medicaid and food stamp benefits might be reduced.

Supplemental Security Income. Two types of home sharing arrangements will reduce benefits of SSI recipients:

1. When an SSI recipient lives in the household of another and receives both food and shelter from that other person, the SSI recipient's benefits are reduced automatically by one-third. There is a way to avoid this “one-third reduction rule.” If the recipient pays a pro rata or equal share of all monthly household expenses, the rule will not apply.

2. When an SSI recipient receives free food or shelter from another home sharer, the Social Security Administration will place a value on what is received. This amount will be treated as income to the SSI recipient and will then be subtracted from the recipient's benefits. However, as long as the recipient is paying fair value of the items received, or one-third of the maximum monthly SSI benefit, whichever is lower, then the recipient's SSI benefits will not be reduced.

Medicaid. A Medicaid recipient's benefits are not affected by the recipient's home sharing arrangement unless the recipient is receiving rent payments from another home sharer. In that case, rent may be treated as income to the Medicaid recipient. Even if the Medicaid recipient is living rent-free in someone else's home, the value of that housing is not counted as income under Medicaid as it is under SSI (see above). (See Medicaid)

FOOD STAMPS

Food stamps are given to “households.” A disabled person or a person age 60 and over can maintain a separate household for food stamp purposes. A “household” can consist of one individual or a group of individuals. An individual, or a couple, in a shared home may want to maintain the status of a separate household in order to receive greater food stamp benefits.

Home sharers usually can avoid reduction or loss of food stamps by following simple rules. To be considered a separate “household” for the food stamp program, an individual, or group of individuals, must buy and prepare food separately from other “households” sharing the home. The “household” does not necessarily have to store the food separately or use a different stove or refrigerator, but home sharers, to be on the safe side, may wish to carefully label their food and store the food on separate shelves of the refrigerator and in separate cabinets.

A “boader” is an individual living with others who pays a reasonable compensation to the others for meals. Those home sharers who fit into the “boader” category are only eligible for food stamps if their household wants them included. (See Food Stamps)
ZONING LAWS
Zoning laws often restrict an area to “family dwellings.” Despite the intent of a group of elderly home sharers to live together as a family, many municipalities simply do not recognize a group of unrelated individuals as a family. On shared housing could run into trouble with local zoning laws.
This obstacle is not always a serious problem. Many municipalities allow as many as eight unrelated persons to reside in single-family residences. The best advice for those who are contemplating home sharing is to check local zoning ordinances to see whether unrelated individuals may live together as a family in a single-family zone. Even if the zoning ordinance does prove to be restrictive, potential home sharers should consider contacting a lawyer for assistance in challenging the law. Many people have successfully challenged overly restrictive ordinances that are based on a narrow definition of “family.”

TAX LAWS
Federal and state income tax laws provide both incentives and disincentives to home sharing.

Personal exemptions. Personal exemptions provide an incentive in some situations for a taxpayer to share his home with others who pay the tax or rent, that rent counts as gross income to the taxpayer. This might discourage some home owners from sharing their houses with others. On the other hand, if the homeowner is over 65, he may be in a lower income tax bracket, because of loss of earnings due to retirement, for example, and may not suffer dramatically because of the rental inclusion. So the taxing of rental income may not be a major drawback to this home sharing arrangement.

HOME EQUITY CONVERSION

“Home equity conversion” (HEC) refers to a variety of financial plans which enable home owners to “convert” the accumulated equity in their homes into additional spendable income, without having to move out of their homes. An elderly person with limited income facing the increasing costs of remaining in their home may be able to increase their monthly income to meet those costs.

REVERSE MORTGAGES
The most common home equity conversion method is the reverse mortgage (RM). There are several different types of RMs. RMs are called reverse mortgages because they are just the opposite of the traditional mortgage. The lender pays you at certain intervals and you do not pay on the principal, interest or service fees for as long as you live in your home. The money you receive from the lender can be used for any purpose, such as property taxes, home owners insurance, utility expenses, home maintenance or renovation, health insurance or healthcare.

The following is a brief summary of common features of reverse mortgages:

- Interest is added to principal each month and therefore the total debt owed increases over time.
- Fixed or adjustable interest rates may be available.
- Interest is not income tax deductible until you pay off all or part of the debt.
- Origination fees and closing costs are charged and insured plans charge insurance premiums.
Lenders may be willing to finance these charges for you.
- Payments you receive are not taxable. You must be careful about the effect of payments on other benefits you might receive, however.

- You may be able to request a large loan advance at the closing that is much larger than the rest of your payments. This could allow you to pay off bills, or make needed repairs or renovations to your home.
- The total amount you owe is limited by the value of your home at the time the loan is paid. This may or may not include the appreciated value of your home at that time.
- Part or all of your equity in your home will be used, therefore leaving fewer assets for you and your heirs in the future.

EFFECT ON GOVERNMENT BENEFITS
Many elderly home owners who can benefit most from RMs receive needs-based public benefits or are likely to need them in the future. It is very important to understand whether public benefits would be reduced, terminated or denied in the future if you receive payments from a RM. These payments will not affect your Social Security or Medicare benefits. This should also be true if you receive Supplemental Security Income, Food Stamps or Medicaid, as the payments should not be counted as income. However, the amount of the RM payment you receive that you do not spend in the month in which you receive the payment will be considered a resource in the following month and could therefore put you over the resource limit for SSI, Food Stamps or Medicaid. If you receive a monthly amount which is annualized, referred to as a RAM, then your monthly payments will be counted as income for SSI, Medicaid and Food Stamps.

If you receive SSI, Food Stamps or Medicaid, you should carefully calculate the monthly amount or lump sum you receive from the RM. You should receive the payment early in the month to give you enough time to spend the money before the end of the month. As long as you are careful about spending the RM payments, you should not have any problems with your public benefits. If you do have any problems, you should seek legal advice as soon as possible.

FHA INSURES REVERSE MORTGAGES
Reverse mortgages are available from approved lending institutions, and they are insured under the federal government’s Federal Housing Administration (FHA) insurance program.

To qualify for an FHA-insured reverse mortgage, you must be at least 62 years old and either own your home free and clear or nearly free and clear. Any single-unit residence meeting HUD Minimum Property Standards and occupied by a qualified borrower is eligible, including single family homes, condominiums and planned-unit developments. The maximum amount you can borrow will be based on a HUD formula. You may receive monthly loan advances for a fixed term or for as long as you live in the home, a line of credit or monthly loan advances plus a line of credit.

The FHA-insured RM also allows changes in payment at little cost and protects you by guaranteeing that loan advances will continue to be made if a lender should default. Payments will continue even if, for health reasons, you may have to live somewhere other than your home for up to 12 consecutive months. You must also agree to accept mortgage counseling prior to the closing of the RM from a HUD approved counseling agency, to make sure you understand all of the possible terms and conditions of the RM, and to help you select the option that best fits your current and future needs.

IS HOME EQUITY CONVERSION RIGHT FOR YOU?
The Federal Truth in Lending Act requires lenders to inform you about the HEC plan’s terms and costs. Be sure you understand them before signing. Lenders must disclose the annual percentage rate and payment terms. On plans with adjustable rates, lenders must provide specific information about the variable rate feature. On plans with credit lines, lenders must also inform you of any charges to open and use the account such as an appraisal, a credit report or attorney’s fees.

Before you decide to enter into a HEC transaction, you need to consider more than just the terms and conditions of the transaction itself. You may want to consider involving your immediate family in deciding whether the HEC is right for you. Your family may be willing to work out a different plan to meet your needs, rather than use up the equity in your home that may have real and sentimental family value. If you want to enter into a HEC because you want to pay for your home maintenance or renovation, health insurance or healthcare.
for in-home care if you are or may become too ill or frail to live alone in your home, you should also plan to transfer legal authority to someone who can continue to manage your personal and financial affairs when you are no longer able to do so on your own. (See Managing Your Affairs and Planning for Your Future) This will ensure that you do not default on your obligations under the HEC transaction. It is also important that you consult someone familiar with the various eligibility requirements of public benefits programs to be sure that the HEC will benefit you in the long run.

A HEC plan may offer you a substantial measure of economic and personal self-reliance and independence. It is your choice to exercise your legal authority and provides your instructions for handling life's business if you are incapacitated. Legal devices for achieving these goals include the power of attorney and the living trust. (See below)  

Managing Your Affairs and Planning for Your Future

As you grow older, you may want or need help managing your affairs or taking care of yourself. On the other hand, you probably do not want anyone intruding more than is necessary into your life. Many lawyers now engage in a practice of law that has come to be called ‘Lifetime Planning.’ Lifetime Planning means maintaining control, and having your wishes carried out despite incapacity, terminal illness, or costly long term healthcare. A comprehensive ‘Lifetime Plan’ addresses four major areas of concern:

1. It designates the person of your choice to exercise your legal authority and provides your instructions for handling life's business if you are incapacitated. Legal devices for achieving these goals include the power of attorney and the living trust. (See below)

2. It states your desires about the use of life-prolonging medical technology and names your choice of representative to give consent to medical care when you are unable. The legal devices for achieving these goals include power of attorney for healthcare, appointment of healthcare representative and living will. 

3. It addresses the financial security of your spouse and other family members if you have a long term care need. Useful planning tools are long term care insurance and trusts. (See below)

4. It provides for an orderly and efficient transition for your survivors at your death. This goal is achieved using the will, the trust and estate planning that coordinates all of the methods of passing property at death into a single, organized and efficient plan. (See Planning for Death)

Even those persons who do not choose to see an attorney for their future planning needs are often confronted with the subject of lifetime planning. Certain Medicaid and Medicare certified healthcare providers, including hospitals, nursing homes and home health agencies, must give you information about your rights under state law to use “advance directives,” such as the power of attorney and living will, to instruct others on your care in the event of your incapacity.

While the Patient Self-Determination Act, which took effect in 1991, requires providers to give you the information, it also says that providers cannot force you to have advance directives before they will provide you with care. While many providers will now be giving out advance directive forms, such as the living will, for interested patients to sign, the planning process should be a thoughtful one, one in which you consider your individual needs and desires.

You should read this section of the book in conjunction with the sections on healthcare and planning for death. This chapter focuses on a number of different means by which you can plan for possible incapacity while you are still capable of doing so. By carefully and thoughtfully planning for your future, you can decide not only who will manage your affairs for you if you are incapacitated, but also in many instances how the decisions about your affairs and your care will be made. Each planning tool is helpful for certain needs, but you should be sure you understand the consequences of your choices.

POWER OF ATTORNEY

A power of attorney is a document which you, “the principal”, sign giving another person, “the attorney in fact”, the authority to handle your affairs. Its use is often essential to lifetime planning as you can not only give the authority for a person of your choice to act on your behalf but also provide instructions to your attorney in fact on how you want things managed. Used as a planning tool, the power of attorney may avoid the need for guardianship in the future.
Although the term is power of attorney and the person acting for you is an attorney in fact, you do not have to give this power to a lawyer. You can give the power to a relative or anyone you trust who will agree to be responsible for acting under the power of attorney. You should try to name at least one successor attorney in fact in case the first attorney in fact is unable to serve.

You must be capable in order to give a power of attorney. One does not get a power of attorney over someone who has become incapacitated. If an individual is unable to create a power of attorney because of incapacity, a guardianship may be necessary to manage the affairs of the incapacitated person. (See Guardianship)

Your power of attorney must be in writing, signed by you and notarized. It can be prepared and notarized without witnesses. You should consult a lawyer for drafting the document so that it is worded precisely to achieve your goals. For example, if one of your goals is to plan for the possibility of long term care, you may wish to have special wording in the document giving your attorney in fact the authority to engage in Medicaid planning or to apply for public benefits if appropriate. If you are giving the authority to engage in real estate transactions, the document should be filed in the county recorder’s office. You should keep a copy and the person to whom you give the power of attorney should also get a copy.

Under a law passed by the Indiana General Assembly in 1991, all powers of attorney are “durable.” This means that your power of attorney remains in effect even if you later become incapacitated, unless the document states otherwise.

If you want the power of attorney to take effect only if you later become incapacitated, then the document should state that it takes effect only if you become incapacitated. However, most persons should make their powers of attorney effective upon signing. Making a power of attorney effective upon signing does not mean that you will give up control of your affairs. On the contrary, you remain in charge of your affairs, and you retain the ability to revoke the power of attorney at any time you so choose as noted below.

You can state exactly what powers you want to give to your attorney in fact. For example, you can state that you are giving only the power to sell a specific piece of property.

You can also delegate very broad authority to your attorney in fact, including the authority to make decisions involving the withholding or withdrawal of healthcare. Healthcare, by definition in the power of attorney law, includes the withholding or withdrawal of artificially delivered nutrition and hydration.

However, if you want your attorney in fact to have this type of authority, you must also execute a separate healthcare representative appointment and attach the appointment document to the power of attorney.

The Power of Attorney Act specifically states that certain language be contained in the separate appointment of healthcare representative document in order to give the attorney in fact/healthcare representative the authority to withhold or withdraw healthcare. (See appointment of Healthcare Representative)

Using the power of attorney, you can choose to nominate a guardian to serve in the event a court determines you need a guardianship at some later time. The person you nominate must be given first priority by the court in the selection of the guardian. (See Guardianship)

A guardian has no power to revoke or amend your valid power of attorney without a specific court order to do so. A court cannot make this kind of order without first holding a hearing.

You can revoke or change your power of attorney any time you choose. You must give notice of the revocation to your attorney in fact. If you do not appear to have the capacity to change or revoke the power of attorney, any interested person may petition a court for instructions. A hearing must be held and notice of the hearing given as the court directs.

The power of attorney may also end if you have stated any time limit on the powers and the time expires, or, if you created the power of attorney to accomplish a specific task, and the task is completed. Unless the document states otherwise, your attorney in fact is entitled to reasonable fees for services as well as reimbursement of all reasonable expenses incurred on your behalf.

There are important differences between a power of attorney and a guardianship. (See Guardianship)

1. Giving a power of attorney is voluntary. You choose to give the power, you choose the exact powers to give and you choose the person to whom you give these powers. Guardianship may be voluntary, but a court might appoint a guardian even if you do not want one, and the court might appoint someone you would not choose to represent you.

2. You cannot create a power of attorney unless you are capable at the time you give the power, although your power of attorney continues to take effect after you become incapacitated or unless you otherwise direct. On the other hand, a guardian is appointed for you only if you are incapacitated.

3. You can revoke a power of attorney at any time by giving notice to your attorney in fact. It is very difficult to terminate a guardianship as there must be a court determination of your capacity.

Because a power of attorney allows you more freedom and flexibility than a guardianship, you might want to create a power of attorney now to avoid guardianship later.

APPOINTMENT OF HEALTHCARE REPRESENTATIVE

The Indiana Health Care Consent Act allows you to appoint a person to make your healthcare decisions if you are incapable of doing so. The appointment must be in writing and witnessed by an adult other than the person you are naming as representative.

Your representative cannot overrule your own previous instructions, such as those you have made in a living will, to your healthcare provider.

If you want your power of attorney to have the authority to withhold or withdraw healthcare, including artificially delivered nutrition and hydration, the Indiana Power of Attorney Act requires you to use language in “substantially the same form” as that provided in the Act. It is important that you see an attorney to prepare a form which includes the required language. In addition, the appointment of a healthcare representative with the required language must be attached to a power of attorney which gives the attorney in fact healthcare powers.

Elder law attorneys will often suggest that certain language be contained in the separate appointment of a healthcare representative document which combines the healthcare power of attorney, the appointment of healthcare representative, and the appointment of a healthcare guardian.

Although your power of attorney continues to last if you are capable at the time you give the power, the opposite of the living will. It states your wishes for medical treatment decisions even if the person is incapable at the time a decision must be made to provide, withhold or withdraw treatment. A living will is not really a will at all, at least not in the sense that most of us understand the term. Whereas a will has to do with what happens to your property after death, the living will deals with the manner of your death. It is a document in which you state your desires to not have extraordinary life-prolonging measures used on you when recovery is not possible. Use of artificial respirators, surgeries, radiation and other treatments which may delay but would not prevent imminent death can be avoided by use of a living will.

The living will and the life prolonging procedures declaration operate to continue an adult’s right to control medical treatment decisions even if the person is incapable at the time a decision must be made to provide, withhold or withdraw treatment.

Both of these documents are authorized under Indiana’s Living Will and Life Prolonging Procedures Act. One of the most important benefits of using either document is that you relieve your loved ones of the burden of making these difficult decisions by stating your intentions in advance.

In order to execute either of these documents, you must be competent and you must sign the document in the presence of at least two witnesses, who also must sign. Witnesses cannot be your parents, spouse, or any adult other than the person you are naming as representative.
children or anyone who can benefit from your estate. Either document must be delivered to your attending physician who should make it a part of your medical record. The remainder of this section focuses primarily on the living will.

It is important that you understand the current limitations of the living will in Indiana. Your living will takes effect only when you have a terminal illness. The Act defines terminal illness as one which will result in death within a short period of time if life prolonging procedures are not used. For example, if you are in a persistent vegetative state is not necessarily terminally ill as the patient can remain in this state for an indefinite period of time.

The Act also provides for the withholding or withdrawal of medical procedures, treatments or interventions. These terms can include the withholding or withdrawal of artificially delivered nutrition and hydration, if you choose that option in writing.

Sue Ann Lawrence was a young Indiana woman who was left in a persistent vegetative state as the result of an accident. She was kept alive by feeding tubes at the time her case became public. Even if Sue Ann had been able to execute a living will prior to her incapacity, it may not have helped her because of the limitations of the Indiana law.

Although it is not absolutely binding on your doctor or healthcare institution, your living will is generally honored, especially if you have discussed your desires with your doctor, as well as your family, before a crisis arises.

**CPR and Do Not Resuscitate Orders**

When you enter a hospital or nursing home, it is normally as the result of a medical crisis or the need for continuous care. It is a time in your life when acute medical circumstances may arise which require rapid decisions at odd hours, decisions in which you and your appointed healthcare representative have a right to participate. The healthcare provider will often want you to make a decision or sign a form concerning your wishes on resuscitation.

If you do not want to receive cardiac pulmonary resuscitation (CPR), your doctor can write an order in your medical record which tells the staff in the hospital or nursing home that you do not wish to have the procedure applied. This order is commonly referred to as a Do Not Resuscitate (DNR) order. Many persons choose to have a DNR order placed in their medical record. It is also possible for persons who are not in a hospital or other healthcare facility to obtain an Out of Hospital Do Not Resuscitate Order. Without such an order, emergency personnel are obligated to take all possible steps, including CPR, even if the effort is excessively burdensome or futile. To obtain an Out of Hospital Do Not Resuscitate Order, your attending physician must certify that you either: 1) have a terminal condition that can result in death within a short period; or 2) you have a medical condition that would result in resuscitation being unsuccessful, or you shortly would experience repeated cardiac or pulmonary failure resulting in death.

Once you have obtained an Out of Hospital DNR Order, you should obtain an identification bracelet to wear that will alert emergency personnel of the order. Such bracelets can be ordered from MedIdent by calling (800) 825-3785.

**Living Trusts Flexibility and Control**

What is a trust? A trust involves the transfer of your assets into the name of a trustee, person or financial institution, to be handled as you direct in the trust document. You are called the “grantor,” and the person who gets title to the assets is called the “trustee.”

You may be your own trustee or co-trustee in order to remain in full control as long as it is possible or as long as you are comfortable with the responsibility of managing the assets in the trust. The trustee manages and distributes the assets for one or more “beneficiaries,” according to your directions in the trust agreement.

A trust can be created during your lifetime for your own benefit or for the benefit of someone else, or it can take effect at your death, through your will. Depending on the goals you wish to accomplish, a trust can be written to be revocable or irrevocable. A revocable, living trust can be changed or ended altogether if you choose, and the assets will be put back into your own name. An irrevocable trust, as its name indicates, cannot be changed or ended except under very special circumstances, and you cannot later get the assets back into your own name.

Irrevocable trusts allow management for lifetime gifts. In fact, you can set up an irrevocable trust yet retain a lifetime income from the assets. Estate planners and lawyers may prefer a trust arrangement since it is a flexible planning device.

Traditionally, trusts have been a mainstay of financial planning, particularly for older persons. They can be used to serve a number of functions, for example:

1. Provide a caretaker of funds for a child or an incapacitated adult to be used as the grantor directs.
2. Provide financial management for the grantor’s own assets and a means to pay bills, etc., even if he or she becomes incapacitated. A power of attorney can serve this purpose as well.
3. Provide a gift management device for your lifetime gift recipients, especially children.
4. In some cases shift income to a person in a lower tax bracket as a tax planning device.
5. Pass property at death without probate proceedings.

A trust can be simple or quite complex. A lawyer writes a trust to meet the legal requirements and to help you accomplish your particular goals. You, as grantor, decide whom to select as trustee to carry out your desires, what assets are to go into the trust and how those assets will be managed and distributed.

A properly drafted document signed by the grantor and accepted by the trustee makes a valid trust. Generally there is no court oversight of the trustee unless a lawsuit is brought by someone with an interest in a transaction. Trusts often continue for many years, sometimes through two or more generations. Thus they require careful planning and wording.

The creation of a trust does not necessarily mean that you give up control over your assets. In fact, a living trust can be written to make you your own trustee. Another useful device is to create a trust agreement with a bank or individual but postpone placing assets into the trust until a later time of need. This can be done through a power of attorney where your agent transfers the assets to the previously created trust at your direction or in the event of your incapacity.

A trust does not mean that your current investments must change. Bank accounts, certificates of deposit, stocks, bonds, real estate and other assets can be transferred to your trustee to be held or you can leave all investment decisions to your trustee’s judgement. It depends on the directions you give when you create the trust.

Keep in mind that your living trust can be a transfer device like a will for the assets in the trust. Other estate planning tools, such as a power of attorney and a will, are used along with the living trust.

The cost of preparing a trust varies greatly, depending on the complexity of your goals. Trusts that are designed to solve many different problems can take longer to prepare and will involve large attorney’s fees. The trustee is entitled to a fee for managing the trust. Banks, acting as trustee, usually charge a fee based on a small percentage of the trust’s assets each year.

A lawyer or bank trust officer can tell you more about whether a trust might be right for you.

**Taxes**

**Federal income tax.** Most federal income tax laws apply to taxpayers of all ages. There are, however, some special tax benefits for the elderly. For more information about federal income tax and who must file, contact the Internal Revenue Service (IRS), listed in the telephone book with offices of the U.S. Government. Or call the IRS toll-free, (800) 829-1040. Ask for the free booklet: Tax Benefits for Older Americans, Publication #554.

The IRS has a special program of volunteers who can help you fill out your tax return. The service is free. The program is called VITA (Volunteer Income Tax Assistance), and is available between January 1 and April 15 each year. To find out the nearest site for getting this help, call the IRS toll-free, (800) 829-1040. The IRS also coordinates a program called TCE (Tax Counseling for the Elderly), which includes a limited program for homebound seniors.

Some other organizations also provide free help with tax forms. To find out who provides this service in your area, contact your Area Agency on Aging. A lawyer or other tax advisor can also give current tax advice.

Tax laws change frequently and have recently changed significantly, so be sure you have up-to-date information.

**Indiana income tax.** As with federal tax laws, Indiana income tax laws also apply to taxpayers of all ages.
Indiana tax law is subject to frequent change. You can get up-to-date information on Indiana income tax filing requirements by contacting:

**Indiana Department of Revenue**
Indiana Government Center North, Room N105
100 N. Senate Avenue
Indianapolis, IN 46204
(317) 232-2240, or (800) 382-4646 (roll-free)
(317) 232-4952, or (800) 382-4539 (TTY)

**Property tax.** Older persons who pay property taxes may be eligible for special exemptions. The laws governing property tax are also subject to frequent change. The County Auditor or County Assessor listed in the telephone book under county offices can give you the information you need.

**ConCluSion**

No two persons’ circumstances are exactly alike. The process of making a lifetime plan is a very individualized and personal process. It is essential to get the facts about your options from a knowledgeable person. By making a comprehensive lifetime plan with expert advice, you can help assure that both you and your loved ones will be protected and able to handle life’s business according to your own values and lifestyles even if the unexpected happens. The Indiana State Bar Association, (317) 631-9424, also has detailed information about “advance directives” and planning for incapacity. (317) 639-5465)

**P r o c e d u r e s f o r E s t a b l i s h m e n t o f G u a r d i a n s h i p**

Any interested person may file a petition for the appointment of a guardian of an incapacitated person. The person filing the petition is not necessarily the person who will be appointed guardian. The individual for whom the guardianship is sought has the right to both notice, which includes

**Rights of the ProtecteD Person**

The court should always look to the least restrictive alternative available to protect the interests of the incapacitated person. Courts should create “limited guardianships” whenever it is appropriate in order to encourage the self-improvement, self-reliance and independence of the protected person. In other words, if an individual is capable of making her own healthcare decisions, but cannot balance her checkbook, the court should create a guardianship limited to management of the checkbook.

Even though a guardianship may help a person who is no longer capable of property management or self-care, it may also mean a loss of rights for the protected person. The law is not entirely clear on what personal rights the protected person has in an unlimited guardianship. The protected person may lose the right to make a gift, marry, drive a car and make decisions about healthcare and housing arrangements. The protected person does not necessarily lose the right to make a will. The protected person can make a will if she is capable of understanding what property she has and knows the “objects of her bounty,” the people who would receive the property when she dies.

Letters of Guardianship, a document issued by the court, should explain exactly what powers the guardian has and whether there are any limitations on the guardianship.

As guardianship can be a right-stripping process, the law provides a formal procedure with built-in protections that must be followed before a guardian can be appointed.

**DefinitionS**

1. **Guardian.** Someone appointed by a court to make decisions for an incapacitated person. In Indiana, conservator and guardian mean the same thing. Almost any capable adult can serve as guardian. A county Division of Family and Children or a private charity can be a guardian. A non-resident person or corporation can serve as guardian if it is in the best interests of the person under guardianship.

2. **Incapacitated person.** Description of someone who is incapable of either managing property or providing self-care or both. Incapacity may stem from infirmity, insanity, mental illness, alcoholism, excessive use of drugs or other incapacity. Although these conditions may contribute to incapacity, a person who has one or more of these problems is not necessarily incapable. Old age is never a basis upon which guardianship can be granted. A person does not need a guardian just because he or she is old or infirm. A guardian should not be appointed for a person unless the individual cannot manage property or provide self-care.

3. **Protected person.** A person for whom a guardian has been appointed.

**G u a r d i a n s h i p**

When a person can no longer manage property or provide self-care, a guardianship may be appropriate. Guardianships can provide important protection to someone who is incapacitated. On the other hand, sometimes guardianships are unnecessarily imposed on persons who are capable of making their own decisions. Because the appointment of a guardian is more complex and serious than giving someone a power of attorney, you should definitely talk to a lawyer if you think that you or someone you know might need a guardian. Planning ahead can often avoid the need for guardianship. (See Managing Your Affairs and Planning for Your Future)
both a notice of rights and the petition for guardianship itself, and a hearing. The notice also must be given to the spouse, adult children, the attorney in fact under a power of attorney for the individual and in case a person serving as guardian for, or who has the care and custody of, the alleged incapacitated person.

If there are no adult children, notice must also go to the parents of the individual. If there are no parents, spouse or adult children, then at least one person most closely related by blood or marriage to the alleged incapacitated person must receive notice. The court may also direct any other person to receive notice.

The notice must be in substantially the same form that the guardianship law provides and must advise the individual that the proceeding may substantially affect the rights of the individual. The notice should also explain the rights of the individual to attend the hearing and be represented by an attorney, or if there is no attorney, a court-appointed guardian ad litem.

The hearing provides an opportunity for the alleged incapacitated person to present evidence and cross-examine witnesses, or in other words, to show the court why a guardianship should not be established.

The alleged incapacitated person must be present at the hearing unless the court determines by evidence that it is a risk to the individual's health or safety or that the individual has either knowingly and voluntarily consented to the appointment of a guardian or has knowingly or voluntarily waived notice of the hearing. However, if a consent or waiver is signed, the judge must make sure that the person for whom a guardianship should not be established.

WHO SHOULD BE GUARDIAN

Once a judge or jury determines that a person is incapacitated and in need of a guardian, the court must then determine who is best qualified to serve as guardian.

The court must give consideration for appointment to the following persons in the order in which they are listed:

1. A person designated in the power of attorney of the incapacitated person.
2. The spouse of the incapacitated person.
3. An adult child of the incapacitated person.
4. A parent of the incapacitated person or a person nominated by will of a deceased parent of the incapacitated person.
5. Any person related by blood or marriage with whom the incapacitated person has resided for more than six months prior to the filing of the petition.
6. A person nominated by the incapacitated person who is caring for, or paying for the care of, the incapacitated person.

The court may pass over a person having priority in order to serve the best interests of the incapacitated person.

END OF A GUARDIANSHIP

There are several ways that a guardianship might end:

1. Any person, including the protected person may ask the court to end the guardianship. That person must convince the court that the protected person has regained capacity.
2. A guardianship ends automatically when the protected person dies, but, the guardian may have limited authority to pay the protected person's debts, relating to funeral, burial, last illness, taxes, etc., if the court approves.
3. A guardianship limited to management of the estate may be terminated by the court if the guardianship property is reduced to $10,000 or less.
4. A guardianship also ends when the protected person moves to another state and has a new guardian appointed there. When a guardianship ends, the guardian must make a final report to the court.
Planning for Death

When you try to order your affairs so that your property is distributed the way you want after your death, you are doing estate planning. The law provides several devices for the orderly transfer of property after death. The living trust described previously may be an attractive alternative to some of the uses of a will. In fact, a living trust may be the centerpiece of your estate plan. This discussion will describe wills. Though estate planning focuses on transfers at death, adults with family responsibilities should exercise their rights and responsibilities by estate planning throughout life. This may suggest life insurance, establishing trusts for minor children or perhaps a pre-nuptial agreement to limit rights of a surviving spouse. For more information about these devices and about estate planning generally, you should consult a lawyer. (See Legal Services)

ESTATE PLANNING

If you make a will, you have, in a sense, made an estate plan because you have planned for the distribution of your property after your death. The term estate planning, however, also refers to a coordinated effort by you and your professional advisors, lawyer, accountant, insurance agent, financial planner and others, to minimize the state and federal death taxes and the expenses of death. Most financial transactions, whether they occur before or after death affect your estate plan. Estate planning includes the process of arranging your financial affairs so that transactions both before and after death reduce administrative expenses and tax burdens upon your heirs and loved ones.

Estate planning is broader than just tax planning, because proper estate planning also considers the non-tax consequences for you and your loved ones. For example, state and federal income and estate taxes might be reduced by periodic lifetime gifts to a loved one. For example, state and federal income and estate taxes might be reduced by periodic lifetime gifts to a loved one.

Estate planning involves a high degree of skill and experience and can best be accomplished with professional guidance.

WILLS

IF YOU HAVE NO WILL

If you die without a will, you are said to have died intestate, and an administrator, or administratrix, will be appointed to collect your assets, pay debts collectible against you, pay your funeral and burial expenses, and then distribute the remainder of your possessions to persons specified under fixed rules of Indiana law.

For example, if you die without a will and leave a spouse but no children and no parents, your prop-
A surviving spouse can choose to take against the will, or in other words, to ignore what he has been given in the will and take instead one-half of the net estate. However, if the surviving spouse is a second or subsequent spouse who did not have children with the decedent, the spouse is only entitled to one-third of the personal estate and 25% of any real estate. To choose this option, he must state his choice in writing within 10 days after the end of the time that other claims can be filed against the estate. The time to file claims against an estate ends three months after the date of death.

Your personal representative will most likely hire an attorney to collect your probate assets, pay debts, expenses and taxes and carry out the terms of the will. An experienced attorney can be a valuable asset in administering your estate. An attorney can help avoid unnecessary delays and expenses in the probate process.

Your personal representative to collect your probate assets, pay debts, expenses and taxes and carry out the terms of the will. An experienced attorney can be a valuable asset in administering your estate. An attorney can help avoid unnecessary delays and expenses in the probate process.

A lawyer should draft a codicil to make sure it is valid. You can revoke any will by intentionally destroying it and all copies or by creating a valid new will. A lawyer should draft a codicil to make sure it is valid. You can revoke any will by intentionally destroying it and all copies or by creating a valid new will. A later will replaces and revokes all earlier ones. Revocation of one will, however, does not necessarily mean that an earlier will is revived.

Probate and estate administration is a series of steps. The probate court appoints a personal representative, executor, and the estate is “opened” with the aid of legal counsel. Notice is published of the opening of a decedent’s estate. A three month period begins during which creditors of the deceased person submit their claims.

Known creditors and beneficiaries of the will are entitled to a direct notice of death by the personal representative. The personal representative must identify the assets and determine their fair market value. Identification and valuation also applies to assets that will not require probate. Many assets transfer by alternative legal arrangements such as right of survivorship for joint property, individual beneficiaries on life insurance, living trusts, life estates and other contractual or legal arrangements like retirement benefits and social security entitlement for survivors. These alternative arrangements may avoid the need for probate.

Death taxes, federal estate and Indiana inheritance taxes, present a separate set of concerns. Some of the assets that avoid the probate process can be subject to both federal estate and Indiana inheritance taxes. Whether the assets were held in a joint tenancy, tenancy in common, solely owned, in trust or in a legal life estate, they are subject to death taxes. However, assets going outright to or in a properly structured trust for a surviving spouse, who is a U.S. citizen, are 100% deductible for federal estate tax purposes and 100% exempt for Indiana inheritance tax.

The following chart shows under current law what the exclusion amount and tax rate are scheduled to be in the future years.

<table>
<thead>
<tr>
<th>Year</th>
<th>Exclusion Amount</th>
<th>Highest Tax Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>2009</td>
<td>$3.5 million</td>
<td>45%</td>
</tr>
<tr>
<td>2010</td>
<td>“Repeal”</td>
<td>= no tax</td>
</tr>
<tr>
<td>2011</td>
<td>Tax Act “Sunsets”</td>
<td>(Expires and reverts to old tax law)</td>
</tr>
<tr>
<td>2011+</td>
<td>$1.0 million</td>
<td>53%</td>
</tr>
</tbody>
</table>

Probate is the process by which the property of a deceased person is distributed to that person’s heirs, if no will, or to the persons listed in his or her will. Probate is necessary to establish clear title to assets in the name of heirs or beneficiaries. 

Probate and estate administration is a series of steps. The probate court appoints a personal representative, executor, and the estate is “opened” with the aid of legal counsel. Notice is published of the opening of a decedent’s estate. A three month period begins during which creditors of the deceased person submit their claims.

Known creditors and beneficiaries of the will are entitled to a direct notice of death by the personal representative. The personal representative must identify the assets and determine their fair market value. Identification and valuation also applies to assets that will not require probate. Many assets transfer by alternative legal arrangements such as right of survivorship for joint property, individual beneficiaries on life insurance, living trusts, life estates and other contractual or legal arrangements like retirement benefits and social security entitlement for survivors. These alternative arrangements may avoid the need for probate.

Death taxes, federal estate and Indiana inheritance taxes, present a separate set of concerns. Some of the assets that avoid the probate process can be subject to both federal estate and Indiana inheritance taxes. Whether the assets were held in a joint tenancy, tenancy in common, solely owned, in trust or in a legal life estate, they are subject to death taxes. However, assets going outright to or in a properly structured trust for a surviving spouse, who is a U.S. citizen, are 100% deductible for federal estate tax purposes and 100% exempt for Indiana inheritance tax.

The following chart shows under current law what the exclusion amount and tax rate are scheduled to be in the future years.

<table>
<thead>
<tr>
<th>Year</th>
<th>Exclusion Amount</th>
<th>Highest Tax Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>2009</td>
<td>$3.5 million</td>
<td>45%</td>
</tr>
<tr>
<td>2010</td>
<td>“Repeal”</td>
<td>= no tax</td>
</tr>
<tr>
<td>2011</td>
<td>Tax Act “Sunsets”</td>
<td>(Expires and reverts to old tax law)</td>
</tr>
<tr>
<td>2011+</td>
<td>$1.0 million</td>
<td>53%</td>
</tr>
</tbody>
</table>

Probate is the process by which the property of a deceased person is distributed to that person’s heirs, if no will, or to the persons listed in his or her will. Probate is necessary to establish clear title to assets in the name of heirs or beneficiaries. 

Probate and estate administration is a series of steps. The probate court appoints a personal representative, executor, and the estate is “opened” with the aid of legal counsel. Notice is published of the opening of a decedent’s estate. A three month period begins during which creditors of the deceased person submit their claims.

Known creditors and beneficiaries of the will are entitled to a direct notice of death by the personal representative. The personal representative must identify the assets and determine their fair market value. Identification and valuation also applies to assets that will not require probate. Many assets transfer by alternative legal arrangements such as right of survivorship for joint property, individual beneficiaries on life insurance, living trusts, life estates and other contractual or legal arrangements like retirement benefits and social security entitlement for survivors. These alternative arrangements may avoid the need for probate.

Death taxes, federal estate and Indiana inheritance taxes, present a separate set of concerns. Some of the assets that avoid the probate process can be subject to both federal estate and Indiana inheritance taxes. Whether the assets were held in a joint tenancy, tenancy in common, solely owned, in trust or in a legal life estate, they are subject to death taxes. However, assets going outright to or in a properly structured trust for a surviving spouse, who is a U.S. citizen, are 100% deductible for federal estate tax purposes and 100% exempt for Indiana inheritance tax.

The following chart shows under current law what the exclusion amount and tax rate are scheduled to be in the future years.

<table>
<thead>
<tr>
<th>Year</th>
<th>Exclusion Amount</th>
<th>Highest Tax Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>2009</td>
<td>$3.5 million</td>
<td>45%</td>
</tr>
<tr>
<td>2010</td>
<td>“Repeal”</td>
<td>= no tax</td>
</tr>
<tr>
<td>2011</td>
<td>Tax Act “Sunsets”</td>
<td>(Expires and reverts to old tax law)</td>
</tr>
<tr>
<td>2011+</td>
<td>$1.0 million</td>
<td>53%</td>
</tr>
</tbody>
</table>
Most decedents have far less than the amount that will be subject to the federal estate tax. Remember that the surviving spouse could receive large sums from a deceased spouse with no estate tax since what he or she receives is 100% deductible. If there is no surviving spouse to take from a decedent’s estate of more than the exclusion amount set for that particular year, there may be a big tax to pay.

Indiana has an inheritance tax for children and others for large transfers. Children and other lineal descendants, i.e. grandchild, great-grandchild, have a $100,000 exemption. If the estate is less than or equal to $25,000, 3% on the next $25,000, 2% up to $50,000 and then 3% on up to $200,000. The rate goes up to 10% for more than 1.5 million.

The standard administration in Indiana is supervised, the estate administration, unsupervised or accomplished by a “no administration” procedure. Supervised administration requires probate court approval for asset distribution. An unsupervised means court approval is not needed for each step of the probate process. Unsupervised administration is elected by the personal representative and allowed by the court if there are no valid objections. An unsupervised administration is permitted only when the estate is solvent, and as a practical matter, only when the personal representative employs experienced legal counsel.

No administration, small estates, is a third alternative for completing the probate process. It may be elected when the value of the gross probate estate, wherever located, less debts on those assets does not exceed $25,000. In addition, 45 days must have elapsed since the decedent’s death; no petition for appointment of a personal representative is pending; and the claimant(s) is entitled to payment of the probate property. An unsupervised administration is elected by the personal representative and allowed by the court if there are no valid objections. An unsupervised administration is permitted only when the estate is solvent, and as a practical matter, only when the personal representative employs experienced legal counsel.

There is a special procedure for automobile transfer where no probate administration is anticipated. If the person wanting title to the car either owned it jointly or is entitled to it under the will or the law for intestate succession, the Bureau of Motor Vehicles has a form to fill out which is similar to the affidavit. A copy of the death certificate should be taken to the BMV five days or more after death. There is only a five day waiting period from date of death to transfer a vehicle.

If there are assets discovered later or a court judgment or settlement received into the estate of a decedent, these additional assets can be distributed to the beneficiaries under the will of record. If the assets are available more than three years after death, and the will was not “spread of record” with the probate court, the will is no longer recognized. In that case, heirs at law, those entitled to inherit when there is no valid will, will take then. The Beneficiary of a testamentary trust will may or may not be different from the heirs at law.

“no administration” may even be available to the estate of a decedent who had significant wealth. Assets held jointly with rights of survivorship, living trust assets and many other asset arrangements avoid the probate classification. While the no administration procedure can be available for many estates with estate planning, estate and inheritance taxes are a separate consideration.

In addition, a summary administration procedure is available when an estate is less than allowances, costs, expenses of administration and funeral expenses. In this situation, the personal representative may be allowed to make distribution of assets to those who are entitled to them by law. This allows for the transfer of assets of someone who died more than three months ago.

A husband and wife may be co-owners as tenants in common. They may switch from joint ownership to tenants in common in the process of estate planning. Once they are tenants in common their respective shares avoid rights of survivorship. This allows each spouse to do some restrictive planning with respect to their shares.

Again, if you want to evaluate alternatives for ownership of real estate, you should consult an estate planning lawyer. There may be important tax consequences in any transfer or change of ownership of real estate. Be sure you understand the tax implications of your current situation and of the alternatives.

JOINT REAL ESTATE

If you hold title to property in your name alone, then when you die your property will pass under your will or, if there is no will, according to the rules for intestacy, the rules which apply when you don’t have a will. It is common for a husband and wife to hold title to their home or other real estate in joint name with right of survivorship. This is called ownership as tenants by the intestates. Under this arrangement, upon the death of either spouse, the property passes automatically to the other, no matter what the will says about the property. A survivorship affidavit should be filed at the county recorder’s office to update ownership records when the joint owner dies.

It is also possible for a person to hold property jointly with someone not his spouse. Joint ownership with someone else can be either with survivorship rights or without. If there is a right of survivorship, the death of one of the joint owners passes his ownership rights automatically to the other owner. If there are no survivorship rights, then the owners are called tenants in common. A tenant in common’s interest does not pass to the other co-owner; instead, it passes to the tenant’s beneficiaries.

A husband and wife may be co-owners as tenants in common. They may switch from joint ownership to tenants in common in the process of estate planning. Once they are tenants in common their respective shares avoid rights of survivorship. This allows each spouse to do some restrictive planning with respect to their shares.

Again, if you want to evaluate alternatives for ownership of real estate, you should consult an estate planning lawyer. There may be important tax consequences in any transfer or change of ownership of real estate. Be sure you understand the tax implications of your current situation and of the alternatives.

JOINT BANK ACCOUNT

A joint bank account is one in which two or more persons have the right to withdraw funds at any time before you die. The accounts are owned entirely by the persons whose names are on the accounts. The general rule is that a joint bank account is owned as tenants in common. The rights and duties of a joint bank account owner are determined by the right of survivorship of the account. This is determined by the state law of the state in which the account is located. In most states, if a person dies while his or her name is still on the account, the funds in the account belong to the surviving joint bank account owner or owners. In some states, if a person dies while his or her name is still on the account, the funds in the account belong to the surviving joint bank account owner or owners.

The general rule is that a joint bank account is owned as tenants in common. The rights and duties of a joint bank account owner are determined by the right of survivorship of the account. This is determined by the state law of the state in which the account is located. In most states, if a person dies while his or her name is still on the account, the funds in the account belong to the surviving joint bank account owner or owners. In some states, if a person dies while his or her name is still on the account, the funds in the account belong to the surviving joint bank account owner or owners.
LIFE INSURANCE

Many people have some life insurance and have named the person to receive the death benefit upon their death. Death benefits are paid directly to the beneficiary by the insurance company and do not go through probate.

Benefits payable directly to beneficiaries may be an important source of funds during estate administration, probate. Some estate plans may provide large sums of insurance to help meet your family goals and obligations.

Life insurance owned by the deceased person and payable to the estate or to an individual beneficiary is subject to federal estate tax, if applicable. Life insurance payable to an individual beneficiary is exempt from Indiana inheritance tax and federal and state income tax.

ANATOMICAL GIFTS

The medical need for human organ transplant such as the heart, kidneys, pancreas, lungs, liver and intestines has prompted many older persons to make anatomical gifts following death. In addition to organs, there is a need for tissues such as the cornea, skin, bone marrow, heart valves and connective tissue to treat otherwise catastrophic illness. A number of persons have chosen to donate their entire body after death for use in the education of future doctors and dentists. Donation of one's body can, if appropriately planned, reduce or eliminate funeral and interment costs.

In Indiana, if you are of sound mind and at least 18 years of age, you can choose to give all or part of your body for a transplant or for use in medical education or science. Persons under 18 years of age must have a parent or guardian’s consent. The law also allows a family member or guardian to authorize a gift of all or part of your body, unless you have indicated that such a gift is not to be made. The law does not permit family members to prevent donation if you have chosen to do so.

There are several ways in which you can direct that the gift be made. You can make the gift in your will, by completion of a donor card, by indicating your wish on your driver’s license or by another written document. Each of the documents, except for your driver’s license, require your signature and the signature of two witnesses who witness your signature and then sign in your presence. If you are unable to sign, you can direct someone else to sign for you in the presence of the witnesses. The easiest and most effective methods of donating are the use of either a donor card or your driver’s license.

Regardless of how you indicate the gift, it is essential that you discuss your wishes with your family and other care givers. Discussion of your wishes with one of the organizations listed below is also highly recommended as they can provide detailed information and guide you through the process.

You can change or revoke a gift at any time by formally changing your will or destroying the donor card or document and preparing a new one. Any change in your wishes should be discussed with your family members and care givers.

Details of organ, tissue or whole body gifts and donor cards may be obtained from any of the following organizations:

Organ, Tissue and Eye Donations
Indiana Organ Procurement Organization
429 N. Pennsylvania St., Suite 201
Indianapolis, IN 46204-1816
(317) 685-0389, or (888) 275-4676 (24 Hours)
www.ipo.org

Eye Tissue
Indiana Lions Eye & Tissue Transplant Bank
Indiana University Medical Center
702 Rotary Circle
Indianapolis, IN 46202
(317) 274-6527, or (800) 232-4384 (24 Hours)
www.tbionline.org

Whole Body Donation
I.U. School of Medicine
Anatomical Education Program
Medical Science Building, Rm 5035
635 Barnhill Drive
Indianapolis, IN 46202-5120
(317) 274-7450
www.anatomy.iupui.edu/anatomical

General Organ Donation Information (National)
www.organdonor.gov

FUNERAL AND BURIAL PLANNING

PREPAYMENT METHODS

There are advantages in arranging in advance for your funeral and burial and in prepaying for these services. First, this allows you to make certain that your wishes will be followed. It also allows you to make thoughtful, unpressured decisions and insure that your family will not need to make quick decisions at a time of grief. Also, the law does not require embalming except in some cases, such as certain communicable diseases, or transporting a body interstate, etc. A viewing of the body may be beneficial but is not required. The body may be buried immediately; there is no required waiting period.

If the body is cremated, there is a 48-hour waiting period. Indiana law allows the ashes to be buried in a cemetery or scattered on waterways or on private property if the property owner consents.

If a funeral director misrepresented the law to you or uses misleading advertising, you should send a detailed complaint to:

Indiana State Board of Embalmers and Funeral Directors
1021 State Office Building
100 North Senate Avenue
Indianapolis, IN 46204

When making arrangements with a cemetery for burial, you should get an itemized list of services that the cemetery provides. Some cemeteries are charitable organizations and have rate structures related to ability to pay. If the cemetery allows, you might save money by buying the grave marker from an independent dealer. Some cemeteries, however, charge extra to install markers that are not their own. Cemeteries often charge for installing and maintaining grave markers. The law does not require a grave liner or grave vault, except in the case of certain diseases, but the cemetery may require one of these.

If you need help paying for a funeral, you might be eligible to receive death benefits from Social Security, the Veterans Administration, or Medicaid.

It is a good idea to arrange for someone to house-sit at the decedent’s house during visiting hours at the funeral home and during the funeral. Burglars sometimes read the obituaries in the newspaper to find out the homes that are likely to be empty during a funeral or visiting hours. Prepaying also insures that your family will not need to concern itself with payment arrangements. Another advantage is that funds used for prepayment will not be considered in determining eligibility for Medicaid if the arrangements are irrevocable.

Indiana law provides that funeral and burial expenses can be prepaid with an irrevocable funeral trust fund. You enter a contract with a funeral home listing the services, equipment, facilities and merchandise to be provided and listing the cost for all items. The amount can be deposited in a trust fund in an Indiana financial institution. The interest earned accrues to the trust fund, and after your death the principal and interest are distributed to the funeral home for performance of the contract. You have the right to change the funeral home selected at any time.

Some funeral homes use an insurance policy to fund prepaid funeral and burial expenses. Ownership of the policy must be irrevocably assigned to the funeral home as a trustee for you, and the funeral home cannot borrow against the policy.

Indiana law provides that you have 30 days after signing a contract for prepayment to revoke the contract by giving the funeral home written notice of your decision to revoke the contract. This requirement may be waived by you if you are applying for Medicaid. If you revoke the contract in a timely manner, the funeral home must refund all payments you have made.

FUNERAL ARRANGEMENTS

The funeral director should explain to you about the services offered and the price for each service. If the funeral is sold as a package, he or she should tell you exactly what services are included in the package. He or she may be willing to eliminate some unnecessary services from a package if you do not want to pay for them.

You may want to ask about less expensive alternatives. For example, you can ask if there are less expensive caskets than the ones that are shown to you; there is usually a great range in prices for caskets. The law does not require a casket, although there must be some container. The cemetery or crematory, however, may require a casket. A sealed casket is not required except in the case of certain communicable diseases.

You can sign a funeral planning declaration which will control funeral and burial or cremation plans,
providing arrangements and payment have been made. This will help avoid disputes about your arrangements.

**WHEN SOMEONE DIES**

The death of someone close to you brings shock, grief and bewilderment. The purpose of this discussion is to answer some questions that you might ask right away or in the first few overwhelming days. You will, of course, need more detailed answers, but this discussion can be a starting point. Throughout this discussion, the person who has died is called the decedent.

**WHOM TO CALL FIRST**

If someone dies at a hospital or a nursing home, the staff will usually know whom to contact. If the death occurs somewhere else, you will need to call a doctor to verify the death.

You should then call a funeral home. The decedent may have made arrangements with a particular home. If not, your clergy person or doctor might recommend a good funeral home. Someone from the funeral home will come to get the body and will talk with you about arrangements for the funeral, visiting hours and burial. The funeral director will consult with your clergy person and family concerning any funeral and burial services.

**ANATOMICAL GIFTS**

The person who has died may have intended to donate his body or some part of it, for transplanting or for medical science or education. If so, this gift needs to be made immediately after death. Check with the decedent's close relatives and check his will and the back of his driver's license to see if he expressed an intention to make such a gift. If he did not, a guardian or certain close relatives can make the decision.

If eyes or kidneys are to be donated, they will be removed without unnecessary harm to the body, and the body will then be returned to the family.

If the whole body is to be donated, you should call a funeral director. If the decedent has not already made arrangements with a particular funeral director, the family may choose any director located in Indiana. The funeral director must sign the proper papers with the Department of Health and get the necessary information from the decedent's doctor and family. The director will also make sure that the body is delivered in time.

The Indiana State Anatomical Board will directly pay the funeral home director for the embalming. The funeral home may, however, charge more for these arrangements than the board will pay. You should ask the funeral director what expenses you will have to pay. There may be a funeral service, after which the body will be delivered to the Anatomical Board. After the scientific study of the body, the remains will be cremated and the ashes either returned to the family or buried in Crown Hill Cemetery in Indianapolis.

**JOINT BANK ACCOUNTS**

Any money held by the decedent and someone else in a joint account is presumed to belong to the surviving owner. The money is not, however, automatically available right away to that joint owner. Money held in a joint account may be frozen when one of the owners dies. You must call the bank and find out how to re-open the account. Someone may have to fill out a form and get it approved by the County Assessor's office.

**SAFE DEPOSIT BOXES**

The decedent's safety deposit box is not automatically available to survivors. If a personal representative or administrator is appointed, they will have access to the safety deposit box by showing the bank the document showing their appointment. If no estate is opened, the personal representative or administrator can sign a special kind of affidavit to gain access to the box.

**MEDICARE**

If the decedent participated in Medicare, Medicare will pay directly to the hospital, nursing home or home health agency for covered services provided to that person prior to death. (See Medicare, Part A) For bills of doctors and other medical suppliers covered under Medicare, Part B payment will depend on whether the bills have already been paid. If a bill is already paid by the patient before he died, or has been paid with funds from the decedent's estate, Medicare will pay the representative of the estate. If there is no legal representative of the estate, Medicare can send payments to a surviving member of the patient's immediate family. If someone other than the patient has paid the bill, Medicare can pay that person; that person should get the required claim form from a Social Security office. If the bill has not been paid, Medicare will pay the doctor or other supplier directly if that doctor or supplier has accepted an assignment of the claim. Otherwise, the person legally responsible for paying the medical bills can submit to the Social Security office an itemized bill and Medicare can then pay that person for the bill.

For more information about Medicare payments for someone who has died, call a Social Security office. Look in the telephone book under offices of the U.S. government.

**SOCIAL SECURITY**

If a person who received Social Security dies, the check for the month that person dies should not be cashed. For example, if the recipient dies in October, the November check, which is the payment for October, should be returned. This is true even if the recipient dies at the end of the month. Be sure to notify the Social Security Administration of the death. Otherwise, if you keep checks mailed to a decedent after his death, you may be required to pay them back later. (See Overpayment)

If the decedent had the required number of quarters of work, a surviving spouse or child may receive a one-time death benefit of $255. The death benefit can no longer be paid directly to a funeral home. For information about this Social Security death benefit, call a Social Security office.

**VETERANS' BENEFITS**

The Veterans Administration (VA) can pay up to $300 for expenses of burying a veteran and up to $150 for a cemetery space. The VA will also give the next of kin an American flag for use at the funeral. For information, contact a VA office.

County governments can pay up to $100 for burial costs, and up to $30 for setting a government headstone in the county of burial. Apply for these benefits at the County Auditor's office.

**WHOM TO NOTIFY**

You should notify any agency from which the decedent was receiving assistance checks. For example, if the decedent was receiving Social Security or SSI benefits, notify the Social Security Administration. If the decedent was receiving Medicaid or other welfare assistance, notify the Family and Social Services Administration.

Survivors should check to see if they are eligible for death benefits or survivor's benefits under the decedent's public retirement system including Social Security, Railroad Retirement, Civil Service Retirement, Veterans' Pensions, etc. (See Public Pensions)

If the decedent received a private pension, notify the administrators of the pension plan; ask whether the surviving spouse is eligible to start receiving payments. (See Private Pensions)

Notify any insurance company with whom the decedent had an insurance policy. Notify life insurance companies right away; there may be a deadline for giving them notice.

You might also check with the decedent's employer or former employer to see if survivors are eligible for any employee death benefits.

**WILLS AND PROPERTY**

If the decedent's estate is worth more than $50,000, then the estate must be probated in court. If there is no will, the court will appoint an administrator to administer the estate. If there is a will, the will must be probated which means that it must be proven in court. The court will appoint a personal representative, usually the person named in the will, to administer the estate. The personal representative may be asked to post a bond. The personal representative should get legal advice about his duties.

A lawyer can explain to you the procedures involved in administering an estate.

**INCOME TAX RETURNS**

If the decedent would have had to file a tax return if he had been living, then both federal and state income tax returns must be filed for him for the year of death. A copy of the death certificate must be attached to the state return. A surviving spouse can still file a joint return for the year of death. For the next two years after the year of death, the surviving spouse can file as a widow(er) and take advantage of joint return rates if that spouse has not remarried, has a dependent child and provides more than half the cost of keeping the home for himself and the child.

**CONSUMER FRAUD**

Some dishonest salespersons aim their frauds at grieving relatives. Especially be aware of the salesperson who delivers goods and tells you that the decedent had ordered the goods, perhaps as a surprise for you, and asks you to pay for them. Insist on proof that the decedent did order the goods.
The Indiana Attorney General’s Office offers the following services and programs to protect seniors against fraud and other crimes:

- **Telemarketing Fraud** – Sign up for the Do Not Call list to reduce your risk of fraud and scams
- **Identity Theft** – Avoid falling prey to America’s fastest growing crime by using the prevention tools provided by the office
- **Consumer Fraud** – Utilize consumer tips and alerts from the office to help deter consumer fraud and elder financial exploitation
- **Patient Abuse** – Help combat abuse and neglect of Hoosier patients in residential care facilities by reporting it to the office

For more information call 1.800.382.5516 or visit us online at www.IndianaConsumer.com

**CRIMES AND ADULT PROTECTIVE SERVICES**

Indiana law makes it a crime to physically abuse, neglect or exploit an endangered adult or a dependent. Failure to report suspected battery, neglect or exploitation of an endangered adult or dependent is a crime.

An endangered adult is a person at least 18 years old who:

1. Cannot manage her property or take care of herself;
2. Because of some incapacity resulting from mental illness, mental retardation, dementia, habitual drunkenness, excessive use of drugs or other physical or mental capacity, and
3. Is harmed or threatened with harm from neglect or battery, or exploitation of her personal services or property.

A dependent includes an adult who is mentally or physically disabled.

**BATTERY AGAINST OLDER ADULTS**

A battery is the deliberate touching of a person in a rude, insolent, or angry manner. Although a battery against anyone is a crime, a battery against an endangered adult results in a greater criminal punishment. Also, a battery against a dependent results in a greater punishment if the person who committed the battery was a caretaker of the victim.

**NEGLECT OF OLDER ADULTS**

The crime of neglect includes the deliberate abandonment or cruel confinement of a dependent, depriving that person of necessary support, or placing that person in a situation that may endanger that person’s life or health.

**EXPLOITATION OF OLDER ADULTS**

Exploitation of a person refers to the deliberate and unauthorized use of that person’s personal services or property for the advantage or profit of another. In Indiana, exploitation of a dependent or endangered adult is a crime.

**REPORTING OF ADULT ABUSE**

Anyone who suspects that an endangered adult is being neglected, battered or exploited has the duty to report the facts. Failure to report is a crime. The report should be made to the police, to an adult protective services unit or to the state Division of Aging and Rehabilitative Services at (800) 992-6978.

Persons who in good faith make such a report are protected from retaliation and from liability for making the report, even if the report turns out to be wrong. Also, if the investigation fails to support the report, the government should destroy all identifying records about the report.

When a report is received, the government will investigate the situation. If the investigation reveals that the person is indeed an endangered adult, as defined above, then the protective services unit of government may begin procedures to intervene in the situation and provide the victim with needed protective services.

**PROTECTIVE SERVICES**

Protective services may include medical, psychiatric, residential and social services. The endangered adult should, if possible, participate in the plan for services to help that person. It is also possible to get a court order to stop other persons from interfering with the provision of needed services.

These laws will not help stop abuse unless the victim is willing to assist the prosecution. Yet the victim may be embarrassed or afraid of retaliation. The victim may be afraid of going to a nursing home if the caretaker is removed. The victim may choose to live with a bad situation rather than have a son or daughter arrested. In these cases, Adult Protective Services
may arrange for help. A trained caseworker can help the victim with the process of prosecuting the abuser.

If the victim is not competent to make decisions, a friend or family member can seek guardianship, and the guardian can seek prosecution on the victim’s behalf. If it is the guardian who is abusing the dependent or misusing funds, anyone can contact the probate court to have the guardianship changed.

These laws about protective services are designed to help persons who need help. If, on the other hand, a competent person does not want these services, that person’s right to refuse such services are also protected by the law.

If the endangered adult does not or cannot consent to the protective services that the government wants to provide, then there must be a court hearing to determine whether a judge should order the provision of the services. At that hearing the person for whom services are asked has the right to be represented by a lawyer and has the right to have the court appoint a lawyer if the person cannot afford one.

The court can order protective services over the victim’s objection only if it finds the person to be an endangered adult who needs the services and who cannot make an informed decision about the need for those services. Any services that the court orders must be those that interfere as little as possible with the victim’s liberty while providing the protection needed.

The court order must then be reviewed at least every six months and can be continued only if the reviewing court finds that (1) the services will probably lead to achievement of their goal, or (2) ending the order would endanger the adult’s physical or mental health. Also, a request to change or end the court order for services may come from the endangered adult, the guardian or custodian, or anyone providing services, as well as from the government.

In an emergency, protective services can be ordered after a less formal hearing. Emergency orders, however, can last only 10 days or, in extraordinary cases, 30 days. After that, the government must ask for a more formal hearing in order to continue the services.

THIEF OF SOCIAL SECURITY CHECKS

Stealing Social Security checks is a crime. Report misuse of Social Security checks to the local Social Security office. Arranging for direct deposit of these checks might prevent such abuses. If the check is stolen from the mail box, also make a report with the local post office.

The Social Security Administration allows a person to choose a representative payee to receive that person’s Social Security funds if the person is unable to manage the funds. The person may change representative payees. If a representative payee misuses the Social Security funds, a report should be made to the Social Security Administration which will investigate complaints.

FEDERAL LAW

Federal law protects older workers against age discrimination in the following employment practices: hiring, firing, retirement, compensation, fringe benefits, including group health plans, work conditions and privileges promotion, referral to jobs, membership in labor organizations, and classified job advertising.

The federal law prohibits discrimination by most private employers with at least 20 employees, government employers, labor unions with at least 25 members or a hiring hall, and employment agencies.

It is illegal for these employers and agencies to discriminate against workers and applicants for work who are over age 40. There are, however, certain exceptions, including these:

1. Elected state and local officials and their personal staff and policy-making advisors are not protected at all.
2. Executives and other persons in high policy-making positions who are eligible for annual non-forfeitable pensions of $44,000 or more are not protected above age 65.
3. Firefighters and law enforcement officers are subject to certain limitations based on age if state law permits or requires this.

It is otherwise illegal for an employer covered by the federal act to discriminate against you because of your age, whether your age is the sole or determining factor in the employer’s decision or not. The employer should not rely on false stereotypes of older persons, for example, the stereotype that “ability generally declines with age.” The employer may, however, consider some factors that sometimes accompany aging.

An employer covered by federal law cannot force you to retire. There is an exception for high-paid executives; these employees can be retired at age 65. The federal government cannot force its own employees to retire, although there are some exceptions for hazardous jobs.

In the following circumstances, however, an employer is not acting illegally:

1. The employer is not acting illegally if his action is really based on a reasonable factor other than age. He cannot, however, give a reason that is only a pretext or cover-up for age discrimination. If your age is what made the difference, the employer has probably acted illegally.
2. Also, an employer’s action is not illegal, even if it is based on your age, (1) if his age requirement relates to some activity that is reasonably necessary to the normal operation of his business, (2) there is a factual basis for believing that all or most persons in the excluded age category could not perform the activity safely and efficiently, and (3) it is not practical for the employer to consider each worker or applicant individually to determine whether he could perform the activity. For example, an employer can refuse to hire an older actor to portray a young character in a play.

STATE LAW

Indiana’s law protects workers age 40 through 69. Indiana’s law protects only against an employer’s dismissal of an employee or failure to hire or rehire. This law forbids age discrimination by most private employers in for-profit businesses who have fewer than 20 employees, as well as labor organizations and state and local governments and agencies.
ENFORCEMENT

The Indiana Civil Rights Commission (ICRC) administers the state age discrimination law. The Equal Employment Opportunity Commission (EEOC) administers the federal law. If you believe that you have been discriminated against because of your age and you are covered by federal or state age discrimination laws, you may immediately take one of these two steps:

1. If the employer has fewer than 20 employees, file a complaint with the ICRC:

   Indiana Civil Rights Commission
   100 North Senate Street, Room N103
   Indianapolis, IN 46204
   (317) 232-2600, or (800) 628-2909
   www.state.in.us/icrc/

   ICRC can investigate your complaint and try to persuade the employer not to discriminate against you. If this attempt fails, ICRC can issue a complaint and hold a formal hearing. ICRC can order the employer to stop discriminating. This order must be issued within three months of the discriminatory act, so do not delay in filing your complaint.

2. If the employer has 20 or more employees, file a written charge with EEOC:

   Equal Employment Opportunity Commission
   101 West Ohio Street, Suite 1900
   Indianapolis, IN 46204
   (317) 226-7212, or (800) 669-4000

   Someone at the EEOC office can help you write the charge. Be sure to specify age discrimination. To protect your right to sue the employer, you must file with the ICRC and/or the EEOC within 180 days of the discriminatory act.

   EEOC will first hold a conference and try to settle the matter. If this effort fails, EEOC might decide to sue the employer in court. If EEOC does not sue the employer, you can sue the employer yourself in federal court. You must sue within 90 days of the receipt of the Notice of Right to Sue letter otherwise your claim is forever barred. Consult a lawyer promptly if you plan to sue. If the court agrees with your claim, it could order the employer to stop discriminating; hire, reinstate or promote you; and possibly give you damages, including back pay.

   If you have a valid claim of age discrimination and decide not to sue upon it, you may waive your claim in exchange for something of value from your employer.

   What you receive in return must be something more than what you are already entitled to receive.

   An enforceable waiver must, however, be knowable and voluntary, which means, among other things, (1) that it must be written in understandable language and clearly waive your rights, (2) that you have a reasonable time to think about your decision, and (3) that your employer must encourage you to consult an attorney. Keep in mind, you have 28 days to revoke your waiver. You have 21 days to consult with an attorney and seven days to revoke the waiver after you sign it.

   It is illegal for an employer to retaliate or discriminate against you because you have filed a charge or sued under the federal age discrimination laws.

PROVING DISCRIMINATION

Sometimes an employer says directly that your age is the reason he treated you differently. Usually, however, discrimination is more subtle and difficult to prove. You should carefully gather your evidence. Keep all written documents including e-mail you have received in connection with the incident. Write down what was said to you, including dates and the names of persons with whom you have spoken. Find out as much as you can about your employer’s usual practices.

   For example, the following questions suggest information you might obtain if an employer has refused to hire you because of your age. Do not need to answer them all before you file a charge:

   • Did the employer advertise the job opening?
   • Did the ad mention age?
   • What was the job description?
   • What are the qualifications for the job?
   • What are the qualifications of the person who got the job?
   • Did the person who interviewed you mention your age? It is not illegal for an employer to ask your age, so long as he does not use the information to discriminate against you illegally.
   • Did the interviewer emphasize youth?
   • Did he indicate that the job might be too much for you?
   • Why did the employer say you were not hired?
   • What did you lack?
   • If you had to take a test, how was it scored?
   • What was considered a passing score?
   • How does your score compare with the scores of other applicants and with the score of the person who got the job?
   • How old was the person who got the job?
   • Was the person who got the job substantially younger, at least 10 years younger than you?
   • How many older persons work for this employer?

   Present this information to the ICRC or EEOC when you file with these agencies, or to a lawyer.

   For more information about age discrimination laws, contact EEOC or the ICRC at the addresses listed above.

AGE DISCRIMINATION IN HOUSING

When it comes to housing, older people are doubly disadvantaged. Many are unaware of their housing rights. Many are unable to represent their own interest because of the very conditions associated with their age, disabilities and frailty.

   Older persons are frequently subject to discrimination, which isolates them. Fear of reprisal also keeps some from seeking to enforce their rights.

   Federal and state laws provide tools for addressing these issues. The Federal Fair Housing Act as well as the Indiana Fair Housing Act provides for reasonable accommodations which may allow older tenants to retain their housing, and their independence, as they age.

   Sometimes landlords may refuse to rent or sell housing to persons because of the very conditions associated with their age, disabilities and frailty. Older persons are often asked to change their habits to “fit the bill.” And landlords may refuse to rent or sell to older persons because they believe it is not profitable to do so.

   Age discrimination is more subtle and difficult to prove. You should carefully gather your evidence. Keep all written documents including e-mail you have received in connection with the incident. Write down what was said to you, including dates and the names of persons with whom you have spoken. Find out as much as you can about your employer’s usual practices.

   For example, the following questions suggest information you might obtain if an employer has refused to rent or sell housing to persons because of the very conditions associated with their age, disabilities and frailty.

   • Did the ad mention age?
   • What was the job description?
   • What are the qualifications for the job?
   • Did the employer advertise the job opening?

   Present this information to the ICRC or EEOC when you file with these agencies, or to a lawyer.

   For more information about age discrimination laws, contact EEOC or the ICRC at the addresses listed above.

   When it comes to housing, older people are doubly disadvantaged. Many are unaware of their housing rights. Many are unable to represent their own interest because of the very conditions associated with their age, disabilities and frailty. Older persons are frequently subject to discrimination, which isolates them. Fear of reprisal also keeps some from seeking to enforce their rights.

   Federal and state laws provide tools for addressing these issues. The Federal Fair Housing Act as well as the Indiana Fair Housing Act provides for reasonable accommodations which may allow older tenants to retain their housing, and their independence, as they age.

   Sometimes landlords may refuse to rent or sell housing to persons because of the very conditions associated with their age, disabilities and frailty. Older persons are often asked to change their habits to “fit the bill.” And landlords may refuse to rent or sell to older persons because they believe it is not profitable to do so.

   Age discrimination is more subtle and difficult to prove. You should carefully gather your evidence. Keep all written documents including e-mail you have received in connection with the incident. Write down what was said to you, including dates and the names of persons with whom you have spoken. Find out as much as you can about your employer’s usual practices.

   For example, the following questions suggest information you might obtain if an employer has refused to rent or sell housing to persons because of the very conditions associated with their age, disabilities and frailty.

   • Did the ad mention age?
   • What was the job description?
The designee of a parent or legal custodian, with written permission.

Housing for older persons is exempt from this prohibition if:

• The HUD Secretary determines that it is specifically designed for and occupied by elderly persons under a federal, state or local government program.

• It houses at least one person who is 55 or older in at least 80 percent of the occupied units; it has significant services and facilities for older persons; it adheres to a published policy statement that recognizes only one exception to the rigid rule that all tenants must be at least 62 years old.

This means, for example, that if a qualifying retirement community with all older residents receives an application from a husband aged 62 and a wife aged 59, it would have to reject this application because of the wife’s age in order to maintain its “62 or over” exemption. The exemption would also be lost if the community allowed one of its current residents to occupy a unit with a new spouse or other person who is under 62. The community could, however, accept a younger resident and still be exempt if it qualifies for the “55 or over” exemption. The HUD regulations recognize only one exception to the rigid rule that all occupants must be at least 62 years old. According to HUD, units in the development may be occupied by under-62 employees and their families without jeopardizing the exemption you have, the better armed you will be to make wise choices.

INDIANA LAWS OF AGING

“62 OR OVER” HOUSING

The second of the three categories of housing for older persons that is exempt from Title VIII’s prohibitions against familial status discrimination in housing “intended for, and solely occupied by, persons 62 years of age or older.” To qualify under this exemption, all residents of the housing development must be at least 62 years old.

For example, an Indiana statute requires that potential investors receive extensive information at least 72 hours before signing an investment agreement. That same statute gives investors 30 days to change their minds after signing an agreement. For these reasons, if you fail to consult a lawyer before you make a significant business investment, it is still worthwhile to talk with an attorney even after you have signed on the dotted line.

“55 OR OVER” HOUSING

The statute requires that “62 or over” housing not only be solely occupied by people of that age group, but also be intended for such persons. This means that housing could fail to qualify for this exemption even though all of its occupants are older persons if it is not intended for such persons. This would certainly be unusual, for in most cases, the very fact that all of the residents are at least 62 would be strong evidence that the housing was intended for this age group. In addition, the legislative history makes clear that this exemption is available “regardless of what other features the housing may or may not have.” Still, it is at least conceivable that a small apartment building could have all elderly tenants without the landlord having intended this result and would therefore not qualify for the “62 or over” exemption.

“55 OR OVER” HOUSING

The third of the three categories of housing for older persons that is exempt from the acts’ prohibitions against familial status discrimination is housing intended and operated for occupancy by persons 55 years of age or older, and:

• At least 80 percent of the occupied units are occupied by at least one person who is 55 years of age or older.
• The housing facility or community publishes and adheres to policies and procedures that demonstrate the intent required under this subparagraph.
• The housing facility or community complies with rules issued by the Secretary of Housing and Urban Development for verification of occupancy.

The act requires that 80 percent of the units be occupied by at least one person 55 or older and that the housing publish and adhere to policies and procedures that demonstrated an intent to provide housing for this age group.

MAKING A DISCRIMINATION COMPLAINT

If you have a complaint of housing discrimination, you should write HUD or call the Hotline at (800) 669-9777, or (800) 927-9275 (TTD). You may also contact the Indiana Civil Rights Commission, (800) 629-2809, and/or your local civil rights commission.

Beware of:

• Deals that take place in unusual meeting places.
• Deals that require you to pay a large amount of money in advance.
• Salespeople who try to pressure you into making an immediate decision without the benefit of careful thought and the ability to discuss it with someone you trust.

If you do pay a large amount of money, do so by check or credit card instead of cash. This way, you will have a record of the payment in case you are not satisfied with the goods or services. For safety reasons, do not carry a large amount of cash with you. Put your Social Security and pension benefits directly into a deposit account each month.

With the ease of looking up information on the internet, take advantage of this to check out companies when you are shopping for goods and services. The Better Business Bureau, a traditional consumer agency that provides reliable information about companies, has free information online. The Federal Trade Commission identifies many scams by publishing alerts. Internet search engines can help find other sources of information. The more information you have, the better armed you will be to make wise choices.

Most businesses are legitimate. Unfortunately, there are dishonest individuals who try to take advantage of Hoosiers — particularly senior citizens. This section of the reference provides some general advice to protect yourself from fraudulent business practices.

INTRODUCTION

Common scams involve everything from miracle drugs to work at home programs to diet aids to ways to make money for retirement. In any situation, be suspicious of a price or deal that sounds too good to be true — it probably is.

CHARITY FRAUDS

Unfortunately swindlers in this group often use the same approaches as legitimate charities. If you are asked to donate to a charity, find out the name, address and phone number of the organization and contact the organization directly. Legitimate charities are happy to provide you with information on their causes. Never pay by cash, but instead write a check directly to the charity to ensure your donation is going to the group you intend it to help.

A legitimate charity will wait for your contribution and will accept checks. Do not donate to a charity that insists on cash. Be suspicious of a telephone solicitation where the individual wants to pick up your monetary donation at your home. Be careful about charities with names similar to well-known charitable organizations. Again, take your time and investigate the situation. Resist high pressure tactics.

Indian law now requires all professional fund-
raisers working for charities to register with the Consumer Protection Division of the Indiana Attorney General's Office. These fundraisers must disclose the name of the charity and the percentage of collections that will actually go to the charity. Information about current fundraising activities and the financial reports are available at: www.indianaconsumer.com/consumer_guide/can/charitable_fundraising.asp.

CONSUMER LOANS AND CREDIT
Most of us borrow money for various purposes, to buy a car or a house, to pay for school, to finance home repairs, etc. One way of comparing the cost of credit is by the interest rate charged on the loan. However, this is only one factor. There are other costs, such as service charges, that you pay for credit. Credit sellers and lenders are required by the Federal Truth In Lending law to disclose credit terms before or at the time of sale. These disclosures are meant to help you compare terms so that you can get the best deal.

The disclosures should tell you the annual rate of interest, the finance charge, the amount to be financed, the total of the payments, the number of payments, the amount of the payments and when payments are due. The disclosures should also tell you if the loan requires you to give a security interest, or lien, in the item being purchased, the amount of late charges and whether there will be a prepayment charge if you pay off the loan early.

Before you apply for a loan or if you are denied credit, it is useful to look at your credit report. You can obtain a free copy of your credit report each year from www.annualcreditreport.com by calling (877) 322-8228, or writing to Annual Credit Report Request Service, P.O. Box 150281, Atlanta, Georgia 30348-5281.

Reviewing your credit report can help spot errors and identity theft problems. Both good and bad credit information will appear on your report. If you disagree with any information reported, you have a right to challenge it. Contact the credit reporting agency to dispute the information. The credit reporting agency must investigate your concerns.

CREDIT CARDS
Credit cards are open-end loans. Understanding their terms may be more difficult since charges are incurred over a period of time and payment amounts vary based on the balance due. Credit cards also may charge an annual fee in addition to interest. Include that cost when comparing credit cards. Some credit cards include other services beyond the extension of credit that may be desirable discounts. As with any contract, it is important to read the small print.

Throughout the consumer protection section of this book, emphasis has been placed on paying by credit cards. There are two reasons for this advice. First, you are entitled to dispute billing errors on your credit cards. One type of billing error is a charge for goods or services you did not order, accept or that were not delivered as agreed.

To dispute a charge, you need to write to the credit card company within 60 days of when that charge first appeared on your billing statement. Your letter should state your name and account number. Explain why you believe that a specific charge is wrong. The credit card company must then investigate the dispute. While the investigation is taking place, you are not required to pay the disputed amount, and the amount does not accumulate interest.

The second reason to pay by credit card is that for purchases of more than $50 made in your home state within 100 miles of your residence, you can hold the credit card company liable as well as the seller for your claim. A prerequisite to making a claim against a credit card company is that you must notify the seller of the goods/services of your complaint and give the seller an opportunity to correct the situation.

Thanks to the laws outlined above, when you pay by credit card, the credit card company has a financial incentive in your satisfaction with your purchase and will go to bat for you with the seller.

DOOR-TO-DOOR SALES
Be wary of buying goods or services from a door-to-door salesperson, especially if the person comes to your door without your invitation. If you have doubts about a salesperson at your door, ask for the individual's name and the name, address and telephone number of the company. Contact the company, verify that the salesperson is a member of the company. Check on the company's reputation by calling the Better Business Bureau.

Do not be taken in by a young salesperson who claims to be working his or her way through school. It may be true, but it is also a gimmick to win your sympathy. If you do buy a product or service, pay by check and make it out to the company and never to the individual salesperson.

If you agree to buy something, the law in some cases gives you three business days to change your mind. Sundays and legal holidays are not business days. The law provides this "cooling-off" period to protect you against high-pressure sales tactics. It applies whenever you have made a purchase of $25 or more, and the sale takes place in your home or at any place other than the seller's place of business such as sales made in a hotel room or at a product party at someone else's home, for example.

The salesperson is required to tell you about your right to cancel and you must give you two copies of a cancellation form. The salesperson should also give you a dated receipt, and the name and address of the merchant so that you can write to cancel your order, if you decide to do so.

To cancel, sign and date one copy of the cancellation form and mail or hand deliver it to the given address no later than midnight of the third business day after the contract date. To ensure that the merchant receives your cancellation form, you can send it by certified mail. Keep a copy of the form for your records. You do not have to give a reason for the cancellation.

The cancellation needs to be in writing because a merchant may not honor a telephoned or verbal cancellation. If the salesperson does not provide you with a cancellation form, you can write a letter. By canceling in writing, you will have proof of the cancellation.

Within 10 days of cancellation, the merchant must return any papers you signed. The merchant must also refund any money that you paid and return any trade-in. If you have the product in your possession, the merchant should pick up the item within 20 days. If you agree to send the product back, you should be reimbursed for your mailing costs.

Home improvement or home repair salespeople such as asphalt pavers, roofers and tree trimmers often solicit door-to-door. Sometimes home contractors do the work before the cooling-off period is over. If this should happen, do not let this situation stop you from canceling. As long as the work was not an emergency, you can still cancel and you are not obligated to pay for any of it.

The cooling-off rule does not apply to:
- Sales made at the seller's place of business
- Sales of less than $25
- Sales made entirely by mail
- Sales of real estate, insurance or securities
- Emergency home repairs.

GENERAL INFORMATION ABOUT CONTRACTS
Do not sign any contract or document until you have read and understood it. This means reading the fine print, too. Take the contract home to study and discuss with a family member or trusted friend. Be suspicious if the other party will not let you take the contract with you to think about it. Never sign a contract that has blank spaces in it, cross them out first. If you have concerns about a contract, consult an attorney before you sign it.

Make sure that the entire understanding is in the contract. If a salesperson makes a promise, guarantee or statement that you are relying upon, get it in writing as part of the contract. Otherwise, you do not have adequate proof that the promise or statement was made. If a merchant hesitates to put any of his promises in writing, go elsewhere. You may not be able to enforce unwritten promises that were not included in the contract.

Once you sign a contract, keep a copy as a record. Do not sign a contract, or any legal document, without getting a copy for yourself.

To prevent misunderstandings and avoid problems, contracts should be in writing. However, a contract can be verbal-based on spoken promises. This type of contract is usually as binding as a written contract. Realize that you could be responsible for promises you make, even if they are not in writing.

Contracts concerning services should always be in writing. Contracts involving large sums of money should be in writing to avoid disputes. Once you have signed a contract, you are generally bound by it. If you change your mind, you may still be obligated to make payments on the contract. In some cases, there may be a clause in the contract that lets you out of the agreement under certain circumstances. Although there are limited situations where you can cancel a contract within three days, these situations are limited. (See Door-to-Door Sales) Most contracts are valid once signed. So, when in doubt, do not sign a contract until you are satisfied with the deal.

HOME IMPROVEMENT/HOME REPAIR
A common scam on homeowners, particularly senior citizens, involves a salesperson who comes uninvited to your house to sell you repair services.
that you may or may not need. Legitimate businesses, particularly construction companies, do not usually offer their services by unsolicited door-to-door sales. These frauds often involve blacktopping your driveway, putting siding on your house, roofing, furnaces, painting and energy-saving devices. Remember that you can always say no. Call the police if a salesperson refuses to leave your house.

When deciding to hire a business, take your time, shop around and get advice from someone you trust. Do not let a salesperson rush you into any decision!

Be especially suspicious of a salesperson who:
- Just "happens" to have material left over from another job. This is a very common swindle.
- Says your job will be a "sample" or "model" for other customers.
- Will not put total costs in writing.
- Wants an immediate decision.
- Establishes the need for a major repair with a salesperson refuses to leave your house.

Get the name, address and phone number of the company the salesperson represents. Then call the company and check out the legitimacy of both the firm and the salesperson. Ask questions! Find out what other jobs the contractor/salesperson has done, get references and then contact the references.

If you agree to have work done and it will cost more than $150, the company must prepare a written contract and give you a completed copy. Review the contract and be sure you agree with all the terms before signing it. Written terms in the contract trump any spoken promises. If the salesperson is not willing to put the promise in writing, do not rely upon the promise. The contract must contain:
- The price of the work/repairs.
- The approximate start and completion date for the work.
- A statement of any events that might delay completion.
- A reasonably detailed description of the proposed work.
- If specifications, drawings, list of materials, etc., are not available when the contract is signed, they must be given to you for your review and approval before the work begins.

If you decide to have the work done, do not pay more than one-third of the cost as a deposit. Never leave a house key with a repairman while you are gone. Check on the work as it progresses.

Do not pay the remainder of the cost until you are satisfied with the project. Do not sign a completion certificate until the work is done to your satisfaction. When you pay the final bill, pay by credit card or check, if possible, so that you have a record of the payment transaction. Do not pay by cash.

Once you have paid all or most of the money due, it may be extremely difficult to get the job finished to your satisfaction. Do not give in to requests for payment until the work is done.

Even if you are dissatisfied with a home repair, you should get legal advice before you stop payment on a check to the company when you did the work. Otherwise, you risk foreclosure on your house if there is a lien on it. Repairmen and construction companies may take a lien or mortgage your home to make sure you pay them for their work. If they do this, they must tell you clearly in the written contract that this could happen. If you suspect they have done this without your knowledge, contact a lawyer for advice. (See Homeownership Issues)

MAIL ORDERS

Ordering goods via the mail is convenient, and there are many excellent mail order businesses. Unfortunately, some businesses prey on older consumers. Before you order from a company, check with the Better Business Bureau, (317) 488-2222, to make sure there are no complaints filed against the company. Read the description of the goods, and do not rely on pictures that can be misleading. Find out about the company's return policy and keep a copy of your order, marked with the date you mailed the order. Never pay with cash. If possible, pay by credit card so you have a written record of the transaction.

You should receive the ordered goods within a reasonable time, usually 30 days. There are some exceptions such as magazine orders that take longer. If you have trouble with your order, contact the company. You might also get help from the magazine or newspaper that carried the ad for the product or service.

If you received goods that you never ordered, you may choose to either send them back or keep them. If you decide to keep the goods, you do not have to pay for them. Some companies mail you goods that you never ordered in the hope that you will feel compelled to pay for them or that you will like the products and order more. If this same company tries this gimmick again, report it to the postal inspector.

MORTGAGE FORECLOSURE RESCUE SCAMS

The recent rise in mortgage foreclosures has brought with it a rise in scams to "help" homeowners avoid foreclosure. These scam companies often do nothing for the homeowner while charging a substantial fee. Tactics used by scam programs include counseling the homeowner to make payments to the scam company rather than the mortgage company, asking the homeowner to sign over the deed to the home, and asking for predated checks.

As with any service, check with the Better Business Bureau before hiring a mortgage rescue company. Find out if the company is in good standing. Beware of new companies that have no history. Review written contracts carefully before hiring a rescue firm. Be clear on the service to be provided and the cost of the service.

Often the only service that the scam companies can supply is to contact your mortgage company to negotiate a loan modification. The company may emphasize its use of government programs, as if it has special knowledge or access that you do not. However, you can contact your own mortgage company for a loan modification on your own without paying someone else to do it. While this can be a difficult process, there is no reason to think that the scam company can or will do a better job for you. The scam rescue company is only interested in making money from your financial desperation.

Beware of foreclosure rescue companies that operate from out of state. An out of state company cannot represent you in court if you have been sued by your mortgage company. Only a lawyer licensed in Indiana can represent you in court. Ask if the mortgage rescue company has a licensed attorney who will represent you in court. You must not ignore a law suit since failing to take timely action could result in the loss of your home. Do not depend on negotiations and assurances that you can ignore the law suit while a loan modification is pending. Once you are sued by your mortgage company, you need to contact a lawyer.

REFINANCING YOUR HOME MORTGAGE

For most people, the most valuable asset they own is their home. It is important to use caution before taking out a new mortgage on your home or refinancing the existing mortgage. Each time you do, you reduce the accumulated equity in your house.

Equity is the difference between the market value of your home less any liens/mortgages on the title. Equity represents your investment in the house. Retired people often rely on not having a mortgage payment to ease their living expenses in retirement. Equity can be a source of funds for repairs, emergencies, downsizing to a smaller home or an asset to pass on to your heirs.

It is possible to refinance your mortgage to the extent that you have used up all of the equity in your house. When you do that, you have lost your investment in the house until you pay down the mortgage. Chances are the amount of the monthly payments in such cases will strain the ability of a retired homeowner to make the mortgage payments.

Predatory lenders take advantage of homeowners by making his interest loans with harsh terms and without concern for whether the homeowner can make the payments.

Unscrupulous mortgage brokers and lenders will often promise to reduce your existing mortgage payments, but then the actual loan fails to reduce the payments. A common way of doing this is to eliminate escrow payments. Although your mortgage might be lowered, you would pay for your homeowner’s insurance and property taxes separately, which might not reduce your costs at all.

TELEPHONE PRIVACY/TELEMARKETERS

Many companies solicit business over the telephone. While telephone solicitations can be legitimate ways to gain your business, they can also be unwanted intrusions, or even deceptive or fraudulent scams. Indiana’s telephone privacy law helps protect you from unwanted telephone solicitations by allowing you to register your home telephone number on a telephone privacy list maintained by the Office of the Attorney General. You can register your number by logging on to the Attorney General’s website at www.in.gov/attorneygeneral and clicking on the Telephone Privacy link on the left side of the screen. If you do not have internet access, you can also register by calling (888) 834-9969.

As long as your telephone number is on the telephone privacy list, the law prohibits most telemarketers from calling you. The exceptions are:
- Telephone calls that you request
- Telephone calls primarily relating to existing debts or contracts you have with the telemarketer
- Charitable organizations who use employees or volunteers to make the calls
• Newspapers who use employees to make the calls
• Realtors
• Insurance agents

Hoosiers may register at any time because Indiana’s Telephone Privacy List is updated every quarter: January 1, April 1, July 1 and October 1. Registration is free and once your number is registered, you do not have to register again. If you have registered your home phone number on the list, be wary of any telephone solicitation you receive that you believe does not fall within one of the exemptions listed above.

If you receive a call from an organization that you do not believe is exempt from the calling restriction, there are steps you can take that will help the Attorney General’s Office enforce the law. Do not hang up. Find out as much information about the group calling you as possible so that the Attorney General’s Office can investigate the problem:

• Name of the company making the call
• Date and time of the call
• Product or service offered
• Telephone number of the company calling you.
This is not always possible, but please make every effort to get their phone number.

Once you have gathered this information, simply log on to www.in.gov/attorneygeneral and go to the Telephone Privacy section and click on “download complaint form.” Complete the form, sign it and mail it to the address provided on the form. If you do not have access to the internet, you can call (812) 355-5915 to request a complaint form.

The Attorney General’s staff will review your complaint, contact the telephone solicitor, investigate the matter and notify you of the status. It is very important that you are willing to participate in an investigation. You should be prepared to testify in court and obtain phone records from your telecommunications carrier.

Indiana law provides additional protections for you in the event you are a victim of telemarketing abuse or fraud. For these reasons, you should contact an attorney and the Consumer Protection Division of the Office of the Attorney General if you feel you have been abused or defrauded through an unwanted telemarketing call.

TIMESHARES
Timeshares at vacation properties, permanent ownership of a specific week of time at a resort, are often aggressively marketed. If you are lured by the promise of a big prize, keep in mind that the “sports car” offerd may be the small matchbox kind. If a free weekend trip is offered, you will very likely have to listen to a long, high-pressure sales pitch in order to get the trip.

Contrary to the sales pitch, if you consider purchasing a timeshare, it can be difficult to trade your timeshare unit for another one in a different part of the world. The ease or difficulty of doing a trade depends on the season, week of the year that you “own”, and the location of your unit and how desirable it is to others.

Beware of claims that your timeshare unit or membership is re-sellable. Usually it is not, and the seller will rarely buy it back from you. If the company or seller assures you that the seller will buy it back from you, get that promise in writing along with information about the re-purchase price.

ADDITIONAL ASSISTANCE
The Consumer Protection Division of the Indiana Attorney General’s Office provides free assistance to Hoosiers who may have been the victims of consumer fraud and have been taken advantage of in a consumer transaction.

In order for the staff to investigate a situation, a consumer complaint form MUST be completed, signed and mailed back to the Attorney General’s Office at: Indiana Attorney General’s Office Consumer Protection Division 402 West Washington Street Indianapolis, IN 46204

The quickest way to access a complaint form is to log on to the Attorney General’s website at www.in.gov/attorneygeneral and click on Consumer Services and then click on “download complaint form.” If you do not have access to the internet, you may call (317) 232-6330 or toll-free (800) 382-3516 and request that a complaint form be mailed to you.

C H A P T E R  T W E L V E

GRANDPARENTS’ RIGHTS

TIMESHARES

Grandparent Visitations

Normally, grandparents may visit their grandchildren without a court order. Families typically work out the amount and frequency of visitation that the family members want with each other.

CRITERIA FOR SEEKING VISITATION

The grandparent visitation law is meant to help a grandparent who has trouble visiting a grandchild because the grandparent’s child is not the custodial parent of the grandchild. For example, the grandchild lives with the ex-wife of the grandparent’s son. The law is not meant to impose court-ordered visitation where the visitation disagreement is between the grandparent and the grandparent’s child. In those situations, the law favors the parent of the child as being capable of deciding what is in the child’s best interests.

The grandparent visitation law is specific to grandparents and does not apply to great-grandparents. A grandparent may petition a court for visitation rights with a child in limited situations. Not every grandparent is entitled to ask for court-ordered visitation. In Indiana, a grandparent may petition the court if:
1. One or both of the child’s parents is deceased.
2. The marriage of the parents of the child has been dissolved in Indiana.
3. The child was born out of wedlock, except the father’s parents can seek visitation under certain circumstances. You should consult with a lawyer with expertise in this area for assistance.

BEST INTERESTS OF THE CHILD

The court can grant visitation rights if such visitation is found to be in the best interests of the child. The court will consider whether the grandparent has had, or has attempted to have, meaningful contact with the child in deciding if visitation is in the child’s best interests.

The law allows for grandparent visitation where the child has been adopted by a stepparent or a biological grandparent, sibling, aunt, uncle, niece, or nephew. The amount of visitation that could be ordered by the court is decided on a case by case basis. There is no set rule for the amount or frequency of visitation that a court must order. The court may consider who else is entitled to visitation and what the history of visitation has been, as well as the age of the child and the geographic distance involved. The court may even interview the child to determine whether visitation is appropriate.

RESOURCES ON GRANDPARENT VISITATION

The law in this area, as in others, is constantly changing. You should check sites such as www.aarp.org for information on the latest developments in grandparent visitation rights. In the absence of court-ordered visitation, grandparents should try to work out visitation arrangements with the parents of the child. For instance, an offer to babysit may help everyone involved appreciate the value of the grandparent/grandchild relationship.

GRANDPARENTS RAISING GRANDCHILDREN

Recent census data indicated that about 4.4 million grandchildren in this country lived with grandparents who had one or more of their grandchildren living with them. Statistics also show that these numbers have been steadily increasing. In 1970 about 2.8 million children lived in a grandparent’s home while 3.9 million children lived with a grandparent in 1997.

TAX BREAKS FOR RAISING A GRANDCHILD

If you are raising a grandchild and are financially responsible for the child, you should be aware of tax

102 INDIANA LAWS OF AGING

INDIANA LAWS OF AGING 103
benefit plans, including health insurance plans.

Tax laws change almost every year, so please check with your accountant or tax preparer for the current tax breaks for which you qualify. The AARP offers their Tax-Aide program in which volunteers help seniors with tax questions and returns. Call the AARP at (888) 227-7669 for a location near you.

The IRS also sponsors a free program to help you with tax questions. The Volunteer Income Tax Assistance (VITA) program offers free tax help to individuals whose incomes qualify for the Earned Income Tax Credit, $42,000 or less for tax year 2008. The qualifying amount usually increases each year. VITA Volunteers are trained by the IRS to help you prepare and file your tax return. Call (800) 829-1040 for the most convenient location for you.

These volunteer tax programs will also help you prepare and file your Indiana Income Tax Return so that you will benefit by including all eligible grandchildren as dependents on your Indiana return and also receive the Indiana Earned Income Tax Credit if you qualify.

CHILD SUPPORT AND PUBLIC BENEFITS

Grandparents who are raising their grandchildren are entitled to child support and may petition a court for child support from the parents. A grandparent may also apply for Temporary Aid for Needy Families (TANF), which are cash benefits available from the county office of the Division of Family Resources (DFR). The grandparent’s income is not considered in establishing the child’s eligibility for TANF benefits. The amount of TANF benefits is relatively low, $139 per month for one child. Besides TANF, a child living with a grandparent may also be eligible for Medicaid benefits. Application for both benefit programs may be made at the same time at the local DFR office.

 programs and Services for Older Hoosiers

If you do not drive a car but need an identification card, for example for voting purposes, you can obtain an identification card at a license branch. These identification cards are available free of charge to any resident of Indiana who is at least 16 years old and who does not have a valid Indiana driver’s license. You do not have to be handicapped to get a card. The identification card will have the same shape as a driver’s license and will contain similar information to identify you. The cards are valid for four years and can be renewed.

When you go to apply for a card, take two items with your signature. If possible, also take a birth certificate or another document, Medicare card, hospital card, etc., that shows your age. You can also keep track of the latest documentation requirements since they do change from time to time by visiting the Bureau of Motor Vehicles website at www.in.gov/bmv/.

WORK PROGRAMS

SENIOR CORPS PROGRAMS

The federal government sponsors several programs that give older persons the chance to volunteer to help others. These programs are administered through the Senior Corps program and are described below. Some of these programs are available only in parts of Indiana, so if you are interested in volunteering for a program be sure to ask whether that program is available in your area. For information, write or call the ACTION office for Indiana:

Senior Corps
46 East Ohio Street
Room 226
Indianapolis, IN 46204
(317) 226-6724

You could also look in your telephone book under the name of the specific program.

Volunteers in Service to America (VISTA)

Volunteers in Service to America is a national program of volunteers who serve low-income communities in the United States, Puerto Rico, Virgin Islands and Guam. Volunteers work particularly on the problems of troubled youth, low-income elderly and the disabled or handicapped. Volunteers live and work among the poor for one year, mostly on local development projects. About 15% of volunteers are 55 years of age and over. For more information contact the VISTA program listed in your local telephone directory.

Retired Senior Volunteer Program (RSVP)

Volunteers in RSVP work part-time for a nonprofit organization in their community. They may choose their assignments from a list of possibilities compiled by the local RSVP office. For example, RSVP volunteers may serve in hospitals, nursing homes, offices of charities, or schools. Anyone who is at least 60 years old and retired can volunteer. There are no requirements of income, education, or experience. Volunteers receive no pay, but do receive training and may also receive assistance with transportation to and from their work.

Foster Grandparent Program

Foster grandparents are persons 60 years of age or older who volunteer to work with children who have special needs. A foster grandparent must have a low income and be willing to devote four hours of attention, five days a week, to two children who need special attention. Many of these children are sick, neglected, handicapped, retarded, or disturbed. The program provides its volunteers with a small tax-free stipend, hot meals during work times, a transportation allowance, training, insurance, and an annual physical exam.
SENIOR COMPANION PROGRAM (SCP)

The Senior Companion Program is open to low-income persons at least 60 years old who want to serve as companions to frail and infirm elderly persons in their communities. Each volunteer serves two clients, each for 10 hours a week. Companions perform such services as reading and writing letters, escorting clients on errands, shopping and generally visiting with the clients. Volunteers receive a small, tax-free stipend, hot meals during work times, a transportation allowance, training, insurance coverage and an annual physical exam. The only SCP program in Indiana is in Indianapolis.

SENIOR COMMUNITY SERVICES EMPLOYMENT PROGRAM

This program provides training and employment opportunities for low-income persons age 55 or older who are not working. Most areas of the state are covered. For information and to see if you are eligible, contact:

Experience Works
200 E. 3rd St.
P.O. Box 687
Seymour, IN 47274
(800) 843-0885

DISCOUNTS

Banks, utility companies, stores and other businesses sometimes offer discounts or other special considerations to older adults. You may be asked to show proof of your disability or handicap by getting a written document from your doctor.

To save money on prescription drugs, ask your doctor about generic drugs. Generic drugs are drugs identified by their chemical names instead of brand names. They are often much less expensive than brand name drugs.

Members of United Senior Action (USA) who are 60 or older can participate in USA’s Discount Plan and receive discounts at many places. Most of these places are in central Indiana, but the program is expanding statewide and older persons anywhere in Indiana can participate by joining USA. USA is a coalition of groups interested in senior citizens. Individuals as well as organizations can join. To find out about USA’s Discount Plan, call or write:

United Senior Action
324 W. Morris St., #114
Indianapolis, IN 46225
(317) 634-0872, or (800) 495-0872

PARKING FOR THE HANDICAPPED

Many parking lots now reserve special parking spaces for physically handicapped persons. Any car that parks in these spaces must have a special placard or registration plate. A placard may be available for $5 from the bureau of motor vehicles. A person of any age may be eligible for a placard if he (1) has a temporary or permanent physical disability that requires him to use a wheelchair, walker, braces or crutches, or (2) has temporarily or permanently lost the use of one or both legs, or (3) is certified by a doctor as being severely restricted in mobility, either temporarily or permanently, by a heart condition, arthritis or orthopedic or neurological impairment. Persons who transport these eligible handicapped persons may also obtain a placard. Certain disabled veterans may be eligible for a handicapped permit. This placard must be displayed on the vehicle’s dashboard. A disabled person who is eligible may use the placard in any vehicle in which he is riding.

It is against the law to misrepresent your eligibility for a placard or to use the placard when no one in the car at the time is eligible.

Many parking lots now reserve special parking spaces for physically handicapped persons. Any car that parks in these spaces must have a special placard or registration plate. A placard may be available for $5 from the bureau of motor vehicles. A person of any age may be eligible for a placard if he (1) has a temporary or permanent physical disability that requires him to use a wheelchair, walker, braces or crutches, or (2) has temporarily or permanently lost the use of one or both legs, or (3) is certified by a doctor as being severely restricted in mobility, either temporarily or permanently, by a heart condition, arthritis or orthopedic or neurological impairment. Persons who transport these eligible handicapped persons may also obtain a placard. Certain disabled veterans may be eligible for a handicapped permit. This placard must be displayed on the vehicle’s dashboard. A disabled person who is eligible may use the placard in any vehicle in which he is riding.

It is against the law to misrepresent your eligibility for a placard or to use the placard when no one in the car at the time is eligible.

Resource Guide

INDIANA LEGAL SERVICES OFFICES

Indianapolis
151 N. Delaware, Suite 1800
Indianapolis, IN 46204
(317) 631-9410
(800) 869-0212
(317) 631-9424 (Senior Law Project Hotline)

Counties – Boone, Decatur, Delaware, Fayette, Franklin, Hamilton, Hancock, Hendricks, Henry, Johnson, Madison, Marion, Randolph, Rush, Shelby, Union, Wayne

Fort Wayne
915 S. Harrison, Suite 200
Fort Wayne, IN 46802
(260) 424-9155
(888) 442-8600

Counties – Adams, Allen, Blackford, DeKalb, Grant, Huntington, Jay, Steuben, Wells, Whitley

Columbus
1531 13th Street, Suite G
Columbus, IN 47201-1302
(812) 372-6918
(866) 644-6407

Counties – Bartholomew, Brown

Bloomington
214 S. College Avenue, Second Floor
Bloomington, IN 47404
(812) 339-7668
(800) 822-4774

Counties – Clay, Greene, Jackson, Lawrence, Monroe, Morgan, Orange, Owen, Parke, Putnam, Sullivan, Vigo

Lafayette
P.O. Box 1455
639 Columbia Street
Lafayette, IN 47902
(765) 423-5327
(800) 382-7581

Counties – Benton, Carroll, Cass, Clinton, Fountain, Howard, Miami, Montgomery, Tippecanoe, Tipton, Vermillion, Wabash, Warren, White

Indiana Legal Services Offices

New Albany
Plaza Square South, Suite 5
3303 Plaza Drive
New Albany, IN 47150
(812) 945-4123
(800) 892-2776

Counties – Clark, Crawford, Dearborn, Floyd, Harrison, Jefferson, Jennings, Ohio, Ripley, Scott, Switzerland, Washington

Evansville
2425 US 41 N., Suite 401
Evansville, IN 47711
(812) 426-1295
(800) 852-3477

Counties – Daviess, Dubois, Gibson, Knox, Martin, Perry, Pike, Posey, Spencer, Vanderburgh, Warrick

South Bend
105 E. Jefferson Boulevard, Suite 600
South Bend, IN 46601
(574) 234-8121
(800) 288-8121

Counties – Elkhart, Fulton, Kosciusko, LaGrange, LaPorte, Marshall, Noble, Pulaski, St. Joseph, Starke

Gary-Merrillville
5401 Broadway, Suite A
Merrillville, IN 46410
(219) 886-3161
(888) 255-5104

Counties – Jasper, Lake, Newton, Porter

Hammond
5927 Columbia Avenue
Hammond, IN 46320
219-853-2360

Counties – Lake, Porter

Statewide Resources

Check out the Indiana Family and Social Services, Division of Aging website for a map of resources by county: www.in.gov/fssa/da/3453.htm
ADULT PROTECTIVE SERVICES

For assistance statewide, contact:

Adult Protective Services Program
Division of Aging
PO. Box 7083, MS21
492 W. Washington Street, Room W-454
Indianapolis, IN 46207-7083
(317) 233-2182
(888) 673-0002
www.in.gov/fssa/da/3479.htm

Mental Health America
227 E. Washington Boulevard
Fort Wayne, IN 46802
(260) 422-6441
(800) 992-6978

Area 1 – Adams, Allen, DeKalb, Huntington,
LaGrange, Noble, Steuben, Wells, Whitley
Bartholomew County Prosecutor
234 Washington Street
Columbus, IN 47201
(812) 379-1670
(812) 458-6329

Area 2 – Bartholomew, Brown, Decatur, Jackson,
Jennings
Family Services Agency, Inc.
615 N. 18th Street, Suite 201
Lafayette, IN 47904
(765) 423-5361
(800) 875-5361
www.fsilafayette.org

Area 3 – Benton, Carroll, Clinton, Fountain,
Montgomery, Tippecanoe, Warren, White
Madison County Prosecutor
16 E. 9th Street
Anderson, IN 46016
(765) 641-9585

Area 4 – Blackford, Delaware, Grant, Henry, Jay,
Madison, Randolph
Marion County Prosecutor & Investigators
Mail:
203 E. Washington, Suite 560
Indianapolis, IN 46204
Located:
129 E. Market Street, 6th Floor
Indianapolis, IN 46204
(317) 327-1403
Area 5 – Boone, Hamilton, Hendricks, Marion
Wabash County Prosecutor
200 Court Park
Logansport, IN 46947
(574) 753-7790
Area 6 – Cass, Fulton, Howard, Miami, Tipton, Wabash
Clark County Prosecutor
501 E. Court Avenue
Jeffersonville, IN 47130
(812) 285-6264
Area 7 – Clark, Floyd, Harrison, Scott
Vigo County Prosecutor
33 S. 3rd Street
Terre Haute, IN 47807
(812) 462-3286
Area 8 – Clay, Parke, Putnam, Sallisaw, Vermillion, Vigo
Washington County Prosecutor
806 Martinsburg Road, Suite 202
Salem, IN 47167
(812) 883-6560
Area 9 – Crawford, Lawrence, Orange, Washington
Daviess County Prosecutor
P.O. Box 647
200 E. Walnut Street
Washington, IN 47501
(812) 254-8681

Area 10 – Daviess, Dubois, Greene, Knox, Martin, Pike
Dearborn-Ohio County Prosecutor
215 W. High Street
Lawrenceburg, IN 47025
(812) 537-8884

Area 11 – Dearborn, Jefferson, Ohio, Ripley, Switzerland
St. Joseph County Prosecutor
227 W. Jefferson Boulevard, 10th Floor
South Bend, IN 46601
(574) 235-9544

Area 12 – Elkhart, Kosciusko, Marshall, St. Joseph
Wayne County Prosecutor
401 E. Main Street
Richmond, IN 47374
765-973-9394
Area 13 – Fayette, Franklin, Rush, Union, Wayne
Vanderburgh County Prosecutor
Civic Center Complex, Room 108
1 N.W. Martin Luther King, Jr. Boulevard
Evansville, IN 47708
(812) 435-5150
Area 14 – Gibson, Perry, Posey, Spencer, Vanderburgh, Warrick
Shelby County Prosecutor
407 S. Harrison Street
Shelbyville, IN 46176
(317) 835-2798
(317) 392-6495
Area 15 – Hancock, Johnson, Shelby
LaPorte County Prosecutor
813 Lincolnway
LaPorte, IN 46350
(219) 326-8088 (ext. 505)
Area 16 – Jasper, LaPorte, Newton, Porter,
Pulaski, Starke
Lake County Prosecutor
2293 N. Main Street
Building B, First Floor
Crown Point, IN 46307
(219) 755-3863
Area 17 – Lake
Monroe County Prosecutor
311 N. College Avenue, Room 211
Bloomington, IN 47404
(812) 349-2670
Area 18 – Monroe, Morgan, Owen

For assistance in your area, contact:  
Adult Protective Services Program  
Division of Aging 
1 N.W. Martin Luther King, Jr. Boulevard 
Evansville, IN 47708 
(812) 435-5150
**Ombudsman & Area Agencies on Aging**

The Indiana State Long Term Care Ombudsman Program provides advocacy and related services for consumers of long term care services, such as nursing facilities, residential care facilities, assisted living facilities, adult foster care homes and county operated residential care facilities, regardless of age or payer source. To reach the state's ombudsman or for general information statewide, contact:

Arlene Franklin, Long Term Care Ombudsman  
Indianiana Family & Social Services Administration  
Division of Aging  
P.O. Box 7083  
Indianapolis, IN 46207-7083  
(317) 232-7134  
(800) 622-4484

**The following resources are the Ombudsman and then the local Area Agency on Aging for those counties listed.**

**Area 1 – Jasper, Lake, Newton, Porter, Pulaski, Starke**  
Northwest Indiana Community Action Corp.  
5240 Fountain Drive  
Crown Point, IN 46307  
(219) 794-1829  
(800) 826-7871

**Area 2 – Elkhart, Kosciusko, LaPorte, Marshall, St. Joseph**  
REAL Services, Inc.  
1151 S. Michigan  
P.O. Box 1835  
South Bend, IN 46634-1835  
(574) 284-2644 (Ombudsman)  
(574) 233-8205 (Area Agency on Aging)  
(812) 876-3383 (Ombudsman)

**Area 3 – Adams, Allen, DeKalb, Huntington, LaGrange, Noble, Steuben, Wells, Whitley**  
Aging & In-Home Services of Northeast Indiana, Inc.  
2927 Lake Avenue  
Fort Wayne, IN 46805-5414  
(260) 469-3161 (Ombudsman)  
(260) 745-1200 (Area Agency on Aging)  
(800) 552-3662

**Family Services Agency, Inc.**  
615 N. 18th Street, Suite 201  
Lafayette, IN 47904  
(765) 423-5361  
(800) 875-5361  
www.fsilafayette.org

**Area IV Agency on Aging**  
P.O. Box 4727  
660 N. 36th Street  
Lafayette, IN 47903-4727  
(765) 447-7683  
(800) 382-7556  
www.areavagency.org

**Area 5 – Cass, Fulton, Howard, Miami, Tipton, Wabash**  
Area 5 Agency on Aging and Community Services, Inc.  
1801 Smith Street, Suite 300  
Logansport, IN 46947-1577  
(574) 737-2169 (Ombudsman)  
(574) 722-4451 (Area Agency on Aging)  
(800) 654-9421  
www.areafive.com

**Area 6 – Blackford, Delaware, Grant, Henry, Jay, Madison, Randolph**  
LifeStream Services, Inc.  
P.O. Box 308  
1701 S. Pilgrim Boulevard  
Yorktown, IN 47396  
(765) 759-1121 (ext. 145)  
(800) 589-1121  
www.lifestreaminc.org

**Area 7 – Clay, Parke, Putnam, Sullivan, Vermillion, Vigo**  
West Central Indiana Economic Development District, Inc.  
P.O. Box 359  
1718 Wabash Avenue  
Terre Haute, IN 47808-0359  
(812) 238-1251  
(800) 489-1561

**Area 8 – Boone, Hamilton, Hancock, Hendricks, Johnson, Marion, Morgan, Shelby**  
Indiana Legal Services  
151 N. Delaware Street  
Suit 1800  
Indianapolis, IN 46204  
(317) 631-9410 (ext. 2255)  
(800) 869-0212

**CICOA Aging & In-Home Solutions**  
4755 Kingsway Drive, Suite 200  
Indianapolis, IN 46205-1560  
(317) 254-5465  
(800) 432-2422

**Area 9 – Fayette, Franklin, Rush, Union, Wayne**  
Area 9 In-Home & Community Service Agency  
520 S. 9th Street, Suite 100  
Richmond, IN 47374-6230  
(765) 966-1795  
(800) 458-9345  
www.sue.indiana.edu/departments/Area9/

**Area 10 – Monroe, Owen**  
Area 10 Agency on Aging  
7500 W. Reeves Rd.  
Bloomington, IN 47404  
(812) 876-3383  
(800) 844-1010

**Area 11 – Bartholomew, Brown, Decatur, Jackson, Jennings**  
Aging & Community Services of South Central Indiana, Inc.  
1531 13th Street, Suite G900  
Columbus, IN 47201  
(812) 372-6918  
(812) 372-6918 (Ombudsman, ext. 2760)  
(866) 644-6407

**Area 12 – Dearborn, Jefferson, Ohio, Ripley, Switzerland**  
Ombudsman  
P.O. Box 904  
1531 13th Street, G900  
Columbus, IN 47201  
(812) 372-6918 (Area Agency on Aging)  
(812) 432-5215  
(800) 742-5001  
www.lifetimeresources.org

**Area 13 – Daviess, Dubois, Greene, Knox, Martin, Pike**  
Generations  
P.O. Box 314  
1031 N. 4th Street  
Vincennes, IN 47591  
(812) 888-5158 (Ombudsman)  
(812) 888-5080 (Area Agency on Aging)  
(800) 742-9002  
www.generationsnetwork.org

**Area 14 – Clark, Floyd, Harrison, Scott**  
LifeSpan Resources, Inc.  
P.O. Box 995  
31 State Street, Suite 308  
New Albany, IN 47151  
(812) 948-6428 (Ombudsman)  
(812) 948-6930  
(888) 948-8330  
www.lifespanresources.org

**IN BIBLIOGRAPHY**

- www.fsilafayette.org
- www.fsslafayette.org
- www.lifetimeresources.org
- www.lifespanresources.org
- www.generationsnetwork.org
- www.areafive.com
- www.areaav agency.org
- www.in.gov/fssa/da/3474.htm
- www.aginginhs.org
- www.agingihs.org
- www.lifespanresources.org
Area 15 – Crawford, Lawrence, Orange, Washington
Ombudsman
Southern Indiana Center for Independent Living
521 W. Main Street
Bedford, IN 47421
(812) 277-9626
(800) 845-6914
Hoosier Uplands Economic Development Corporation
521 W. Main Street
Mitchell, IN 47446
(812) 849-4457
(800) 333-2451
www.hoosieruplands.org

Area 16 – Gibson, Perry, Posey, Spencer, Warrick, Vanderburgh
Indiana Legal Services
2425 US 41 N., Suite 405
Evansville, IN 47711
(812) 423-2927
Vanderburgh County VOICES, Inc.
651 X Street
Bedford, IN 47421
(812) 277-9626
(800) 845-6914

INDIANA PRO BONO DISTRICTS

District One
651 E. Third Street
P.O. Box 427
Hobart, IN 46342
(219) 945-1799
(800) 945-1799

District Two
The Volunteer Lawyer Network
52303 Emmons Road, Suite 23
South Bend, IN 46637
(574) 277-0075

District Three
Volunteer Lawyer Program of Northeast Indiana
927 S. Harrison
Fort Wayne, IN 46802
(260) 407-0917

District Four
Indiana Legal Services–Lafayette
639 Columbia Street
P.O. Box 1455
Lafayette, IN 47902
(765) 423-5327
(800) 382-7581

District Five
Indiana Legal Services—Lafayette
639 Columbia Street
P.O. Box 1455
Lafayette, IN 47902
(765) 423-5327
(800) 382-7581

District Six
District 6 Access to Justice, Inc.
P.O. Box 324
New Castle, IN 47362
(765) 521-6979
(800) 910-4407

District Seven
P.O. Box 3342
Terre Haute, IN 47803
(812) 478-2666

District Eight
Heartland Pro Bono Council
151 N. Delaware St., Suite 1800
Indianapolis, IN 46204
(317) 814-5304

District Nine
P.O. Box 94
Richmond, IN 47375
(800) 935-5053

District Ten
P.O. Box 8382
Bloomington, IN 47407
(812) 339-3610

District Eleven
Legal Aid-District Eleven, Inc.
1531 13th Street, Suite G330
Columbus, IN 47201
(877) 378-0358

District Twelve
Legal Volunteers of Southeast Indiana, Inc.
318 N. Walnut Street
Lawrenceburg, IN 47025
(812) 537-0123
(877) 237-0123

District Thirteen
Volunteer Lawyer Program of Southwestern Indiana
123 NW 4th Street, Suite 618
Evansville, IN 47708
(812) 434-4886
(812) 434-4889(f)

District Fourteen
406 Pearl Street
New Albany, IN 47150
(812) 949-2292
**LAWYER REFERRAL SERVICES**

*For your local bar association president to make a referral in your county, contact:*

**Indiana State Bar Association**
One Indiana Square, Suite 530
Indianapolis, IN 46204
(317) 639-5465
(800) 266-2581
www.inbar.org

**Allen County Bar Association**
924 South Calhoun Street
Fort Wayne, IN 46802
(260) 423-2358
www.allencountybar.com

**Evansville Bar Association**
123 N.W. 4th Street, Suite 18
Evansville, IN 47708
(812) 426-1712
www.evvbar.org/

**Indianapolis Bar Association**
107 N. Pennsylvania Street, Suite 200
Indianapolis, IN 46204
(317) 269-2000
www.indybar.org

**Lake County Bar Association**
291 W. 84th Drive, Suite B
Merrillville, IN 46410
(219) 736-1905
www.lakecountybar.com

**Marion County Bar Association**
617 Indiana Avenue, Suite 211
Indianapolis, IN 46202
(317) 634-3950

**St. Joseph County Bar Association**
101 S. Main Street
South Bend, IN 46601
(574) 235-9627
www.sjcb.org

**Terre Haute Bar Association**
506 Ohio Street, Suite 7
Terre Haute, IN 47808
(812) 234-8800

**VETERANS’ RESOURCES**

**Medical Centers**

- **Roudebush VA Medical Center**
  1481 W. 10th Street
  Indianapolis, IN 46202
  (317) 554-0000
  www.roudebush.va.gov

- **Northern Indiana Healthcare System**
  2121 Lake Avenue
  Fort Wayne, IN 46802
  (260) 426-5431
  www.nihs.org

- **1700 E. 38th Street**
  Marion, IN 46953
  (765) 674-3321

**Clinics**

- **200 E. Winslow Road**
  Bloomington, IN 47401
  (812) 353-2600

- **9330 S. Broadway**
  Crown Point, IN 46307
  (219) 662-5000

- **710 W. Eads Pkwy.**
  Lawrenceburg, IN 47025
  (812) 539-2313

- **3500 W. Purdue Ave.**
  Muncie/Anderson, IN 47304
  (765) 284-6822

- **113 Northgate Blvd.**
  New Albany, IN 47150
  (866) 463-9838

- **142 W. Honey Creek Pkwy.**
  Terre Haute, IN 47802
  (812) 232-2890

- **3851 N. River Road**
  West Lafayette, IN 47906
  (765) 464-2280

**Veterans Centers**

- **311 N. Weinbach Ave.**
  Evansville, IN 47711
  (812) 473-5993

- **528 W. Berry St.**
  Fort Wayne, IN 46002
  (260) 460-1456

- **6505 Broadway Ave.**
  Merrillville, IN 46410
  (219) 736-5633

- **3833 N. Meridian St.**
  Indianapolis, IN 46208
  (317) 988-1600

**National Cemeteries**

- **Crown Hill**
  700 W. 38th Street
  Indianapolis, IN 46208
  (317) 925-3800

- **1700 E. 38th St.**
  Marion, IN 46952
  (765) 674-0284

- **1943 Ekin Ave.**
  New Albany, IN 47150
  (812) 948-5234

**Helpful Websites**

- **U.S. Department of Veterans Affairs**
  www.va.gov

- **U.S. Department of Veterans Affairs Insurance Service**
  www.insurance.va.gov

- **U.S. Department of Veterans Affairs National Cemetery Benefits**
  www.cem.va.gov

- **Indiana Department of Veterans Affairs**
  www.in.gov/veteran

- **Indiana Veterans Service Officers Association**
  www.invsoa.homestead.com
Notes

Promoting equal access to justice for all of Indiana’s citizens

The Indiana Bar Foundation makes access to justice and education possible throughout the state:

Laws of Aging

Civic Education — educating Indiana’s youth on the importance of becoming engaged and active citizens through its We the People and Project Citizen programs.

Indiana Pro Bono Commission — providing access to justice through bono services in each of the 14 districts throughout Indiana.

To support these worthy endeavors and ensure access to justice throughout Indiana, make a difference through the Indiana Bar Foundation today:

800-279-8772
www.inbf.org
Don’t Be Unprepared For the Inevitable

The members of the Elder Law Section, Family & Juvenile Law Section, General Practice, Solo & Small Firm Section and the Probate, Trust & Real Property Section of the Indiana State Bar Association are prepared to ensure their clients are prepared through thoughtful estate planning.

Estate Planning

Consider an ISBA attorney when preparing for life’s many inevitabilities.

Indiana State Bar Association • One Indiana Square, Suite 530 Indianapolis, IN 46204 • http://www.inbar.org • 317-639-5465

Senior Living Made Affordable
You’re Experts on Elder Law, We’re Experts on Elder Care

Crestwood Village is owned and operated by the Justus Companies. We’re the largest operator of senior housing in Indiana, as recognized in the Indianapolis Business Journal. If you’re looking for the best and most experienced leader in the senior housing industry, look no further than Crestwood Village. Plus, Crestwood Village has free utilities and free transportation. To find out more, call us at 877-202-0994 or stop by today.

Crestwood Village
877-202-0995

Visit us online at Crestwood-Living.com today!

Utilities paid | 24-hour care | Fitness programs | Free transportation | Housekeeping
*Available at select locations for a limited time. Restrictions apply.
We Profit From Your Success.

At Westminster Village North We Put Our Residents First!

As a not-for-profit community, the well being of our residents and quality of care is our number one concern. It shows in everything we do. Our focus is serving our residents rather than increasing the bottom line. We promise our life-occupancy residents, that they will always have a home at Westminster Village North, even if they are unable to pay for our services.

It’s that spirit that makes us special — we’re a community of caring individuals who together create this friendly and welcoming neighborhood. Of course we’ll mow the lawn or fix a leaky faucet, but Westminster Village North is far more than just a beautiful, wooded and spacious maintenance-free community. Our dedicated staff is always on hand to help make your clients’ retirements everything they dreamed it could be.

And our complete, accredited continuum of care offers your clients the comfort and security of knowing our skilled nursing and health care professionals are available with physical and occupational therapy, rehabilitation, memory care – everything your clients need to navigate life’s little stumbles or something more permanent. Westminster Village North offers the lifestyle and quality of care they deserve. And it all comes with peace of mind, knowing their future is secure because their health and wellness are our top priority.