

Professional Fiduciaries Bureau
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Website: www.fiduciary.ca.gov



Professional Fiduciaries Bureau Education Sub-Committee Meeting

**Thursday, December 12, 2013
10:00 a.m. – 12:00p.m.**

**Meeting Location:
Myers Urbatsch P.C.
625 Market Street, 4th Floor
San Francisco, CA 94105**

Subcommittee Members Present

Barbara de Vries, Subcommittee Chair
Kevin Urbatsch, Subcommittee Vice Chair
Prescott Cole

Staff Members Present

Julia Ansel, Bureau Chief
Angela Bigelow, Program Analyst

- 1) Call to Order – Barbara de Vries, Subcommittee Chair
- 2) Introductions / Role Call – Julia Ansel, Bureau Chief
- 3) Approval of Minutes of the Education Subcommittee Minutes from the November 19, 2013 Meeting
- 4) Purpose of Subcommittee – Julia Ansel, Bureau Chief
 - Discussion on Committee Developing a Criteria List to Assist Bureau in Evaluating/ Approving Providers
 - Review of Current Laws and Regulations that Pertain to Education
- 5) Internship Discussion – Barbara de Vries, Subcommittee Chair
 - Feasibility of Requiring Internship
 - Feasibility of Continuing Education Provider Requiring Internship
 - Feasibility of the Bureau Requiring Internship
- 6) Specific Subject Matter Requirements for Continuing Education – Prescott Cole
 - Advocacy
 1. Nursing Homes
 2. Residential Facilities
 3. Assisted Living Facilities
 - Spotting Scams

- Government Benefits and Programs
- 7) Practical Component and Increasing Pre-licensing and Continuing Education Hours Requirements – Kevin Urbatsch, Subcommittee Vice Chair
 - Including a Practical Component within the Required Education Hours
 - Specify within the Hours Requirement the Number or Percentage of Hours Required in Each Subject
 - Increase the Number of Required Hours
 - 8) Task to be Completed by Subcommittee Members Prior to the Next Meeting
 - 9) Future Agenda Items
 - 10) Future Meeting Dates
 - 11) Adjournment

Note: The Professional Fiduciaries Bureau Advisory Committee may not discuss or take action on any matter raised that is not included in this agenda. The Committee may however decide to place the matter on the agenda of a future meeting.

Notice: The meeting is accessible to the physically disabled. A person who needs disability-related accommodations or modifications in order to participate in the meeting should make a request no later than five working days before the meeting to the Bureau by contacting Angela Bigelow at (916) 574-7341, angela.bigelow@dca.ca.gov or by sending a written request to the Professional Fiduciaries Bureau, 1625 North Market Blvd., Ste. S-209, Sacramento, California 95834. Requests for further information should be directed to Ms. Bigelow at the same address and telephone number.

MEMORANDUM

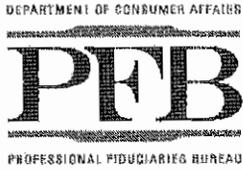
DATE	December 12, 2013
TO	Education Subcommittee Members Professional Fiduciaries Bureau
FROM	Professional Fiduciaries Bureau
SUBJECT	Agenda Item #1 - Call to Order- Barbara de Vries, Subcommittee Chair Agenda Item #2 – Introductions/Role Call – Julia Ansel, Bureau Chief

Education Subcommittee Members:

Barbara de Vries – Subcommittee Chair

Kevin Urbatsch – Subcommittee Vice Chair

Prescott Cole – Governor Appointee – Nonprofit organization advocating on behalf of the elderly



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MEMORANDUM

DATE	December 12, 2013
TO	Education Subcommittee Members Professional Fiduciaries Bureau
FROM	Professional Fiduciaries Bureau
SUBJECT	Agenda Item #3 – Approval of Minutes of Education Subcommittee Minutes from the November 19, 2013 Meeting

Attachment #1: November 19, 2013 Education Subcommittee Meeting Minutes

Public Comment:

Attachment #1

**Professional Fiduciaries Bureau
Education Subcommittee Meeting
November 19, 2013**

**Department of Consumer Affairs
1625 N. Market Blvd., 1st Floor Hearing Room
Sacramento, CA 95834**

Committee Members Present

Barbara de Vries, Subcommittee Chair
Kevin Urbatsch, Subcommittee Vice Chair
Prescott Cole

Staff Present

Julia Ansel, Bureau Chief
Sonja Merold, Acting Chief, Division of Programs and Policy Review
Angelique Scott, DCA Legal Counsel
Angela Bigelow, Program Analyst

I. Call to Order – Barbara de Vries, Subcommittee Chair
The meeting was called to order by Ms. Lorenz at 9:08am.

II. Introductions/Role of Subcommittee – Julia Ansel, Bureau Chief
Those in attendance introduced themselves. Ms. Ansel explained according to the minutes from the April 3, 2013 Advisory Committee meeting, the role of the education Subcommittee is to: explore new education opportunities, review existing opportunities and suggest improvements, and look at improving the existing regulations. The Subcommittee should report back to the full Advisory Committee.

III. Purpose of Subcommittee – Julia Ansel, Bureau Chief
Ms. Ansel stated according to the minutes from the April 3, 2013 Advisory Committee meeting, the Bureau asked that the Subcommittee offer advice and direction for Bureau staff on how to approve education providers and education courses. This would help to assist the Bureau in the future. Ms. de Vries asked if the criteria would also be used to look at existing providers and possibly remove the providers from the Bureau's existing list. Ms. Scott stated the subcommittee can develop criteria for the Bureau and the Bureau staff can advise current providers if they no longer qualify and the Bureau could work with the provider to re-qualify if possible. The provider will have to re-apply once criteria is established. At this time the providers are in the actual regulation and cannot be removed without a regulation change.

IV. Bagley-Keene Open Meeting Act – Julia Ansel, Bureau Chief
Ms. Ansel explained the Bagley-Keene Act does apply to subcommittees and referred the committee members to page 3, paragraph 3 which defines a public meeting to be a

meeting when 3 or more committee members are present. This subcommittee consists of 3 persons and is required to be noticed and open to the public. The meetings can be held as it is today, prior to the full Advisory Committee Meeting or by teleconference. If the meeting is held by teleconference, all locations must be open to the public and meet the requirements of the Bagley-Keene Act and must also be ADA compliant. The Subcommittee Chair must work with the Bureau staff to notice the meeting and Bureau staff must be present at the meetings.

V. Discussion on adding additional members to the committee

Ms. Ansel explained the subcommittee can decide to add additional members to the subcommittee. If the subcommittee decides to add additional members, the subcommittee will also need to decide how those members will be recruited/accepted into the subcommittee.

Mr. Cole stated he believes it is essential to start with a small core and feels a committee of 3 is sufficient at this time.

Ms. de Vries stated she has had a request for someone to join but feels if the meetings are open to the public, then it is fine to leave the committee at 3 members and allow public comment to be received at the public meetings. Mr. Urbatsch agreed and stated that more members could be added at a later date if needed.

VI. Committee to discuss items to be addressed in regard to education

Ms. de Vries stated the subcommittee has had the certificate programs present at the Advisory Committee. Today will be UC Riverside. Next time will be Berkeley. Then the subcommittee can work on standardization between the programs and make recommendations.

Ms. de Vries would like to see applicants complete an internship before entering the programs. The internship requirement would be to serve a specific amount of time working with a licensed Professional Fiduciary or mentoring group. Ms. Ansel asked if this would be required by the certificate program or the Bureau. Ms. de Vries would like to research this. Ms. Scott stated if this is going to be a requirement prior to licensure it could be part of the 30 hour requirement. Also, it could be a requirement in the section for approving providers.

Mr. Cole would like to have a category that requires providers to include in their educational packet areas of advocacy for the client. This would include education of what is going on in nursing homes, residential facilities, and assisted living facilities so Professional Fiduciaries would understand what is happening and how best to advocate for their clients. Also, there is a need for understanding government programs such as Medicare and long term care and how you qualify for these programs. Another area the Professional Fiduciaries should be trained in is spotting scams. There are a lot of scams and traps out there and the licensee should know how to spot these scams.

Mr. Urbatsch would like to see a practical component as well as adding in the advocacy material. Mr. Urbatsch would like to see that within the requirement those hours be carved out and specific hour requirements be given to each component. Mr. Urbatsch would also like to see the hours required increased. Ms. Scott stated the hours cannot be increased without a change in legislation. Ms. Scott asked that the subcommittee members review the regulations for education requirements specifically sections 4440 through 4444. The subcommittee can recommend to the Bureau how to split up the hours and request the regulations be amended. Any internship hours would also have to be included within the hours required in the regulations, the Bureau cannot make this a separate section. Mr. Urbatsch asked if the Bureau has the authority to require the

certificate programs to include an internship component. Ms. Scott replied the Bureau has authority only in what applicants are required to complete.

Mr. Cole asked if the subcommittee members can share information with each other outside of the meetings. Ms. Scott replied it would be best to forward to the Bureau staff and the staff can distribute the information.

Ms. Bigelow clarified the topics that would be shared at the Advisory Committee Meeting:

Including internship within the 30 hour prelicensing requirement and whether this would be a requirement by the providers or the Bureau. Including advocacy with information on nursing homes, residential facilities, and assisted living facilities to be included in education requirements. Also including spotting scams and information about government benefits. A practical component to be included in the education hours and breaking the hours up and requiring a certain number of hours on each topic.

Ms. Lorenz suggested requirements of ICB.com be looked at as the training is set up much like what she heard at this meeting. She has talked to new licensees who have stated CSUF classes are disconnected from the Professional Fiduciary exam and the preparation is not relevant to prepare for the exam. She suggested that as education requirements are improved, the exam should also be updated to reflect the changes.

Ms. Bessey stated she is in agreement with segmenting credits and PFAC is looking at doing this also. Internship is a concern for PFAC as there is a liability for the licensee. PFAC does agree with mentoring.

Ms. Scott reviewed items that were brought up in previous meetings in regard to the education subcommittee. Adding a self-study quiz on the e-newsletter was suggested at a previous meeting. Mr. Cole stated this would be low on the list for the subcommittee.

Ms. Scott also stated there was a request to change the list of providers in CCR 4446.

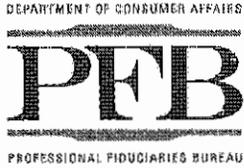
Ms. de Vries asked for clarification. Ms. Bigelow clarified the providers are written in the regulations and to add, delete, or change providers requires a regulation change. Most other Boards and Bureaus list them on the website not in regulations.

VII. Future Meeting Dates

Ms. Ansel stated the subcommittee members could decide if they would like to meet prior to the full Advisory Committee Meeting or by teleconference. Ms. Bigelow explained the notice must be posted on the website and mailed to the interested parties list at least 10 days prior to the meeting. Mr. Cole asked if all materials have to be posted for the public. Ms. Scott stated yes they would need to be available for the public at the meeting. Mr. Cole suggested the meetings be held by teleconference due to the location of the members and that the meetings should be held more than once a quarter. The Education Subcommittee will meet on December 12, 2013 at 9:30am.

VIII. Adjournment

The meeting was adjourned at 10:05a.m.



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MEMORANDUM

DATE	December 12, 2013
TO	Education Subcommittee Members Professional Fiduciaries Bureau
FROM	Professional Fiduciaries Bureau
SUBJECT	Agenda Item #4 – Purpose of Education Subcommittee – Julia Ansel, Bureau Chief

Purpose:

- Discussion on Committee Developing a Criteria List to Assist Bureau in Evaluating/Approving Providers

- Review of Current Laws and regulations that Pertain to Education
Attachment #2 – Laws
Attachment #3 - Regulations

Public Comment:

Attachment #2

BUSINESS AND PROFESSIONS AUTHORITY CITED SECTIONS

6517.

The bureau may adopt, amend, or repeal, in accordance with the provisions of the Administrative Procedure Act (Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code), regulations necessary to enable the bureau to carry into effect the provisions of law relating to this chapter.

(Added by Stats. 2006, Ch. 491, Sec. 3. Effective January 1, 2007.)

152.6.

Notwithstanding any other provision of this code, each board within the department shall, in cooperation with the director, establish such license periods and renewal dates for all licenses in such manner as best to distribute the renewal work of all boards throughout each year and permit the most efficient, and economical use of personnel and equipment. To the extent practicable, provision shall be made for the proration or other adjustment of fees in such manner that no person shall be required to pay a greater or lesser fee than he would have been required to pay if the change in license periods or renewal dates had not occurred.

As used in this section "license" includes "certificate," "permit," "authority," "registration," and similar indicia of authority to engage in a business or profession, and "board" includes "board," "commission," "committee," and an individual who is authorized to renew a license.

(Added by Stats. 1968, Ch. 1248.)

BUSINESS AND PROFESSIONS REFERENCED SECTIONS

6533.

In order to meet the qualifications for licensure as a professional fiduciary a person shall meet all of the following requirements:

(e) Have completed the required prelicensing education described in Section 6538.

(Amended by Stats. 2007, Ch. 354, Sec. 5. Effective January 1, 2008.)

6538.

(a) To qualify for licensure, an applicant shall have completed 30 hours of prelicensing education courses provided by an educational program approved by the bureau.

(b) To renew a license, a licensee shall complete 15 hours of approved continuing education courses each year.

(c) The cost of any educational course required by this chapter shall not be borne by any client served by a licensee.

(Added by Stats. 2006, Ch. 491, Sec. 3. Effective January 1, 2007.)

134.

When the term of any license issued by any agency in the department exceeds one year, initial license fees for licenses which are issued during a current license term shall be prorated on a yearly basis.

(Amended by Stats. 1978, Ch. 1161.)

Attachment #3

Article 3. Prelicensing and Continuing Education

Section 4440. Prelicensing Education Requirements.

To qualify for licensure under the Act an applicant shall complete thirty (30) hours of prelicensing education credit subject to the conditions of this Article. The following courses shall qualify for prelicensing education credit:

- (a) Any education course taken on or after January 1, 2007, that meets the requirements of an approved education course under Section 4444.
- (b) Any fiduciary management course taken from the California State University, Fullerton, Extended Education Program.

NOTE: Authority cited: Section 6517, Business and Professions Code. Reference: Section 6538, Business and Professions Code.

Section 4442. Continuing Education Requirements.

(a) Annual time requirements.

(1) To renew a license, a licensee shall earn during each annual renewal period a minimum of fifteen (15) hours of continuing education credit from approved education courses as defined in Section 4444 subject to the conditions of this Article. 5/30/2013 4

(2) Courses qualifying for continuing education credit must be completed following licensure and within the one-year renewal period each cycle.

{3} A licensee who serves as an instructor in an approved education course for continuing education as provided for in subdivision (a) of Section 4444, may receive 1.5 hours of continuing education course participation credit for each hour of new course instruction presented. A maximum of 6 of the fifteen (15) hours of continuing education credit may be earned under this paragraph.

{4} A maximum of 4 of the fifteen (15) hours of continuing education credit may be earned through independent study under the supervision of an approved education provider pursuant to Section 4446 that supplies evidence of completion.

(b) Annual subject topic requirements.

(1) Continuing education credit shall be earned by taking approved education courses in at least one of the subject topics as provided for in Section 4444.

(2) At least 2 hours of continuing education credits each year shall be in ethics for fiduciaries.

NOTE: Authority cited: Section 6517, Business and Professions Code. Reference: Section 6538, Business and Professions Code.

Section 4443. Continued Education for First License Renewal.

For the initial license period established pursuant to Section 4428, each licensee must comply with the continued education requirements of Section 4442.

NOTE: Authority cited: Sections 152.6, and 6517, Business and Professions Code. Reference: Sections 134 and 152.6, Business and Professions Code.

Section 4444. Approved Education Courses.

(a) Eligible education courses, as defined in subdivision (b), offered or approved by an approved education provider listed in Section 4446, are approved education courses that meet the prelicensing and continuing education requirements of this Article.

{b) Programs, seminars, and courses of study that are relevant to fiduciary responsibilities of estate management or of fiduciary responsibilities of the person for at least one of the subject topics as specified in subdivision (e), that address the areas of proficiency, competency, and performance of a fiduciary, and impart knowledge and increase understanding of the fiduciary profession or of the California judiciary or the legal process as it relates to the administration of fiduciary responsibilities are eligible education courses.

(c) An approved education course may be offered in a real-time classroom setting, delivered by video presentation from a remote location or by other delivery means, including online.

(d) An approved education course may include independent study, subject to the limitations of paragraph (4) of subdivision (a) of Section 4442, if the education provider supplies evidence of completion. A course is not independent study if the education provider requires evidence of comprehension prior to issuing a certificate of completion, as required in subdivision (c) of Section 4448.

- (e) Subject topics for eligible education courses, as defined in subdivision (b), include the following:
- (1) Conservatorship;
 - (2) Guardianship;
 - (3) Trust administration;
 - (4) Durable Power of Attorney;
 - (5) The California court system including court jurisdiction and responsibilities; the state and federal constitution, California statutes, rules of court, case law, administrative law, and current issues in the California court system relevant to the fiduciary profession;
 - (6) Ethics for fiduciaries.

NOTE: Authority cited: Section 6517, Business and Professions Code. Reference: Section 6538, Business and Professions Code.

Section 4446. Approved Education Providers.

(a) Approved education providers may include accredited educational institutions, professional associations, professional continuing education entities, public or private for-profit or not-for-profit entities, and court-connected groups. An "accredited educational institution" is a college or university, including a community or junior college, accredited by a regional accrediting organization recognized by the Council for Higher Education Accreditation.

(b) The following educational entities that offer or approve eligible education courses as defined in subdivision (a) of Section 4444, in accordance with the requirements of Section 4448, are approved education providers of courses that meet the prelicensing and continuing education requirements of this Article:

- (1) An accredited educational institution;
- (2) An education provider offering courses sponsored by a local court of the State of California;
- (3) An education provider offering courses approved by the California State Bar for continuing education;
- (4) An accountancy organization or an education provider, if the education qualifies with the California State Board of Accountancy for continuing education credit for renewal of an individual license as a Certified Public Accountant;
- (5) An education provider offering courses registered with the Certified Financial Planner Board of Standards, Inc.;

(6) An education provider offering courses approved by the California Department of Insurance;

(7) An education provider of continuing education courses approved by the California Board of Registered Nursing;

(8) An education provider offering courses approved by the California Board of Psychology;

(9) An education provider offering courses approved by the California Board of Behavioral Sciences;

(10) The California Department of Mental Health, Social Services and Developmental Services;

(11) The Professional Fiduciary Association of California;

(12) The California State Association of Public Administrators, Public Guardians, and Public Conservators;

(13) The National Guardianship Association and its state affiliates;

(14) The National Association of Professional Geriatric Care Managers;

(15) The American Bar Association;

(16) The American Society of Aging;

(17) The Gerontological Society of America;

(18) The National Association of Social Workers;

(19) The National College of Probate Judges;

(20) The National Elder Law Foundation;

(21) The American Bankers Association and its training providers;

(22) The Cannon Financial Institute.

(23) Any Long Term-Care Ombudsman program certified by the California Department of Aging; and,

(24) An Internal Revenue Service/Office of Professional Responsibility Approved Program Sponsor for Continuing Education for Enrolled Agents.

NOTE: Authority cited: Section 6517, Business and Professions Code. Reference: Section 6538, Business and Professions Code.

Section 4448. Requirements for Education Providers.

Each education provider shall:

(a) Ensure that the instructors teaching qualified education courses are proficient and knowledgeable in the subject matter;

(b) Monitor and evaluate the quality of courses, curricula, instructors, and instructor training;

(c) Maintain records of attendance or independent study and distribute to each participant a certificate of completion that identifies the education provider and documents the subject taught, the date of completion of the education course, and the amount of education credit offered;

(d) Maintain documentation of approved education courses offered for prelicensing and continuing education credit under this article for a period of at least five years from the date the education course was offered; and

(e) Provide to the Bureau upon request any documentation of approved education courses for prelicensing and continuing education credit, including records of attendance or independent study.

NOTE: Authority cited: Section 6517, Business and Professions Code. Reference: Section 6538, Business and Professions Code.

Section 4450. Proof of Compliance of Prelicensing Education.

Each applicant is responsible for ensuring compliance with the prelicensing education requirements of this Article.

(a) To demonstrate compliance an applicant shall sign under penalty of perjury on an application form, as provided for in Section 4422, provided by the Bureau that they have completed thirty (30) hours of approved prelicensing education courses.

(b) An applicant shall maintain documentation of completion of prelicensing education courses for a period of at least three years from the date of the issuance of the license.

(c) Each applicant shall provide any information requested by the Bureau within ten (10) business days of the request, to determine compliance with the prelicensing education requirements of the Act.

NOTE: Authority cited: Section 6517, Business and Professions Code. Reference: Section 6538, Business and Professions Code.

Section 4452. Proof of Compliance of Continuing Education Requirements.

Each applicant is responsible for ensuring compliance with the continuing education requirements of this Article.

(a) To demonstrate compliance a licensee shall sign under penalty of perjury on an annual renewal application form provided by the Bureau that they have completed fifteen (15) hours of approved continuing education courses.

(b) A licensee shall maintain documentation of completion of continuing education courses for a period of at least three years from the date of renewal.

(c) Each licensee shall provide any information requested by the Bureau within ten (10) business days of the request, to determine compliance with the continuing education requirements for license renewal.

NOTE: Authority cited: Section 6517, Business and Professions Code. Reference: Section 6538, Business and Professions Code.



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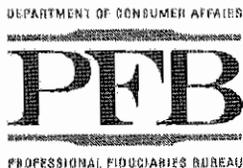


MEMORANDUM

DATE	December 12, 2013
TO	Education Subcommittee Members Professional Fiduciaries Bureau
FROM	Professional Fiduciaries Bureau
SUBJECT	Agenda Item #5 – Internship Discussion – Barbara de Vries, Subcommittee Chair

- Feasibility of Requiring Internship
- Feasibility of Continuing Education Provider Requiring Internship
- Feasibility of the Bureau Requiring Internship

Public Comment:



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BUSINESS, CONSUMER SERVICES, AND HOUSING AGENCY
GOVERNOR EDWARD G. BROWN JR.

MEMORANDUM

DATE	December 12, 2013
TO	Education Subcommittee Members Professional Fiduciaries Bureau
FROM	Professional Fiduciaries Bureau
SUBJECT	Agenda Item #6 – Specific Subject Matter Requirements for Continuing Education – Prescott Cole

Attachment #4 – Advocacy Materials

- Advocacy
 1. Nursing Homes

 2. Residential Facilities

 3. Assisted Living Facilities

- Spotting Scams

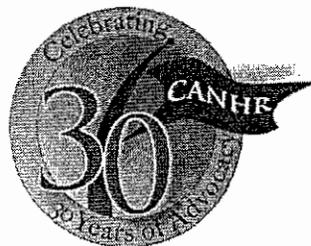
- Government Benefits and Programs

Public Comment:

Attachment #4

Elder Financial Abuse Litigation Guide

California Advocates for Nursing Home Reform
650 Harrison Street, 2nd Floor San Francisco, CA 94107
(415) 974-5171 or (800) 474-1116 (Consumers Only)
www.canhr.org



Elder Financial Abuse Litigation Guide
California Advocates for Nursing Home Reform

This elder financial abuse litigation guide is designed to familiarize legal services staff with useful California elder financial abuse statutes and to provide them with the tools to litigate elder and dependent adult financial abuse cases. An understanding of how financial abuse occurs will help the plaintiff's attorney develop a cogent recitation of the facts that led up to the abuse. This guide provides the legislative intent behind the establishment of the Elder and Dependent Adult Civil Protection Act (EADACA), which will help direct the trier of fact to the importance of these cases, the impact on seniors, and society's intention to do what it can to combat this insidious activity. The guide also highlights the prominent statutes being used to pursue civil litigation, including a number of several prototype complaints that can be used as a guide when developing a private cause of action.

Special thanks to the following lawyers who have generously shared their work products: Kelly Morgantini, Esq., Daniel Murphy, Esq., Steve Riess, Esq. and Kathryn Stebner, Esq.

All information included in this Guide is up to date as of January 1, 2013. Since laws are subject to change, attorneys using CANHR's publications or information in dealing with a specific legal matter should also research original sources of authority.

The sample documents included in this Guide may not be regarded as legal advice. Statements of fact or opinion are solely the responsibility of the authors and do not imply an opinion or endorsement on the part of CANHR officers, staff or directors unless otherwise specifically stated.

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CANHR

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Preface

It is important for lawyers working with senior victims of financial abuse to be familiar with elder financial abuse statutes. Elder financial abuse is becoming the “growth industry” of the 21st century, affecting hundreds of thousands of elderly persons each year. As the holders of the largest percentage of wealth and with access to vast equity reserves in family homes, the elderly are prime targets of greedy family members, friends and caregivers, telemarketing and internet scam artists, and a growing number of unethical professionals. Changes in cognitive abilities, coupled with the fear of outliving resources, make seniors prime targets for financial abuse. Seniors with mild cognitive impairment but who are capable of performing the necessary activities of daily living to remain “independent” in the community are particularly vulnerable to being victimized. Those having trouble with their critical thinking skills can become confused and easily manipulated when it comes to managing their property, personal finances, and estates. Professional predators are expert in selling products that are often inappropriate, such as trusts, annuities, long term care insurance, and reverse mortgages.

II. How to Recognize Financial Abuse

a. Transaction Abuse Indicators

- Inappropriate banking activity, such as unusually large withdrawals or withdrawals from automated banking machines when the elder cannot get to the bank
- Signatures on checks that do not resemble the elder’s signature
- Legal documents signed when the elder is physically incapable of writing
- Checks written out to “cash” being negotiated by the elder’s caregiver
- Checks signed by the senior but filled out by someone else
- A surge of activity in accounts which have been static for years
- Expensive gifts made by the elder to a caretaker
- Checks or credit card transactions made out to direct mail or telemarketing promotions
- Contributions going to newly formed religious or non-profit causes
- Investments in time shares, real property, annuities or financial products
- Large loans against equity in real property to finance investments

b. Possible Legal Document Abuse Indicators

- Power of attorney given by the elder when he or she lacks mental capacity
- A will being made when the elder is not mentally competent
- Elder taking his or her name off of property titles
- The elder adding the name of a caretaker to real property or money accounts in exchange for commitments of continued care and/or affection

c. Life-Style Change Indicators

- Lack of amenities, such as personal grooming items or appropriate clothing, when the elder can well afford it
- Under-deployment of the elder’s existing resources that should be spent on personal care, housing, and maintenance
- Missing cash, jewelry and personal belongings

d. Personal Relationship Abuse Indicators

- Unusual interest by a family member in “conserving” the money being spent for the care of the elder
- Reluctance or refusal by “responsible party” to spend money on the elder’s care
- Recent acquaintances or long-lost relatives expressing affection for a wealthy elder
- A caretaker taking an inappropriate level of interest in the elder’s financial matters

III. FINANCIAL ELDER ABUSE LAWS

Crimes of financial abuse against elder or dependent adults are cowardly and despicable acts that are psychologically devastating and destroy independence. The good news is California has many elder and dependent adult statutes that can be used by criminal prosecutors, civil litigators and those engaged in protective services. Those advocating for the rights and safety of our elder and dependent citizens need to be conversant in the legal resources available. This Guide provides essential information to help advocate for elders or dependent adults who have been financially abused.

a. California's Elder and Dependent Adult Civil Protection Act (EADACPA)

The California Legislature recognized that special laws are needed to protect elder and disabled individuals. The California Legislature declared that elder adults are deserving of special consideration and protection. To that end, statutes were created in both criminal and civil law that encourage prosecution of cases and enhances punishment for those who have been found guilty of the abuse of an elder or dependent adult [Welfare and Institutions Code Section 15600(a)]. The Legislature desired to direct special attention to the needs and problems of elderly persons, recognizing that these persons constitute a significant and identifiable segment of the population and that they are more subject to risks of abuse, neglect, and abandonment [Welfare and Institutions Code Section 15600(b)].

In enacting EADACPA [WIC § 15600 (h)(i)] the Legislature found and declared that infirm elderly persons and dependent adults are a disadvantaged class, that cases of abuse of these persons are seldom prosecuted as criminal matters, and few civil cases are brought in connection with this abuse due to problems of proof, court delays, and the lack of incentives to prosecute these suits. The intent of the Legislature in enacting this chapter was to provide that adult protective services agencies, local long-term care ombudsman programs, and local law enforcement agencies shall receive referrals or complaints from public or private agencies, from any mandated reporter submitting reports pursuant to Section 15630, or from any other source having reasonable cause to know that the welfare of an elder or dependent adult is endangered, and shall take any actions considered necessary to protect the elder or dependent adult and correct the situation and ensure the individual's safety.

Defining Civil Elder and Dependent Adult Financial Abuse (Welfare and Institutions Code Section 15610.30)

- (a) "Financial abuse" of an elder or dependent adult occurs when a person or entity does any of the following:
- (1) Takes, secretes, appropriates, obtains, or retains real or personal property of an elder or dependent adult for a wrongful use or with intent to defraud, or both.
 - (2) Assists in taking, secreting, appropriating, obtaining, or retaining real or personal property of an elder or dependent adult for a wrongful use or with intent to defraud, or both.
 - (3) Takes, secretes, appropriates, obtains, or retains, or assists in taking, secreting, appropriating, obtaining, or retaining, real or personal property of an elder or dependent adult by undue influence, as defined in Section 1575 of the Civil Code.
- (b) A person or entity shall be deemed to have taken, secreted, appropriated, obtained, or retained property for a wrongful use if, among other things, the person or entity takes, secretes, appropriates, obtains, or retains the property and the person or entity knew or should have known that this conduct is likely to be harmful to the elder or dependent adult.

Private Cause of Action - Civil Suits for Elder And Dependent Adult Abuse (Welfare and Institutions Code § 15657.5)

Where it is proven by a preponderance of the evidence that a defendant is liable for financial abuse, as defined in Section 15610.30, in addition to compensatory damages and all other remedies otherwise provided by law, the court shall award to the plaintiff reasonable attorney's fees and costs.

Statute of Limitation for Financial Abuse (Welfare and Institutions Code § 15657.7)

There is a four-year statute of limitations in elder and dependent adult financial abuse cases.

Surviving Cause of Action (Code of Civil Procedure § 377.30)

After the death of the elder or dependent adult, the right to commence or maintain an action shall pass to the personal representative of the decedent. If there is no personal representative, the right to commence or maintain an action shall pass to an heir or an intestate heir whose interest is affected by the action, and the decedent's successor in interest. A creditor or a person who has a claim against the estate who is not an heir or beneficiary of the decedent's estate does not have standing.

Civil Attorneys Freezing Assets (Welfare and Institutions Code § 15657.01)

An attachment may be issued in any action for damages pursuant to Section 15657.5 for financial abuse of an elder or dependent adult, as defined in Section 15610.30. The other provisions of the Code of Civil Procedure not inconsistent with this article shall govern the issuance of an attachment pursuant to this section. In an application for a writ of attachment, the claimant shall refer to this section. An attachment may be issued pursuant to this section whether or not other forms of relief are demanded.

Wrongful Taking from a Decedent (Probate Code § 859)

If a court finds that a person has in bad faith wrongfully taken, concealed, or disposed of property belonging to the estate of a decedent, conservatee, minor, or trust, or has taken, concealed, or disposed of the property by the use of undue influence in bad faith or through the commission of elder or dependent adult financial abuse, as defined in Section 15610.30 of the Welfare and Institutions Code, the person shall be liable for twice the value of the property recovered by an action under this part. The remedy provided in this section shall be in addition to any other remedies available in law to a trustee, guardian or conservator, or personal representative or other successor in interest of a decedent.

Undue Influence (Civil Code Section 1575)

Undue influence is where a person who has the confidence or authority over another uses their relationship to take advantage of that person's necessities in a grossly oppressive manner. According to California Civil Code Section 1575, undue influence consists of:

1. The use, by one in whom a confidence is reposed by another, or who holds a real or apparent authority over him, of such confidence or authority for the purpose of obtaining an unfair advantage over him;
2. Taking an unfair advantage of another's weakness of mind; or,
3. Taking a grossly oppressive and unfair advantage of another's necessities or distress.

b. The Consumer Legal Remedies Act (CLRA)

The CLRA can be used in cases where goods or services have been sold through unfair or deceptive sales practices. An injured party would want to use the CLRA because they can be awarded restitution of their property, punitive damages, court costs and attorneys fees, in addition to any other relief that a court may deem proper. Civil Code Section 1761 defines what is meant by goods and services and who and what is covered by the act. Section 1770 enumerates the various acts considered to be deceptive practices. Section 1780 lays out the remedies and procedures necessary in order to obtain the remedies. Of extreme importance is to note that the person or party who allegedly committed the acts must notify and demand correction of the alleged violation thirty days prior to the commencement of any action under CLRA.

Preliminary Notices and Demands Owed to the Defendant (Civil Code § 1782)

The plaintiff is required to notify the defendant, and make a demand on the defendant thirty days prior to the commencement of an action for damages. If the defendant complies then no action for damages may be maintained under the provision of § 1781.

Additional Remedies for Elder or Disabled Adults under CLRA [Civil Code § 1780 (b)]

Any consumer who is a senior citizen or a disabled person may seek and be awarded, in addition the remedies specified, up to five thousand dollars (\$5,000) where the trier of fact (1) finds that the consumer has suffered substantial physical, emotional or economic damage resulting from the defendant's conduct, (2) makes an affirmative finding in regard to one or more of the factors set for in subdivision (b) of Section 3345 (the defendant knew or should have known that his or her conduct was directed at senior citizens or disabled persons, when the defendant's conduct caused senior citizens or disabled persons to suffer a loss of property that was essential to their well being, and the seniors or disable persons actually suffered substantial physical, emotional, or economic damage resulting from the defendant's conduct), and (3) finds that an additional award is appropriate.

Factors for Tripling an Award (Civil Code § 3345)

With Civil Code § 3345 the trier of fact may triple an award for a senior or dependent adult. Section 3345 only applies in actions for senior citizens or disabled persons to redress unfair or deceptive acts, practices, or unfair methods of competition. Section 3345 can only be brought when the defendant knew or should have known that his or her conduct was directed at senior citizens or disabled persons, when the defendant's conduct caused senior citizens or disabled persons to suffer a loss of property that was essential to their well being, and when the seniors or disable persons actually suffered substantial physical, emotional, or economic damage resulting from the defendant's conduct.

c. False and Misleading Business Practices - Business and Professions Code

The Business and Professions Code has many sections a practitioner can use to pursue suits for unlawful and deceptive tactics against the elderly or dependent adults. In some instances the business practices of predators may have victimized hundreds of persons.

Business and Professions Code § 6126

Practicing law without a license

Business and Professions Code § 6152

Running and capping for an attorney (illegal solicitation of clients)

Business and Professions Code § 6126

Attorneys selling financial products to their clients:

A lawyer, while acting as a fiduciary, may sell financial products to an elder client with whom the lawyer has or has had, within the preceding three years, an attorney-client relationship, if the transaction or acquisition and its terms are fair and reasonable to the client, and if the lawyer provides that client with a disclosure that satisfies all of the following conditions ... "Financial products" means long-term care insurance, life insurance, and annuities governed by the Insurance Code [B&P § 6175(d)].

Business and Professions Code § 6450

Illegal paralegals:

"It is a misdemeanor for any paralegal to offer legal advice to the public or induce a person to make an investment, purchase a financial product or service, or enter into a transaction from which income or profit may be derived."

Business and Professions Code § 1720

Unfair competition means any unlawful, unfair or fraudulent business act or practice or any unfair, deceptive, untrue or misleading advertising.

Business and Professions Code § 17206.1

Penalties and action for recovery:

(a) Any person who engages, has engaged, or proposes to engage in unfair competition shall be liable for a civil penalty not to exceed two thousand five hundred dollars for each violation.

Business and Professions Code § 17206.3

Additional penalties for violations against senior citizens:

- (a) In addition to any liability for a civil penalty pursuant to Section 17206, any person who violates this chapter, and the act or acts of unfair competition are perpetrated against one or more senior citizens may be liable for a civil penalty not to exceed two thousand five hundred dollars for each violation.

Business and Professions Code § 17500

False or misleading statements:

“It is a misdemeanor for any person to induce a sale through an advertisement that is untrue or misleading information...or which by the exercise of reasonable care should be known, to be untrue or misleading...”

Business and Professions Code § 17500.3

Home solicitations:

“It is unlawful for any person to solicit a sale at the residence of a prospective buyer without clearly revealing, before making any statements other than a greeting, that the purpose he or she has of being there is to effect a sale.”

d. Regulating the Conduct of California Insurance Agents and Brokers - Insurance Code

Insurance Code § 785

Conduct:

“All insurers, brokers, and agents owe a prospective insured who is over 65 a duty of honesty, good faith and fair dealing.

Insurance Code § 785.1

Insurance agents or brokers cannot have a financial relationship with those selling reverse mortgages or veterans' benefits if that relationship leads to the sale of an annuity to a senior.

Insurance Code § 785.4

Insurance agents cannot deliver living trusts or legal documents to the home of a senior if the insurance agent intends to use the delivery as a means of gaining entrance into the seniors' home to attempt to sell an insurance product.

Insurance Code § 789.8

Notice explaining Medi-Cal eligibility requirements

Insurance Code § 789.8

Restriction of annuity sales for Medi-Cal planning. Prohibition where the senior's assets are less than Community Spouse Resource Allowance (CSRA), if the senior would have been eligible for Medi-Cal without having purchased the annuity. There is also a prohibition against selling an annuity to a senior if after the purchase the senior still would be ineligible.

Insurance Code § 789.10

Written notification:

An insurance agent shall notify a senior, 24 hours in advance of a home visit, that the insurance agent intends to go to the senior's home to solicit the sale of an annuity.

Insurance Code § 790.03

Prohibition against unfair or deceptive sales practices.

Conclusion

Elder abuse appears in many forms. There are numerous special statutes to protect the elderly population. A practitioner has an obligation to his or her client to take full advantage of the Legislature's desire to protect this vulnerable population.

IV. Documents

Included you will find examples of how causes of actions have been pled in a variety of civil elder and dependent adult financial abuse cases. These examples are meant to serve as a template for future financial abuse complaints. Scroll down and you will see under each cause of action the name of the case or cases that used that particular cause of action in the pleading.

Cases & Sample Complaints

"Bert & Ernie" Financial Abuse Complaint Template, Plaintiff's Attorney Kathryn Stebner, Esq.

Bert-Ernie Template (Doe V AAA) in Word format

Husband and Wife v. Broker Services, Plaintiff's Attorney Kellie Morgantini, Esq.

Husband and Wife v. Philanthropic Charities, Plaintiff's Attorney Kellie Morgantini, Esq.

McLaughlin v. Holody, Sheer, AEPC, Plaintiff's Attorney Steven Riess, Esq.

Pitts v. The Money Shack, Plaintiff's Attorney Daniel Murphy, Esq.

Plaintiff v. Sanchez, Plaintiff's Attorney Kellie Morgantini, Esq.

Shaufler v. Day, Plaintiff's Attorney Daniel Murphy, Esq.

Smith v. Veteran's Benefits Group, Plaintiff's Attorney Kathryn Stebner, Esq.

Tener v. OM Financial Life, Plaintiff's Attorney Steven Riess, Esq.

V. Guide to Cases and Causes of Action

Breach of Contract

Plaintiff v. Sanchez

Breach of Oral Contract

Husband and Wife v. Broker Services

Breach of Fiduciary Duty and Abuse of an Elder (WIC § 15600, *et seq.*)

a. B&E Template

b. Elder McLaughlin v. Holody

c. Husband and Wife v. Broker Services

d. Plaintiff v. Sanchez

e. Smith v. Veteran's Benefits Group

f. Tener v. OM Financial Life

Breach of Written Contract

Husband and Wife v. Broker Services

Business and Professions Code § 17200, *et seq.*

B&E Template

Cancellation of Instrument based on Fraud in Factum

Pitts v. The Money Shack

Competition Act

Pitts v. The Money Shack

Constructive Fraud

B&E Template

Shaufler v. Day

Consumer Legal Remedies Act (Civil Code § 1770, *et seq.*)

McLaughlin v. Holody

Smith v. Veteran's Benefits Group

Conversion

Tener v. OM Financial Life

Default Judgment

Husband and Wife v. Philanthropic Charities

Elder Abuse

B&E Template

Elder Financial Abuse

McLaughlin v. Holody

Pitts v. The Money Shack

Smith v. Veteran's Benefits Group

Tener v. OM Financial Life

Fraud

B&E Template

McLaughlin v. Holody

Pitts v. The Money Shack

Plaintiff v. Sanchez

Shaufler v. Day

Tener v. OM Financial Life

Injunctive Relief

Pitts v. The Money Shack

Insurance Code § 785 *et seq.*

Shaufler v. Day

Insurance Code § 789.8

B&E Template

Shaufler v. Day

Mortgage Foreclosure Consultant Law (CC § 2945, *et seq.*)

Plaintiff v. Sanchez

Negligence

B&E Template

Smith v. Veteran's Benefits Group

Shaufler v. Day

Tener v. OM Financial Life

Negligent Infliction of Emotional Distress

Smith v. Veteran's Benefits Group

Negligent Misrepresentation

Husband and Wife v. Broker Services

Probate Code Relief § 850

Shaufler v. Day

Recession

Tener v. OM Financial Life

Shaufler v. Day

Unfair Competition Law (B&P ¶ 17200, *et seq.*)

B&E Template

Shaufler v. Day

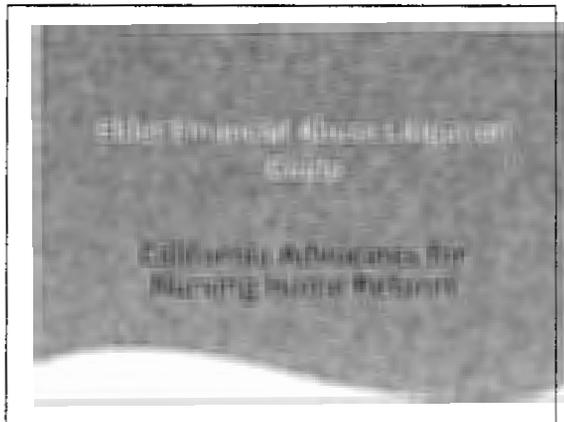
Smith v. Veteran's Benefits Group

Unfair Business Practices (B&P § 17200, *et seq.*)

Husband and Wife v. Broker Services

Plaintiff v. Sanchez

Tener v. OM Financial Life



*Inappropriate banking activity, such as unusually large withdrawals or withdrawals from automated banking machines when the elder cannot get to the bank

*Signatures on checks that do not resemble the elder's signature

*Legal documents signed when the elder is physically incapable of writing

*Checks written out to "cash" being negotiated by the elder's caregiver

*Checks signed by the senior but filled out by someone else

*A surge of activity in accounts which have been static for years

*Expensive gifts made by the elder to a caretaker

*Checks or credit card transactions made out to direct mail or telemarketing promotions

*Contributions going to newly formed religious or non-profit causes

*Investments in time shares, real property, annuities or financial products

*Large loans against equity in real property to finance investments

Possible Legal Document Abuse Indicators

*Power of attorney given by the elder when he or she lacks mental capacity

Possible Legal Document Abuse Indicators

*A will being made when the elder is not mentally competent

Possible Legal Document Abuse Indicators

*Elder taking his or her name off of property titles

Possible Legal Document Abuse Indicators

*The elder adding the name of a caretaker to real property or money accounts in exchange for
*commitments of continued care and/or affection

Life Style Change Indicators

*Lack of amenities, such as personal grooming items or appropriate clothing, when the elder can well afford it

Life Style Change Indicators

*Under-deployment of the elder's existing resources that should be spent on personal care, housing, and maintenance

FINANCIAL ABUSE INDICATORS

- *Missing cash, jewelry and personal belongings

Personal Relationship Abuse Indicators

- *Unusual interest by a family member in “conserving” the money being spent for the care of the elder

Personal Relationship Abuse Indicators

- *Reluctance or refusal by “responsible party” to spend money on the elder’s care

Personal Relationship Abuse Indicators

- *Recent acquaintances or long-lost relatives expressing affection for a wealthy elder

Personal Relationship Abuse Indicators

- *A caretaker taking an inappropriate level of interest in the elder’s financial matters

FINANCIAL ELDER ABUSE LAWS

- *In enacting EADACPA [WIC § 15600 (h)(i)] the Legislature found and declared that infirm elderly persons and dependent adults are a disadvantaged class

Enforcing Civil Elder and Dependent Adult Abuse and Neglect Statutes (California and Instituting Code Section 15610.30)

(a) "Financial abuse" of an elder or dependent adult occurs when a person or entity does any of the following:

(a) "Financial abuse"

(1) Takes, secretes, appropriates, obtains, or retains real or personal property of an elder or dependent adult for a wrongful use or with intent to defraud, or both.

(a) "Financial abuse"

(2) Assists in taking, secreting, appropriating, obtaining, or retaining real or personal property of an elder or dependent adult for a wrongful use or with intent to defraud, or both.

(a) "Financial abuse"

(3) Takes, secretes, appropriates, obtains, or retains, or assists in taking, secreting, appropriating, obtaining, or retaining, real or personal property of an elder or dependent adult by undue influence, as defined in Section 1575 of the Civil Code.

Enforcing Civil Elder and Dependent Adult Abuse and Neglect Statutes (California and Instituting Code Section 15610.30)

(b) A person or entity shall be deemed to have taken, secreted, appropriated, obtained, or retained property for a wrongful use if, among other things, the person or entity takes, secretes, appropriates, obtains, or retains the property and the person or entity knew or should have known that this conduct is likely to be harmful to the elder or dependent adult.

Where it is proven by a preponderance of the evidence that a defendant is liable for financial abuse, as defined in Section 15610.30, in addition to compensatory damages and all other remedies otherwise provided by law, the court shall award to the plaintiff reasonable attorney's fees and costs.

Statute of Limitation for Financial Abuse (Welfare and Institutions Code § 15657.7)

Statute of Limitation for Financial Abuse (Welfare and Institutions Code § 15657.7)

Surviving Cause of Action (CCP § 377.40)

After the death of the elder or dependent adult, the right to commence or maintain an action shall pass to the personal representative of the decedent.

Civil Attorneys Freezing Assets (WIC § 15657.01)

An attachment may be issued in any action for damages pursuant to Section 15657.5 for financial abuse of an elder or dependent adult.

Wrongful Taking from a Decedent (Probate Code § 504)

If a court finds that a person has in bad faith wrongfully taken the property belonging to the estate of a decedent, conservatee, or trust, or has taken, concealed, or disposed of the property by the use of undue influence in bad faith or through the commission of elder or dependent adult financial abuse, as defined in WIC § 15610.30, the person shall be liable for twice the value the property recovered by an action under this part.

Undue Influence (Civil Code Section 1570)

Undue influence is where a person who has the confidence or authority over another uses their relationship to take advantage of that person's necessities in a grossly oppressive manner.

Undue Influence (Civil Code Section 1570)

1. The use, by one in whom a confidence is reposed by another, or who holds a real or apparent authority over him, of such confidence or authority for the purpose of obtaining an unfair advantage over him;

Civil Code Section 1770
(Civil Code Section 1770)

2. Taking an unfair advantage of another's weakness of mind; or,

Civil Code Section 1770
(Civil Code Section 1770)

3. Taking a grossly oppressive and unfair advantage of another's necessities or distress.

The Consumer Legal Remedies Act
(CLRA)

The CLRA can be used in cases where goods or services have been sold through unfair or deceptive sales practices.

The Consumer Legal Remedies Act
(CLRA)

Plaintiff can be awarded restitution of their property, punitive damages, court costs and attorneys fees.

The Consumer Legal Remedies Act
(CLRA)

Civil Code Section 1761 defines what is mean by goods and services and who and what is covered by the act.

The Consumer Legal Remedies Act
(CLRA)

Section 1770 enumerates the various acts considered to be deceptive practices.

The Consumer Legal Remedies Act (CLRA)

Section 1780 lays out the remedies and procedures necessary in order to obtain the remedies.

The Consumer Legal Remedies Act (CLRA - Civil Code § 1780)

The person or party who allegedly committed the acts must notify and demand correction of the alleged violation thirty days prior to the commencement of any action.

Civil Code § 1780 (Additional Remedies of Consumer Remedies Act)

In addition the remedies specified, up to five thousand dollars (\$5,000) where the trier of fact:

Civil Code § 1780 (Additional Remedies of Consumer Remedies Act)

(1) finds that the consumer has suffered substantial physical, emotional or economic damage resulting from the defendant's conduct,

Civil Code § 1780 (Additional Remedies of Consumer Remedies Act)

(2) makes an affirmative finding in regard to one or more of the factors set for in subdivision (b) of Section 3345

Civil Code § 1780 (Additional Remedies of Consumer Remedies Act)

(2) makes an affirmative finding in regard to one or more of the factors set for in subdivision (b) of Section 3345

Older Americans Benefit Act (OABA)
 (Older Americans Benefit Act)

and (3) finds that an additional award is appropriate.

Older Americans Benefit Act (OABA)
 (Older Americans Benefit Act)

*when the defendant knew or should have known that his or her conduct was directed at senior citizens or disabled persons,

Older Americans Benefit Act (OABA)
 (Older Americans Benefit Act)

*when the defendant's conduct caused senior citizens or disabled persons to suffer a loss of property that was essential to their well being,

Older Americans Benefit Act (OABA)
 (Older Americans Benefit Act)

*and when the seniors or disabled persons actually suffered substantial physical, emotional, or economic damage resulting from the defendant's conduct.

Business and Professions Code
 (Business and Professions Code)

Use to pursue suits for unlawful and deceptive tactics against the elderly or dependent adults

Business and Professions Code
 (Business and Professions Code)

Business and Professions Code § 6126
 Practicing law without a license

Fair and Misleading Business Practices
Business and Professions Code

Business and Professions Code § 6175.3
Attorneys selling financial products to their clients

Fair and Misleading Business Practices
Business and Professions Code

Business and Professions Code § 6450
Illegal paralegals:

“It is a misdemeanor for any paralegal to offer legal advice to the public or induce a person to make an investment, purchase a financial product or service, or enter into a transaction from which income or profit may be derived.”

Fair and Misleading Business Practices
Business and Professions Code

Business and Professions Code § 1720

Unfair competition means any unlawful, unfair or fraudulent business act or practice or any unfair, deceptive, untrue or misleading advertising.

Business and Professions Code § 17206
Unfair Competition Law

P&P Code § 17206.1

(a) Any person who engages, has engaged, or proposes to engage in unfair competition shall be liable for a civil penalty not to exceed two thousand five hundred dollars for each violation.

Business and Professions Code § 17206.3
Additional penalties for seniors

(a) In addition to any liability for a civil penalty pursuant to Section 17206, any person who violates this chapter, and the act or acts of unfair competition are perpetrated against one or more senior citizens may be liable for a civil penalty not to exceed two thousand five hundred dollars for each violation.

Business and Professions Code § 17206
Unfair Competition Law

“It is a misdemeanor for any person to induce a sale through an advertisement that is untrue or misleading information ... or which by the exercise of reasonable care should be known, to be untrue or misleading...”

Business and Professions Code § 17200
Selling without title

“It is unlawful for any person to solicit a sale at the residence of a prospective buyer without clearly revealing, before making any statements other than a greeting, that the purpose he or she has of being there is to effect a sale.”

Guide to
Causes and Causes of Action

- *Breach of Contract
- *Breach of Oral Contract

Guide to
Causes and Causes of Action

- *Breach of Fiduciary Duty and Abuse of an Elder

Guide to
Causes and Causes of Action

- *Breach of Written Contract

Guide to
Causes and Causes of Action

- *Business and Professions Code § 17200

Guide to
Causes and Causes of Action

- *Cancellation of Instrument based on Fraud in Factum

Guide to
Elder and Causes of Action

- *Competition Act
- *Constructive Fraud

Guide to
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- *Consumer Legal Remedies Act - CLRA

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- *Conversion
- *Default Judgment
- *Elder Financial Abuse
- *Fraud

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- *Injunctive Relief
- *Negligence
- *Negligent Inflection of Emotional Distress
- *Recession

Guide to
Elder and Causes of Action

- *Unfair Business Practices

CONCLUSION

There are many statutes litigators can use to fight for the rights of victims of elder abuse.



What You Need to Know About Residential Care Facilities

What is Residential Care for the Elderly?

Residential Care Facilities for the Elderly (RCFEs) — sometimes called “Assisted Living” (e.g., 16+ beds) or “Board and Care” (e.g., 4 to 6 beds) — are non-medical facilities that provide room, meals, housekeeping, supervision, storage and distribution of medication, and personal care assistance with basic activities like hygiene, dressing, eating, bathing and transferring. Residential Care Facilities for the Elderly (RCFEs) serve persons 60 years of age and older.

This level of care and supervision is for people who are unable to live by themselves but who do not need 24 hour nursing care. **They are considered non-medical facilities** and are not required to have nurses, certified nursing assistants or doctors on staff.

How Does a Residential Care Facility for the Elderly Differ From an Assisted Living Facility?

From a licensing standpoint, there is no difference. In California, facilities describing themselves as assisted living and offering personal care and supervision are licensed as Residential Care Facilities for the Elderly.

Residential Care Facilities for the Elderly are dominated by smaller (i.e., 6 to 15 beds), locally owned facilities with shared rooms. Larger facilities usually offer private apartments and tend to be corporately owned. Many larger facilities have different fee options depending on the type of care needed.

Are Residential Care Facilities for the Elderly Regulated?

Yes. Residential Care Facilities for the Elderly or Assisted Living Facilities must meet care and safety standards set by the State and are licensed and inspected by the Department of Social Services, **Community Care Licensing (CCL)**.

Senior housing complexes, retirement villages or retirement hotels that provide only housing, housekeeping and meals are **not required to be licensed as Residential Care Facilities for the Elderly.**

Can A Residential Care Facility for the Elderly Care for Persons with Dementia?

Maybe. Some facilities offer special services to persons with dementia if they meet certain licensing requirements. **Make sure that the facility has experience in providing dementia care** and meets all of the state licensing standards to provide dementia care.

Will a Residential Care Facility for the Elderly Accept or Retain Someone with Medical Care Needs?

It will depend on the type and severity of the medical condition(s) and whether the facility meets the state licensing standards for restrictive health conditions. **Some medical conditions are not allowed in a Residential Care Facility for the Elderly** (e.g., tube feeding, or treatment of open bedsores). Check the facility's license to see if it has met the requirements to serve persons who need help in leaving the building in case of emergency (i.e., **non-ambulatory**) or with certain medical conditions (e.g., **hospice waiver**).

What if my medical needs increase, can I stay?

Maybe. Since residential care is not licensed as a "medical" facility, persons requiring tube feeding, treatment of open bedsores or in need of 24-hour nursing care are not permitted to reside in RCFEs. However, some RCFEs have permission to care for persons on hospice.

What are the qualifications for staff?

Minimal Training: *Administrators* must take a 40-hour certification program, pass a simple state exam, and obtain 40 hours of continuing education every two years. *Staff* must receive at least 10 hours of training at the facility within 4 weeks of employment, and at least 4 hours annually thereafter. For facilities advertising dementia care, 6 hours of orientation specific to dementia care within the first 4 weeks, and at least 8 hours annually of in-service training.

Minimal Qualifications: *Administrators* must be 21 years of age and possess a high school diploma or equivalent for facilities of 15 beds or less — these comprise over 80% of all RCFEs. For facilities of 16 to 49 beds, the administrator needs 15 college credits; and for facilities of 50+ beds, 2 years of college or 3 years experience, or equivalent education and experience. *Staff* must only be 18 years of age and pass the criminal background check. **Note:** Because RCFEs are non-medical facilities, there is no requirement for RNs, LVNs or CNAs or any medically-trained personnel. Check on the qualifications of the administrator and key staff.

Are there staff ratios?

There isn't any specific staff to resident ratio for assisted living/residential care facilities. Regulations state that facility personnel shall at all times be sufficient in numbers, and competency to provide the services necessary to meet resident needs. (CCR, Title 22, Section 87411.)

In regards to night supervision, for facilities with 15 or fewer residents, there has to be one "qualified" person on call and on the premises; in facilities with 16–100 residents, there shall be one person awake and on the premises, and another on call and capable of responding within 10 minutes. (CCR, Title 22, Section 87415.)

What Does Residential Care for the Elderly or Assisted Living Cost?

The cost will depend on a variety of factors such as the type of accommodations (e.g., apartment, private room, shared room), the range of services needed, and the geographic area. **The average monthly cost in California is from \$2,500 to \$3,000**, with costs ranging from a low of around \$1,000 a month for a resident on Supplemental Security Income (SSI) to over \$5,000 a month. Specialized services like dementia or hospice care are more costly.

Is there a limit on how much facility's can raise private pay rates?

No. Since residential care is a private business, providers will charge what the market will bear. However, facilities must issue 60-day notices to increase rates but can raise charges for level of care changes immediately and provide notice within 2 working days. (See CANHR's fact sheet on Admission Agreements)

Can facilities charge a pre-admission fee?

Yes. Some providers charge nothing or a minimum amount to cover costs of conducting an assessment, obtaining medical records and setting up files. Others charge fees of thousands of dollars. Demand a written description of what the fees cover. Negotiate the amount if too high, or look for another facility. Facilities are prohibited from charging security deposits. (See fact sheet on Admission Agreements)

Who Pays the Bill for Residential Care for the Elderly or Assisted Living?

Most people must pay privately for care. Long-term care insurance only covers a very small percentage of people. There is very limited public funding through Supplemental Security Income (SSI) for RCFE residents who qualify for this program (see CANHR's fact sheet on SSI in a RCFE). Unfortunately, the SSI rate is so low that fewer and fewer facilities will accept persons on SSI.

Aid and Attendance is a benefit paid by Veterans Affairs (VA) to veterans, veteran spouses or surviving spouses that may help pay for residential care. To learn more about criteria for Aid and Attendance see CANHR's Fact sheet on Aid and Attendance.

Will Medicare or Medi-Cal pay?

No. Because these are not medical facilities, neither Medicare nor Medi-Cal pays directly for the residential care/assisted living. There is an experiment in only three counties (L.A., Sacramento, San Joaquin) — the Assisted Living Waiver Pilot Project — to use Medi-Cal to pay for residents assessed to need nursing home level care. (See CANHR's fact sheet on Assisted Living Waiver (ALW))

How do I find out about the track record of a facility?

Upon request, a facility must show you the most recent copy of its latest inspection report (Note: Inspections are only required every five years, and annually if the facility is in non-compliance); and a copy of any substantiated complaints within the past year. The regulatory agency does not post compliance information on its web site or make such information available electronically to organizations like CANHR. The only way to view the record to is go to one of the district offices of Community Care Licensing and request to view the public record of the facility.

How Do I Find Out More About Residential Care for the Elderly?

You can contact the local **District Office of Community Care Licensing** to receive a listing of facilities. Some **Ombudsman Programs** also have listings, offer pre-placement services, and provide access to licensing reports.

For more information, see CANHR's RCFE fact sheets and Residential Care Guide — a listing of all Residential Care Facilities for the Elderly in California. The Guide also provides helpful information on services, staffing and costs for a growing number of facilities that have responded to CANHR's RCFE Questionnaire.

Dementia Care Checklist

Environment

- Is the facility calm and quiet?
- Does the facility use soft music and/or natural scents to create a soothing atmosphere?
- Is the facility well lighted? Adequate natural light?
- Are there complex patterns on carpets or walls?
- Can staff easily observe the facility's common areas? Outside areas?
- Can staff easily observe the residents' rooms?
- How does the environment promote resident functioning, e.g., a picture of a toilet on the bathroom door?
- Does the facility have a wander alert system?
- Are the doors equipped with a system to delay exit?
- Is there a locked or secured outside area for walking?

Philosophy of Care

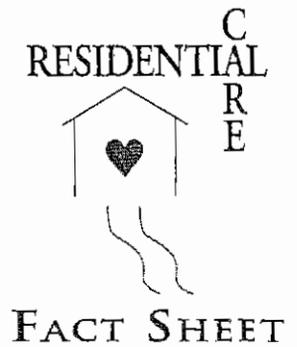
- Is the facility's philosophy for caring for persons with dementia consistent with your beliefs?
- Does facility provide services to persons at all stages of the disease process?
- What conditions or behaviors determine whether a facility will either admit or retain someone with dementia?
- Is dementia care provided in a separate unit or as an integral part of the facility's services?
- Is the facility's philosophy and practice of handling "difficult behaviors" compatible with your views? (Give a few examples and ask staff how they would handle the situation.)
- What is the facility's philosophy in using physical restraints to deal with certain behaviors?*
- Does the facility recommend the use of psychoactive drugs to treat behaviors?*

*Note: Residential Care Facilities for the Elderly have severe restrictions on the use of restraints and the use of psychoactive medications. Psychoactive drugs are often contraindicated for elderly people with dementia and should only be used as a last resort, if ever. For more information, go to <http://www.canhr.org/stop-drugging/>

Services

- Are there activities specially designed for persons with dementia?
- Do activity programs operate throughout the day? In the evening? And on weekends?
- Are activities individualized for each resident?
- Does the facility operate a "Safe Return" program (e.g., residents registered with police) for all residents?
- Does the facility provide nutritious finger foods?
- Are water and decaffeinated beverages available throughout the day?
- Does the facility do periodic night checks? Number of staff who are awake during the night?

Note: Dementia care is often characterized by locked doors or otherwise secured perimeters to prevent residents from leaving the facility unsupervised. California law requires the resident's or a court-appointed conservator's consent before he or she may be placed in a locked or secured perimeter facility. (22 CCR § 87705(l); Health and Safety Code § 1569.698(f)) No other person may give consent. That includes a family member, responsible party, or an agent named in an Advance Health Care Directive. Even a conservator cannot authorize a locked-door admission unless a court has granted specialized dementia powers regarding placement. (Probate Code § 2356.5)



Evaluation Checklist

This checklist provides a useful tool when investigating and evaluating Residential Care for the Elderly or Assisted Living Facilities. The checklist is divided into two sections: Quality Dimensions and Practical Dimensions.

Although the quality dimensions are crucial, they need to be balanced by practical considerations. If the “best” home in an objective analysis is not affordable or is too far away to visit frequently, it will probably not work for the resident or the family members. Depending on the person’s needs and preferences, some questions will be more important than others. Also refer to the Dementia Care Checklist.

In using the checklist, keep in mind the following general tips:

- Start the process early before there is a crisis.
- Involve the prospective resident as much as possible in the process.
- Use the checklist to get an overall feel for the facility and its practices.
- Pay special attention to how residents are being treated by staff and the quality and responsiveness of the services. Don’t be sold only on the attractiveness of the facility.
- Narrow the options down to two or three facilities.
- Visit each facility several times.
- In making visits, walk through the whole facility and visit at different times.
- Drop by unannounced and visit at night and/or on the weekend.
- Make sure that you visit during a mealtime.
- Obtain a copy of the admission agreement. Read it carefully. Understand the services, costs and conditions for transfer.

Before you make a final decision, **check the latest survey report and any other citations issued by the state licensing agency.** Facilities should make these reports available to you upon request. Or you can view the reports at the Community Care Licensing Office, California Department of Social Services, or at some Ombudsman Offices.

QUALITY DIMENSIONS

Quality of Care and Service

- Do residents appear well cared for?
- Are residents up, clean, and dressed by 10 AM?
- Are the residents well groomed, e.g., (shaved, clean clothes, nails trimmed and hair done)?
- Is there a written plan of care for each resident? How often is the care plan reviewed and changed? By whom?

- Does the facility offer programs and/or services which meet your particular care needs; e.g., dementia unit, etc.?
- What is the system for distribution of medication? Who does it? What is their level of training?
- Does the facility have access to doctors, hospitals, home health agencies and adult day health care services?
- Does facility provide transportation to medical services? Charges?
- Are there clear procedures for responding to medical emergencies?
- Quality of Food
- Does the food appear and smell appealing? Are fresh ingredients used?
- Do residents seem to be enjoying the food?
- Are residents receiving the assistance needed in eating?
- Are meals served at appropriate temperatures?
- Do menus offer choice? How often are menus changed? (Ask to see a copy of the week's menu.)
- Can the facility meet special dietary needs? Ethnic preferences?
- Are nutritious snacks available?
- Is fresh drinking water available?
- Can residents prepare meals in apartments?
- Does the facility make provisions to serve residents in rooms? Costs?
- Quality of Social Interaction
- Are residents interacting with staff and/or each other?
- Are residents occupied in meaningful activities?
- Does the facility have a planned activities program? Are activity calendars posted? On weekends?
- Is there a designated staff who coordinates activities? Are activities individualized or only done in large groups?
- Do volunteers and outside groups regularly visit the facility?
- Are there planned trips outside the facility?
- Is transportation provided for shopping and personal errands? Charges?
- Are pets allowed? Does the facility have pets?
- Are residents encouraged to bring in some of their own furnishings?
- Are religious services offered at the facility?

Quality of Participation

- Are residents and family members involved in assessment and care planning?
- Are residents and family members involved in roommate selection?
- Do residents have an opportunity to provide input into menu and activity planning?
- Are there procedures for responding to requests for information and complaints?
- Is the Ombudsman Program's poster and telephone number posted?
- Does the facility have a residents' council? Does the facility have a family council or support group?

Quality of Staff

- How long has the key staff been working at the facility, i.e., administrator and assistant administrator, activities coordinator, cook, and nurse consultant?
- Has there been a recent turnover in key staff?
- How many direct care staff are there for each shift?
- What is the staff to resident ratio? What is the ratio on the night shift? Weekends?
- What is the turnover rate among direct care staff?
- Does direct care staff understand and speak English?
- What special training do staff receive in working with persons with dementia?
- Do the administration and staff know the residents by name?
- Does staff take time to talk with residents?
- Do administration and staff interact with residents in a respectful way?
- How long does it take for staff to respond to a resident's request for help or to a call bell?
- Does staff respect residents' privacy by knocking on doors or announcing themselves before entering rooms?
- Does the staff wear name badges?

Quality of Environment

- Is the overall décor pleasant and homelike?
- Is the environment clean and odor free?
- Is the facility quiet or noisy?
- Is the temperature comfortable?
- Does the building seem safe and free from dangerous hazards? Cluttered?
- Are the residents' rooms, hallways, and common areas well lighted?
- Are floors of non-skid material and are carpets firm to ease walking and to prevent falls?
- Is the dining room pleasant and inviting?
- Are common areas, bedrooms and bathrooms accessible to wheelchairs and walkers?
- Are bathrooms conveniently located?
- How many residents share a bathroom?
- Do all bathrooms, showers and bathtubs have handgrips or rails?
- Are call bells accessible to residents? By bed? In bathrooms?
- Is there privacy in residents' rooms, especially in shared rooms?
- Is there any place to have a private conversation?
- Is there a bedside table, reading light, chest of drawers and at least one comfortable chair for each resident?
- Is there a locked drawer to store valuables? If not, does facility make provisions to store valuables?
- Is there adequate space for clothing and personal belongings in each room?
- Does the facility have extra storage space for residents' belongings?
- Are there outside sitting and walking areas for residents? Are any covered to protect from sun or rain?
- Is there a fenced yard? Locked?

- Are there enough fire and carbon monoxide detectors?
- Is there a designated smoking area? Inside? Outside?
- Is there a disaster plan posted? How often does the facility hold drills?

PRACTICAL DIMENSIONS

Accessibility

- Is the facility close to family and friends who will be visiting most frequently?
- Is the facility near public transportation?
- Is the facility in an area where it would be safe to visit at night?
- Is the facility convenient to the resident's doctor? Home health agency?
- Is the facility close to a hospital?
- Are family and friends welcome at any time or are there strict visiting hours?

Suitability

- Does the facility have a good reputation in the community?
- Will they give you a list of references?
- Are residents and/or family members willing to talk with you about the facility?
- How did the administrator and staff treat you when showing you around?
- Did they answer all your questions to your satisfaction?
- Did they show you around the entire facility? Were any areas or sections not shown to you? Why?
- Do you feel that the administrator and staff are people you can work with and communicate with honestly?
- How would you or your loved one fit in? Is this facility compatible with your lifestyle?
- Can you imagine yourself or your loved one living here?
- How did you feel when visiting the facility?

Affordability

- Are Supplemental Security Income (SSI) residents accepted?
- Do the estimated monthly costs (including extra charges) compare favorably with other facilities?
- Are there any upfront fees, e.g., assessment, community fees?
- What services are included in the basic rate?
- What is the cost for extra services? Levels of care? How is the need for extra services or higher levels of care determined?
- What are the costs for specialized services, e.g., dementia unit?
- Do the estimated monthly costs (including extra charges) compare favorably with other facilities?
- Are the costs and payment schedule clearly described in the admission agreement?
- Are the total monthly charges affordable over time?
- Will the facility give you a copy of the admission agreement to take home and study before making a final decision?



Admission Agreements

Buyer Beware! An Admission Agreement is a legal contract. As a legal document, it states the responsibilities of both the facility and the resident. Admission agreements vary widely from facility to facility. **Before signing the agreement, read and study it carefully.**

- Ask to take a copy home to study.
- Make sure that you read all documents that are referred to in the Agreement such as house rules and visiting policies.
- Develop a list of all your questions about what is contained in the agreement.
- Make sure that all your questions are answered to your satisfaction before signing.
- Use the agreement as an opportunity to clarify expectations and to negotiate care needs and costs.
- Consider having the document reviewed by an attorney or consumer advocate.

What Needs to Be in an Admission Agreement?

The law requires that admission agreements describe the types of services that the facility will offer and their costs. The agreement must also state how, when and to whom the rates will be charged, how changes in the rates will be determined, and any conditions for refunds. Other aspects that are required to be covered in the admission agreement are:

- Description of residents' rights
- Right of residents to execute advance directives (e.g., Power of Attorney for Health Care)
- Eviction conditions and notification procedures
- Visiting policies
- Theft and loss policies
- Procedure for making complaints or grievances
- House rules or policies that may be contained in a resident handbook
- Availability of special telecommunication devices for residents who are deaf, hard of hearing, or who have other disabling conditions
- Other services not provided directly by the facility but offered at the facility through another provider, (e.g., hair grooming)
- Authority of the licensing agency to inspect the facility and to review records
- Provisions for terminating the agreement.
- Explanation of facility's responsibilities and residents' rights when a facility closes and residents are evicted: Relocation evaluation for each resident, approved closure plan when 7 or more residents are relocated, and 60-day written notice requirements.

What Can the Facility Charge for Services?

The facility can charge whatever the market will bear! However, **any fee charged, whether prior to or after admission, must be clearly stated in the Admission Agreement.**

Some facilities charge a flat or fixed rate for all services. However, most facilities combine a fixed rate with extra charges for more care or services and/or for changes in care levels.

- **Increased charges are often triggered by an assessment of the resident's needs conducted by the facility—a level of care point system.** Check carefully the type and frequency of services offered for the fixed rate and how the point system works. For instance, many residents are surprised when they receive charges for more than one shower a week or for having food trays brought to the room when they are sick.
- **It is common for facilities to charge higher rates for specialized dementia care or for hospice care.** Again these charges must be clearly stated in the Admission Agreement.
- If the resident is on Supplemental Security Income (SSI), the **SSI rate covers the full charges for all basic services.** Extra charges for a resident on SSI can only be made for special food services or a private room.

Can the Facility Require Families of Residents on SSI to Pay More?

No. Families cannot be required to supplement the SSI rate as a condition for placing or keeping a person at the facility.

- Families or other parties **can make voluntary contributions** to the facility on behalf of the resident. These voluntary contributions are not part of the formal admission agreement, and if not paid, cannot be grounds to evict a resident.
- In order to protect the resident's SSI and Medi-Cal eligibility, voluntary contributions must be made directly to the facility, rather than to the resident, and must be used only for care and supervision services, not for shelter or food.

Can the Facility Charge Upfront Fees?

Maybe. But all upfront fees must be stated clearly in the Admission Agreement.

- **Residents on SSI cannot be charged pre-admission fees.**
- If the facility charges a pre-admission fee, the resident or the resident's representative must be provided with a written statement describing the costs associated with the fee.
- Refunds of all or a portion of a preadmission fee are required if the person does not enter the facility. A portion of the preadmission fee must also be refunded if the individual leaves during the first three months of residency.
- It is becoming common practice for facilities to charge first and last month's rent. The last month's rent must be safeguarded and separately accounted for by the facility. **Note: The facility cannot charge a security or damage deposit or a cleaning fee.**

Can the Facility Raise Rates?

Yes. The Admission Agreement must state how rates may be changed. **Rate increases generally require a 60-day written notice.** However, if written into the agreement, rate increases for level of care changes can take place in a matter of days. The facility must provide written notice of the level of care rate increase within two business days after initially providing services at the new care level. The notice must include a detailed explanation of additional services and itemization of charges. The resident and/or the resident's family member or responsible person should ask to review the process, criteria and assessment results used in determining the change in care levels. For residents on Supplemental Security Income (SSI), the SSI annual cost of living increase can also become effective immediately once the facility is notified of the increase by the government.

Are There Other Things That You Need to Know About Admission Agreements?

- **Read carefully the house rules or policies.** Do they seem reasonable to you? Pay special attention to policies that might impact your lifestyle choices, (e.g., restrictions on leaving the facility) or your quality of life, (e.g., quiet hours or times to go to bed, set or flexible meal times, etc.).
- **Also review the facility's policies regarding visitors.** Visiting policies should be designed to encourage the involvement of family and friends. Again, will the stated policies meet your needs? If not, is there flexibility in how policies are interpreted and implemented?
- **The facility cannot require a resident to use a particular pharmacy or medical supply provider.**
- More and more facilities are including in their Admission Agreements legal language to protect the facility's liability such as a **requirement to arbitrate all disputes.** This can eliminate the resident's right to take appropriate legal action such as filing a lawsuit. The law already allows someone to seek arbitration when advised by counsel that it is the most prudent strategy.

When Does the Admission Agreement Take Effect?

In order for the document to be legally binding, **it must be entered into voluntarily, signed and dated by both the facility and the resident** (or the resident's agent or legal representative). This also applies to any attachments to the admission agreement, such as a copy of the house rules. Any future changes in the agreement must also be in writing, signed by both parties and dated.

- The original of the admission agreement must go into the resident's file at the facility and a copy must be provided to the resident (or his/her agent or legal representative).
- **Keep a copy of the Admission Agreement on file** and refer to it to answer questions and resolve concerns.
- If someone other than the resident signs the agreement, make sure that this person does not become a "legally responsible party" - one held personally responsible for paying the facility's fees.

How Do You End the Agreement?

The resident or resident's agent or legal representative gives a **written 30-day notice** to end the agreement and to leave the facility. The agreement will **automatically be terminated upon the death of the resident** unless stated otherwise in the agreement.

Note: In accordance with Title 22 Regulations, (CCR 87507(h)), the resident or responsible person will not be liable for any payment beyond that due at the date of death unless agreed to in writing or ordered by the court. If this is stated in a resident's admission agreement, make sure you are aware of the amount that you or your loved ones will be charged after the resident's death.

What About Refunds?

Most facilities will not refund a resident if the person decides to move out or has to move out because of illness **unless the resident gives a 30-day written notice** (some admission agreements state a 60-day written notice is needed). Consumers should always make an argument for a refund.

- **Review carefully the conditions stated for receiving a refund in the admission agreement.** The law requires a refund in only two situations: upon the death of the resident, and when the state licensing office requires the resident to relocate due to a health or safety risk.
- **Request a refund for all the days that the resident has paid for but not used the room or apartment.**
- Remove all personal items from the room as soon as possible so that the room is available for occupancy by a new resident. Check to see if another resident has occupied the room.
- Support the argument for a refund by citing circumstances like a stroke that make giving proper notice impossible.
- And, in all cases, demand a refund where the facility might be responsible for the resident having to leave the facility prematurely, (e.g., a fall requiring surgery and rehabilitation).
- Request refund of proportional month's rent and proportional refund of any pre-admission fee of over \$500 paid in the past two years when a facility closes and residents are evicted and relocated.

The most pertinent laws and regulations are found in California Health and Safety Code Sections 1569.880 through 1569.888 and California Code of Regulations, Title 22, Div. 6, Sections 87507 and 87463. You can also find pertinent information in California Health and Safety Code Sections 1569.159, 1569.2, 1569.312, 1569.313, 1569.54, 1569.651, 1569.655, 1569.657, 1569.682, and in Department of Social Services, Community Care Licensing Policy Memoranda, January 15, 1998, May 14, 2001, and July 29, 2005.



Resident's Rights

Persons who live in a Residential Care Facility for the Elderly or in an Assisted Living Facility keep the rights they have had all their lives. They also gain special rights under state laws and regulations.

The basic rights for residents are outlined below. If a person is unable to exercise these rights, family members, legal representatives, or consumer advocates (e.g., Ombudsmen) can act on the resident's behalf to protect and promote these basic rights.

Fairness and Dignity

- Visit facility prior to signing a contract.
- Review a copy of the admission agreement.
- Receive written information about all services and their costs, and the policies and procedures governing the care facility.
- Be free from discrimination because of age, race, religion, physical or mental disability, gender, sexual orientation, financial status, nationality, or family status.
- Be treated with courtesy, respect, and dignity.
- Be informed and given a copy of the resident's personal rights in a language that is understandable.
- Be given information on how residents and others can file complaints.

Safety

- Live in a safe and clean environment.
- Keep and use personal belongings without loss or theft.
- Be free from punishment, humiliation, intimidation, isolation, or retaliation.
- Safely store personal belongings.

Freedom

- Be free from physical, emotional and verbal abuse and neglect.
- Be free from restraining devices.
- Participate in religious, social, community and other activities.
- Leave the facility and return without unreasonable restriction.
- Be free from unjustified room transfers or discharge (eviction) from the facility.

Self-Determination

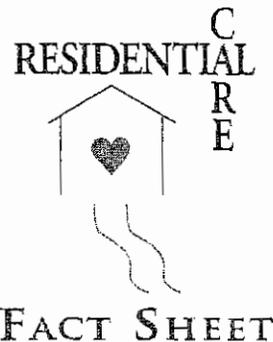
- Choose one's doctor, pharmacist, and other health care providers.
- Be given all information about their condition, care, and needs.
- Make their wishes known about personal care and medical treatment; have advance directives, such as powers of attorney for health care.
- Participate in the development of one's own plan for care and services.
- Refuse treatment or services.
- Express preferences with respect to room, roommates, food, and activities.
- Use personal belongings and furnishings as space permits.
- Manage and control personal finances, or be given a written record of all transactions.
- Voice grievances to the facility staff, family, licensing agency, the Ombudsman Program or any other person, without fear of reprisal or retaliation.
- File complaints and have them promptly addressed and resolved.
- Organize and participate in a resident council and recommend changes and improvements in the facility's policies and services.
- Receive assistance in exercising the right to vote.
- Move from the facility.

Privacy

- Have personal privacy, including visits, telephone calls, and unopened mail.
- Have reasonable access to telephones in making or receiving confidential calls.
- Communicate privately and freely with any person.
- Guarantee of privacy during bathing, medical treatment, and personal care.
- Maintain confidential records.

See CANHR's Fact Sheet, Outline of Residents' Rights, for more detailed information on rights of RCFE residents.

The most pertinent laws are found in California Health and Safety Code, Sections 1569.1, 1569.30, 1569.31, 1569.312, 1569.313 and the most relevant regulations in California Code of Regulations, Title 22, Division 6, Sections 80072, 87468, and 87221.



Assessment and Care Planning

Assessment, sometimes called appraisal in Residential Care Facilities for the Elderly, is a process to gather information about a person's life, functional abilities and needs in order to develop an individualized plan of care. The plan of care describes the strategies that the facility and staff will use to enhance, restore or maintain a person's optimal physical, mental and psychosocial well-being.

What Kind of Information Does the Facility Want to Know About a Resident?

The Residential Care Facility (RCFE) is required to complete a pre-admission appraisal that evaluates a prospective resident's functional capabilities, mental condition and such social factors as likes, dislikes and interests. A medical assessment must also be conducted if one hasn't been completed in the past year. Prior to a person's acceptance as a resident, the facility should obtain a medical assessment, signed by a physician. This assessment includes a diagnosis, examination for TB and other contagious diseases, medical history, record of medications, and identification of physical and mental limitations that might prevent a person from receiving adequate care at RCFE level. Note: For residents with dementia, there must also be a written plan of care by the resident's doctor to minimize the use of psychoactive medications.

Why Does the Facility Need to Know All This Information?

The detailed and comprehensive information provided in the assessment gives the facility a "whole picture" of the resident. The information helps tell a person's story, giving insight into their strengths, interests, likes and dislikes, routines, habits and patterns of daily living. For example, this type of information can transform a resident with a diagnosis of dementia in room 12 into a real person. Facilities can then create an individualized plan that will provide good quality of care and enhance the resident's quality of life.

When Will the Facility Want to Obtain This Information?

The RCFE is required to obtain most of this information before admitting someone as a resident. Either prior to admission or within 2 weeks after being admitted, the facility must meet with the resident and his/her family, agent or legal representative to develop a care plan.

What is the Role of the Resident and Family Members or Representatives in the Assessment & Care Planning Process?

The resident, family and legal representatives have the right to participate in the assessment, reassessment and care planning process. Their role is essential to providing a complete picture of the resident. Note: The resident also has a right to refuse treatment and services, once advised of their benefits and risks, and the offer of alternative treatment approaches.

How Often Will the Care Plan Be Reviewed?

RCFEs are supposed to make a reassessment and care plan revisions at least annually. However, a reassessment and care plan update are required whenever there are significant changes in the resident's physical, medical, mental, and/or social condition. Ask for a quarterly review. This allows for mutual feedback, adjustments in the care plan and preventive intervention.

What Happens at a Care Plan Meeting?

The Care Plan meeting provides an opportunity to see if the plan is meeting the needs of the resident by reviewing what strategies are working and which ones are not. It can identify changes in the resident's condition or behavior that will require revisions of the care plan. The meeting also gives residents, family members or representatives, as well as facility staff, a chance to discuss and resolve problems and concerns.

How Will I Know if the Care Plan is Working?

The true measure of a good care plan is the degree to which it meets the person's care needs and enhances the quality of life. Other important criteria for evaluating a care plan are:

- Is the plan resident-centered and individualized?
- Is it understandable to the resident, family and to the staff?
- Does it clearly indicate what is to be done, by whom, how and by when?
- Is staff consistently following the plan?

If the care plan is not working, request a meeting to review the care plan. Also ask that other persons with expertise be consulted, (e.g., doctor, nurse, social workers, Ombudsman, etc.), and be involved in the care planning process.

How Often Will the Care Plan Be Reviewed?

RCFEs are supposed to make a reassessment and care plan revisions at least annually. However, a reassessment and care plan update are required whenever there are significant changes in the resident's physical, medical, mental, and/or social condition. Ask for a quarterly review. This allows for mutual feedback, adjustments in the care plan and preventive intervention.

The most pertinent laws and regulations are found in California Health & Safety Code Section 1569.80 and in California Code of Regulations, Title 22, Sections 87458, 87608, 87219, 87457 through 87505.



Eviction Protections for RCFE / Assisted Living Facility Residents

Residents have rights and protections against eviction actions.

Causes for Eviction

Current laws and regulations recognize **ONLY five (5) reasons for eviction:**

- **Failure of resident to pay** agreed upon rate for basic services within ten (10) days of due date.
- **Failure of resident to comply with state or local law** after receiving notice of the alleged violation, (e.g., drug use, assault, violation of probation, etc.).
- **Failure of resident to follow facility policies** that are in writing, are stated or referenced in the Admission Agreement and are for the purpose of making it possible for residents to live together.
- After formal assessment, **the facility determines that it can no longer meet the resident's changing care needs.**
- **The facility changed its purpose.**

Please note that a resident may *not* be evicted for refusing to sign a new admission agreement.

Written Notice & Documentation Requirements

Generally, the facility is required to give a **30-day written notice to evict**. If the resident has lived in the facility for more than one year, the RCFE must give **60 days** written notice. (Civil Code Section 1946.1(b)) The notice must be delivered to the resident, to their agent or legal representative and to the licensing agency. The notice must contain the following elements:

- Reason or reasons for eviction, i.e., one or more of the 5 reasons stated above;
- Specific facts pertaining to each reason for eviction, e.g., dates, places, circumstances surrounding the event(s) and identification and statements of witnesses;
- The effective date of the eviction;
- A list of resources available to assist in identifying alternative housing and care options, including public and private referral services and case management organizations;
- Information about the resident's right to file a complaint with the department regarding the eviction, with the name, address, and telephone number of the nearest office of community care licensing and the State Ombudsman; and
- The following statement: "In order to evict a resident who remains in the facility after the effective date of the eviction, the residential care facility for the elderly must file an unlawful detainer action in superior court and receive a written judgment signed by a judge. If the

facility pursues the unlawful detainer action, you must be served with a summons and complaint. You have the right to contest the eviction in writing and through a hearing.”

There are some **exceptions to the 30-day notice requirement**. However, a written notice is still required except when the licensing agency orders an urgent or immediate relocation due to a finding that the resident is in imminent danger and requires inpatient care.

- **3-Day Eviction** will sometimes be granted to the facility by the licensing agency when the resident is demonstrating behavior that threatens the mental and/or physical health and safety of the resident or other residents.
- **Health Relocation Order** issued by the licensing agency when the resident’s condition is prohibited from being treated in a Residential Care Facility for the Elderly, e.g., Stage 3, open bed sore. The notice of relocation is sent to the facility, resident and/or resident’s responsible person, and the Long Term Care Ombudsman Program stating the reasons for the order and the right to appeal the decision.
- **Facility closure** when residents are evicted requires a **60-day written notice**. (See CANHR’s Fact Sheet “RCFE Closures: Residents’ Rights and Protections” for more details about closures.)

Readmission After a Hospital Stay

RCFEs may not refuse to readmit a resident following a stay in a hospital. If the facility believes that one of the five reasons for eviction is satisfied, it must nonetheless readmit the resident until it has complied with all of the legal eviction procedures.

Can a New Owner Require Me to Sign a New Admission Agreement?

No. Be aware that new owners often ask residents to sign new admission agreements with unfavorable terms. By law, the new owner takes the facility subject to your currently existing admission agreement. The existing agreement is not terminated by the sale of the facility. The new owner may not take an adverse action against you for refusing to sign a new admission agreement.

SSI Residents and Evictions

Private paying residents of RCFEs cannot be evicted if they later qualify for Supplemental Security Income (SSI). It is common for low-income RCFE residents to qualify for SSI when they spend down their savings below \$2,000, the asset limit for SSI. If an RCFE resident qualifies for SSI and is approved by the Social Security Administration, the facility should lower its rate for basic services to \$961 or \$981. See CANHR’s fact sheet on SSI in Residential Care Facilities for more information about eligibility and related issues.

In some cases, an RCFE will claim that it is not an “SSI facility,” and will continue to bill the resident at the private pay rate. However, there is no such thing as an SSI facility in California. A California regulation that applies to all RCFEs establishes a limit on charges to SSI recipients. This regulation states: “If the resident is an SSI/SSP recipient, then the basic services shall be provided and/or made available at the basic rate at no additional charge to the resident.” (Section 87464(e) of Title 22 of the California Code of Regulations)

However, be on the alert when care needs increase. SSI recipients are more vulnerable than private paying residents for eviction in this situation.

Protections

Because of the seriousness of eviction proceedings and the potential for harm to residents, it is advisable to **seek assistance from the Long Term Care Ombudsman Program and/or Senior Legal Services.**

Use the approaches listed below carefully. Make sure that the resident's continuing care needs will be met throughout the process. It can be very detrimental to residents to remain in facilities that are either unable or unwilling to meet the resident's care needs.

- Do not act on a verbal statement by the facility that the resident must move. **Demand a written notice.**
- **Make sure that the notice for eviction meets all the legal standards**, i.e. states one of the five reasons for eviction and provides necessary documentation. If not, the eviction is not valid and the notice must be reissued. This buys time for the resident to consider other options.
- **Challenge unreasonable facility policies** as a basis for eviction.
- Remedy the cause stated for the eviction, e.g., pay the monthly fee or comply with the house rules. Then insist that the eviction be withdrawn.
- **Insist on a written relocation plan** to ease the transition and to reduce transfer trauma. Negotiate for more time to make a good relocation plan.
- **File a complaint with the licensing agency** over the process used by the facility.
- **Make an appeal of the licensing agency's health relocation order.** The appeal must be requested within 3 business days of the notice. Licensing's decision will be reviewed by an independent team.
- **Exercise the right to a judicial hearing.** In order to evict a resident, the facility must go to court first and get an order from a judge. An eviction from an RCFE is legally the same as an eviction from a house or an apartment. (Civil Code Section 1940(a)) The resident must be served with a summons and complaint and has the right to contest the eviction in writing and through a hearing.
- **Assert rights when facility closes** for a 60-day written notice, relocation evaluation (and relocation plan approved by licensing when 7 or more residents are affected), proportional refund of prepaid month's rent and of pre-admission fees over \$500 paid in the past two years, file a complaint with licensing, and exercise the right to file a civil lawsuit covering costs and attorney's fees. Note: The licensing agency has the right to issue daily fines per violation of residents' relocation rights to produce facility compliance.

These rights are found in California Law: California Civil Code Sections 1940 and 1946.1; Health & Safety Code Sections 1569.54, 1569.73, 1569.682 and 1569.683; and in California Code of Regulations, Title 22, Division 6, Sections 87224 and 87612.

Outline of Nursing Home Residents' Rights

CANHR is a private, nonprofit 501 (c)(3) organization dedicated to improving the quality of care and the quality of life for long term care consumers in California.

Key:

USC	United States Code	H&S Code	California Health and Safety Code
CFR	Code of Federal Regulations	W&I Code	California Welfare & Institutions Code

I. Admission Rights

(A) Rights regarding admissions contracts		
1	Nursing home must make reasonable efforts to communicate contents of contract to resident prior to admission	H&S Code §1599.65
2	Contract shall not contain waivers of liability for health, safety or personal property of resident	H&S Code §1599.62
3	Contract must clearly and explicitly state whether the facility participates in the Medi-Cal program	H&S Code §1439.8; H&S Code §1599.66; W&I Code §14022.3
4	Contract shall not require notice of resident's intent to convert to Medi-Cal status	H&S Code §1599.69(b)
5	Contract shall state clearly what services and supplies are covered by the facility's basic rate and identify charges for optional services and supplies	H&S Code §1599.67(a)
6	Contract shall state that residents will receive monthly statements itemizing all charges incurred by them	H&S Code §1599.67(a)
7	Contract shall not require payment beyond date of death or involuntary discharge from nursing home	H&S Code §1599.71(a)
8	Contract shall not require advance notice of voluntary discharge from nursing home	H&S Code §1599.71(b)
9	Contract shall not list any ground for discharge or involuntary transfer except those grounds listed in federal or state law	Code §1599.76
10	Contract shall state that, except in an emergency, no resident may be involuntarily transferred within the facility or discharged unless reasonable written notice and transfer or discharge planning are given as required by law	H&S Code §1599.78
11	Contract shall not require residents to consent to all treatment ordered by a physician	H&S Code §1599.72
12	Contract shall not require or imply a lesser standard of responsibility for residents' personal property than is required by law	H&S Code §1289.5
13	Contract must contain a copy of the Patient's Bill of Rights	H&S Code §1599.74(b)
14	Contract must provide that if the resident is transferred to an acute care hospital, his/her bed will be held for seven days	H&S Code §1599.79; 22 CCR §72520

15	Contract must state that the facility is required to give 30 days written notice of any rate increase in the facility	H&S Code §1599.67(c)
16	Every nursing home must use a standardized admission agreement developed by the Department of Public Health (DPH) (on hold until regulations are finalized)	H&S Code § 1599.61
17	The contract must contain an attachment that discloses the name of the owner and licensee of the skilled nursing facility and the name and contact information of a single entity that is responsible for all aspects of resident care and operation at the facility.	H&S Code §1599.64
(B) Arbitration agreements		
1	Nursing home cannot require applicants or residents to sign an arbitration agreement as a condition of admission or medical treatment	H&S Code §1599.81(a)
2	An arbitration agreement must be on a form separate from the admission agreement and require separate signatures	H&S Code §1599.81(b)
3	A resident cannot waive his or her ability to sue for violations of residents' rights	H&S Code §§1430(b) & 1599.81(d)
4	Residents and their legal representatives can rescind an arbitration agreement by giving written notice to the facility within 30 days of their signature	California Code of Civil Procedure §1295(c)
(C) Notice of rights		
1	Nursing home must inform the resident both orally and in writing in a language that the resident understands of his or her rights	42 CFR §483.10(b)(1); 22 CCR §72527(a)(1)
2	Nursing home must give the resident written information about advance directives explaining: (1) the right to make health care decisions; (2) the right to accept or refuse medical treatment; (3) the right to prepare an advance health care directive; and (4) the facility's policies governing use of advance directives	42 USC §1395cc(f); 1396a(w); 42 USC 1396r(c)(2)(E); 42 CFR §489.102; 42 CFR §483.10(b)(8)
(D) Right to reimbursement under Medicaid and Medicare programs		
1	Medi-Cal and/or Medicare certified nursing homes must not require applicant to waive rights to Medicare or Medicaid benefits as part of admission practice	42 USC §1395i-3(c)(5)(A)(i)(I); 42 USC §1396r(c)(5)(A)(i)(I); 42 CFR §483.12(d)(1)(i)
2	Medi-Cal and/or Medicare certified nursing home must not require oral or written assurances that residents or potential residents are not eligible for, or will not apply for, Medicare or Medicaid benefits	42 USC §1395i-3(c)(5)(A)(i)(II); 42 USC §1396r(c)(5)(A)(i)(II); 42 CFR §483.12(d)(1)(ii)
3	Medi-Cal and/or Medicare certified nursing home must prominently display and provide information about how to apply for Medicare or Medicaid benefits and how to receive refunds for services already paid for	42 U.S.C. 1395i-3(c)(5)(A)(i)(III); 42 USC §1396r(c)(5)(A)(i)(III)
4	Medi-Cal certified nursing home must give the resident, his or her spouse, and representative a state-mandated notice explaining Medi-Cal financial eligibility requirements	W&I Code §14006.3 & 14006.4
5	Medi-Cal certified nursing home shall not require the resident to pay privately for any period during which the resident has been approved for payment by Medi-Cal	H&S Code §1599.69(a)

6	Medi-Cal certified nursing home must submit a Medi-Cal reimbursement claim for approved beneficiaries and must return any and all payments made by the beneficiary, or any person on behalf of the beneficiary, upon receipt of Medi-Cal payment	H&S Code §1599.69(a), W&I Code §14019.3; 42 CFR §483.10(b)(10)
7	Medi-Cal and/or Medicare certified nursing home must inform beneficiaries of Medicare and Medi-Cal covered items and services for which they may not be charged and those other items and services not covered for which they may be charged, and the amount of charges for those services	42 CFR §483.10(b)(5); H&S Code §1599.67(b)
8	If a nursing home files a notice of intent to withdraw from Medi-Cal, all residents admitted prior to the notification date have the right to remain in the facility and receive Medi-Cal payment for their care if they are eligible for Medi-Cal or become eligible	W&I Code §14022.4; 42 USC §1396r(c)(2)(F)

(E) Right to be free from financial pre-conditions to admission

1	Nursing home may not require third party guarantee of payment as a condition of admission or expedited admission	42 USC §1395i-3(c)(5) (A)(ii); §1396r(c)(5)(A) (ii); 42 CFR §483.12(d)(2); W&I Code §14110.8(b)
2	If individual is entitled to Medicaid, nursing home may not charge, solicit, accept, or receive any amount as precondition of admission, or as a requirement of continued stay	42 USC §1396r(c)(5) (iii); 42 CFR §483.12(d) (3); H&S Code §1599.70(a); W&I Code §14110.9
3	Nursing home cannot require or accept a deposit if Medi-Cal or Medicare is paying for a resident's stay	H&S Code §1599.70(a); W&I Code §14110.9; 42 CFR §489.22; 42 CFR §483.12(d)(3)

(F) Right to return of security deposit:

1	When resident converts to Medi-Cal	H&S Code §1599.70(b); W&I Code §14110.8(d)
2	Within 14 days after account is closed	H&S Code §1599.70(b)
3	No later than 14 days after the resident's death, to the heir, legatee or personal representative	H&S Code §1599.71(a); 22 CCR §72531(c)

II. Transfer & Discharge Rights

(See Licensing & Certification Policy & Procedure Manual Section 618 et.seq.)

(A) Prohibitions against transfer or eviction

1	Medi-Cal certified nursing home shall not transfer or seek to evict resident due to resident changing from private pay or Medicare to Medi-Cal	42 CFR §483.12(c)(1); W&I Code §14124.7(a)
2	Nursing home shall not seek to expel resident in retaliation for filing of complaint; attempt to evict resident within 180 days of filing of complaint against facility is rebuttably presumed to be retaliatory	H&S Code §1432 (a), (b)

3	Medi-Cal certified nursing home shall not evict or transfer residents who have made a timely application for Medi-Cal and for whom an eligibility determination has not yet been made	W&I Code §14124.7
(B) Right not to be transferred or discharged from facility unless:		
1	Transfer or discharge is necessary to meet resident's welfare; or	42 USC §1395i-3(c)(2)(A)(i); 42 USC §1396r(c)(2)(A)(i); 42 CFR §483.12(a)(2)(i); 22 CCR §72527(a)(5)
2	The resident's health has improved sufficiently so that the resident no longer needs the facility's services; or	42 USC §1395i-3(c)(2)(A)(ii); 42 USC §1396r(c)(2)(A)(ii); 42 CFR §483.12(a)(2)(ii)
3	The safety of individuals in the facility is endangered; or	42 USC §1395i-3(c)(2)(A)(iii); 42 USC §1396r(c)(2)(A)(iii); 42 CFR §483.12(a)(2)(iii); 22 CCR §72527(a)(5)
4	The health of individuals in the facility would be endangered; or	42 USC §1395i-3(c)(2)(A)(iv); 42 USC §1396r(c)(2)(A)(iv); 42 CFR §483.12(a)(2)(iv); 22 CCR §72527(a)(5)
5	The resident has failed to pay or have payment made on his/her behalf (after reasonable and appropriate notice is given); or	42 USC §1395i-3(c)(2)(A)(v); 42 USC §1396r(c)(2)(A)(v); 42 CFR §483.12(a)(2)(v); 22 CCR §72527(a)(5)
6	The facility ceases to operate	42 USC §1395i-3(c)(2)(A)(vi); 42 USC §1396r(c)(2)(A)(vi); 42 CFR §483.12(a)(2)(vi)
(C) Right to notice prior to transfer or discharge from facility		
1	Transfer or discharge must be ordered in writing by a physician	42 USC §1395i-3(c)(2)(A); 42 USC §1396r(c)(2)(A); 42 CFR §483.12(a)(3); 22 CCR §72527(b)
2	Nursing home must give the resident, family member and legal representative advance notice of the transfer or discharge as soon as practicable	42 USC §1395i-3(c)(2)(B)(i), (ii); 42 USC §1396r(c)(2)(B)(i), (ii); 42 CFR §483.10(b)(10)(i)(D), §483.12(a)(4), (5); 22 CCR §72527(a)(5)
3	Any transfer or discharge requires 30 days written notice, except for when the health or safety of other individuals would be endangered, the resident's health improves sufficiently to allow a more immediate transfer or discharge, the resident's urgent medical needs require a more immediate transfer or discharge, or the resident has resided in the facility less than 30 days.	42 USC §1395i-3(c)(2)(B)(i), (ii); 42 USC §1396r(c)(2)(B)(i), (ii); 42 CFR §483.12(a)(4), (5)

4	Notice of transfer or discharge must include the reason for the transfer or discharge, the effective date of the transfer or discharge, the location to which the resident will be transferred, a statement that the resident has the right to appeal with the name, address and telephone number of the Licensing & Certification District Office, and contact information for the long term care ombudsman.	42 USC §1395i-3(c)(2)(B)(iii); 42 USC §1396r(c)(2)(B)(iii); 42 CFR §483.12(a)(6)
(D) Right to appeal proposed transfer or discharge from facility		
1	Upon request by the resident or representative, the state must conduct appeal hearings that comply with federal requirements	42 USC §1396r(e)(3) & (f)(3); 42 CFR §483.200 et seq.; 42 CFR §483.12(a)(2)
(E) Right to preparation of residents prior to transfer or discharge		
1	Nursing home must provide sufficient preparation and orientation to residents to ensure safe and orderly transfer or discharge from the facility	42 CFR §483.12(a)(7)
2	Nursing home must develop a post-discharge plan of care that is developed with the participation of the resident and his or her family, which will assist the resident to adjust to his or her new living environment	42 CFR §483.20(i)
(F) Right to readmission after hospitalization		
1	Right to receive a written bed-hold notice when transferred to the hospital; nursing home must offer its next available bed to resident upon hospital discharge if it doesn't comply	22 CCR §72520 & 42 CFR §483.12(b)(2)
2	Right to pay to hold bed for up to 7 days during hospitalization and immediate readmission upon discharge	22 CCR §72520(a); 42 CFR 483.12(b)
3	Medi-Cal will pay to hold bed for up to 7 days for beneficiary who is hospitalized	22 CCR 51535.1, 42 CFR §483.12(b)
4	Resident on Medi-Cal has the right to be readmitted to the first available bed in a semiprivate room if the hospital stay exceeds 7 days	42 CFR §483.12(b)(3)
5	A nursing home's refusal to readmit a resident during a bed hold will be treated as an involuntary transfer, allowing the resident the right to appeal the transfer. The resident can remain in the hospital until the final determination of the hearing officer	Health & Safety Code § 1599.1; DPH All Facility Letter 03-13
6	If the resident is not on Medi-Cal and has no other source of payment, the hearing and final determination must be made within 48 hours	Health & Safety Code §1599.1
(G) Right to readmission after leave of absence/therapeutic leave		
1	Medi-Cal will pay to hold bed for 18 days (or more) per year for beneficiaries during leaves that are in accordance with their care plan	W&I Code §14108.2; 22 CCR §51535; 42 CFR §483.12

III. Rights Within Nursing Home

(A) Rights relating to dignity, quality of care, quality of life		
1	Right to receive the necessary care and services to attain or maintain the highest practicable physical, mental and psychosocial well-being	42 USC §1396r(b)(2); 42 USC §1395i-3(b)(2); 42 CFR §483.25; 22 CCR §72315
2	Nursing home must care for its residents in such a manner and in such an environment to maintain or enhance the quality of life of each resident	42 USC §1396r(b)(1); 42 USC §1395i-3(b)(1); 42 CFR §483.15
3	Right to receive care to prevent bedsores and incontinence	H&S Code §1599.1(b)
4	Nursing home shall employ an adequate number of qualified personnel	H&S Code §1599.1(a); 22 CCR §72501(e)
5	Right to be treated with dignity	42 CFR §483.10, 483.15(a); 22 CCR §72527(a)(11); 22 CCR §72315(b)
6	Right to be free from verbal, sexual, physical, and mental abuse, and corporal punishment	42 USC §1395i-3(c)(1)(A)(ii); 42 USC §1396r (c)(1)(A)(ii); 42 CFR §483.13(b); 22 CCR §72315(b); 22 CCR §72527(a)(9)
7	Right to reasonable accommodation of individual needs and preferences	42 USC §1395i-3(c)(1)(A)(v); 42 USC §1396r (c)(1)(A)(v); 42 CFR §483.15(e)(i)
8	Right to food of sufficient quality and quantity to meet the resident's needs	H&S Code §1599.1(c)
9	Right to activity program that meets residents' needs and interests	42 CFR §483.15(f), (g); H&S Code §1439.2; H&S Code §1599.1(d); 22 CCR §72381
10	Right to social services to attain or maintain the highest practicable physical, mental and psychosocial wellbeing	42 CFR §483.15(g)
(B) Right to homelike environment and use of personal belongings		
1	Right to safe, clean, comfortable and homelike environment	42 CFR §483.15(h), H&S Code §1599.1(e)
2	Right to housekeeping and maintenance services necessary to maintain a sanitary, orderly and comfortable environment	42 CFR §483.15(h)(2)
3	Right to clean bed and bath linens that are in good condition	42 CFR §483.15(h)(3)
4	Right to private closet space	42 CFR §483.15(h)(4)
5	Right to adequate and comfortable lighting levels in all areas	42 CFR §483.15(h)(5)
6	Right to comfortable and safe temperature levels	42 CFR §483.15(h)(6)
7	Right to comfortable sound levels	42 CFR §483.15(h)(7)
8	Right to retain and use personal possessions, including some furnishings, and appropriate clothing, as space permits	42 CFR §483.10(l); 22 CCR §72527

(C) Right to make health care decisions, choose health care providers, access records

1	Right to choose personal attending physician	42 U.S.C. 1395i-3(c)(1)(A)(i); 42 U.S.C. 1396r (c)(1)(A)(i); 42 C.F.R. 483.10(d)(1)
2	Right to be given information on the name, specialty, and way of contacting the physician responsible for the resident's care	42 CFR §483.10(b)(9)
3	Right to purchase drugs, or rent or purchase medical supplies or equipment, from pharmacy or medical supplier of choice	H&S Code §1320; 22 CCR §72527(a)(22)
4	Right to participate in planning care and treatment and in changes in care and treatment	42 USC §1395i-3(c)(1)(A)(i); 42 USC §1396r(c)(1)(A)(i); 42 CFR §483.10(d)(3)
5	Right to informed consent	22 CCR §§72527(a)(3)&(5) & 72528; H&S Code §1418.9; 42 USC §1395i-3(c)(1)(A)(i); 42 USC §1396r(c)(1)(A)(i); 42 CFR §483.10(d)(2) & 483.12(b)(1)
6	Right to be fully informed in advance of medical care and treatment in language resident can understand	42 USC §1395i-3(c)(1)(A)(i); 42 USC §1396r(c)(1)(A)(i); 42 CFR §483.10(b)(3), 483.10(d)(2); 22 CCR §72527(a)(3)
7	Right to refuse treatment	42 CFR §483.10(b)(4); 22 CCR §§72527(a)(4), §72528(a)(6); Cobbs v. Grant (1972) 8 Cal.3d 229; Bouvia v. Superior Court (1986) 179 Cal.App.3d 1127; Riese v. St. Mary's Hospital & Medical Center (1987) 209 Cal. App.3d. 1303
8	Right to formulate an advance directive	42 CFR §483.10(b)(4) & (8)
9	Right to self-administer drugs if facility determines it is safe	42 CFR §483.10(n)
10	Right to store non-prescription medications at bedside unless contraindicated by physician or facility	H&S Code §1418.5; 22 CCR §72357
11	Right to prompt notification of resident, legal representative and family member of accident resulting in injury to resident, significant changes in resident's physical, mental or psychosocial status, or need to alter treatment significantly	42 CFR §483.10(b)(10)(i); H&S Code §1795)
12	Right to access and copy at reasonable cost all records including clinical records	42 USC §1395i-3(c)(1)(A)(iv); 42 USC §1396r(c)(1)(A)(iv); 42 CFR §483.10 (b)(2); H&S Code §§123100-123149.5
13	Right to review and obtain copies of facility nurse staffing data	42 CFR §483.30(e)

(D) Right to be free from restraint		
1	Right to be free from involuntary seclusion	42 USC §1395i-3(c)(1)(A)(ii); 42 USC §1396r(c)(1)(A)(ii); 42 CFR §483.13(b), (c); 22 CCR §72319(f)
2	Right to be free from chemical or physical restraints imposed for purposes of discipline or convenience and not required to treat the resident's medical symptoms	42 USC §1395i-3(c)(1)(A)(ii); 42 USC §1396r(c)(1)(A)(i); 42 CFR §483.13(a); 22 CCR §72527(a)(23); 22 CCR §72319
3	Right to be free from unnecessary drugs	42 CFR §483.25(l)
(E) Right to autonomy		
1	Right to choose activities, schedules, and health care, and participate in resident and family groups and other social, religious and community activities	42 USC §1395i-3(c)(1)(A)(vii), (viii); 42 USC §1396r(c)(1)(A)(vii), (viii); 42 CFR §§483.15(b)(1), 483.15(c), (d)
2	Right to make choices about aspects of life in the facility that are significant to the resident	42 CFR §483.15(b)(3)
3	Right to self-determination and communication with and access to persons and services inside and outside the facility	42 USC §1395i-3(c)(3); 42 USC §1396r(c)(3); 42 CFR §483.15; 22 CCR §72527(a)(13), (14), (18), (19), (20), (21)
4	Right to exercise rights as a resident and as a citizen	42 CFR §483.10(a)(1); 22 CCR §72527(a)(7)
5	Right to refuse to perform services for the facility	42 CFR §483.10(h); 22 CCR §72527(a)(12)
6	Right to be temporarily absent from the facility	W&I Code §14108.2; 42 CFR §483.12(b)
7	Right to organize and participate in a residents' council	H&S Code §1418.2, 42 USC §1395i-3(c)(1)(A)(vii); 42 USC §1396r(c)(1)(A)(vii); 42 CFR §483.15(c)
8	Right to examine the results of most recent survey of facility and any plan of correction	42 USC §1395i-3(c)(1)(A)(ix); 42 USC §1396r(c)(1)(A)(ix); 42 CFR §483.10(g); 22 CCR §72503(a)(5)
(F) Right to privacy/confidentiality/communications/access/visitors		
1	Right to personal privacy in accommodations, medical treatment, written and telephonic communications, personal care, visits and meetings with family and resident groups	42 USC §1395i-3(c)(1)(A)(iii); 42 USC §1396r(c)(1)(A)(iii); 42 CFR §483.10(e); H&S Code §1418.3; 22 CCR §72527(a)(10), (11), (13), (16), (20), (21)
2	Right to reasonable access to telephones and to make and receive confidential calls	22 CCR §72527(a)(21); 42 CFR §483.10(k)
3	Right to send and promptly receive mail that is unopened and to have access to stationery, postage and writing implements	42 CFR §483.10(i); 22 CCR §72527(a)(13)

4	Right to confidential treatment of financial and medical records and to approve or refuse their release	H&S Code §1599.73; 22 CCR §72527(a)(10); 42 USC §1395i-3(c)(1)(A)(iv); 42 USC §1396r(c)(1)(A)(iv); 42 CFR §483.10(e)
5	Right of immediate access to resident by federal, state, or ombudsman's representative, family members and others who visit with the consent of the resident	42 USC §1395i-3(c)(3); 42 USC §1396r(c)(3); 42 CFR §483.10(j)
6	Right to reasonable access to any entity or individual that provides health, social, legal, or other services to the resident, subject to the resident's right to deny or withdraw consent at any	42 USC §1396r(c)(3)(D); 42 CFR §483.10(j)(2)
7	Right to have visits from persons of the resident's choosing at any time if the resident is critically ill	22 CCR §72527(a)(19)
8	Right to privacy for visits by the resident's spouse, and if the spouse is also a resident, to be permitted to share a room	22 CCR §72527(a)(16); 42 CFR §483.10(m)
9	Nursing home shall provide interpreters or other mechanisms to ensure adequate communications between residents and staff if language or communication barriers exist	22 CCR §72501(f)
(G) Right regarding transfer within nursing home		
1	Right to refuse transfer to or from a distinct part of a skilled nursing facility	42 USC §1395i-3(c)(1)(A)(x); 42 USC §1396r(c)(1)(A)(x); 42 CFR §483.10(o)
2	Right to be treated identically with respect to transfers regardless of source of payment	42 U.S.C. 1395i-3(c)(4); 42 U.S.C. 1396r(c)(4); W&I Code §14124.10
3	Right to reasonable, written notification prior to room or roommate change	42 USC §1395i-3(c)(1)(A)(v)(II); 42 USC §1396r(c)(1)(A)(v)(II); 42 CFR §483.15(e)(2); H&S Code §1599.78
4	If the resident changes to Medi-Cal payment status, a Medi-Cal certified nursing homes is prohibited from room-to-room transfers because of change in payment status; however, the resident may be transferred from a private room to a semi-private room.	W&I Code §14124.7
(H) Payment rights		
1	Right not to be discriminated against based on source of payment	42 U.S.C. 1395i-3(c)(4); 42 U.S.C. 1396r(c)(4); W&I Code §14124.10
2	Right to return of payment for services later paid by Medi-Cal	W&I Code §14019.3
3	Nursing home must inform resident of available services and related charges, including any charges for services not covered by its basic rate or not covered by Medi-Cal or Medicare	22 CCR §72527(a)(2); 42 U.S.C. 1395i-3(c)(1)(B)(iii); 42 U.S.C. 1396r(c)(1)(B)(iii); 42 C.F.R. 483.10(b)(5), (6)
4	Nursing home must give 30 days written notice of any rate increase in the facility.	H&S Code §1288(a)
5	Nursing home must provide monthly statements itemizing all charges incurred by residents	H&S Code §1599.67(a)

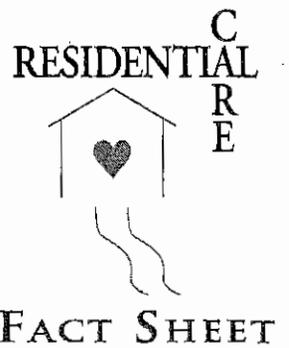
6	Nursing home cannot impose a charge for any item or service for which payment is made under Medicaid or Medicare, except for applicable deductible and coinsurance amounts	42 CFR §483.10(c)(8)
7	Nursing home must not charge a resident or representative for any item or services not requested by the resident	42 CFR §483.10(c)(8)(iii)
8	Nursing home must not require a resident or representative to request an item or service as a condition of admission or continued stay	42 CFR §483.10(c)(8)(iii)
9	Nursing home must inform the resident or representative requesting an item or service for which a charge will be made that there will be a charge for the item or service and what the charge will be	42 CFR §483.10(c)(8)(iii)
10	Nursing home must return any advance payments no later than 14 days after the resident's discharge or death to the heir, legatee or personal representative	22 CCR §72531; H&S Code §1599.71
11	Medi-Cal beneficiaries' right to use their share-of-cost to pay for medically necessary care not paid for by the Medi-Cal program	Johnson v Rank, Case No. 84-5979-SC, Consent Decree 11/23/85; 42 CFR §435.831(e); ACWL No. 89-54

(I) Rights on protection of funds and property

1	Right to manage own financial affairs; facility may not require residents to deposit their personal funds with the facility	42 USC §1395i-3(c)(6)(A)(i); 42 USC §1396r(c)(6)(A)(i); 42 CFR §483.10(c)(1); 22 CCR §72527(a)(8)
2	Nursing home must safeguard and account for residents funds deposited with the facility	42 USC §1395i-3(c)(6)(A)(ii); 42 USC §1396r(c)(6)(A)(ii); 42 CFR §483.10(c)(2); 22 CCR §72527(a)(8); 22 CCR §72529
3	Nursing home must convey resident's funds and final accounting to the legal representative of a deceased resident within 30 days of death	42 USC §1395i-3(c)(6)(B)(iii); 42 USC §1396r(c)(6)(B)(iii); 42 CFR §483.10(c)(6); 22 CCR §72529(a)(9)
4	Right to notification upon admission of the facility's policies and procedures to prevent theft and loss of possessions	H&S Code §1289.4(l)
5	Nursing home shall reimburse resident for current value of stolen or lost property if it fails to make reasonable efforts to safeguard property	H&S Code §1289.3
6	Nursing home must inventory resident's personal property on admission and upon death or discharge	H&S Code §1289.4(d); H&S Code §1418.7(a)(4), (5)
7	Nursing home must update resident's inventory upon written request when items are brought into or removed from the facility	H&S Code §1289.4(d)
8	Nursing home must secure resident's personal property	H&S Code §1289.4(j); H&S Code §1418.7(a)(9)
9	Nursing home must mark resident's personal property	H&S Code §1289.4(h); H&S Code §1418.7(a)(7)
10	Nursing home must establish theft and loss record for items worth \$25 or more	H&S Code §1289.4(c); H&S Code §1418.7(a)(3)

11	Nursing home must report theft of property with a value of \$100 or more to police	H&S Code §1289.4(i); H&S Code §1418.7(a)(8)
12	Nursing home must surrender resident's personal property upon death or discharge	H&S Code §1289.4(e),(f); H&S Code §1418.7(a)(5)
13	Resident has the right to locked area for safekeeping of personal property. The nursing home must provide a lock for the resident's drawer or cabinet at the request of and at the expense of the resident or the resident's representative	H&S Code §1289.4(j)
(J) Notice of Ownership Changes		
1	Within 30 days of an approved ownership change, the nursing home must send written notification to all current residents and to their primary contacts disclosing the name of the owner and licensee of the skilled nursing facility and the name and contact information of a single entity that is responsible for all aspects of resident care and operation at the facility	H&S Code §1599.645
(K) Equal Rights Amendment		
1	Rights established by federal regulations apply to all California nursing home residents, regardless of their payment source or the Medicare or Medi-Cal certification status of the nursing home	H&S Code §1599.1(i)
(L) Exercise of rights by surrogates		
1	A resident's representative may exercise rights on behalf of the resident	22 CCR §72527(c); 42 CFR §483.10(a)(3)&(4)
2	Persons who may act as a resident's representative are a conservator, a person appointed by the resident through a durable power of attorney for healthcare or advance health care directive, a resident's next-of-kin, or other persons lawfully appointed by the resident or a court	22 CCR §72527(d); 42 CFR §483.10(a)(3)&(4)
(M) Rights of family members		
1	Right to visit at any time	H&S Code §1418.3, 42 USC §1395i-3(c)(3); 42 USC §1396r(c)(3); 42 CFR §483.10(j)
2	Right to participate in planning the resident's care	42 USC §1395i-3(b)(2); 42 USC §1396r(b)(2); 42 CFR §483.20(k)(2)
3	Right to be informed of residents' rights	H&S Code §1599.1
4	Right to immediate notification of an accident resulting in injury, a significant change in the resident's condition, a need to alter treatment significantly, or a decision to transfer the resident	42 CFR §483.10(b)(11)(i)
5	With the resident's consent, the right to be notified if a physician orders or increases an order for an antipsychotic medication	H&S Code §1418.9
6	Right to be notified promptly if the resident is going to be moved to another room or if there is a change of roommates	42 CFR §483.10(b)(11)(ii)
7	Right to organize and participate in a family council	H&S Code §1418.4; 42 CFR §483.15(c)

(N) Right to exercise rights and voice grievances		
1	Right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising rights	42 USC §1395i-3(c)(1)(A)(vi); 42 USC §1396r(c)(1)(A)(vi); 42 CFR §483.10(a); 22 CCR §72527(a)(7)
2	Right to voice grievances and recommend changes in policies and services to facility staff, to contact outside representatives, to file complaints, and to cooperate in inspections and investigations free from restraint, interference, coercion, discrimination or reprisal	H&S Code §1432, 22 CCR §72527(a)(7); 42 USC §1395i-3(c)(1)(A)(vi); 42 USC §1396r(c)(1)(A)(vi); 42 CFR §483.10(f)
3	Right to prompt efforts by the facility to resolve grievances, including those involving the behavior of other residents	42 CFR §483.10(f)(2)
4	Right to contact and receive information from agencies acting as client advocates	42 CFR §483.10(g)(2)
(O) Right to file complaint		
1	Any person has the right to file a complaint by phone, in writing, or in person with the Department of Public Health (DPH) against a nursing home	H&S Code §1419(d)
2	DPH shall not disclose the complainant's name	H&S Code §1419(e)
3	DPH shall notify the complainant of the assigned inspector's name within 2 working days of the receipt of the complaint.	H&S Code §1420(a)(1)
4	DPH shall notify the complainant of the opportunity to accompany the investigator during the inspection of the facility	H&S Code §1420(a)(1)
5	DPH shall make an onsite inspection or investigation within 24 hours of the receipt of the complaint if there is a serious threat of imminent danger of death or serious bodily harm; onsite investigations of all other complaints must begin within 10 working days of receipt of the complaint.	H&S Code §1420(a)(1); CANHR v DHS, San Francisco Superior Court, Case # CPF-05-505749, Order for Writ of Mandate, 9/27/06
6	DPH shall notify the complainant of the results in writing within 10 days of the completion of the investigation.	H&S Code §1420(a)(3)
7	DPH shall notify the complainant of the right to appeal the findings, initially to the district office that investigated the complaint, and if still dissatisfied, to DPH's state office	H&S Code §1420(b), (c)
8	DPH shall send a copy of any citation issued as a result of the complaint to the complainant by registered or certified mail.	H&S Code §1420(d)
9	DPH shall advise the facility that it is unlawful to discriminate or seek retaliation against a complainant.	H&S Code §1420(e)
10	Nursing home may not seek to expel resident in retaliation for filing of complaint; attempt to evict resident within 180 days of filing of complaint against facility is rebuttably presumed to be retaliatory	H&S Code §1432 (a), (b)
(P) Enforcement of rights		
1	Right to sue facility for injunction or damages for violation of rights	H&S Code §1430



California's Assisted Living Waiver

Background

In March 2006, Medi-Cal began paying for assisted living care to select aged and disabled residents of Los Angeles, Sacramento and San Joaquin counties under the Assisted Living Waiver Pilot Project (ALWPP). The ALWPP was created by legislation that directed the California Department of Health Care Services (DHCS) to develop and implement the project. A key goal of the pilot project was to enable low-income, Medi-Cal eligible seniors and persons with disabilities, who would otherwise require nursing facility services, to remain in or relocate to the community. The program was approved by the Centers for Medicaid and Medicare and was converted into a five-year federal waiver program as of March 1, 2009.

Scope of Program

ALW serves the counties of Fresno, Los Angeles, Riverside, Sacramento, San Bernardino, San Joaquin and Sonoma.

Overview

Participants in ALW have access to four different waivers:

- Assisted Living Services: these services are provided in a Residential Care Facility for the Elderly (RCFE) or Assisted Care: which are provided by a licensed home health agency and provided to residents in public housing. The following is a list of some of the services of the assisted living program that must be provided to ALW participants:
 - A care plan for each resident
 - Providing personal care and assistance
 - Laundry
 - Housekeeping
 - Maintenance of the facility
 - Providing intermittent skilled nursing care
 - Meals and snacks
 - Providing assistance with self-administration of medications
 - Providing or coordinating transportation
 - Providing recreational activities
 - Providing social services

- Care Coordination: identifying, organizing, coordinating and monitoring services needed by clients.
- Nursing Facility Transition Care Coordination: services help transition participants from a nursing home to the community.
- Consumer Education: to help the client take control and responsibility for their care and services.

Eligibility

Participants must be eligible for full-scope or share-of-cost Medi-Cal benefits and require a nursing facility level of care. The latter requirement is key to eligibility because the program is designed to serve people who would otherwise need nursing home care. Contracted Care Coordination Agencies use a standardized assessment tool to determine the clients need for nursing home level of care. The project serves people age 21 and older.

People living in other counties can receive services if they are otherwise qualified, willing to relocate to one of the participating counties, and work with an enrolled care coordination agency.

Care Planning

Using the standardized assessment tool, care coordination agencies will determine the level of care each participant needs. DHS established four levels of care – known as tiers – and a payment level for each tier.

Care coordinators will establish individualized service plans for each participant, including services that are covered by Medi-Cal through the pilot project and other services funded by other sources. Participating RCFEs must develop a care plan to implement the service plan for each resident.

A licensed, Medi-Cal certified home health agency will implement care plans for participants who live at public housing sites. In this setting, the services provided are called Assisted Care.

Payment Rates

Participants pay for their own room and board at rates set by facilities. Medi-Cal payments only cover costs for specified care and services.

RCFEs and home health agencies are reimbursed at four levels of care, with daily rates ranging from \$52 per day for tier 1 to \$82 per day for tier 4. RCFEs and home health agencies cannot negotiate the services to be delivered or the payment rate.

Care coordination agencies will be paid \$200 per participant, per month, for care coordination services and for the coordination of other waiver benefits and services.

Additional funds are available. Up to \$2500 is available to help a nursing home resident return to a community setting, plus \$1,000 is available to cover care coordination services for such individuals. Up to \$1500 per participant in public housing is available for environmental accessibility adaptations. Other benefits include consumer education and interpretation and translation.

Provider Eligibility

Provider participation is voluntary. Interested providers must enroll as a Medi-Cal assisted living waiver provider. There is no limit to the number of providers that can enroll and participate.

Below are the basic requirements for the three main care provider types.

RCFEs must be licensed, not be on probation or have pending accusations against their license, and be in substantial compliance with licensing requirements. Additionally, RCFEs must:

- Meet care needs of all participants in accordance with their care plans at all four levels of care.
- Have awake staff 24 hours a day, except in facilities with 6 or fewer residents.
- Employ or contract with a nurse or nursing agency to provide any required nursing services as often as is necessary.
- Have a hospice waiver and be able to care for cognitively impaired residents.
- Have single occupancy rooms for participants, unless a participant chooses to have a roommate.
- Have private bathrooms or bathrooms shared by no more than 2 participants.
- Have a kitchenette in the room of each participant, except in facilities with 6 or fewer residents, where the requirement is waived if the resident has continuous access to the facility's kitchen.

Care coordination agencies must have five years experience in this field, have R.N. and social services care coordinators on staff, and meet other requirements.

Home health agencies must be licensed, enter into an operating agreement with the publicly funded housing site where they deliver services, open a branch office at that site, and meet other requirements.

Choosing a Facility

Participants select the facility or provider of their choice. Care coordination agencies will inform participants about available facilities and providers. RCFEs are allowed to reject a participant. However, once a facility admits someone, it must provide necessary services and adapt services as the person's needs change. All providers are expected to deliver all four levels (tiers) of care.

More Information

For more information about how to apply, contact:
<http://www.dhcs.ca.gov/SERVICES/LTC/Pages/ALWPP.aspx>

ALW
Long-Term Care Division
1501 Capitol Avenue, MS 4503
PO Box 997419
Sacramento, CA 95899-7419

Phone: 916-552-9105



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Veterans Affairs Aid and Attendance Benefits

CANHR is a private, nonprofit 501(c)(3) organization dedicated to improving the quality of care and the quality of life for long term care consumers in California.

What Are Aid and Attendance benefits?

Aid and Attendance is a benefit paid by Veterans Affairs (VA) to veterans, veteran spouses or surviving spouses. It is paid in addition to a veteran's basic pension. The benefit may not be paid without eligibility to a VA basic pension. Aid and Attendance is for applicants who need financial help for in-home care, to pay for an assisted living facility or a nursing home. It is a non-service connected disability benefit, meaning the disability does not have to be a result of service. You cannot receive non-service and service-connected compensation at the same time. Aid and Attendance benefits are paid to those applicants who:

- Are eligible for a VA pension
- Meet service requirements
- Meet certain disability requirements
- Meet income and asset limitations

Who is Eligible for Veterans Affairs Basic Pension and Aid and Attendance?

A pension is a benefit that the VA pays to wartime veterans who have limited or no income and who are at least 65 years old or, if under age 65, are permanently or completely disabled. There are also "Death Pensions," which are needs based for a surviving spouse of a deceased wartime veteran who has not remarried.

What are the Service Requirements for Aid and Attendance?

A veteran or the veteran's surviving spouse may be eligible if the veteran:

- Was discharged from a branch of the United States Armed Forces under conditions that were not dishonorable **AND**
- Served at least one day (did not have to be served in combat) during the following wartime periods and had 90 days of continuous military service:
 - World War I: April 6, 1917, through November 11, 1918
 - World War II: December 7, 1941, through December 31, 1946
 - Korean War: June 27, 1950, through January 31, 1955
 - Vietnam War: August 5, 1964 (February 28, 1961, for veterans who served "in country" before August 5, 1964), through May 7, 1975
 - Persian Gulf War: August 2, 1990, through a date to be set by Presidential Proclamation or Law.

If the veteran entered active duty after September 7, 1980, generally he/she must have served at least 24 months or the full period for which called or ordered to active duty (there are exceptions to this rule).

What are the Disability Requirements for Aid and Attendance?

Veterans, spouses of veterans or surviving spouses can be eligible for Aid and Attendance benefits if they meet the following disability requirements:

- The aid of another person is needed in order to perform personal functions required in everyday living, such as bathing, feeding, dressing, toileting, adjusting prosthetic devices, or protecting himself/herself from the hazards of his/her daily environment; or

- The claimant is bedridden, in that his/her disability or disabilities require that he/she remain in bed apart from any prescribed course of convalescence or treatment; or
- The claimant is in a nursing home due to mental or physical incapacity; or
- The claimant is blind, or so nearly blind as to have corrected visual acuity of 5/200 or less, in both eyes, or concentric contraction of the visual field to 5 degrees or less.

What are the Income Requirements for Aid and Attendance?

The claimant's countable family income must be below a *limit* set yearly by law (see chart below for amounts). *Countable Income* means income received by the claimant and his or her dependents. It includes earnings, disability and retirement payments, interest and dividends, and net income from farming or business. *Excluded* from the countable monthly income are unreimbursed medical expenses and public assistance such as SSI. The annual income limits for the Aid and Attendance program are higher than those set for the basic pension. The Aid and Attendance benefit amount is determined on the claimant's countable income. The maximum Aid and Attendance benefit that can be paid monthly to a single veteran is \$1,733, but the veteran must have *countable* income of \$0 to receive this amount.

The following chart includes the set yearly income rate, annual basic pension called the MAPR (Maximum Annual Pension Rate) and Aid and Attendance limits set by Congress; it also includes the maximum monthly benefit:

Aid and Attendance Maximum Annual Pension Rate (MAPR) Category <i>If you are a...</i>	Basic Pension MAPR	5% of Basic Pension MAPR (The amount you subtract from medical expenses...)	Annual Aid and Attendance Pension Rate Your yearly income must be less than...
Single Veteran	\$12,465 (\$1,039 per month)	\$623	\$20,795 (\$1,733 per month)
Veteran with Spouse/Dependent	\$16,324 (\$1,360 per month)	\$816	\$24,652 (\$2,054 per month)
Two Veterans Married to Each Other	\$16,324 (\$1,360 per month)	\$816	\$32,115 (\$2,676 per month)
Surviving Spouse	\$8,359 (\$697 per month)	\$417	\$13,362 (\$1,114 per month)
Surviving Spouse with One Dependent	\$10,942 (\$912 per month)	\$547	\$15,940 (\$1,328 per month)

Unreimbursed Medical Expenses

A portion of unreimbursed medical expenses paid by claimants may reduce the countable income.

Unreimbursed medical expenses include: cost of a long term care institution or assisted living, health related insurance premiums (including Medicare premiums), diabetic supplies, private caregivers, incontinence supplies, prescriptions and dialysis not covered by any other health plan. **Only the portion of the unreimbursed medical expenses that exceed 5% of the basic pension MAPR may be deducted (see above chart for this amount).**

Example A: Single Veteran/No Spouse or Dependents — Income Above MAPR – Medical deduction

- Jim is disabled and needs help paying for care. His yearly income is \$40,000 and he has \$35,000 unreimbursed medical expenses this year.
 - $\$12,465 \text{ basic pension MAPR} \times 0.05 = \623
 - $\$35,000 \text{ medical expenses} - \$623 = \$34,377 \text{ medical deduction}$
 - $\$40,000 \text{ Jim's income} - \$34,377 = \$5,623 \text{ Countable Income}$
- The countable income is subtracted from the maximum annual Aid and Attendance Rate to determine the benefit amount.
 - $\$20,795 \text{ (Aid and Attendance Rate)} - \$5,623 \text{ (countable income)} = \$15,172$
- Jim's Aid and Attendance benefit would be \$15,172 or \$1,264/monthly

Example B: Single Veteran/No Spouse or Dependents — Income Over MAPR — No Med Deduction

- Frank's countable income is \$1,300 per month (\$15,600 per year). Because his annual income is more than \$12,465 (more than \$1,039 monthly), and he does not have any medical expenses to deduct, he is not eligible for VA Veterans Pension with Aid and Attendance.
- Frank may reapply again when his countable income falls below the limit or when he has unreimbursed medical expenses that would reduce his income.

Example C: Married Veterans — Income Below MAPR — Need Aid and Attendance

- Both Carlos and Patricia live in a senior apartment and need a caregiver 24 hours a day to remain safely in their house. SSI is their only monthly income. Since SSI is not counted, their countable income for VA purposes is \$0. They are eligible for \$2,676 per month (\$32,115 annually), the maximum benefit to help pay for their care.

Example D: Surviving Spouse of Veteran — Income Above MAPR — In Assisted Living

- June is an assisted living facility. Her income is \$12,000 per year in Social Security. Her children help pay for the assisted living cost of about \$4,000 monthly. Thus, June's unreimbursed medical expenses are \$4,000 per month or \$48,000 per year.
 - $\$8,359 \text{ MAPR} \times 0.05 = \417
 - $\$48,000 - 417 = \$47,583 \text{ total unreimbursed medical expenses}$
 - $\$12,000 \text{ income} - \$47,583 \text{ expenses} = \text{June has } \$0 \text{ countable income.}$
- Thus, June would be eligible for the maximum benefit of \$1,114 to help her children pay for the assisted living facility.

What are the Asset Requirements for Aid and Attendance?

Net Worth (the value of your assets) also affects eligibility. VA pensions are a need-based benefit, and a large net worth might affect your eligibility. All personal goods are exempt from the net worth. These goods include the home you live in, a vehicle used for the care of the claimant, and household goods and personal effects such as clothes, jewelry and furniture. Unfortunately, there is no asset limit set by law, and the determination of eligibility can be made at the discretion of a VA caseworker.

How does Aid and Attendance affect Medi-Cal Benefits?

In the community:

Aid and Attendance payments are not counted as income for Medi-Cal or IHSS purposes for those beneficiaries who reside at home (not in an institution). However, the basic pension does count as income.

In a Nursing Home:

If you are in nursing home under Medi-Cal, you are allowed to keep \$35 out of your monthly income for personal needs. If you receive Aid and Attendance benefits, you will be allowed to keep an additional \$90 (\$125 total) for the monthly personal needs allowance; the remaining Aid and Attendance payments will be counted as income and will need to be paid as part of your monthly share of cost, unless there is a community spouse or dependent child at home.

How do You Apply for Veterans Affairs Benefits?

Applying for VA pension is often complicated and may take some time. It is a good idea to keep copies of all unreimbursed medical bills for at least twelve months. The average wait for approval is six months. However, the benefits are retroactive to the date of application.

There are several ways you can apply for non-service connected pensions:

1. You can contact the VA at 1-800-827-1000.
2. You can apply online at: <https://www.ebenefits.va.gov/>
3. Veteran's applying for the first time can download the "VA Form 21-526, Veteran's Application for Compensation and/or Pension" at www.vba.va.gov/pubs/forms/VBA-21-526-ARE.pdf and send the completed application to the VA regional office that serves your county (listed below). If you have applied for pension, compensation or Dependency and Indemnity Compensation (DIC) in the past there may be other applications you can use (i.e. VA Form 21-527).
4. Surviving spouse's applying for the first time can download the "VA Form 21-534, Application for Dependency and Indemnity Compensation, Death Pension and Accrued Benefits by Surviving Spouse or Child" at <http://www.vba.va.gov/pubs/forms/VBA-21-534-ARE.pdf> and send the completed application to the VA regional office that serves your county. If you have applied for pension, compensation or DIC in the past there may be other applications you can use (i.e. VA Form 21-0518 or 21-0519).

VA Regional Offices:

- o The Los Angeles Regional Office covers the following counties:
Inyo, Kern, Los Angeles, San Luis Obispo, Santa Barbara, San Bernardino and Ventura.
Los Angeles Regional Office
Federal Building, 11000 Wilshire Boulevard
Los Angeles, CA 90024
- o The San Diego Regional Office covers the following counties:
Imperial, Orange, Riverside and San Diego.
San Diego Regional Office
8810 Rio San Diego Drive
San Diego, CA 92108
- o The Reno Regional Office covers the following counties:
Alpine, Lassen, Modoc, and Mono.
Reno Regional Office
5460 Reno Corporate Drive
Reno, NV 89511
- o The Oakland Regional Office covers all remaining counties.
Oakland Regional Office
1301 Clay Street, Room 1400 North
Oakland, CA 94612

Or

The claimant may also contact a Veterans Service Officer (VSO) from a veteran's service organization in their county. A VSO is a professional veteran affairs advocate. They play a critical role in advocacy and are often the initial contact in the community for veteran services. A VSO can help fill out the application. To search for the nearest VSO see: <http://www.va.gov/ogc/apps/accreditation/index.asp>

What Documents are needed to apply for Aid and Attendance?

The veteran or surviving spouse will need to gather the following VA Forms (Forms can be found at <http://www.va.gov/vaforms/>) before applying for benefits:

- Discharge or Separation Documents (DD 214)
- VA Form 21-22 if a Veteran's Service Organization or 21-22a if individual is acting as the claimant's representative
- Form 21-4142: Authorization and Consent to Release Information to the Department of Veterans Affairs
- Letter from the claimant's attending physician VDVA Form 10
- Physician Statement, VA Form 21-2680 or Nursing Home Statement, VA Form 21-0779
- Medical Expenses incurred, VA Form 21-8416

In addition to the VA forms, an applicant will need to gather the following documents:

- Marriage Certificate and Death Certificate (Surviving Spouses only)
- Asset Information (bank account statements, etc.)
- Verification of Income (social security award letter, and statements from pensions, IRAs, annuities, etc)
- Proof of Medical Premiums (Insurance Statements, Medication or Medical bills that are not reimbursed by Medi-Cal or Medicare)
- Voided Check for Aid and Attendance Direct Deposit

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Veterans Affairs Aid and Attendance Benefits

What Are Aid and Attendance benefits?

Aid and Attendance is a benefit paid by Veterans Affairs (VA) to veterans, veteran spouses or surviving spouses. It is paid in addition to a veteran's basic pension. The benefit may not be paid without eligibility to a VA basic pension. Aid and Attendance is for applicants who need financial help for in-home care, to pay for an assisted living facility or a nursing home. It is a non-service connected disability benefit, meaning the disability does not have to be a result of service. You cannot receive non-service and service-connected compensation at the same time. Aid and Attendance benefits are paid to those applicants who:

- Are eligible for a VA pension
- Meet service requirements
- Meet certain disability requirements
- Meet income and asset limitations

Who is Eligible for Veterans Affairs Basic Pension and Aid and Attendance?

A pension is a benefit that the VA pays to wartime veterans who have limited or no income and who are at least 65 years old or, if under age 65, are permanently or completely disabled. There are also "Death Pensions," which are needs based for a surviving spouse of a deceased wartime veteran who has not remarried.

What are the Service Requirements for Aid and Attendance?

A veteran or the veteran's surviving spouse may be eligible if the veteran:

- Was discharged from a branch of the United States Armed Forces under conditions that were not dishonorable **AND**
- Served at least one day (did not have to be served in combat) during the following wartime periods and had 90 days of continuous military service:
 - World War I: April 6, 1917, through November 11, 1918
 - World War II: December 7, 1941, through December 31, 1946
 - Korean War: June 27, 1950, through January 31, 1955
 - Vietnam War: August 5, 1964 (February 28, 1961, for veterans who served "in country" before August 5, 1964), through May 7, 1975
 - Persian Gulf War: August 2, 1990, through a date to be set by Presidential Proclamation or Law.

If the veteran entered active duty after September 7, 1980, generally he/she must have served at least 24 months or the full period for which called or ordered to active duty (there are exceptions to this rule).

What are the Disability Requirements for Aid and Attendance?

Veterans, spouses of veterans or surviving spouses can be eligible for Aid and Attendance benefits if they meet the following disability requirements:

- The aid of another person is needed in order to perform personal functions required in everyday living, such as bathing, feeding, dressing, toileting, adjusting prosthetic devices, or protecting himself/herself from the hazards of his/her daily environment; or

- The claimant is bedridden, in that his/her disability or disabilities require that he/she remain in bed apart from any prescribed course of convalescence or treatment; or
- The claimant is in a nursing home due to mental or physical incapacity; or
- The claimant is blind, or so nearly blind as to have corrected visual acuity of 5/200 or less, in both eyes, or concentric contraction of the visual field to 5 degrees or less.

What are the Income Requirements for Aid and Attendance?

The claimant's *countable family income* must be below a *limit* set yearly by law (see chart below for amounts). *Countable Income* means income received by the claimant and his or her dependents. It includes earnings, disability and retirement payments, interest and dividends, and net income from farming or business. *Excluded* from the countable monthly income are unreimbursed medical expenses and public assistance such as SSI. The annual income limits for the Aid and Attendance program are higher than those set for the basic pension. The Aid and Attendance benefit amount is determined on the claimant's countable income. The maximum Aid and Attendance benefit that can be paid monthly to a single veteran is \$1,733, but the veteran must have *countable* income of \$0 to receive this amount.

The following chart includes the set yearly income rate, annual basic pension called the MAPR (Maximum Annual Pension Rate) and Aid and Attendance limits set by Congress; it also includes the maximum monthly benefit:

Aid and Attendance Maximum Annual Pension Rate (MAPR) Category <i>If you are a...</i>	Basic Pension MAPR	5% of Basic Pension MAPR (The amount you subtract from medical expenses...)	Annual Aid and Attendance Pension Rate Your yearly income must be less than...
Single Veteran	\$12,465 (\$1,039 per month)	\$623	\$20,795 (\$1,733 per month)
Veteran with Spouse/Dependent	\$16,324 (\$1,360 per month)	\$816	\$24,652 (\$2,054 per month)
Two Veterans Married to Each Other	\$16,324 (\$1,360 per month)	\$816	\$32,115 (\$2,676 per month)
Surviving Spouse	\$8,359 (\$697 per month)	\$417	\$13,362 (\$1,114 per month)
Surviving Spouse with One Dependent	\$10,942 (\$912 per month)	\$547	\$15,940 (\$1,328 per month)

Unreimbursed Medical Expenses

A portion of unreimbursed medical expenses paid by claimants may reduce the countable income.

Unreimbursed medical expenses include: cost of a long term care institution or assisted living, health related insurance premiums (including Medicare premiums), diabetic supplies, private caregivers, incontinence supplies, prescriptions and dialysis not covered by any other health plan. **Only the portion of the unreimbursed medical expenses that exceed 5% of the basic pension MAPR may be deducted (see above chart for this amount).**

Example A: Single Veteran/No Spouse or Dependents — Income Above MAPR – Medical deduction

- Jim is disabled and needs help paying for care. His yearly income is \$40,000 and he has \$35,000 unreimbursed medical expenses this year.
 - $\$12,465 \text{ basic pension MAPR} \times 0.05 = \623
 - $\$35,000 \text{ medical expenses} - \$623 = \$34,377 \text{ medical deduction}$
 - $\$40,000 \text{ Jim's income} - \$34,377 = \$5,623 \text{ Countable Income}$
- The countable income is subtracted from the maximum annual Aid and Attendance Rate to determine the benefit amount.
 - $\$20,795 \text{ (Aid and Attendance Rate)} - \$5,623 \text{ (countable income)} = \$15,172$
- Jim's Aid and Attendance benefit would be \$15,172 or \$1,264/monthly

Example B: Single Veteran/No Spouse or Dependents — Income Over MAPR — No Med Deduction

- Frank's countable income is \$1,300 per month (\$15,600 per year). Because his annual income is more than \$12,465 (more than \$1,039 monthly), and he does not have any medical expenses to deduct, he is not eligible for VA Veterans Pension with Aid and Attendance.
- Frank may reapply again when his countable income falls below the limit or when he has unreimbursed medical expenses that would reduce his income.

Example C: Married Veterans — Income Below MAPR — Need Aid and Attendance

- Both Carlos and Patricia live in a senior apartment and need a caregiver 24 hours a day to remain safely in their house. SSI is their only monthly income. Since SSI is not counted, their countable income for VA purposes is \$0. They are eligible for \$2,676 per month (\$32,115 annually), the maximum benefit to help pay for their care.

Example D: Surviving Spouse of Veteran — Income Above MAPR — In Assisted Living

- June is an assisted living facility. Her income is \$12,000 per year in Social Security. Her children help pay for the assisted living cost of about \$4,000 monthly. Thus, June's unreimbursed medical expenses are \$4,000 per month or \$48,000 per year.
 - $\$8,359 \text{ MAPR} \times 0.05 = \417
 - $\$48,000 - 417 = \$47,583 \text{ total unreimbursed medical expenses}$
 - $\$12,000 \text{ income} - \$47,583 \text{ expenses} = \text{June has } \$0 \text{ countable income.}$
- Thus, June would be eligible for the maximum benefit of \$1,114 to help her children pay for the assisted living facility.

What are the Asset Requirements for Aid and Attendance?

Net Worth (the value of your assets) also affects eligibility. VA pensions are a need-based benefit, and a large net worth might affect your eligibility. All personal goods are exempt from the net worth. These goods include the home you live in, a vehicle used for the care of the claimant, and household goods and personal effects such as clothes, jewelry and furniture. Unfortunately, there is no asset limit set by law, and the determination of eligibility can be made at the discretion of a VA caseworker.

How does Aid and Attendance affect Medi-Cal Benefits?

In the community:

Aid and Attendance payments are not counted as income for Medi-Cal or IHSS purposes for those beneficiaries who reside at home (not in an institution). However, the basic pension does count as income.

In a Nursing Home:

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Filing Complaints Against Continuing Care Retirement Communities (CCRCs)

CANHR is a private, nonprofit 501 (c)(3) organization dedicated to improving the quality of care and the quality of life for long term care consumers in California.

Consider filing a formal complaint with the appropriate regulatory agency if informal approaches to solving one's problems are not successful (Refer to Fact Sheet – *Exercising Your Rights & Resolving Problems in CCRCs*.) The CCRC resident has clearly established rights to file complaints without provider retaliation. (Health & Safety Code §1771.7(f)(g) and 1788(a)(30)(B))

Since CCRCs provide a continuum of care, there are different agencies that regulate CCRCs. Where to file a complaint will depend, not only on the nature of the problems, but also at what level of care the problem has occurred or is occurring.

Continuing Care Contracts Branch (CCC Branch) – All Care Levels

California Department of Social Services
744 P Street, M.S. 10-90
Sacramento, CA 95814
(916) 657-2592
www.calccrc.ca.gov

The Continuing Care Contracts Branch, California Department of Social Services – Community Care Licensing, is the designated regulatory agency for CCRCs. The CCC Branch views its primary mission as monitoring the financial soundness of CCRCs. However, it also has statutory authority and responsibility to:

- Accept resident complaints concerning the violation of rights stated in the Resident Rights – Health & Safety Code §1771.7 (H&S 1771.7(f))
- Respond within 15 business days to residents' rights, service-related, and financially related complaints by residents (H&S 1776.3(d)(1))
- Review the transfer process for disputed level of care transfers (H&S 1788(a)(10)(D))

Note: The CCC Branch provides the Continuing Care Contracts Advisory Committee with an annual summary of all residents' rights, service-related, and financially related complaints by residents. (H&S 1776.3(d)(2)) These summary complaint reports are public information and can be accessed on CANHR's website.

Community Care Licensing– Independent Living Units & Assisted Living

Department of Social Services – Senior Care Program
<http://www.cclcd.ca.gov/res/pdf/ACPO.pdf> (Listing of District Offices)

Since both the Independent Living Units and the Assisted Living units of CCRCs are regulated as Residential Care Facilities for the Elderly (RCFEs), the Senior Care Division of Community Care Licensing monitors CCRCs for compliance with the RCFE laws and regulations regarding buildings

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and grounds, accommodations, care and supervision of residents, and quality of service. (Refer to CANHR's website on RCFEs/Assisted Living, www.canhr.org, and to the Fact Sheets on *Rights of Residents in RCFEs* and *Filing Complaints*.)

Licensing and Certification – Skilled Nursing

California Department of Public Health

<http://cdph.ca.gov/certlic/Facilities/Pages/LCDistrictOffices.aspx> (List of District Offices)

Skilled Nursing residents have substantial rights established by both federal and state law. Skilled Nursing is regulated by the California Department of Public Health, Licensing and Certification. (Refer to CANHR's website on Nursing Homes, www.canhr.org, and to the Fact Sheets on *Rights of Residents in Nursing Homes* and *Filing Complaints*.)

Commission on Accreditation of Rehabilitation Facilities (CARF)

4891 E. Grand Ave.

Tucson, AZ 85712

(866) 510-2273 Toll Free

FAX (520) 318-1129

Email: feedback@carf.org

Some CCRCs participate in a voluntary accreditation program. If the CCRC is accredited, send a copy of your complaints or submit a separate letter summarizing the complaint(s).

Where to Go for Help

Contact CANHR at 1-800-474-1116 (Consumers only) or 415-974-5171. Consider using one of CANHR's Complaint Forms for either Assisted Living/Residential Care or Nursing Homes.

Contact the local Long Term Care Ombudsman Program to assist in filing a complaint to a regulatory agency. The Ombudsman is a resident advocate. Visit the website for the address and number of local offices, <http://www.aging.ca.gov/programs/ombudsman.asp>, or call the Crisis Line Number 1-800-231-4024 after hours or on the weekends.

If the complaint involves serious neglect or abuse, contact the Ombudsman Program, local law enforcement, and the California Attorney General's Bureau of Medi-Cal Fraud & Elder Abuse at 1-800-722-0432 or <http://ag.ca.gov/bmfea/> or mail to BMFEA, P.O. Box 944255, Sacramento, CA 94244-2550.

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How to Choose a Nursing Home

What to Look for...How to Choose a Facility

Choosing a nursing home for a family member is one of the most difficult decisions in life. It is a stressful, time-consuming task that is often made worse by the fact that a loved one has suffered a medical crisis. You may face great pressure to locate a nursing home and arrange care in a very short period of time.

Fortunately, there are time-tested methods for identifying and evaluating nursing homes. Some important factors to consider include the location of the home, its participation in the Medicare and Medi-Cal programs, its compliance with public standards, and whether its services meet your needs and desires.

Consult CANHR's Nursing Home Guide

CANHR's online guide (www.nursinghomeguide.org) has in-depth information on all 1300+ nursing homes in California, including interactive searches, comparisons and details on violations, staffing and services. Get started by using Nursing Home Guide to learn about nursing homes in your community and find out about their histories of complaints, deficiencies and citations. Additionally, lists of nursing homes by county are available at CANHR's main website (www.canhr.org).

Medicare and Medi-Cal Considerations

If you want Medicare or Medi-Cal to help pay for the nursing home care, you must select a facility that is certified by these programs. Due to the extremely high cost of nursing home care – which averages above \$200 per day or \$6,000 per month – few people can afford to pay privately for very long. Most California nursing homes participate in both Medicare and Medi-Cal.

Medicare's short-term skilled nursing facility benefit is very limited, but is often helpful to gain admission to a nursing home, especially when skilled nursing care or therapy are needed after hospitalization due to a stroke, surgery, injury or other medical conditions. Medicare covers up to 100 days of skilled nursing care following a hospital stay of at least three days.

Medi-Cal helps pay nursing home care for two-of-every-three residents in California. Due to the high cost of nursing home care, most people in nursing home's will meet Medi-Cal's financial eligibility requirements sometime during their stay. CANHR's website provides extensive information on Medi-Cal eligibility for nursing home care.

Even if you don't need or qualify for Medi-Cal now, it is best to select a Medi-Cal certified facility. Uncertified facilities can evict you when your money and insurance runs out. Your choice of other facilities at that point may be very limited. Medi-Cal certified facilities cannot evict residents who qualify for Medi-Cal during their stay.

Although it is illegal for a certified nursing home to require a resident to pay privately for any set period of time, many nursing homes give preference to applicants who can pay privately. The longer you can pay the private rate, the more options you will have when looking for a facility.

Location

It is important to select a nursing home that is close and convenient to the person(s) who will be visiting the resident most often. Residents who have frequent visitors often recover faster, are happier and healthier from the love and attention received and tend to receive a higher quality of care. When family members and

friends are close enough to visit frequently, they can monitor the resident's condition, participate in care planning and respond quickly to emergencies.

Special Needs

Always seek a nursing home that can meet any special care needs your loved one may have. For example, some residents need specialized respiratory care, such as a ventilator, that is only available at certain facilities. Or an individual may need extra supervision and assistance due to behaviors associated with dementia. Ask detailed questions to make sure facilities under consideration are currently able to provide the necessary care.

Seek References

If possible, seek information about facilities under consideration from people you trust. Relatives, friends, clergy, local senior groups, ombudsman programs, Alzheimer's support groups, hospital discharge planners, doctors and others may have recent experiences with nursing homes in your area. You can also seek opinions from residents and visitors while making visits to check on nursing homes.

Nursing Home Ratings

Many people consult online nursing home rating systems when selecting a nursing home. The most popular sites are *Nursing Home Compare* (operated by Medicare) and *CalQualityCare* (run by the California HealthCare Foundation and UCSF).

Although the ratings have serious limitations, they can be very useful in narrowing your choice. It is almost always best to avoid lower rated nursing homes if you can.

However, nursing home ratings are not reliable in identifying high quality facilities because they are largely based on inspection findings that often overlook or understate serious problems. The quality of California's nursing home inspection system is poor, at best. Adding to this problem, *Nursing Home Compare's* ratings do not take into account any violations of California nursing home standards or California citations issued to nursing homes. You cannot rely on ratings alone to find a good nursing home.

Personal Visits

Nothing substitutes for a personal visit to the facility. Once you have identified a nursing home that seems (on paper, at least) to be affordable, to have the services necessary and to have a vacancy, visit the facility. Ask to see the entire facility, not just the nicely decorated lobby or a designated unit. Try to get a feel for the quality of care and how residents are treated by the staff. Resident appearance, use of restraints, residents' rooms, quality of food and activities are all-important factors in evaluating a nursing home. However, nothing is more important than the quality and quantity of nursing home staff.

How do you feel when you visit the facility? How does it compare to others? How did the administrator and staff treat you? Remember that you'll be depending on these people to take care of your loved one. If you don't like visiting there, imagine what it would be like living there.

People sometimes over-estimate the importance of an attractive building. While a nursing home should be safe, clean and comfortable, it doesn't do the potential resident any good to choose a "fancy" nursing home if the resident can't afford it, if it can't meet the resident's needs or if it is too far away for family and friends to visit.

Do comparative shopping. Use CANHR's Fact Sheet, [Nursing Home Evaluation Checklist](#) to help you evaluate facilities under consideration.

Arranging Care During Hospitalization

Many people are admitted to nursing homes from hospitals. If your family member or friend is hospitalized, contact the hospital's discharge planning or social work office as soon as possible to request assistance in

arranging nursing home care. Hospitals are required to help patients locate and obtain care and services they will need upon discharge. Some hospitals are more helpful and cooperative than others but all are equally responsible to give you professional, timely assistance.

Hospitals cannot discharge patients to nursing homes without their consent and cannot charge for extra days of care if they have not met their discharge planning responsibilities. See CANHR's Fact Sheet, Challenging Hospital Discharge Decisions, for more information on hospital discharge rights.

More Information

It is a good idea to review CANHR's Fact Sheet on Nursing Home Admission Agreements before admission to a facility. CANHR also publishes several other fact sheets on nursing homes, such as Residents' Rights and Making Care Plans Work, that give important information about your rights and how to get the best possible care.

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Nursing Home Evaluation Checklist

The following checklist will give you, as an observer, a general idea of the quality of care provided in a nursing home. Depending on a resident's needs, preferences and payment source, questions will vary.

Ask to see the entire facility, not just the nicely decorated lobby and one wing or floor. Remember that appearances can be deceptive. Though environment is important, try to get a feel for the care provided and how the residents are treated by staff.

Staff

- Are there adequate staff? What is the staff to resident ratio? Are call bells and resident requests responded to in a timely manner (5 minutes or so)?
- Are the staff courteous to residents? Do they treat residents with dignity and respect? Or is the staff attitude condescending? Are childish or otherwise inappropriate nicknames used when speaking with residents? Do staff talk about residents as if they were not present or as if they were children?
- Does the administrator/manager and director of nurses appear to know the residents?
- Is the administrator friendly and receptive to questions?
- Is privacy respected (e.g., knocking on doors before entering rooms, keeping privacy curtains drawn while care is being given)?
- Do staff wear name-tags?
- Are there therapists on staff or does the facility contract out for therapy?
- Is there a licensed social worker on staff? Full-time?
- Does the facility have permanent full-time nurses and certified nurse assistants (CNA's) or are registry nurses and aides used?
- Are the staff visible and actively assisting residents?
- In addition to English, what languages do the staff speak?
- What is the facility's communication strategy when a resident's first language is not English?
- Does the facility conduct background checks before hiring staff?

Resident Appearance

- Are residents up and dressed for breakfast? Does the staff get them up hours before breakfast (too early) or just before lunch (too late)?
- Are the residents well-groomed (shaved, clothes clean, hair combed, nails trimmed and clean)?
- Do residents appear alert, content and occupied? Or are they lethargic, listless or stuporous?
- Is the administrator friendly and receptive to questions?
- Are residents comfortably positioned in comfortable chairs? Are they restrained in their chairs or beds? Are they in chairs that have a tray or "lap buddy"?

Resident Rooms

- In which area of the facility would the resident's room be located?
- How many residents share a room? Generally, rooms should have no more than four beds, at least three feet apart, with privacy curtains around each bed.
- Does each bedroom have a window?
- Is there a bedside stand, reading light, chest of drawers, and at least one comfortable chair for each resident? Is there adequate storage space and is it separate from other roommates?
- Are the beds easy to reach? Is there room to maneuver a wheelchair or Gerichair easily?
- Are call buttons accessible to residents?
- Is there fresh drinking water at the bedside?
- Are residents allowed and encouraged to bring any of their own belongings or furniture? Have residents personalized their rooms?

Facility Environment

- Is there an obvious odor in the facility? Strong urine and body odors may indicate poor nursing care or poor housekeeping. Heavy "air freshener", deodorants, and other temporary chemical cover-ups may be substitutes for conscientious care and maintenance.
- Is the facility maintained at a comfortable temperature? Do the rooms have heating, air conditioning, and individual thermostats?

- Is the facility clean, well-lit and free of hazards? Do you see soiled linen or is it properly disposed of? Is there adequate linen?
- Is furniture sturdy and comfortable?
- Are floors clean and non-slippery?

Hallways, Stairs and Lounges

- Are halls free of obstacles and debris?
- Are stairways and exits clearly marked?
- Are there handrails in all corridors?
- Are fire extinguishers visible? Is there a disaster plan posted and does the facility have drills?
- How many lounge areas are available for residents and visitors? Are they clean and comfortably furnished? Is there sufficient room for visiting?

Bath and Shower Rooms

- Are bathrooms conveniently located?
- How many residents share a bathroom?
- Do bathrooms have handgrips or rails near all toilet and bathing areas?
- Is there a call button near the toilet?
- Do residents have a choice between a shower or bath, how frequent and during which shift?

Kitchen and Dining Areas

- Is the kitchen clean and well-organized?
- Is the food handled and stored in a safe and sanitary manner?
- Is the dining area pleasant, clean and comfortable?
- How many residents eat in the dining area? Is it large enough to accommodate most of the residents? Are there shifts for meals?
- Do chairs fit under the table so that residents are comfortably close to their food?

Menus and Food

- Try to visit the facility during a meal. Observe the way the food is served, how residents are assisted with eating and what their reaction is to the food. You can probably buy a meal to sample the food.
- A menu for the current and following week should be posted. If a menu is not posted, ask to see one. Is the food listed on the menu actually being served?
- How often are meals repeated? Are alternatives available, as required by law?
- Does the food appear and smell appetizing? Is it nutritious? Are fresh foods used, or is it mostly canned or frozen? Do residents enjoy the food?
- Are dishes and silverware used, or are disposable plates and utensils used?
- Are those residents who need assistance with eating and who are being fed by nurse's aides finishing their meals and eating at their own pace? Are assistive devices available to those who may be able to feed themselves with a little help?
- Are meals served at appropriate temperatures?
- What provisions are made for patients who are unable to eat in the dining room?
- Who plans the meals? Is a professional dietician on staff? How are special dietary needs met?

Activities

- Are activity calendars posted? If not, ask for a description of the activity program. Meet the Activity Director if possible.
- Do the activities cover a broad range of interests?
- Are activities tailored to individual preferences?
- Does the facility have outside areas for resident use? Do staff assist the residents in using these areas?
- What activities are available to residents confined to their rooms?
- Do volunteers visit the facility?
- What arrangements are made for residents to participate in religious services of their choice?
- What is done for holidays and birthdays?
- Is there a resident council? When does it meet and what is its function?

Miscellaneous

- Is there a Family Council? When does it meet and who are the officers?
- How often do residents' physicians visit the facility? It should be at least once every 30 days.
- How long has the facility been operating under the present management? Are there any plans to change in the near future?
- What hospital is used in emergencies?
- What is the billing procedure?
- Who should be contacted when there is a problem?
- How does the facility notify the resident and family members of the time and place of the quarterly care planning meetings?
- Is the Ombudsman Program's phone number posted?
- Are the results from the last inspection by the Department of Public Health posted?
- Ask to review a copy of the admission agreement. Does the facility demand a "responsible party" signature? What is their "informed consent" policy?
- What is included in the basic costs and what is extra?
- If you are looking at an Alzheimer's Unit within a facility, what makes it different from the rest of the facility (especially if it costs more)?
- How is transportation provided for trips to hospitals, medical offices, or community functions? Is there a charge?
- How is personal laundry handled?
- Is there a system to protect wanderers? Is it operational? Ask for a demonstration.

California's Standard Admission Agreement for Nursing Home Residents

CANHR is a private, nonprofit 501(c)(3) organization dedicated to improving the quality of care and the quality of life for long term care consumers in California.

When you are admitted to a nursing home, you will be asked to sign an admission agreement that explains your rights and responsibilities and those of the nursing home. In years past, this involved signing contracts written by nursing homes that often contained deceptive or illegal terms.

California is the first state in the nation to outlaw the use of admission contracts written by nursing homes. By law (SB 1061, 1997), all California nursing homes must now use the Standard Admission Agreement developed by the California Department of Public Health. (California Health and Safety Code §1599.61) After more than a decade of delays, the Standard Admission Agreement took effect on April 6, 2012.

The Standard Admission Agreement's purpose is to give you peace of mind that you are signing a document that protects your rights and does not expose you or your family to unexpected financial liability. It is important, however, for you to read the document carefully and to make sure you fully understand its terms before you sign it.

The Agreement

The California Department of Public Health has posted the [Standard Admission Agreement \(CDPH 327\)](#) and its attachments on its website. The Standard Admission Agreement is available in [English](#), [Chinese](#), [Korean](#), [Spanish](#), [Vietnamese](#) and [Braille](#).

The Standard Admission Agreement consists of the basic Agreement and the following attachments:

- Attachment A – Facility Owner and Licensee Identification
- Attachment B-1 – Supplies and Services Included in the Basic Daily Rate for Private Pay and Privately Insured Residents
- Attachment B-2 – Optional Supplies and Services Not Included in the Basic Daily Rate for Private Pay and Privately Insured Residents
- Attachment C-1 – Supplies and Services Included in the Basic Daily Rate for Medi-Cal Residents
- Attachment C-2 – Supplies and Services Not Included in the Medi-Cal Basic Daily Rate That Medi-Cal Will Pay the Dispensing Provider for Separately
- Attachment C-3 – Optional Supplies and Services Not Covered by Medi-Cal That May Be Purchased by Medi-Cal Residents
- Attachment D-1 – Supplies and Services Covered by the Medicare Program for Medicare Residents
- Attachment D-2 – Optional Supplies and Services Not Covered by Medicare That May Be Purchased by Medicare Residents
- Attachment E – Authorization for Disclosure of Medical Information
- Attachment F – Resident Bill of Rights

Before Signing the Agreement

Before signing the Standard Admission Agreement:

- Read it and its attachments carefully;
- List any questions about your rights and responsibilities;
- Make sure that all your questions are answered to your satisfaction before signing;
- Use the Agreement as an opportunity to clarify expectations and to negotiate care needs and costs.
- Consult an attorney or advocate if you have concerns or questions about the Agreement.

Carefully review the actual written Agreement the nursing home is asking you to sign. Do not rely on the standard version of the Agreement on the Department of Public Health website. Although a nursing home cannot legally alter or amend the Agreement unless it receives written permission from the California Department of Health Public Health (Title 22 California Code of Regulations §73518), it is possible that a nursing home may have altered the Agreement with or without the required permission.

Please inform CANHR if a nursing home asks you to sign an Agreement that has been significantly altered from its standard terms.

Signing the Agreement

The person being admitted to the nursing home is the only person required to sign the Standard Admission Agreement. (California Health & Safety Code §1599.65) Section I (Preamble) of the Agreement states:

If you are able to do so, you are required to sign this Agreement in order to be admitted to this Facility. If you are not able to sign this Agreement, your representative may sign it for you.

Make sure you obtain a copy of the signed Agreement and any other documents presented or signed at admission. Section XII of the Agreement requires the facility to give you a copy of the signed agreement, all attachments, any other documents you sign at admission, and a receipt for any payments you make at admission, upon your request.

Financial Responsibility of Residents' Representatives Who Sign the Agreement

The resident is responsible for paying any nursing home bills under the Agreement, not his or her family or friends. (Title 42 United States Code §1396r(c)(5), Title 42 Code of Federal Regulations §483.12(d)(2), California Welfare & Institutions Code §14110.8)

Signing the Standard Admission Agreement as a resident's representative does not make you responsible for using your own money to pay for care provided by the nursing home. Section II (Identification of Parties to this Agreement) of the Agreement states:

IF OUR FACILITY PARTICIPATES IN THE MEDI-CAL OR MEDICARE PROGRAM, OUR FACILITY DOES NOT REQUIRE THAT YOU HAVE ANYONE GURANTEE PAYMENT FOR YOUR CARE BY SIGNING OR COSIGNING THIS ADMISSION AGREEMENT AS A CONDITION OF ADMISSION.

Additionally, it states:

Signing this Agreement as a Resident's Representative does not, in and of itself, make the Resident's Representative liable for the Resident's debts. However, a Resident's Representative acting as the Resident's financial conservator or otherwise responsible for distribution of the Resident's monies shall provide reimbursements from the Resident's assets to the Facility in compliance with Section V. of the agreement.

The resident's authorized financial representative is responsible to use the resident's funds to pay nursing home fees, such as a share-of-cost set by Medi-Cal for a resident on Medi-Cal. (California Welfare & Institutions Code §14110.8)

Signing Other Documents at Admission

You and your representative cannot be required to sign any other document at the time of admission or as a condition of admission or continued stay in a California nursing home. (Title 22 California Code of Regulations §73518) This right is stated in Section I, the Preamble to the Agreement.

Do not sign any forms or documents that conflict with the Standard Admission Agreement or attempt to restrict your rights. Avoid signing any documents that seek waiver of liability, binding arbitration or general consent to treatment. The Agreement already includes a general consent to treatment and emergency care in Section III so additional forms are not needed for this purpose at admission.

Although you are not required to sign other documents, the nursing home may ask you to do so. It is usually best not to sign other documents at admission. Ask the nursing home to give you copies of any forms to review in advance before making decisions about signing them.

If you have any concerns or doubts about a document you are asked to sign, seek advice from a qualified attorney or advocate before doing so.

Binding Arbitration Agreements

Do not sign a binding arbitration agreement at admission. Nursing homes use arbitration agreements to prevent residents from being able to sue for abuse or neglect.

By signing a binding arbitration agreement, you give up your constitutional right to go to court if a dispute arises in the facility, even if it involves abuse or neglect. There is no right to appeal a decision made through binding arbitration.

Nursing homes cannot require you to sign an arbitration agreement and cannot present an arbitration agreement as part of the Standard Admission Agreement. (California Health & Safety Code §1599.81, Title 22 California Code of Regulations §73518). Any arbitration agreement shall be separate from the Standard Admission Agreement and shall contain the following advisory in large, bold type at the top of the agreement:

Residents shall not be required to sign this arbitration agreement as a condition of admission to this facility, and cannot waive the ability to sue for violation of the Resident Bill of Rights.

Residents and their legal representatives can rescind an arbitration agreement by giving written notice to the facility within 30 days of their signature. (California Code of Civil Procedure §1295)

To learn more about problems with binding arbitration, read [CANHR's fact sheet](#) on this subject.

Advance Directives

At admission, the nursing home should ask you for a copy of your advance directive and, if you don't have one, may suggest you establish one. Although it is a good idea to have an advance directive, nursing homes cannot require you to have or to make one as a condition of admission or continued stay. This issue is addressed in Section III, Consent to Treatment, in the Standard Admission Agreement.

Advance directive is the general term used to describe instructions you give someone about preferences for your future medical treatment. At admission, the nursing home must give you written information about advance directives explaining: (1) your right to direct your own health care decisions; (2) your right to accept or refuse medical treatment; (3) your right under California law to prepare an advance health care directive; and (4) the facility's policies that govern the use of advance directives. (Title 42 United States Code §§1395cc(f), 1396r(c)(2)(E) & 1396a(w), Title 42 Code of Federal Regulations §§489.102, 483.10(b)(8) & 431.20)

There are different types of advance directives. The following types are examples, not a complete list.

An Advance Health Care Directive (AHCD), also known as a Power of Attorney for Health Care, allows you to appoint an agent to make health care decisions for you. Your agent only makes decisions for you if you have lost capacity, unless you state otherwise in the document. You can give an agent limited or broad powers in an AHCD, from the right to access medical records to the power to make anatomical gifts. You may also specify healthcare instructions you want to be followed. All adults should have an AHCD.

A Physician Order for Life-Sustaining Treatment (POLST) is another form of advance health care planning where you or your legally authorized surrogate can express end-of-life care preferences. The form instructs providers about what to do regarding CPR, comfort care measures, artificial nutrition and hydration, and other important treatments. A POLST must be signed by a physician and is thus an actual medical order that nurses and nursing assistants must follow. The document is meant for people who are terminally ill as a way to control their end-of-life care.

In recent years, some nursing homes have told residents and their representatives that a POLST form is required at admission. This is not true. Establishing a POLST is a choice, not a requirement. To learn about the pros and cons of POLST, read [CANHR's report](#) on this subject. To learn more about advance directives, read [CANHR's fact sheet](#).

Participation in Medi-Cal and Medicare

The admission agreement must clearly state whether the nursing home participates in the Medi-Cal and Medicare programs. (California Health & Safety Code §§1599.66 & 1439.8, California Welfare & Institutions Code §14022.3) This information is found in Section V (Financial Arrangements) of the Standard Admission Agreement.

If a nursing home is withdrawing from the Medi-Cal program, it must include this information in Section V (Financial Arrangements) of the Agreement and give the date that it notified the Department of Health Care Services of its intent to withdraw from Medi-Cal. A nursing home that is withdrawing from Medi-Cal is not required to accept Medi-Cal for residents admitted after it notified the State of its intent to withdraw. The Standard Admission Agreement explains that residents admitted on or before the date of the withdrawal notice can use Medi-Cal to pay for their care, even if they become eligible for Medi-Cal after that date. (California Welfare & Institutions Code §14022.4, Title 42 United States Code §1396r(c)(2)(F))

Requirements to Pay Privately

It is illegal for a Medicare or Medi-Cal certified nursing home to require a resident to pay privately for any set period of time. (Title 42 United States Code §§1395i-3(c)(5)(A) & 1396r(c)(5)(A), and Title 42 Code of Federal Regulations §483.12(d)) When a resident qualifies for Medi-Cal or Medicare nursing home coverage, nursing homes certified by these programs must accept their payments. (California Health & Safety Code §1599.69 & 1599.76, California Welfare & Institutions Code §14019.3, and Title 42 Code of Federal Regulations §483.10(b)(10))

Section V of the Agreement on Financial Arrangements includes the following statement:

You should be aware that no facility that participates in the Medi-Cal program may require any resident to remain in private pay status for any period of time before converting to Medi-Cal coverage. Nor, as a condition of admission or continued stay in such a facility, may the facility require oral or written assurance from a resident that he or she is not eligible for, or will not apply for, Medicare or Medi-Cal benefits.

Some nursing homes require applicants to disclose financial information that is used to project how long they can pay privately before qualifying for Medi-Cal. Applicants with more money are usually given preference. Although this practice is of questionable legality, federal and California authorities are doing nothing to stop it.

Notice About Medi-Cal Eligibility

Prior to admission, Medi-Cal certified nursing homes must notify you about Medi-Cal eligibility standards, using a State mandated notice. (California Welfare & Institutions Code §§14006.3 & 14006.4) The legislature required the notice after learning that some nursing homes misinformed applicants and residents about Medi-Cal eligibility.

The notice contains important information, including:

- You do not have to use all your resources to qualify;
- Your home is an exempt resource. Its value does not affect your eligibility, and you have the right to transfer the home;
- Medi-Cal has special rules for married couples that protect resources and income for the spouse who is not in the nursing home.

Deposits

A nursing home cannot require or accept a deposit if Medi-Cal or Medicare is helping to pay for your stay. (California Health & Safety Code §1599.70, California Welfare & Institutions Code §14110.9, Title 42 Code of Federal Regulations §489.22 & 483.12(d)(3))

Nursing homes may require a deposit if you are paying privately for your care. Deposits paid by private paying residents must be returned when Medi-Cal or Medicare start paying for their nursing home care. (California Welfare & Institutions Code §14110.8 & Health & Safety Code §1599.70)

This issue is addressed in Section V(B) of the Agreement on Security Deposits.

Rate Changes

If a nursing home plans to increase its daily rate or service fees, it must give residents 30 days written notice of the changes. (California Health & Safety Code §1288, 1599.67)

Refunds and Charges Following Discharges

You cannot be charged for any days of care after discharge or death and are entitled to a refund of any advance payments made to the nursing home. (California Health & Safety Code § 1599.71) See Section V of the Agreement on Financial Arrangements. The only exception is if you leave the nursing home voluntarily within three days of admission, in which case you may be charged for up to three days at the basic daily rate if Medicare or Medi-Cal are not paying for your nursing home care.

If you are due a refund after your discharge, the nursing home must pay it to you within 14 days of your leaving the facility. See Section V(E) of the Agreement on Payment of Other Refunds to You.

If a resident dies, any advance payments must be returned to the heir, legatee or personal representative of the resident within two weeks after discharge or death. (California Health & Safety Code §1599.71(a) and Title 22 California Code of Regulations §72531)

Discharge Notice

The Admission Agreement shall not require a resident to provide advance notice of when he or she is moving out of a facility. (California Health & Safety Code §1599.71.)

Personal Possessions

At admission, the nursing home must establish a personal property inventory and give you or your representative a copy. (California Health & Safety Code §1289.4) Keep the inventory sheet current and save a copy.

The nursing home is also required to give you a copy of its policies and procedures regarding protection of your personal property and the state laws that require those policies. (California Health & Safety Code §§1289.3, 1289.4, 1289.5 & 1418.7) See Section VIII of the Agreement on Personal Property and Funds.

Confidentiality

You have a right to confidential treatment of your medical and health information. (California Health & Safety Code §1599.73, Title 22 California Code of Regulations §72527(a)(10) &72543(b), Title 42 United States Code §§1395i-3(c)(1)(A)(iv) & 1396r(c)(1)(A)(iv), and Title 42 Code of Federal Regulations §483.10(e)). You may authorize the nursing home to disclose medical information about you to a family member or other person by completing Attachment E to the Standard Admission Agreement, the "Authorization for Disclosure of Medical Information" form.

Your Rights

The Standard Admission Agreement is intended to inform you about your rights as a nursing home resident. Certain rights are discussed within the Agreement, but Attachment F (Bill of Rights) is a more comprehensive description of your rights. It is a verbatim collection of selected federal and state laws and regulations. Attachment F, however, is 39 pages long and not an easy way to learn about your rights.

CANHR's fact sheet on this subject provides a quicker way to learn about your rights.

Admission Agreement Complaints

If your nursing home is not using the Standard Admission Agreement or violates any of your rights, you may file a formal complaint with the California Department of Public Health. For information on filing a complaint, see CANHR's fact sheet, How to File a Nursing Home Complaint.

You can also contact your attorney, local ombudsman program or CANHR to discuss your concerns.

BE SURE TO REQUEST AND KEEP A SIGNED COPY OF THE ADMISSION AGREEMENT!

Restraint-Free Care

CANHR is a private, nonprofit 501(c)(3) organization dedicated to improving the quality of care and the quality of life for long term care consumers in California.

There is a common misconception that restraints help improve the safety of frail elders. The truth, however, is that restraints are dangerous and often cause more risks than benefits. Many studies document the dangers and recommend more dignified methods to improve residents' safety.

Reflecting this understanding, current nursing home laws aim to prevent the unnecessary use of restraints. Except in an emergency, a nursing home cannot use restraints without your consent. You have a right to be free from any restraint imposed for discipline or convenience. A restraint may only be used if your doctor has ordered it to treat your medical symptoms and only if the restraint will help you function at your highest level.

Despite strong California and federal protections against restraint use, far too many California nursing home residents suffer from unlawful restraint. On average, California nursing homes physically restrain about one of every twelve residents, twice the national average. Many more residents are chemically restrained.

What is a Restraint?

There are two types of restraints, physical and chemical.

Physical restraints are items or practices used to restrict a person's movement. They include leg and arm restraints, hand mitts, vests, soft ties, or anything else that prevents you from moving around. The way an item is used determines if it is considered a physical restraint. Trays, tables, bars and belts found on some chairs are considered restraints if they are used to restrict your movement and you cannot easily remove them. Other methods of restraint are moving your wheelchair against a wall so that you cannot move, using a bedrail to prevent you from getting out of bed, or tucking in a bed sheet so tightly that you cannot move.

Chemical restraints are drugs used to control a person's behaviors when other forms of care are more appropriate. Psychoactive drugs, which affect emotions or behavior, are often used for this purpose. These drugs are not considered chemical restraints when used for the proper treatment of mental illness such as depression or schizophrenia. Psychoactive drugs are chemical restraints when they are prescribed to control an individual's behavior without adequate medical justification.

Risks Caused by Restraints

Physical restraints are most often used to prevent someone from falling out of a bed or a chair. Although restraints may prevent some falls and accidents, they cause significant risks. Many residents have been seriously injured while trying to escape restraints or by improperly applied restraints. For example, many people have died from strangulation or been seriously injured when they became trapped or entangled in bedrails.

Other common side effects of physical restraints are incontinence, increased agitation, poor circulation, weak muscles, chronic constipation, pressure sores, depressed appetite, loss of mobility and increased illness. Restraints also diminish independence and social contact, often leading to withdrawal, depression, anxiety and agitation.

Even when used properly, most psychoactive drugs have numerous potential side effects. The dangers multiply quickly when these drugs are used as chemical restraints. Although the risks vary by the drug, some common side effects are agitation, sedation, disordered thinking, decreased appetite, constipation, low blood pressure and muscle disorders. One problem tends to lead to another. For example, residents who are over-sedated face most of the side effects caused by physical restraints.

Alternatives to Restraints

A nursing home has many options to help improve safety, including the following examples:

Methods to Improve Your Safety

- Using pads and pillows to support you in a comfortable and safe position;
- Adapting and tailoring chairs you use to ensure comfort and safety;
- If you use a wheelchair, ensuring that it is the correct size, comfortable and in good condition;
- Responding quickly to your physical needs such as hunger, thirst, sleeping, toileting and exercise;
- Tailoring care and caregiver assignments to your preferences;
- Providing therapy and restorative care to improve your abilities to stand, transfer and walk safely;
- Using devices that monitor your efforts to rise from your bed or chair;
- Helping you to get in and out of bed as often as needed and desired.

Methods to Improve Safety of All Residents

- Increasing staffing levels to improve supervision;
- Adapting the environment through good lighting, safe beds, alarms, and other features;
- Removing accident hazards, such as over-bed tables with wheels and cluttered dining rooms;
- Providing safe areas for residents to walk;
- Training staff on methods to calm residents who are anxious or agitated;
- Arranging mental health treatment for residents who need it.

A variety of strategies may be needed to improve your care and avoid use of restraints. The nursing home must carefully assess the symptoms that cause concern for your health and safety and consult with you and your representative about treatment options. Every appropriate option should be tried before restraints are considered.

Nursing homes must establish an individualized care plan for each resident that spells out care needs and how they will be met. For more information on care plans and your right to help shape yours, see CANHR's Fact Sheet, [Making Care Plans Work](#).

Right to Accept or Refuse Restraints

You and your legal representative have the right to accept or refuse any type of care or treatment, including restraints. Before restraints can be used, your doctor must seek your consent and disclose, at a minimum, the following information: (1) the reason for the restraint and why it is recommended; (2) the medical condition for which the restraint is needed; (3) the type of restraint that is recommended; (4) how long and how often the restraint will be used; (5) how your medical condition will be affected; (6) the nature, degree, duration and probability of known side effects; (7) the reasonable alternative treatments; and (8) your right to accept or refuse care and treatment.

You do not have to accept a doctor's recommendation to use restraints. Except in an emergency, the nursing home cannot use restraints without consent from you or your representative. You can request the doctor and nursing home to use alternative methods of treatment. Before making a decision, ask your doctor and the nursing home these questions:

- What symptom prompted the need for a restraint?
- Has the cause of the symptom been identified?
- What efforts have been made to treat or eliminate the cause?
- Can the medical problem be treated without using a restraint?
- What alternatives have been considered and tried? Are other options still available?
- What are the risks and side-effects of using the restraint?
- What are the nursing home's policies on using restraints?

If the resident is capable of granting or withholding consent, only the resident may do so. If the resident lacks capacity to make a decision, then the resident's representative may grant or refuse consent. A resident and legal representative can withdraw consent to use a restraint at any time. A nursing home cannot use a restraint when it is not medically necessary even if a resident or legal representative requests it to do so.

Under California law, persons who may act as your representative include a conservator, an agent designated under a valid power of attorney for health care and your next of kin.

Protecting Your Rights

If your rights are being violated, contact your local ombudsman office or CANHR for information on actions you can take. You have the right to file a complaint with the California Department of Public Health, the agency that licenses nursing homes. For information on how to file a complaint, see CANHR's Fact Sheet [How to File a Complaint Against a Nursing Home](#).

The most pertinent laws and regulations are found in:

United States Code: 42 USC §1396r(c)(1)(A)(ii)

Code of Federal Regulations: 42 CFR §483.13(a), 42 CFR §483.25(l)

California Code of Regulations: Title 22, Division 5, §72527(a)(5)&(23), §72528(b)&(c)

Transfer & Discharge Rights

CANHR is a private, nonprofit 501(c)(3) organization dedicated to improving the quality of care and the quality of life for long term care consumers in California.

Residents have very specific rights regarding the facility's ability to transfer or discharge a resident out of a skilled nursing facility.

A resident may be transferred or discharged only if:

- The resident's health has improved sufficiently so the resident no longer needs the services provided by the facility (42 C.F.R. §483.12(a)(2)(ii));
- It is necessary for the resident's welfare and the resident's needs cannot be met in the facility (42 C.F.R. §483.12(a)(2)(i));
- The health of individuals would otherwise be endangered (42 C.F.R. §483.12(a)(2)(iv));
- The safety of individuals is endangered (42 C.F.R. §483.12(a)(2)(iii));
- The resident has failed, after reasonable and appropriate notice, to pay (42 C.F.R. §483.12(a)(2)(v));
- The facility ceases to operate (42 C.F.R. §483.12(a)(2)(vi)).

Documentation

The facility must have adequate documentation in the resident's records to substantiate a transfer or discharge (42 C.F.R. §483.12(a)(3)). The records must document accurate assessments and attempts through care planning to address the resident's needs, through multi-disciplinary interventions, attention to the resident's customary routines, and accommodation of individual needs. Under reasons 1 and 2 listed above, the resident's physician must provide documentation. Under reason 3, any physician can provide documentation. Under reason 5, for a resident who becomes eligible for Medi-Cal after admission, only allowable charges may be imposed by the facility. Conversion from private pay to Medi-Cal is not grounds for eviction (Cal. Welfare & Institutions Code §14124.7).

Written Notice

Before transferring or discharging a resident, the facility must provide written notice to the resident, and if known, to a family member or legal representative. Except when specified below, the notice must be given at least 30 days before the discharge date (see the next section). The notice must contain all the following information. If any of the following items are missing, the notice is not valid:

- the reason for the transfer or discharge and the effective date (42 C.F.R. §483.12 (a)(6)(i - ii));
- the location to which the resident will be transferred (42 C.F.R. §483.12 (a)(6)(iii));
- a statement that the resident has the right to appeal to the state (42 C.F.R. §483.12 (a)(6)(iv));
- the name, address and phone number of the Transfer and Discharge Appeal Unit operated by the Office of Administrative Hearings and Appeals within the California Department of Health Care Services (California Department of Public Health All Facility Letter (AFL) 10-20);

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- the name, address and phone number of the Long-Term Care Ombudsman (42 C.F.R. §483.12 (a)(6)(v));
 - a statement that the resident may represent him/herself or use legal counsel, a relative, friend or other spokesperson (PPM §618.03);
 - a statement that the resident or resident's representative must be allowed to review, prior to and during the appeal hearing, the resident's medical records and the documents to be used by the state (PPM §618.03);
 - a statement that the resident may bring witnesses to the hearing (PPM §618.03);
 - a statement that the resident should file the appeal within 10 days so as not to jeopardize the ability of the state to make a ruling prior to the discharge date (PPM §618.03);
 - a statement that the facility may permit the resident to remain even if the state has not made a decision within 30 days (PPM §618.03);
 - a statement that if the state upholds the discharge notice, that the resident should be prepared to be transferred (PPM §618.03).

Exceptions to 30-Day Notice

As mentioned above, there are a few exceptions to the 30-day notice requirement. Generally these exceptions are for more serious or immediate situations. Under California law, "reasonable notice" must be given in all cases of transfer or discharge, unless there is an emergency (Cal. Health & Safety Code §1599.78). Under federal law, notice may be made "as soon as practicable" when: the health or safety of individuals in the facility would be endangered; the resident's urgent medical needs require a more immediate transfer; the resident's health has improved sufficiently and a more immediate transfer is appropriate; the resident has resided in the facility less than 30 days (42 C.F.R. §483.12(a)(5)). *Even if an exception to the 30-day notice requirement is satisfied, the facility must nevertheless provide written notice in advance of a proposed transfer or discharge.*

Converting to Medi-Cal

Facilities are prohibited from transferring or discharging residents who have made a timely application for Medi-Cal and for whom an eligibility determination has not been made. In addition, facilities are prohibited from transferring the resident to a different room because of that payment change, except that the resident may be transferred from a private room to a semi-private room (Cal. Welfare & Institutions Code §14124.7).

Readmission to a Nursing Home After a Hospital Stay

Nursing home residents have the right to be readmitted after a hospital stay. Whenever a resident is transferred to a hospital, the nursing home must allow the resident or family member to hold the resident's bed for up to seven days (22 Cal. Code of Regulations §72520). This is called a bed hold. If the resident is on Medi-Cal, the Medi-Cal program will pay for the bed hold for up to seven days (22 Cal. Code of Regulations §51535.1).

Nursing homes must offer a written bed-hold notice to the resident and a family member when a resident is transferred to the hospital (22 Cal. Code of Regulations §72520(b) & 42 C.F.R. §483.12(b)(2)). If the nursing home doesn't comply, the nursing home must offer its next available bed at the conclusion of the hospital stay (22 Cal. Code of Regulations §72520(c)).

Furthermore, any resident on Medi-Cal has a right to be readmitted to a nursing home even if the resident's hospital stay exceeds seven days. If the resident still needs nursing home care, the nursing home must readmit him or her to the first available bed in a semi-private room (42 C.F.R. §483.12(b)(3)).

The facility's refusal to honor a bed hold or readmit a resident following a hospital stay will be treated as an involuntary transfer, allowing the resident the right to appeal the transfer (Cal. Health & Safety Code §1599.1(h)). **To request an appeal, call the Transfer/Discharge and Refusal to Readmit Unit of the Department of Health Care Services at (916) 445-9775 or (916) 322-5603 and ask for a readmission appeal.** If the resident is Medi-Cal eligible or has another source of payment, he/she can remain in the hospital until the final determination of the hearing officer. If the resident is not on Medi-Cal or has no other source of payment, the hearing and final determination must be made within 48 hours (Cal. Health & Safety Code §1599.1(h)). See the "Appealing a Transfer or Discharge" section below for more information regarding appeals.

Transfer Trauma

The facility must also provide sufficient preparation and orientation to residents to ensure safe and orderly transfer or discharge from the facility (42 C.F.R. §483.12 (a)(7)). Staff should take steps to minimize unnecessary and avoidable anxiety or depression that often accompanies a transfer. This phenomenon is known as "transfer trauma", and it occurs when residents have little choice or control over their discharge.

Resident Dumping

Facilities often try to "dump" residents they view as undesirable. However, no resident may be transferred or discharged unless all of the procedural requirements previously discussed are satisfied. Nursing homes are bound by law to provide services to allow each resident to attain or maintain his/her highest practicable physical, mental and psychosocial well being (42 C.F.R. §483.25). Facilities that attempt to dump residents typically have failed to provide such services.

Admission Contracts

Some nursing home admission agreements include promises about eviction procedures in addition to what the law requires. These promises are enforceable.

Retaliation

Facilities also attempt to evict residents when a family member has filed a complaint with the state. State law forbids a nursing home from evicting a resident because someone has filed a complaint on the resident's behalf. Any attempt to do so within 180 days of the complaint will be presumed as retaliation or discrimination (California Health & Safety Code § 1432).

Facility Closures

If a facility is closing, it must provide the residents with a minimum of 30 days advance written notice. In addition, the facility must make significant efforts to minimize transfer trauma such as identifying residents' relocation needs and suggesting alternative placements (Cal. Health & Safety Code §1336.2). If 10 or more residents are going to be discharged as a result of the closure, the facility must develop a relocation plan and obtain state approval.

Appealing a Transfer or Discharge

A resident has the right to appeal the nursing home's attempted transfer or discharge, and have a hearing and decision issued by the California Department of Health Care Services. It is very important that the resident file an appeal and request for hearing within 10 days of the date of the transfer/discharge notice. **To request an appeal, call the Transfer/Discharge and Refusal to Readmit Unit of the Department of Health Care Services at (916) 445-9775 or (916) 322-5603.**

A hearing officer who works for the Department of Health Care Services will conduct the hearing and issue a written decision. The hearings are usually held at the nursing home where the resident resides.

Here are a few basic steps to follow if a nursing home attempts an eviction:

- **Has the resident received anything in writing about the proposed transfer/discharge?**
 - If not, the nursing home cannot evict the resident. (see above, "Exceptions to 30-day Notice.")
 - If the resident has received written notice, check that it contains all of the information listed above under "Written Notice." If it does not, then the notice is not valid, and the nursing home cannot evict the resident until it gives a complete, proper notice. Has the nursing home given less than 30 days notice? If so, check above under "Exceptions to 30-Day Notice" to see if the nursing home is allowed to do so.
 - Is the reason given for transferring the resident one of the 6 valid reasons listed at the beginning of page one of this fact sheet? If not, the attempted transfer is not legal.
- **Has the resident's discharge been properly planned?** A nursing home is not allowed to simply evict a resident, but rather it must provide planning, in advance, to help the resident get oriented to the new place he or she will be going. If no discharge planning has been done, the proposed eviction may be challenged on that basis.
- **File an appeal and a request for hearing within 10 days of receipt of a written notice of transfer or discharge.**
- **File a complaint with the California Department of Public Health.** In addition to filing an appeal, you may file a complaint with the Department of Public Health (DPH), the California agency charged with licensing and inspecting nursing homes. The DPH will make its own findings on the nursing home's compliance with transfer and discharge requirements. To file a complaint with DPH, contact the district office of the Licensing and Certification Division in your area. Information on filing a complaint and contact information for the district offices is available at: http://canhr.org/factsheets/nh_fs/html/fs_NH_complaint.htm#licensing.
- **Contact the Ombudsman.** The Long-Term Care Ombudsman Program helps residents resolve conflicts with nursing homes. Getting the Ombudsman involved can sometimes help stop an improper eviction. Call the statewide Elder Service Locator number at 1-800-510-2020 for your local ombudsman office.
- **Contact the nursing home.** Talk to the Administrator of the nursing home and tell him or her the reasons that the proposed transfer or discharge is not proper (e.g. the resident has not been given written notice, the reason given for the transfer is not one of the allowable 6 reasons, no discharge planning has been done, etc.). After talking to the Administrator, always document the conversation in writing, by sending a letter to the nursing home outlining what was discussed, and reiterating that the proposed eviction is improper. Always send such a letter by certified mail.

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Theft and Loss

Anyone who has been a victim of theft knows how violating it feels. For a nursing home resident, that loss is magnified, as personal possessions are often the only symbol of independence remaining. Despite state and federal laws mandating protections for residents' personal property, theft and loss continues to be one of the most prevalent (and unreported) problems in California nursing homes. Problems such as missing clothing, rings pulled off residents' fingers, stolen radios, lost dentures, eyeglasses and hearing aids are still too common. Such losses not only undermine the psychological well-being of residents, but in some cases, such as lost dentures, also jeopardize a resident's life.

So few official complaints of theft and loss are filed in relation to the number of actual incidents that it appears theft & loss is an "accepted" consequence of one's stay in a nursing home. *BUT, it does not have to be!*

Theft & loss *can* be reduced by understanding the facility's responsibility and by using the protections and remedies afforded under the law. Facilities which fail to make reasonable efforts to safeguard resident property must reimburse a resident or replace stolen or lost property at its then current value.

Responsibilities of Nursing Homes

- Establish and post policies regarding theft and investigation procedures (H & S code* §1289.4 (a))
- Orient employees about theft and loss policies within 90 days of employment (H & S code* §1289.4 (b))
- Document at least twice a year efforts to control theft and loss (H & S code* §1289.4 (g))
- Establish theft and loss record for items worth \$25 or more (H & S code* §1289.4 (c))
- Give a written report to police within 36 hours of suspected theft of an item worth \$100 or more (H & S code* §1289.4 (i))
- Establish and maintain written inventory of each resident's property, add to inventory upon request and provide copy to resident or resident's representative (H & S code* §1289.4 (d))
- Mark all residents' property, including engraving of dentures and tagging prosthetic devices (H & S code* §1289.4 (h))
- California Health and Safety code.

What You Can Do About Theft & Loss

- Make sure old and new items are recorded in the inventory; keep a copy of the inventory and of any additions;
- Take pictures of valuables;
- Keep copies of all receipts for any items taken to the resident;
- Buy a lock for the resident's drawers and/or cabinets - only the resident or resident's representative and the administrator can have a key;
- Report any loss or suspected theft immediately to the administrator, local ombudsman and licensing department;
- Write a demand letter to the nursing home for replacement or reimbursement;
- Sue in Small Claims Court for replacement value of article - up to \$5,000. Visit www.canhr.org to order the *Small Claims Guide for Nursing Home Residents*.

How To File a Nursing Home Complaint

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Stage 1 - Filing the Complaint

Who Can File a Complaint?

Any person (not just residents or their family members) or organization can file a complaint about a nursing home with the Licensing and Certification Division of the California Department of Public Health (DPH). DPH is the state agency that enforces nursing home laws and regulations through regular inspections and complaint investigations.

What Can I File a Complaint About?

You can file a complaint about abuse, neglect and any other matter protected by law. For example, you can file a complaint about violations of your rights, poor care, lack of staffing, unsafe conditions, mistreatment, improper charges, transfer and discharge concerns, and a failure to readmit you after a hospital stay.

When Should I File a Complaint?

File a complaint with DPH when problems are serious and/or other steps to resolve your concerns have not been effective. Although you are not required to try other dispute remedies first, it is usually best to do so.

Start by communicating with staff of the facility or a family council if one exists. Another option is contacting the long term care ombudsman office in your county for assistance (<http://www.aging.ca.gov/Programs/LTCOP/Contacts/>). The ombudsman program helps residents resolve concerns about their care and rights. It can try to resolve the complaint with the nursing home, express concerns with outside officials and help you file a formal complaint with DPH. The ombudsman does not have any powers or direct authority over the nursing home, however.

If your concerns are not resolved, file a complaint with DPH.

Where Do I File a Complaint?

See the list of DPH Licensing and Certification district offices below to find the district office for your area.

How Do I File a Complaint?

Complaints may be made orally or in writing. If you phone in a complaint, follow up with a written complaint to ensure a paper trail. Attached is a form you may use to file a complaint.

What Information Should I Include in My Complaint?

Taking notes or keeping a written log will enable you to retrieve specifics later. When writing a complaint, be brief but complete. No investigator wants to read a long letter to figure out what's going on. Stick with the facts ("the nurse hit my mother"), and avoid stating generalities ("the facility is guilty of elder abuse").

CANHR

650 HARRISON STREET, 2ND FLOOR • SAN FRANCISCO, CA 94107

Your complaint should include:

- Name and address of the facility
- Your name, address, phone number, and relation to the resident
- Name of the resident on whose behalf the complaint is made
- Date(s) and time(s) of incidents
- Specific complaints
- Names of witnesses (including other health care providers, such as hospital personnel)
- Names of staff, if relevant to the complaint
- Records that should be examined

Stage 2 - Notifying Other Authorities of Your Complaint

Should I Notify Other Agencies or People About My Complaint?

Yes, other organizations may have authority to investigate your complaint or be able to give you advocacy support or information. Also, DPH may give your complaint better attention if it knows you have alerted other authorities. Send a copy of your complaint to CANHR, the local ombudsman office, and to:

- Your California Assembly Member and Senator: They make laws governing nursing homes and DPH. If DPH does not respond properly to your complaint, tell your legislators about your experience and urge them to take action. You can identify the Assembly Member and Senator for your district at: www.leginfo.ca.gov/yourleg.html
- The Bureau of Medi-Cal Fraud & Elder Abuse (BMFEA): Send BMFEA a copy of your complaint if it involves serious neglect, abuse or Medi-Cal fraud. The BMFEA, a division of the California Attorney General's office, investigates and prosecutes those who abuse and neglect nursing home residents. There are three ways to file your complaint: (1) Call it at 800-722-0432; (2) File your complaint on-line at www.ag.ca.gov/bmfea; or (3) Mail a copy of your complaint to the California Department of Justice, Office of the Attorney General, Bureau of Medi-Cal Fraud and Elder Abuse, P.O. Box 944255, Sacramento, CA, 94244-2550.

Stage 3 - Investigation

I've Made a Complaint - What Happens Next?

Under California law, DPH must begin an onsite investigation of your complaint within ten (10) working days of receipt. If the complaint involves a threat of imminent danger of death or serious bodily harm, DPH must investigate onsite within 24 hours of receipt of the complaint.

As a result of a CANHR lawsuit, DPH is under court order to comply with the investigation timelines. CANHR is carefully monitoring its compliance with the court order. Please notify us if your complaint is not investigated within the above timelines.

What Are My Rights as a Complainant?

- You must be notified of the name of the assigned investigator within two working days of your complaint.
- You have the right to be free from retaliation for a complaint. California law prohibits a facility from discriminating or retaliating against a resident or employee who cooperates in an investigation. Any type of discriminatory treatment within 180 days after a complaint is

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- filed is presumed to be retaliatory and is punishable by a civil fine of up to \$10,000.
 - You have the right to remain anonymous. California law requires that DPH keep your identity (and that of any other person named in the complaint) anonymous to the facility. In your complaint, you can also specifically request to remain anonymous. Please note that anonymity can sometimes make it difficult to substantiate a complaint.
 - You have the right to accompany the investigator to the facility. If you wish to do so, include this request in your complaint. DPH should give you up to one-half working day notice of their scheduled, unannounced visit to the facility. Requests to accompany the investigator may not be granted if DPH determines that doing so would violate residents' privacy.
 - You have the right to a response. Within 10 working days of the completion of its investigation, DPH must notify you in writing of its findings.

Stage 4 - The Appeals Process

What If I'm Dissatisfied with DPH's Findings?

If you are dissatisfied with DPH's findings, you have the right to an informal conference. To request the informal conference, write to the DPH district office manager within 5 business days of receipt of the findings. The conference should be scheduled within 30 days of your appeal; you will meet with the DPH district manager (or designee) and possibly the nursing home administrator. Within 10 working days after the informal conference, DPH should notify both you and the facility of its determinations.

What If I'm Dissatisfied with the Results of the Informal Conference?

If you are dissatisfied with the results of the informal conference, you may appeal to the Deputy Director at: California Department of Public Health, Center for Healthcare Quality, P.O. Box 997377, Sacramento, CA 95899-7377. To file this appeal, you have 15 days from receipt of the findings of the informal conference. A representative from the Complainant Appeals Unit will review the findings from the initial investigation and the informal conference. You have the right to request an interview with this representative. Based on the Appeals Unit review, the Deputy Director must make a final determination and notify you and the facility within 30 days. No further appeals are available through DPH.

Despite your legal right to appeal, DPH often ignores complainant appeals. If it does not respond to your appeal in a timely manner, call CANHR for advice.

Stage 5 - Ensuring Proper Investigation

Help! DPH Hasn't Gotten Back to Me in a While - What Do I Do?

If DPH does not keep you notified as detailed above, contact it to check on the status of your complaint. Know your complaint number, as well as the name and direct phone number of the investigator. Keep a timeline of all correspondence and communications with DPH.

If the assigned investigator is not responsive, work the DPH chain of command. Contact the investigator's supervisor, then the district manager if necessary. Advise the legislators for your district and the ombudsman office if they do not take appropriate action to address your concerns.

Call CANHR at 800-474-1116 to discuss additional advocacy steps if your complaint is not addressed to your satisfaction.

You can find your complaint and appeal rights in the California Health & Safety Code, Sections 1419 and 1420. The California Codes are available online at: www.leginfo.ca.gov/calaw.html

District Licensing and Certification Offices

(find the county where the nursing home is and send the complaint to the address for the associated district)

District Numbers, By County

Alameda 01	Kings 05	Placer..... 10	Sierra 03
Alpine 10	Lake 07	Plumas..... 03	Siskiyou 03
Amador..... 10	Lassen 03	Riverside..... 09	Solano..... 07
Butte 03	Los Angeles..... 06	Sacramento..... 10	Sonoma..... 07
Calaveras 10	Madera 05	San Benito 14	Stanislaus..... 10
Colusa..... 03	Marin 07	San Bernardino..... 11	Sutter 03
Contra Costa 01	Mariposa 05	San Diego 12/13	Tehama..... 03
Del Norte 07	Mendocino 07	San Francisco 04	Trinity..... 03
El Dorado 10	Merced 05	San Joaquin..... 10	Tulare 02
Fresno..... 05	Modoc 03	San Luis Obispo 15	Tuolumne..... 10
Glenn 03	Mono..... 11	San Mateo 04	Ventura..... 15
Humboldt..... 07	Monterey..... 14	No. Santa Clara..... 04	Yolo..... 10
Imperial 12	Napa..... 07	So. Santa Clara..... 14	Yuba..... 03
Inyo..... 11	Nevada 03	Santa Cruz..... 14	
Kern 02	Orange..... 08	Shasta..... 03	

District Offices, By District Number

01 East Bay District Office

850 Marina Bay Parkway, Bldg. P, 1st Floor
 Richmond, CA 94804-6403
 (510) 620-3900 / (866) 247-9100
 (800) 554-0352

02 Bakersfield Office

4540 California Avenue, Suite 200
 Bakersfield, CA 93309
 (661) 336-0543 / (866) 222-1903
 (661) 336-0529 Fax

03 Chico Office

126 Mission Ranch Blvd., Chico, CA 95926
 (530) 895-6711 / (800) 554-0350

04 San Francisco Office

150 North Hill Drive Suite 22, Brisbane, CA 94005
 (415) 330-6353 / (800) 554-0353

05 Fresno Office

285 W. Bullard, Suite #101, Fresno, CA 93704
 (559) 437-1500 / (800) 554-0349

06 Los Angeles Office

3400 Aerojet Ave., Suite 323
 El Monte, CA 91731
 (626) 569-3724

07 Santa Rosa Redwood Coast District Office

2170 Northpoint Parkway, Santa Rosa, CA 95407
 (707) 576-6775 / (866) 784-0703

08 Orange County Office

681 S. Parker Street, Ste 200, Orange, CA 92868
 (714) 567-2906 / (800) 228-5234

09 Riverside Office

625 East Carnegie Dr., Ste. 280
 San Bernardino, CA 92408
 (909) 388-7170 / (888) 354-9203

10 Sacramento Office

3901 Lennane Dr., Ste. 210, Sacramento, CA 95834
 (916) 263-5800 / (800) 554-0354

11 San Bernardino Office

464 West Fourth St., Ste. 529, San Bernardino, CA, 92401
 (909) 383-4777 / (800) 344-2896

12 No. San Diego Office

7575 Metropolitan Dr., Ste 104, San Diego, CA 92108
 (619) 278-3700 / (800) 824-0613

13 So. San Diego Office

7575 Metropolitan Dr., Ste. 211, San Diego, CA 92108
 (619) 688-6190 / (866) 706-0759

14 San Jose Office

100 Paseo de San Antonio, Ste. 235, San Jose, CA 95113
 (408) 277-1784 / (800) 554-0348

15 Ventura Office

1889 N. Rice Avenue, Ste. 200, Oxnard, CA 93030
 (805) 604-2926 / (800) 547-8267

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Overview of Medi-Cal for Long Term Care

A. Medi-Cal vs. Medicare

1. Medicare

Medicare is a federal insurance program paid out of Social Security deductions. All persons over 65 or older who have made Social Security contributions are entitled to the benefits, as well as persons under 65 with disabilities who have been eligible for Social Security disability benefits for at least two years, and persons of any age with end-stage renal disease.

Medicare has several parts including Hospital Insurance (Part A) and Medical Insurance (Part B). Those persons eligible for Social Security or Railroad Retirement benefits as workers, dependents or survivors, are eligible for Part A, Hospital Insurance, when they turn 65. If a person has not worked long enough to be covered for benefits, s/he may enroll in Part A and pay a monthly premium. If Medicare Hospital Insurance is purchased, that person must also enroll in Part B, Medical Insurance.

Participants in the Medicare program are liable for co-payments and deductibles as well as for monthly payments for Part B coverage. Medicare is not based on financial need. Anyone who meets the age, disability and/or coverage requirements is eligible.

Medicare does not pay for all medical expenses, and usually must be supplemented with private insurance ("medigap") or consumers can enroll in an HMO plan that contracts with Medicare. After 3 days of prior hospitalization, Medicare will pay up to 100% for the first 20 days of skilled nursing care. For the 21-100 days, the patient will pay a co-payment. The premiums and copayments are increased every year. There will be no Medicare coverage for nursing home care beyond 100 days in any single benefit period.

It should be noted that Medicare only pays for "skilled nursing care," does not pay for "custodial care" and the average stay in a nursing home under Medicare is usually less than 24 days. Thus, few can look to Medicare to pay for any substantial nursing home costs.

2. Medi-Cal

Medi-Cal is a combined federal and California State program designed to help pay for medical care for public assistance recipients and other low-income persons. Although Medi-Cal recipients may receive Medicare, the Medi-Cal program is not related to the Medicare program. Medi-Cal is a need-based program and is funded jointly with state and federal Medicaid funds.

B. Medi-Cal Eligibility

SSI and other categorically-related recipients are automatically eligible. Others, whose income would make them ineligible for public benefits, may also qualify as "medically needy" if their income and resources are within the Medi-Cal limits, (current resource limit is \$2,000 for a single individual). This includes:

- Low-income persons who are 65 or over, blind or disabled may qualify for the Aged and Disabled Federal Poverty Level Program
- Low-income persons with dependent children
- Children under 21
- Pregnant women
- Medically indigent adults in skilled nursing or intermediate care or those who qualify for Medi-Cal funded home and community based waiver programs.

C. Share of Cost

The State sets a "maintenance need standard". Since January 1, 1990 the maintenance need standard for a single elderly/disabled person in the community has been \$600 monthly; the Long Term Care maintenance need level (i.e., personal needs allowance when someone is in a nursing home) remains at \$35 monthly for each person.

Individuals whose net monthly income is higher than the state payment rate may qualify for the program if they pay or agree to pay a portion of their income on monthly medical costs. This is called the share-of cost. Individuals eligible with a share of cost must pay or take responsibility for a portion of their medical bills each month before they receive coverage. Medi-Cal then pays the remainder, provided the Medi-Cal program covers the services. This works much like an insurance deductible. The amount of the share of cost is equal to the difference between the "maintenance need standard" and the individual's net non-exempt monthly income.

Important: All Medi-Cal beneficiaries who have a Medi-Cal share-of-cost of more than \$500 will no longer have their Medicare Part B premium covered by Medi-Cal, it will automatically be deducted from the beneficiary's Social Security check. This does not apply to Medi-Cal eligible nursing home residents, as their Part B premium will continue to be covered by Medi-Cal.

Example #1 Community Based Medi-Cal

Seth is an aged (65) person who lives alone at home and receives \$1,200/month in pension and Social Security benefits. His resources meet the standard set by the state, i.e., \$2,000 or less in liquid assets, but his income is too high.

\$ 1,200	gross unearned income
<u> -20</u>	any income deduction
1,180	net non-exempt income
<u> -600</u>	Maintenance Need Level for 1 single person
\$ 580	Seth's share of cost

Note: If Seth's net non exempt income were \$1,161 or less, he would be eligible for Medi-Cal at no share of cost under the Aged and Disabled Program (visit: http://www.canhr.org/factsheets/medi-cal/fs/html/fs_ADFPLP.htm).

Example #2: Medi-Cal In a Nursing Home

Seth enters a skilled nursing facility. His income is still \$1,200/month.

\$ 1,200	Gross unearned income
<u> -35</u>	Maintenance Need for Long Term Care person
\$ 1,165	Seth's share of cost to be paid each month to the nursing home or for medical costs not covered by Medi-Cal.

* The remaining \$35 is Seth's Personal Needs Allowance.

Other Deductions from the Share of Cost:

In addition to the "any income deduction" and the monthly maintenance needs allowance, any monthly medical premiums can also be deducted before the share of cost is determined such as the your Medicare Part B premium. Other deductions can also be made, depending on the circumstances.

For example, under a legal settlement, *Hunt v. Kizer*, recipients may use old, unpaid medical bills for which the beneficiary is still legally responsible to reduce the monthly Medi-Cal share of cost. Some original documentation showing the billing statement is an outstanding balance should be provided to the County eligibility worker. The Share of Cost will be adjusted to reflect the cost of the outstanding balance, which could, for example, mean no share of cost until the old, unpaid bills are paid off. This is not automatic and should be discussed with the eligibility worker upon application for Medi-Cal.

Under the Johnson v. Rank settlement, recipients may use their share of cost to pay for medically necessary supplies, equipment or services not covered under the Medi-Cal program. A current physician's prescription is necessary and must be put in the recipient's record at the facility. This prescription must be a part of the physician's plan of care. After a copy of the prescription and the bill is presented to the facility, the facility will deduct the cost from that month's share of cost and bill the resident for the remaining share of cost.

D. What Does Medi-Cal Cover?

Medi-Cal pays for health care services which meet the definition of "medically necessary." Services include: some prescriptions (although the Medicare Part D program now covers most prescriptions), physician visits, adult day health service, some dental care, ambulance services, some home health, X-ray and laboratory costs, orthopedic devices, eyeglasses, hearing aids, some medical equipment, etc.

All covered services, or the remaining costs over the share of cost of nursing home care, will be covered if the individual meets income/resource requirements. Some services such as home health care, durable medical equipment, and some drugs require prior authorization.

Nursing home care is covered if there is prior authorization from the physician/health care provider. Residents are admitted on a doctor's order and their stay must be "medically necessary". Residents are allowed to keep \$35 of their income as a personal needs allowance. Residents with no income may apply for the Supplemental Security Income/State Supplemental Program (SSI/ SSP), and, if eligible, they will receive a payment of \$50 as a personal needs allowance.

If the individual qualifies for Medi-Cal, s/he does not need private "medigap" or HMO insurance to pay for costs, though if such insurance is carried, the premiums are deducted from income when computing the share of cost, and therefore costs the beneficiary nothing. **If the HMO coverage includes drug benefits, maintaining the HMO coverage may become more important, as the beneficiary will continue to receive drug benefits from the HMO, which may be more comprehensive than the Medicare Part D coverage.**

E. Resource Limitations (Property/Assets)

To qualify for Medi-Cal the recipient must demonstrate that s/he has limited resources available. Since January 1, 1989, the property limit for one person has been set at \$2,000.

Medi-Cal classifies property as "exempt" and "non-exempt." Exempt property is not counted in determining eligibility; non-exempt property is counted. If the applicant has more than \$2,000 in non-exempt property, he/she will not be eligible, unless the property is spent down for adequate consideration before the end of the application month.

The following property is generally exempt and, therefore, not counted in determining eligibility:

- **The Home:** totally excluded, if it is the principal residence. Includes mobile home, houseboat, or an entire multi-unit dwelling as long as any portion serves as the principal residence of the applicant, and buildings surrounding, contiguous to, or appertaining to the residence. The property remains exempt if a person in a nursing home or the person's representative expresses an intent to return home on the Medi-Cal Application and Statement of Facts, or if an "exempt" individual resides in the home, such as a spouse, a minor, blind or disabled child (of any age) or a sibling or son or daughter who has lived in the home continuously for at least one year before the applicant entered a nursing home. Note that when the home is exempt, it can be transferred without penalty and without affecting the Medi-Cal eligibility.
- **Other Real Property:** can be exempt if the net market value of the property (assessed value or fair market value, whichever is less – minus any encumbrances such as mortgages, loans, etc.) is \$6,000 or less and the beneficiary is "utilizing" the property, i.e., receiving yearly income of at least 6% of the net market value. Property used as a business can also be exempt if it meets the standards under the program, i.e., it is actually used as a business, reported to the IRS as such, etc. – see below for details on other real property and business property.

- **Household Goods and Personal Effects:** totally exempt.
- **Jewelry:** for a single person, wedding, engagement rings and heirlooms are totally exempt and other items of jewelry with a total net market value of \$100 or less are exempt; for spouses, when one spouse is in a nursing home, there is no limit on exempt jewelry for determining institutionalized spouse's eligibility.
- **Cars/motor Vehicles:** one vehicle used for transportation is totally exempt.
- **Whole Life Insurance:** policies with a total face value of \$1,500 or less. If the total face value of the policy or policies exceeds \$1,500, then the cash surrender value of the policies is counted toward the \$2,000 cash reserve. If the cash surrender value exceeds the \$2,000 cash reserve, the applicant will not be eligible unless, he/she reduces the value of the policy.
- **Term Life Insurance:** totally excluded.
- **Burial Plots:** totally excluded.
- **Prepaid irrevocable burial plan of any amount and \$1,500 in designated burial funds:** There is no limit on the amount of the irrevocable burial fund, but the \$1,500 in designated funds must be kept separate from all other accounts and designated as a burial account. Accumulated interest on burial funds is also exempt.
- **IRAs and work-related pensions:**
 - In applicant's/beneficiary's name: The balance of the IRA or the pension is considered unavailable if applicant/beneficiary is receiving periodic payments of interest and principal.
 - In spouse's name: The balance of the IRA or Pension fund is totally exempt from consideration and is not included in the community spouse resource allowance (CSRA).
- **Non work-related annuities:**
 - Annuities purchased prior to 8/11/93: Balance is considered unavailable if applicant/ beneficiary is receiving periodic payments (of any amount) of interest and principal.
 - Annuities purchased between 8/11/93 and 3/1/96: Annuities purchased between 8/11/93 (the date the federal law changed) and 3/1/96 (the date California law changed) that cannot be restructured to meet the new requirements will continue to be treated under the old rules (see above). Written verification from the company or agent who issued or sold the annuity must be obtained stating that the annuity cannot be restructured.
 - Annuities purchased on or after 3/1/96 by the applicant or the applicant's spouse: the individual and/or spouse must take steps to receive periodic payments of interest and principal; payments must be scheduled to exhaust the balance of the annuity at or before the end of the annuitant's life expectancy. Annuities structured to exceed the life expectancy will result in denial or termination of benefits due to transfer of non-exempt assets.
 - Note: Annuities purchased by the applicant/beneficiary on or after 9/1/04 will be subject to Medi-Cal recovery when the beneficiary dies.
 - **Cash reserve:** Applicant/beneficiary may retain up to \$2,000 in liquid assets, e.g., savings, checking, excess cash surrender value of life insurance.
- **Community Spouse Resource Allowance (CSRA):** Community (at home) spouse may retain up to \$115,920 in liquid assets, not including the home and other exempt assets, such as IRAs and retirement funds.
- Any assets above the property reserve limit of \$2,000 or \$115,920, in the case of a community spouse, or any asset that is not exempt will be counted by Medi-Cal in determining eligibility.

F. The Home

The home of a Medi-Cal beneficiary continues to be exempt from consideration as a resource under a wide variety of circumstances. These are spelled out in detail in W&I Code §14006(b). Under these provisions, a home will continue to be considered an exempt principal residence if:

1. During any absence, including nursing home stays, the individual intends to return to the home and states so in writing. If the beneficiary is incapacitated, a family member or someone acting on his/her behalf may so state this intent.
2. The individual's spouse, child under the age of 21, or dependent relative continues to reside in the home.
3. The residence is inhabited by the recipient's sibling, who has an equity interest in the home, or by a son or daughter who has resided there continuously for at least one year prior to the date the recipient entered the nursing home.
4. There are legal obstacles preventing the sale and the applicant/beneficiary provides evidence of attempts to overcome such obstacles.
5. The home is a multiple dwelling unit, one unit of which is occupied by the applicant.

Because the home is exempt for eligibility purposes does not mean that the home is immune from an estate claim after the beneficiary dies. If the home is still in the name of the beneficiary when he/she dies, Medi-Cal can recover from the estate (See CANHR's fact sheet Medi-Cal Recovery Frequently Asked Questions (http://www.canhr.org/factsheets/medi-cal/fs/html/fs_medical_recovery_FAQ.htm) for more information on the Medi-Cal Recovery Program).

Intent to Return

The principal residence is exempt based upon a person's subjective intent to return, even though he/she may never have the ability to return to that residence. If the applicant is unable to complete the application, his/her representative may indicate that intent. The eligibility worker may not restrict, in any way, the individual or his/her representative in the process of indicating that intent. As long as the applicant or beneficiary declares an intention to return home on the Medi-Cal application (i.e., checks the "yes" box), the house will be treated as a principal residence exempt from being counted as a resource by Medi-Cal.

Unless the applicant is requesting an income deduction to maintain the home for the return within six months pursuant to Title 22, Section 50605, the county may not require any verification of the individual's ability to actually return home. If the applicant or his/her representative incorrectly states that there is no intent to return and later makes a correction, the county must accept that correction (See ACWDL Nos. 95-48 and 00-11).

"Intending to return home" will also keep the home exempt if the community spouse dies first, but only for the life of the institutionalized spouse. Applicants/beneficiaries may want to transfer the home entirely to the community spouse in order to avoid an estate claim after the surviving spouse dies. In addition, if the community spouse dies first, the home will likely end up in the probate estate of the institutionalized spouse and be swallowed up in estate recovery claims.

G. Other Real Property/Business Property

Real property other than the principal residence can be exempt if the net market value of the property (minus encumbrances) is \$6,000 or less and if the beneficiary is "utilizing" the property, i.e., receiving yearly income of at least 6% of the net market value. The net market value is the assessed value (which is often lower) or the appraised value, minus encumbrances, whichever is less.

Utilization Requirements

Other real property must meet utilization requirements in order to be exempt. This means that the property must generate at least 6% a year of the net market value. If the property does not generate income, then the full net market value of the property will be counted (22 CCR § 50416(b),(j)).

Good Cause

If the applicant has made bona fide efforts to meet the utilization requirements but is unable to do so, the utilization period can be extended indefinitely and the applicant can be eligible. For example, if the applicant has made bona fide efforts to sell the property, but is unable to do so, the property won't be included in the countable resources. Note that the regulations include specific criteria for what constitutes "good cause" and "bona fide" efforts to sell (§§50416, 50417).

Market Value

The market value of property is very important, since it is used to determine the net market value. The market value of real property in California is one of the following, whichever is less: (22 CCR §50412)

- the assessed value determined under the most recent property tax assessment or
- the appraised value by a qualified real estate appraiser. The market value of real property outside of California is one of the following, whichever is less:
- the value established by the assessment method used where the property is located or
- the appraised value by qualified real estate appraiser.

Business Property

Property used in whole or in part as a business or as a means of self-support is exempt. Rental real property, however, will not be exempt unless the property is clearly held as a business. If the applicant can demonstrate with tax returns or other evidence that the property is clearly a "business," not just investment property, it can be exempt (22 CCR §50485(d), ACWDL 91-28).

Income from Real Property

If a Medi-Cal beneficiary is renting real property, including the principal residence, the "net" income from the property is used in determining what will be counted toward the share of cost. Certain expenses are deducted from the gross rental income to determine the net income. These include taxes and assessments, interest payments (not principal), insurance, utilities and upkeep and repairs.

Upkeep and repairs are the greater of either: the actual amount expended for upkeep and repairs during the month or 15% of the gross monthly rental, plus \$4.17 per month. (22 CCR §50508). Note that other calculations are used for income from rental of rooms, rental of unit(s) in a multiple dwelling unit or other dwellings on the property (22 CCR §50508).

Maintaining the Home for Return of LTC Resident

In addition to the \$35 for personal and incidental needs, a person in long term care can retain an amount of income for upkeep of a home if all of the following conditions are met:

1. The spouse or family of the LTC resident is not living in the home.
2. The home, whether rented or owned by the LTC patient, is actually being maintained for the return of the LTC resident.
3. There is a verified medical statement that the person will return home within six months.

The amount allowed for upkeep of the home depends on the living circumstances of the LTC resident (See 22 CCR §50605(c)).

H. Spending Down/Gifting Assets

Resources must be reduced to the property limit of \$2,000 for at least one day during the month in which a person is establishing eligibility. Giving away non-exempt resources may render a person ineligible for a period of time running from the date of the transfer.

Penalties for transferring or gifting away non-exempt assets only apply if a Medi-Cal beneficiary or applicant enters a nursing home. If an applicant lives at home and gifts away property, there are no transfer penalties. The transfer rules are triggered when a person enters a nursing home and applies for Medi-Cal. The Medi-Cal application will ask if the applicant transferred any assets within the 30 months prior to the date of the application. The transfer rules apply only to non-exempt (countable) assets.

A transfer of non-exempt assets can result in a period of ineligibility which is the lesser of 30 months or the value of the transferred assets divided by the average private pay rate (APPR) at the time of application. The current APPR is \$7,549.

Example:

Mr. D transfers \$15,000 to his son in January 2013, and applies for Medi-Cal in February of 2013. Because Mr. D is in a nursing home, a transfer period will be triggered. The amount transferred (\$15,000) is divided by the 2013 APPR (\$7,549), and Mr. D will be subject to a period of ineligibility of 1.9 months. Since California does not count partial months, he will be ineligible for one month, running from the month of transfer (January 2013). Thus, Mr. D will not be eligible for January of 2013, but he will be eligible as of February 1, 2013.

Example:

If Mr. D transfers \$8,000 to his son and \$8,000 to his daughter in January 2013, each transfer is calculated separately. Each amount transferred (\$8,000) is divided by the APPR of \$7,549, and Mr. D will be ineligible for January 2013 only.

Note: Assets in any amount can be transferred at any time to a blind or disabled child of any age. The child's disability must meet the requirements under the Social Security Act, i.e., the child must meet the disability requirements for SSA or SSI disability benefits. Transfers of a home or any asset to a blind or disabled child will not affect the Medi-Cal beneficiary or applicant's eligibility. However, a transfer of liquid assets may impact the benefits of a child who is receiving SSI benefits, in which case an SSI specialist should be consulted.

I. Spousal Impoverishment Laws

California law allows the community spouse to retain a certain amount of otherwise countable resources available to the couple at the time of application. This is called Community Spouse Resource Allowance (CSRA) and it increases every year according to the Consumer Price Index. The current (2013) CSRA is \$115,920.

Separate property will be counted in the total resources and subjected to the \$115,920 limit. However, only non-exempt resources are counted in the spouses' combined, countable resources at the time of application for Medi-Cal. Thus, IRA's in the community spouse's name, household goods, personal effects, a car, the house, jewelry, etc. are all totally excluded, regardless of value, and the at home spouse can retain these, as well as the CSRA of \$115,920.

Resources acquired after the spouse is institutionalized and before he/she goes on Medi-Cal are not protected and will be counted at the time of application. However, once the spouse is eligible for Medi-Cal, any resources acquired after eligibility by the community spouse are protected and will not affect the institutionalized spouse's eligibility. For example, if the community spouse inherited \$100,000 after the nursing home spouse was on Medi-Cal, she could keep this without affecting the other spouse's eligibility. Resources held prior to the spouse's institutionalization may be transferred under certain conditions.

Spending Down: A spouse can spend down resources on anything, whether or not it is for his or her own benefit. Mortgage notes on property held in the names of both spouses could be paid in full by the institutionalized spouse without a period of ineligibility for transferring assets for less than fair market value.

Income: California law allows the community spouse to retain a minimum monthly maintenance needs allowance (MMMNA) of \$2,898. This amount is adjusted annually by a cost of living increase. Under the "name on the instrument rule," the community spouse may retain any income received in his/ her name alone. It is important to note that the \$2,898 amount is a floor.

Thus, if the community spouse's monthly income is less than the MMMNA of \$2,898, he/she may receive an allocation from the institutionalized spouse's income; file for a fair hearing to increase the CSRA to generate additional income; and/or obtain a court order to obtain additional income-generating resources. With current miniscule interest rates, it is relatively easy for a community spouse to retain assets above the CSRA, if his/her income is low. If the community spouse's income in his or her name alone exceeds the MMMNA, the community spouse may keep it all. For example, if the spouse at home received \$5,000 per month in income, he/she can retain all of that income, but will not receive a spousal allocation from the nursing home spouse, because the community spouse income is above the \$2,898 MMMNA.

J. Family Allocation

Federal and state laws allow for a family allocation to be offset from the income of an institutionalized spouse for the support of a dependent "family member" when there is a community spouse at home. Family members include only natural or adopted minors or dependent children, or dependent parents or siblings of the institutionalized or community spouse who are residing with the community spouse. In order for the children to receive the maximum family member allocation, there must be a community spouse. Grandparents who have legal guardianship over grandchildren have been hit hard by this onerous rule, and foster children are not considered "children" or even "family members" for the purposes of long term care Medi-Cal.

The family member base allocation amount, which is used to determine how much income the long term care beneficiary may allocate to family members, is increased annually. The current amount, \$1,891, is effective June 1, 2012 through June 30, 2013. Of course, the allocation is only possible if the institutionalized spouse has sufficient income left over after the spousal allocation to the community spouse.

The family allocation is calculated separately for each family member. Any income is deducted from the maximum allocation, and the remainder is divided by 3 to arrive at the total maximum allocation. If the child or children receive no income, the maximum family allocation amount would be \$630.33 for each child.

Example

\$ 1,891	(maximum family allocation)
<u>-300</u>	(Social Security income received by child)
1,591	divided by 3 = \$530.33 maximum family allocation for each child

(source: ACWDL 12-20; Form MC 176 W; section IX)

K. Ethical Considerations

Property reduction requirements can usually be easily handled and documented, and it can be tempting for many attorneys to advise clients to reduce excess property on the purchase of exempt assets prior to a nursing home entry. It may be difficult however, to find a nursing home placement for a person who has spent all of his/her resources or who has few resources.

Although "duration of stay" requirements, i.e., requiring private pay for a set period of time, are illegal, nursing homes can and do review potential patients' finances prior to admission. In most cases, they are unwilling to accept Medi-Cal eligible residents upon admission. The longer a person can pay privately, the more options there are available regarding nursing home placement.

In addition, a private pay patient may receive a higher level of service, e.g., a private room, although relatives of nursing home residents are now permitted to supplement the Medi-Cal rate to pay for non-covered services such as a private room, television or phone services. These factors should be considered when advising clients how to reduce excess resources. Once a patient has been admitted to a Medi-Cal certified facility, s/he cannot be transferred or evicted simply because of a change from private pay to Medi-Cal payment status. Thus, unless a person can pay privately for an indefinite period of time, s/he should be advised to seek out a Medi-Cal certified nursing home.

L. Medi-Cal Recovery

Medi-Cal applicants, beneficiaries and their spouses should always be aware of the Medi-Cal Recovery rules and plan ahead if they want to avoid recovery on their home or other assets. For detailed information on the Medi-Cal Recovery program, see CANHR's fact sheet Medi-Cal Recovery Frequently Asked Questions (http://www.canhr.org/factsheets/medi-cal/fs/html/fs_medical_recovery_FAQ.htm).

For more detailed information about Long Term Care Medi-Cal, order a copy of CANHR's "If You Think You Need A Nursing Home: A Consumer's Guide to Financial Considerations and Medi-Cal Eligibility."

CANHR is a private, nonprofit 501(c)(3) organization dedicated to improving the quality of care and the quality of life for long term care consumers in California.

Planning for Long Term Care

Planning for Long Term Care (LTC) is vital to save time, money, and stress. Such planning can seem intimidating. It will seem less so if you and your family approach it one step at a time. Use the following checklist to aid you in your planning.

Healthcare Needs

- Determine the appropriate type of care.
 - In other words, where should the person be? Should the person receive care at home, in a Residential Care Facility for the Elderly (RCFE), in a nursing home, or some other facility?
 - The person's physician should give guidance as to the appropriate level of care. Physician's orders are a prerequisite to nursing home admission.
- Find appropriate long term care facilities.
 - Identify local RCFEs on CANHR's ResidentialCareGuide.org website. Consult CANHR's website or contact CANHR for additional information on RCFEs.
 - Consult CANHR's [Nursing Home Guide](#), to learn about nursing homes in your community. You can search for nursing homes by name, location, acceptance of Medicare/Medi-Cal, and specific medical need. You can also view the inspection record for each facility.
 - Educate yourself.

Start with CANHR's website, www.canhr.org. In addition to nursing home and residential care information, it contains extensive information on many long-term care resources.

Financial Considerations

- Obtain a complete financial picture.
 - Inventory all assets in the person's estate: cash, investments, annuities, CDs, IRAs, and work-related pensions. If the person owns real property, determine the nature of ownership (sole ownership, joint tenancy, etc.). If the person has life insurance, determine the cash surrender value, if applicable. Determine the person's monthly income.
- Determine how to pay for LTC.
 - The average cost of nursing home care is about \$6000 per month. While this is steep, privately paying for even a short time can increase the chances of admission.
 - Medicare may cover up to 100 days of skilled nursing care. HMOs and other health plans may offer LTC coverage. Purchasing LTC insurance may also be an option. For questions about Medicare, HMOs, and LTC insurance, contact HICAP (Health Insurance Counseling and Advocacy Program) at 1-800-434-0222 or www.cahealthadvocates.org.

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- Medi-Cal, California's Medicaid program, can help cover the cost of care at home or in a nursing home. With very limited exceptions (see CANHR's [Fact Sheet on the Assisted Living Waiver Pilot Project](#)), Medi-Cal does not cover the cost of RCFE care. The IHSS (In Home Supportive Services) program can help pay for a caregiver at home. CANHR provides extensive information about [Medi-Cal](#) and IHSS eligibility (see CANHR's [Fact Sheet on IHSS](#)) requirements.

Capacity Considerations

- Determine the person's mental capacity.
 - Can the person make his or own decisions? If the person's mental capacity isn't obvious, seek the opinion of a physician.
- Obtain DPAs or a conservatorship.
 - If the person still has mental capacity, consider arranging for a Durable Power of Attorney (DPA). A DPA ensures that someone can make legal decisions for a person in the case of incapacity. There are two main kinds of DPAs: the DPA for Finance and Property (See CANHR's [Fact Sheet on DPA for Property](#)), and the DPA for Healthcare, which is also called an Advanced Healthcare Directive (see CANHR's [Fact Sheet on DPA for Health Care](#)).
 - If the person does not have mental capacity, a conservatorship (see CANHR's [Fact Sheet on Conservatorship](#)), may be necessary. A conservatorship is a procedure whereby a court appoints someone to manage the person's affairs. Conservatorships can be costly; if possible, DPAs should be established before loss of capacity.
 - In some situations, a living trust can empower a person to act as an individual's agent. For questions about these issues, talk to your attorney, or contact CANHR for a referral.

Legal Considerations

- Plan the estate.
 - Planning for LTC is a chance to plan the estate. Make sure that any wills, trusts, and other legal documents are up-to-date and applicable. CANHR staff can help answer questions about financial options, but we cannot plan your estate.
 - If you wish to plan and protect your estate, CANHR can refer you to a qualified lawyer in your area. Call 800-474-1116 or visit CANHR's website for the only State Bar certified [Lawyer Referral Service](#) in California specializing in long term care.

California's Medi-Cal Recovery Program

Frequently Asked Questions

CANHR is a private, nonprofit 501(c)(3) organization dedicated to improving the quality of care and the quality of life for long term care consumers in California.

California's Medi-Cal applicants and beneficiaries are often confused about their rights regarding Medi-Cal and are particularly concerned that the state will "take" their homes after they die if they received Medi-Cal benefits. The following "Frequently Asked Questions" attempts to answer some of these concerns and to provide consumers with the information necessary to make informed choices about their estates when they are applying for Medi-Cal.

I. Can the State Take my Home If I Go on Medi-Cal?

The State of California does not take away anyone's home per se. Your home can, however, be subject to an estate claim after your death. For example, your home may be an exempt asset while you are alive and is not counted for Medi-Cal eligibility purposes. However, if the home is still in your name when you die, the State can make a claim against your estate for the amount of the Medi-Cal benefits paid or the value of the estate, whichever is less. Thus, if your home or any part of it is still in your name when you die, it is part of your "estate" and can be subject to an estate claim.

II. Can the State Put a Lien on My Home?

Consumers often confuse liens and estate claims. Both have been used by the State in attempts to reimburse the Medi-Cal program for payments made to beneficiaries. Liens are placed on living Medi-Cal beneficiaries' estates to "hold" the property until the person dies. Estate claims are claims made against the estate of the Medi-Cal beneficiary after he or she dies. As of January 1, 1996, California is not permitted to impose liens against the homes of nursing home residents or their surviving spouses, except in cases where the home is not exempt (i.e., the nursing home Medi-Cal applicant did not indicate an intention to return home) and the home is being sold. Under current law, these are the only liens that can be placed on the homes of living beneficiaries.

Most Medi-Cal applicants' homes are exempt because a spouse, child or sibling lives there or they do indicate an intention to return home on the Medi-Cal application, so even these liens are rare. After the beneficiary has died, the heirs or survivors may sign a "voluntary" lien for Medi-Cal recovery purposes, if they cannot otherwise avoid an estate claim against the property.

III. What Happens After I Die If I Received Medi-Cal?

After the Medi-Cal beneficiary's death, the State can make a claim against the estate of an individual who was 55 years of age or older at the time he or she received Medi-Cal benefits or who (at any age) received benefits in a nursing home, unless there is a surviving spouse or a minor, blind or disabled child. Thus, if there are any assets left in the estate of the deceased beneficiary, Medi-Cal will seek to be reimbursed for benefits paid. *It is important to note that, even if you received Medi-Cal at home, any benefits paid while you were 55 years of age or older will be subject to Medi-Cal recovery.*

IV. How Much Can the State Recover?

California's definition of "estate" includes such assets as living trusts, joint tenancies, tenancies in common and life estates, although claims on the remainder interest in life estates are limited to those that were revocable. Many consumers place their property into living trusts, thinking that this will protect it from an estate claim. It does not. The State can still make a claim against property held in a living trust, joint tenancy or tenancies in common, as long as the beneficiary's name is still on the property at the time of death.

However, the amount of recovery is limited to the amount of benefits paid or the value of the beneficiary's estate, whichever is less. For example, if the appraised value of your home is \$200,000 and you left it in joint tenancy with your three children, the State can only collect up to \$50,000, which is your part of the estate - even if the Medi-Cal benefits paid to you is more than \$50,000. The value of the estate is also reduced by any outstanding mortgages or debts on the home. For example, if the home had an outstanding mortgage of \$100,000, this reduces the value of the estate to \$100,000 (the appraised value of \$200,000, minus the mortgage). This, in turn, reduces the amount of the estate claim to \$25,000. (The value of the home (\$100,000) divided by the four joint tenants.) Deducting the amount of burial costs or estate settlement costs can also reduce the claim. Remember to keep receipts and submit them.

When the State files an estate claim, they are also required to send an itemized billing of benefits paid over the deceased's lifetime. It is important to review the billing to see if there are any errors. Payments made for personal care services under the In Home Supportive Services (IHSS) program, the cost of premiums, co-payments and deductibles paid on behalf of either Qualified Medicare Beneficiaries or Specified Low-Income Medicare Beneficiaries (QMB/SLMB) are exempt from recovery. Thus, if payments for these services are included in the itemized billing, the collection representative should delete this from the billing.

V. Are There Any Exceptions to an Estate Claim?

A. Surviving Spouse: The state is prohibited from recovery while a surviving spouse of a deceased Medi-Cal beneficiary is alive. However, after the surviving spouse dies, recovery may be made against any property received by the spouse through distribution or survival, e.g., property left under a will or community property. However, if the home is transferred out of the nursing home resident's name while he or she is alive, no claim can be placed on the home. Spouses should be careful to "transmute" the property, i.e., through a court order or by having the nursing home spouse sign a declaration relinquishing his/her interest in the property.

B. Minor, Blind or Disabled Child: If a minor child under the age of 21 or a blind or disabled child of any age survives the beneficiary, a claim is prohibited by federal and state laws. The surviving minor child or his/her representative only needs to send proof, such as a birth certificate or adoption papers, that they are the child of the decedent or, in the case of disabled child, documentation of disability or blindness, such as a Social Security or SSI award letter and a birth certificate showing they are the child of the deceased. If the surviving child does not have documentation of disability from the Social Security Administration, he/she can still file for a disability determination with the Department of Health Services. It is important to note that the surviving child does not have to live in the home (or even in the State, for that matter) in order for recovery to be barred.

C. When There is Nothing Left in the Estate: Since most deceased Medi-Cal beneficiaries leave nothing but their homes, it is most important to look at the deed to the property. Whose name was on the property at the date of death? If the beneficiary transferred the property outright prior to death, then send a copy of the deed, along with a letter explaining that the beneficiary left nothing in his/her estate and ask that the case be closed. If the beneficiary transferred the home outright while he or she was alive and reserved a life estate or an occupancy agreement, send a copy of the deed showing the property was transferred before the beneficiary died.

VI. What Else Besides My Home Can the State Claim Against?

Under current law, "estate" is defined as any real or personal property and other assets in which the individual had any legal title or interest at the time of death (to the extent of such interest), including assets conveyed through joint tenancy, tenancy in common, survivorship, life estate, living trust or other arrangement. Anything left in the decedent's bank accounts, for example, can be subject to recovery, after estate and burial expenses or other documented expenses are paid. The State can also recovery from annuities purchased by a beneficiary on or after September 1, 2004, regardless of whether the remainder interest in the annuity is a lump sum or a stream of income. Call the CANHR office if you have specific questions regarding what assets are subject to recovery.

Life Estates: Under the new recovery rules, claims on irrevocable life estates are waived, but the state is placing claims on "revocable" life estates. For example, if you retain a life estate and, "upon death the remainder to the children," this would not be considered a transfer and your home could be subject to recovery. If the gift deed transfers the home outright to the individual(s) and you retain a life estate, this would be considered irrevocable and would be immune from recovery.

The State cannot recover from IRAs, work-related pension funds or term life insurance policies, unless they name the state as the beneficiary or they revert to the estate. This is rare, as most people name a beneficiary for pension funds and insurance policies.

VII. How Does the State Know When a Medi-Cal Beneficiary Dies?

A. Notice of Death: When a Medi-Cal beneficiary dies, the County Medi-Cal office notifies the Department of Health Services in Sacramento and benefits are terminated. However, for recovery purposes, the burden of notifying the State of the death is still on the beneficiary's estate. California law, under Probate Code §215, requires that, when a deceased person has received or may have received health care benefits or was the surviving spouse of a person who received such benefits, the estate attorney, the beneficiary of the estate, the personal representative or the person in possession of the property is required to notify the Director of the Department (at the Sacramento office of DHS) no later than 90 days after the person's death. A copy of the death certificate is required to be sent.

Although most consumers simply notify the county Medi-Cal office, this does not count as proper notice and it is important that you send the notice and death certificate to the correct address, if you want the matter to be addressed in a timely manner. The notice of death and the death certificate should be sent by registered or certified mail to: Director of Health Care Services, Estate Recovery Unit, MS-4720, P.O. BOX 997425, Sacramento, CA 95899-7425. That way, you have proof of mailing.

B. Filing The Claim: If the estate is subject to probate or trust administration, the State has four months in which to file a claim. If a claim is not filed within this time, it is forever barred. However, many estates are not subject to probate or trust administration. In these cases, although the State has indicated its policy is to respond within four months, there is no law requiring this. By law, in non-probated estates, the Department must file a claim within three years of receipt of the notice of death.

C. Beware of Forms: The Recovery Unit has sent out a number of questionnaires to consumers implying that they are under a legal obligation to complete and return them. The only legal obligation under law is to send a notice of death and a copy of the death certificate when a deceased Medi-Cal beneficiary or the spouse of a deceased beneficiary dies. If the State has sent an estate claim, then the questionnaire is a way for them to find out what property, if any, is left in the deceased beneficiary's estate. If there was no property left in the deceased's name, then completion of the form (or an attached letter) should be an easy matter. Enclose a copy of the deed to show the property was transferred during the life of the beneficiary. If the estate is more complicated, then consumers should seek advise from their attorney, legal services or CANHR before completing and returning any questionnaires or forms.

VIII. How Does a Survivor Appeal an Estate Claim?

A. Hardship Waivers and Estate Hearings: State regulations provide that the applicant (i.e., the dependent, heir or survivor of the decedent) may file for a hardship waiver within 60 days of notice of the claim. The hardship application is provided with the notice of the claim and the itemized billing, along with a copy of the regulations. Consumers are advised to complete the hardship application as completely as possible and to submit substantial documentation to support any hardship. A written decision regarding the hardship application must be sent to the applicant within 90 days of submission of the application. (Although the Department rarely responds within the legal timelines). Under the new regulations, only the applicant's "proportionate share" of the claim will be waived. So, if there is more than one heir, for example, all must file for hardship waivers, unless there is an exempt survivor, e.g., a spouse, a minor or a disabled child.

The applicant may challenge the Department's hardship waiver decision by requesting an estate hearing within 60 days of the date of the Department's hardship waiver decision. The estate hearing is an administrative law hearing and is required to be set within 60 days of the date of the request and must be conducted in the court of appeals district in which the applicant resides. *Always try to preserve your appeal rights by filing within the time limits and try to get legal representation at the Administrative Law Hearing.*

B. Caregiver Exemption: The new regulations state that the Department shall waive the applicant's proportionate share of the claim if he/she provided care to the decedent for two or more years that prevented or delayed the decedent's admission into a medical or long term care institution. The applicant does not have to be related to the beneficiary, but must be a dependent, heir or survivor. The applicant must have resided in the decedent's home while the care was provided and continue to reside there. The applicant must still complete the hardship waiver form and must also submit written medical documentation that shows that the applicant provided a level of care for at least two years that delayed the deceased beneficiary's entry into a medical facility. This includes a statement from the doctor or other medical provider attesting to the deceased's condition prior to entering the medical facility and what specific level and frequency of care the deceased received from the applicant. Declarations from medical providers, copies of pertinent medical records, etc. can be useful in documenting the extent of the caregiving provided.

C. Judicial Review: Estate hearing decisions can be appealed judicially by filing a writ of mandate with the appropriate court. The state may also refer the claim to the Office of the Attorney General if the claim is not paid and their collection efforts are unsuccessful.

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IX. How Do I Avoid an Estate Claim?

The best way to avoid an estate claim is to leave nothing in the estate. Most Medi-Cal beneficiaries leave nothing but a home. If the property is transferred out of the beneficiary's name during life, the state cannot place a claim. Any transfer of real property can have tax consequences that may outweigh a Medi-Cal estate claim. Currently, there are a number of legal options (irrevocable life estates, occupancy agreements, certain types of trusts) available to avoid probate, avoid tax consequences and avoid estate claims. Anyone considering a transfer of real property should consult an attorney experienced in the Medi-Cal rules and regulations.

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Medi-Cal Resource Limits for Long Term Care

The following property is generally exempt and therefore not counted in determining Long Term Care Medi-Cal eligibility:

- **The home:** totally excluded, if it is the principal residence. The applicant must state an “intent to return to the home.” Includes mobile home, houseboat, or an entire multi-unit dwelling as long as any portion serves as the principal residence of the applicant. (See CANHR’s factsheet, “Your Home & Medi-Cal,” for more information)
- **Other real property:** may be excluded if it is used in whole or in part as a business or means of self-support (you should see an attorney if you have other real property).
- **Household goods and personal effects:** totally exempt.
- **Jewelry:** for a single person, wedding, engagement rings and heirlooms, and items of jewelry with a net market value of \$100 or less are totally exempt; for spouses, there is no limit on exempt jewelry for determining the institutionalized spouse’s eligibility.
- **One car** is generally exempt if used for the benefit of the applicant/beneficiary or if needed for medical reasons.
- **Whole life insurance policies with a total face value** (also called “combined death benefit”) of \$1,500 or less.
- **Term life insurance:** totally excluded.
- **Burial plots:** totally excluded, includes headstone, crypts, etc.
- **Prepaid irrevocable burial plan of any amount and \$1,500 in designated burial funds.** These designated funds must be kept separate from all other accounts.
- Cash surrender value or balance of **pension funds, IRAs** and certain types of **annuities** (you should see an attorney if you are considering buying an annuity—call CANHR for a referral).
- Up to \$2,000 in **cash reserve, e.g.** in savings, checking, etc., for the Medi-Cal applicant.
- **Community Spouse Resource Allowance (CSRA) for 2013:** the spouse at home can keep the first \$115,920 in assets, and may be able to keep more if his/her income is below the **Minimum Monthly Maintenance Needs Allowance (MMMNA)**. For 2013 this amount is \$2,898. **Average Private Pay Rate (APPR)** for 2013 is \$7,549.

IRAs, Pensions & Annuities Under Medi-Cal

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Annuities v. Work Related Pensions

There has been a great deal of confusion regarding the treatment of annuities versus the treatment of IRAs, other work-related pension funds or other periodic payment plans.

The Department of Health Care Services released regulations in 1996 which apply to trusts and annuities established on or after August 11, 1993. It is important to note that the annuities regulations and procedures apply only to annuities, not to IRAs and work-related pension funds.

Definition of Annuity

For the purposes of Medi-Cal eligibility an "annuity" is defined as a "contract to make periodic payments of a fixed or variable sum paid to an annuitant which are payable unconditionally."
(§50489(b)(3))

- Annuity payments may continue for a fixed period of time or for as long as an annuitant lives.
- An annuitant purchases an annuity with his or her property or property rights.
- Annuities shall be established to provide the annuitant with payments representing principal and interest which are more than the fair market value of the property used to purchase the annuity.
- Annuities purchased prior to August 11, 1993, other periodic payment plans, or annuities that are purchased with property rights belonging to someone other than the Medi-Cal applicant/beneficiary or spouse shall continue to be treated in accordance with Title 22, Section 50402 and Article 10.

IRAs and Work-Related Pensions

- In the applicant's or beneficiary's name: The cash surrender value or balance, regardless of value, shall be considered unavailable if the applicant or beneficiary receives periodic payments of interest and principal. (Title 22, §50402(e)) These do not need to meet the Medi-Cal requirements for annuities. The payments will count toward the monthly share of cost.
- In the community spouse's name: Totally exempt from consideration, regardless of value; nor is the cash surrender value included in the CSRA. (Title 22, §50458) However, any income the spouse receives will be counted in determining the community spouse's allocation from the nursing home spouse, if he or she receives such an allocation.

Non Work-Related Annuities

- Annuities purchased prior to 8/11/93: The cash surrender value or balance of the annuity is considered unavailable if the applicant/beneficiary is receiving periodic payments (of any amount) of interest and principal. (Title 22, §50402(e)) Remember, this is the old law, so annuities purchased before the new federal law will be treated under the old law.
- Annuities purchased between August 11, 1993 and March 1, 1996: Annuities purchased between 8/11/93 (the date the federal law changed) and 3/1/96 (the date the state regulations went into effect) must meet the new regulations, which can be waived for hardship. Once the individual or spouse takes steps to receive periodic payments of interest and principal, the balance is considered unavailable. However, the payments must be scheduled to exhaust the balance at or before the end of the annuitant's life expectancy.

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For example, under the actuarial table used for Medi-Cal, an 85-year old female has a life expectancy of 6.63 years. Thus, the annuity must be structured to pay out the balance of the annuity at or before 6.63 years. If the annuity is scheduled for longer than that, 10 years for example, it will be considered to be a transfer of assets, and a period of ineligibility could be imposed.

- **Hardship:** Annuities purchased during this period that cannot be restructured to meet the new requirements will continue to be treated under the old rules (§50402). Written verification that the annuity cannot be restructured must be obtained from the company or agent who issued or sold the annuity.
- **Annuities purchased on or after March 1, 1996:** Must meet the new requirements, no annuity hardship provisions apply. The individual or spouse must take steps to receive periodic payments of interest and principal, scheduled to exhaust the balance of the annuity at or before the end of the annuitant's life expectancy. Annuities structured to exceed the life expectancy of the annuitant will result in denial or termination of benefits due to transfer of assets.
- **Annuities purchased on or after September 1, 2004:** The Department of Health Services has promulgated emergency regulations effective August 2, 2004 pertaining to recovery on annuities. Annuities purchased on or after September 1, 2004 will now be subject to recovery regardless of whether the annuity is designed to pay a lump sum or periodic payments upon the death of the decedent.

Planning Tips

If you think you would like to buy an annuity because you are worried about losing all of your assets under Medi-Cal, it is probably not a good idea unless you know what assets are exempt in the first place. An IRA, for example, does not have to be liquidated to purchase an annuity, since the IRA is already exempt. For more information on the Medi-Cal eligibility criteria, see CANHR's web site at www.canhr.org or call the office.

Following are some tips you should follow if you are approached about an annuity:

- Don't buy anything at the initial presentation. Tell the salesperson you want time to think about the investment.
- Don't buy the first annuity you are offered; investigate and compare it to other products
- Consider other options for planning that might be available, particularly if you are looking at Medi-Cal planning
- Always talk to a neutral third party knowledgeable about Medi-Cal estate planning
- Find out about the surrender penalties and terms and how they might affect the principal
- Find out how much commission the sales agent will make
- Remember, you have 30-days to cancel the contract

Resources

- CANHR: www.canhr.org or call (800) 474-1116
- H.E.L.P.: www.help4srs.org or call (310) 533-1996
- Department of Insurance: www.insurance.ca.gov or call (800) 927-4357
- Department of Corporations, Seniors Against Investment Fraud (SAIF): (866) 275-2677

For more information, contact CANHR at 800-474-1116 (consumers only)

Note: These rights are found in ACWDL 90-01 and ACWDL 02-51.

How to Value Real Property

CANHR is a private, nonprofit 501(c)(3) organization dedicated to improving the quality of care and the quality of life for long term care consumers in California.

Property Other than the Principal Residence

Other real property can be exempt if the net market value of the property is \$6,000 or less and if the beneficiary is "utilizing" the property, i.e., receiving yearly income of at least 6% of the net market value.

Example:

John has some land whose net market value is \$5,000. If he can generate at least \$300/year in income (6% of \$5,000) from the land, the property will be exempt. (§§50427, 50416)

If the net market value of the other real property exceeds \$6,000, the first \$6,000 of net value will be exempt if the property generates yearly income of at least 6% of the net market value. Any property value in excess of \$6,000 will be counted in the property reserve.

Example:

The net market value of John's land is \$9,000. The first \$6,000 of value will be exempt if he can generate at least \$540/year in income (6% of \$9,000), and the remaining \$3,000 in value will be added to the property reserve. Since John can only have \$2,000 in property reserve, he will be ineligible for Medi-Cal unless he can reduce the net market value of the land. (§§50427, 50416)

How To Reduce Net Market Value

The net market value of real or personal property is the owner's equity in that property and is determined by subtracting the encumbrances of record from the market value. Example: The market value of John's land is \$11,000, but he still owes \$2,000 on the property. Thus, the "net" market value is \$9,000. In the example above, John can reduce the net market value to \$8,000 and still be eligible for Medi-Cal if he borrows \$1,000 on the land and generates at least \$480/year (6% of \$8,000) in income from the property. (§§50413, 50415)

Utilization Requirements

Other real property must meet utilization requirements in order to be exempt. This means that the property must generate at least 6% a year of the net market value. If the property does not generate income, then the full net market value of the property will be counted. (§50416(b),(j))

Good Cause

If the applicant has made bona fide efforts to meet the utilization requirements but is unable to do so, the utilization period can be extended indefinitely and the applicant can be eligible. For example, if the applicant has made bona fide efforts to sell the property, but is unable to do so, the property won't be included in the countable resources. Note that the regulations include specific criteria won't be included in the countable resources. Note that the regulations include specific criteria for what constitutes "good cause" and "bona fide" efforts to sell. (§§50416, 50417)

Market Value

The market value of property is very important, since it is used to determine the net market value. The market value of real property in California is one of the following, whichever is less: (§50412)

- the assessed value determined under the most recent property tax assessment
- or
- the appraised value by a qualified real estate appraiser

The market value of real property outside of California is one of the following, whichever is lower:

- the value established by the assessment method used where the property is located
- or
- the appraised value by qualified real estate appraiser

Business Property

Property used in whole or in part as a business or as a means of self-support is exempt. Rental real property, however, will not be exempt unless the property is clearly held as a business. If the applicant can demonstrate with tax returns or other evidence that the property is clearly a "business" not just investment property, it can be exempt. (§50485(d), ACWDL 91-28)

Income from Real Property

If a Medi-Cal beneficiary is renting real property, the "net" income from the property is used in determining the share of cost. Certain expenses are deducted from the gross rental income to determine the net income. These include taxes and assessments, interest payments (not principal), insurance, utilities and upkeep and repairs. Upkeep and repairs are the greater of either: the actual amount expended for upkeep and repairs during the month or 15% of the gross monthly rental, plus \$4.17 per month. (§50508) Note that other calculations are used for income from rental of rooms, rental of unit(s) in a multiple dwelling unit or other dwellings on the property. (§50508)

Maintaining the Home for Return of LTC Resident

In addition to the \$35 for personal and incidental needs, a person in long term care can retain a amount of income for upkeep of a home if all of the following conditions are met:

- the spouse or family of the LTC is not living in the home.
- the home, whether rented or owned by the LTC patient, is actually being maintained for the return of the LTC patient.
- there is a verified medical statement that the person will return home within six months.

The amount allowed for upkeep of the home depends on the living circumstances of the LTC patient. (see 22 CCR §50605(c))

California's Medi-Cal Recovery Program

Frequently Asked Questions

CANHR is a private, nonprofit 501(c)(3) organization dedicated to improving the quality of care and the quality of life for long term care consumers in California.

California's Medi-Cal applicants and beneficiaries are often confused about their rights regarding Medi-Cal and are particularly concerned that the state will "take" their homes after they die if they received Medi-Cal benefits. The following "Frequently Asked Questions" attempts to answer some of these concerns and to provide consumers with the information necessary to make informed choices about their estates when they are applying for Medi-Cal.

I. Can the State Take my Home If I Go on Medi-Cal?

The State of California does not take away anyone's home per se. Your home can, however, be subject to an estate claim after your death. For example, your home may be an exempt asset while you are alive and is not counted for Medi-Cal eligibility purposes. However, if the home is still in your name when you die, the State can make a claim against your estate for the amount of the Medi-Cal benefits paid or the value of the estate, whichever is less. Thus, if your home or any part of it is still in your name when you die, it is part of your "estate" and can be subject to an estate claim.

II. Can the State Put a Lien on My Home?

Consumers often confuse liens and estate claims. Both have been used by the State in attempts to reimburse the Medi-Cal program for payments made to beneficiaries. Liens are placed on living Medi-Cal beneficiaries' estates to "hold" the property until the person dies. Estate claims are claims made against the estate of the Medi-Cal beneficiary after he or she dies. As of January 1, 1996, California is not permitted to impose liens against the homes of nursing home residents or their surviving spouses, except in cases where the home is not exempt (i.e., the nursing home Medi-Cal applicant did not indicate an intention to return home) and the home is being sold. Under current law, these are the only liens that can be placed on the homes of living beneficiaries.

Most Medi-Cal applicants' homes are exempt because a spouse, child or sibling lives there or they do indicate an intention to return home on the Medi-Cal application, so even these liens are rare. After the beneficiary has died, the heirs or survivors may sign a "voluntary" lien for Medi-Cal recovery purposes, if they cannot otherwise avoid an estate claim against the property.

III. What Happens After I Die If I Received Medi-Cal?

After the Medi-Cal beneficiary's death, the State can make a claim against the estate of an individual who was 55 years of age or older at the time he or she received Medi-Cal benefits or who (at any age) received benefits in a nursing home, unless there is a surviving spouse or a minor, blind or disabled child. Thus, if there are any assets left in the estate of the deceased beneficiary, Medi-Cal will seek to be reimbursed for benefits paid. *It is important to note that, even if you received Medi-Cal at home, any benefits paid while you were 55 years of age or older will be subject to Medi-Cal recovery.*

IV. How Much Can the State Recover?

California's definition of "estate" includes such assets as living trusts, joint tenancies, tenancies in common and life estates, although claims on the remainder interest in life estates are limited to those that were revocable. Many consumers place their property into living trusts, thinking that this will protect it from an estate claim. It does not. The State can still make a claim against property held in a living trust, joint tenancy or tenancies in common, as long as the beneficiary's name is still on the property at the time of death.

However, the amount of recovery is limited to the amount of benefits paid or the value of the beneficiary's estate, whichever is less. For example, if the appraised value of your home is \$200,000 and you left it in joint tenancy with your three children, the State can only collect up to \$50,000, which is your part of the estate - even if the Medi-Cal benefits paid to you is more than \$50,000. The value of the estate is also reduced by any outstanding mortgages or debts on the home. For example, if the home had an outstanding mortgage of \$100,000, this reduces the value of the estate to \$100,000 (the appraised value of \$200,000, minus the mortgage). This, in turn, reduces the amount of the estate claim to \$25,000. (The value of the home (\$100,000) divided by the four joint tenants.) Deducting the amount of burial costs or estate settlement costs can also reduce the claim. Remember to keep receipts and submit them.

When the State files an estate claim, they are also required to send an itemized billing of benefits paid over the deceased's lifetime. It is important to review the billing to see if there are any errors. Payments made for personal care services under the In Home Supportive Services (IHSS) program, the cost of premiums, co-payments and deductibles paid on behalf of either Qualified Medicare Beneficiaries or Specified Low-Income Medicare Beneficiaries (QMB/SLMB) are exempt from recovery. Thus, if payments for these services are included in the itemized billing, the collection representative should delete this from the billing.

V. Are There Any Exceptions to an Estate Claim?

A. Surviving Spouse: The state is prohibited from recovery while a surviving spouse of a deceased Medi-Cal beneficiary is alive. However, after the surviving spouse dies, recovery may be made against any property received by the spouse through distribution or survival, e.g., property left under a will or community property. However, if the home is transferred out of the nursing home resident's name while he or she is alive, no claim can be placed on the home. Spouses should be careful to "transmute" the property, i.e., through a court order or by having the nursing home spouse sign a declaration relinquishing his/her interest in the property.

B. Minor, Blind or Disabled Child: If a minor child under the age of 21 or a blind or disabled child of any age survives the beneficiary, a claim is prohibited by federal and state laws. The surviving minor child or his/her representative only needs to send proof, such as a birth certificate or adoption papers, that they are the child of the decedent or, in the case of disabled child, documentation of disability or blindness, such as a Social Security or SSI award letter and a birth certificate showing they are the child of the deceased. If the surviving child does not have documentation of disability from the Social Security Administration, he/she can still file for a disability determination with the Department of Health Services. It is important to note that the surviving child does not have to live in the home (or even in the State, for that matter) in order for recovery to be barred.

C. When There is Nothing Left in the Estate: Since most deceased Medi-Cal beneficiaries leave nothing but their homes, it is most important to look at the deed to the property. Whose name was on the property at the date of death? If the beneficiary transferred the property outright prior to death, then send a copy of the deed, along with a letter explaining that the beneficiary left nothing in his/her estate and ask that the case be closed. If the beneficiary transferred the home outright while he or she was alive and reserved a life estate or an occupancy agreement, send a copy of the deed showing the property was transferred before the beneficiary died.

VI. What Else Besides My Home Can the State Claim Against?

Under current law, "estate" is defined as any real or personal property and other assets in which the individual had any legal title or interest at the time of death (to the extent of such interest), including assets conveyed through joint tenancy, tenancy in common, survivorship, life estate, living trust or other arrangement. Anything left in the decedent's bank accounts, for example, can be subject to recovery, after estate and burial expenses or other documented expenses are paid. The State can also recovery from annuities purchased by a beneficiary on or after September 1, 2004, regardless of whether the remainder interest in the annuity is a lump sum or a stream of income. Call the CANHR office if you have specific questions regarding what assets are subject to recovery.

Life Estates: Under the new recovery rules, claims on irrevocable life estates are waived, but the state is placing claims on "revocable" life estates. For example, if you retain a life estate and, "upon death the remainder to the children," this would not be considered a transfer and your home could be subject to recovery. If the gift deed transfers the home outright to the individual(s) and you retain a life estate, this would be considered irrevocable and would be immune from recovery.

The State cannot recover from IRAs, work-related pension funds or term life insurance policies, unless they name the state as the beneficiary or they revert to the estate. This is rare, as most people name a beneficiary for pension funds and insurance policies.

VII. How Does the State Know When a Medi-Cal Beneficiary Dies?

A. Notice of Death: When a Medi-Cal beneficiary dies, the County Medi-Cal office notifies the Department of Health Services in Sacramento and benefits are terminated. However, for recovery purposes, the burden of notifying the State of the death is still on the beneficiary's estate. California law, under Probate Code §215, requires that, when a deceased person has received or may have received health care benefits or was the surviving spouse of a person who received such benefits, the estate attorney, the beneficiary of the estate, the personal representative or the person in possession of the property is required to notify the Director of the Department (at the Sacramento office of DHS) no later than 90 days after the person's death. A copy of the death certificate is required to be sent.

Although most consumers simply notify the county Medi-Cal office, this does not count as proper notice and it is important that you send the notice and death certificate to the correct address, if you want the matter to be addressed in a timely manner. The notice of death and the death certificate should be sent by registered or certified mail to: Director of Health Care Services, Estate Recovery Unit, MS-4720, P.O. BOX 997425, Sacramento, CA 95899-7425. That way, you have proof of mailing.

B. Filing The Claim: If the estate is subject to probate or trust administration, the State has four months in which to file a claim. If a claim is not filed within this time, it is forever barred. However, many estates are not subject to probate or trust administration. In these cases, although the State has indicated its policy is to respond within four months, there is no law requiring this. By law, in non-probated estates, the Department must file a claim within three years of receipt of the notice of death.

C. Beware of Forms: The Recovery Unit has sent out a number of questionnaires to consumers implying that they are under a legal obligation to complete and return them. The only legal obligation under law is to send a notice of death and a copy of the death certificate when a deceased Medi-Cal beneficiary or the spouse of a deceased beneficiary dies. If the State has sent an estate claim, then the questionnaire is a way for them to find out what property, if any, is left in the deceased beneficiary's estate. If there was no property left in the deceased's name, then completion of the form (or an attached letter) should be an easy matter. Enclose a copy of the deed to show the property was transferred during the life of the beneficiary. If the estate is more complicated, then consumers should seek advise from their attorney, legal services or CANHR before completing and returning any questionnaires or forms.

VIII. How Does a Survivor Appeal an Estate Claim?

A. Hardship Waivers and Estate Hearings: State regulations provide that the applicant (i.e., the dependent, heir or survivor of the decedent) may file for a hardship waiver within 60 days of notice of the claim. The hardship application is provided with the notice of the claim and the itemized billing, along with a copy of the regulations. Consumers are advised to complete the hardship application as completely as possible and to submit substantial documentation to support any hardship. A written decision regarding the hardship application must be sent to the applicant within 90 days of submission of the application. (Although the Department rarely responds within the legal timelines). Under the new regulations, only the applicant's "proportionate share" of the claim will be waived. So, if there is more than one heir, for example, all must file for hardship waivers, unless there is an exempt survivor, e.g., a spouse, a minor or a disabled child.

The applicant may challenge the Department's hardship waiver decision by requesting an estate hearing within 60 days of the date of the Department's hardship waiver decision. The estate hearing is an administrative law hearing and is required to be set within 60 days of the date of the request and must be conducted in the court of appeals district in which the applicant resides. *Always try to preserve your appeal rights by filing within the time limits and try to get legal representation at the Administrative Law Hearing.*

B. Caregiver Exemption: The new regulations state that the Department shall waive the applicant's proportionate share of the claim if he/she provided care to the decedent for two or more years that prevented or delayed the decedent's admission into a medical or long term care institution. The applicant does not have to be related to the beneficiary, but must be a dependent, heir or survivor. The applicant must have resided in the decedent's home while the care was provided and continue to reside there. The applicant must still complete the hardship waiver form and must also submit written medical documentation that shows that the applicant provided a level of care for at least two years that delayed the deceased beneficiary's entry into a medical facility. This includes a statement from the doctor or other medical provider attesting to the deceased's condition prior to entering the medical facility and what specific level and frequency of care the deceased received from the applicant. Declarations from medical providers, copies of pertinent medical records, etc. can be useful in documenting the extent of the caregiving provided.

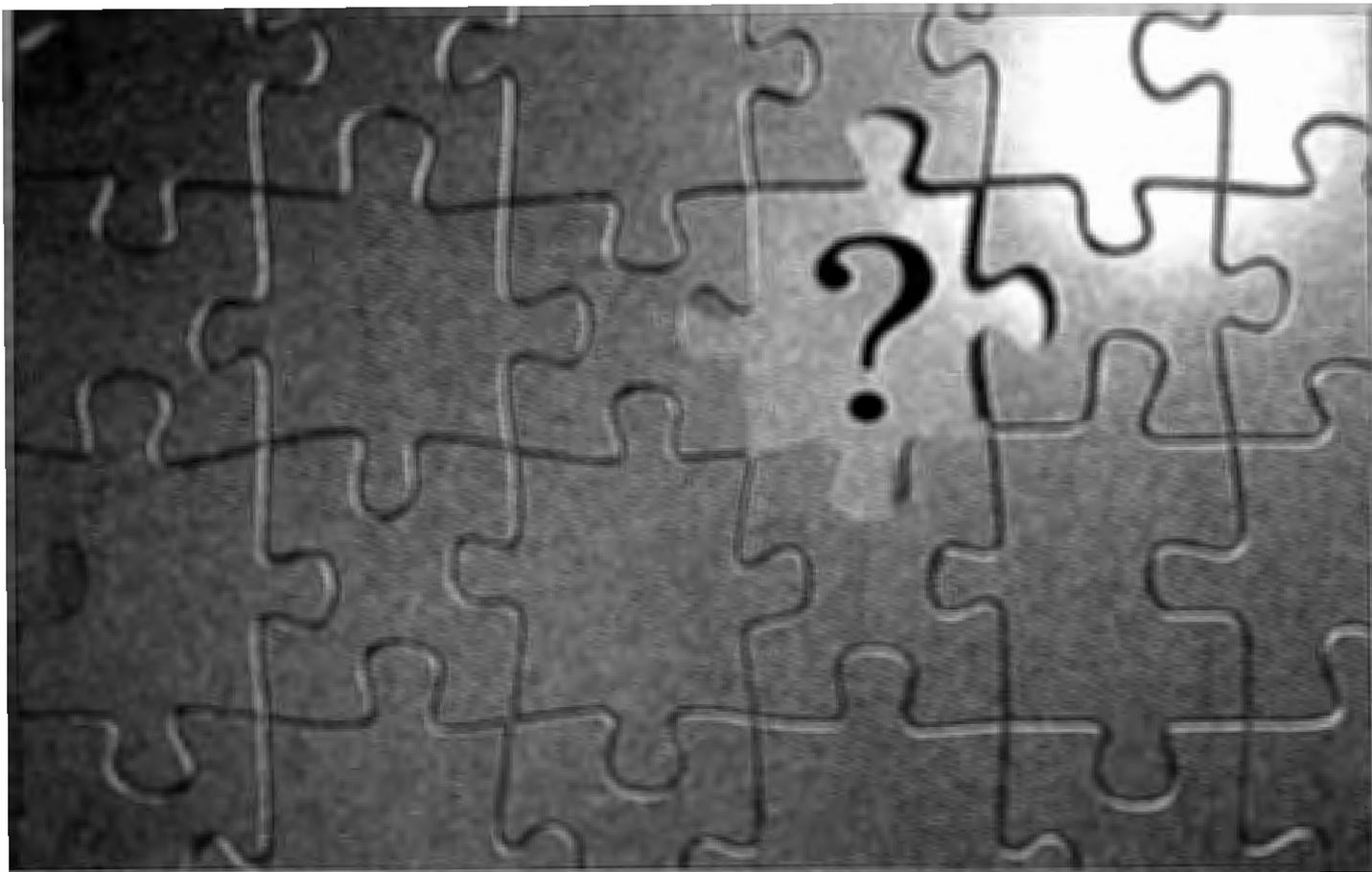
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If You Think You Need A Nursing Home...

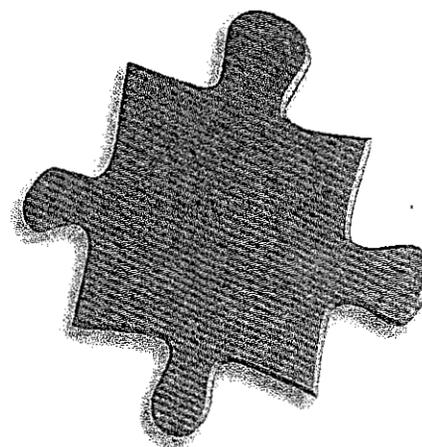


A Consumer's Guide to Financial Considerations and Medi-Cal Eligibility

CANHR

Long Term Care Justice and Advocacy

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ABOUT CANHR

California Advocates for Nursing Home Reform (CANHR), founded in 1983, is a private, not for profit organization dedicated to improving the quality of care and the quality of life for long term care consumers in California. CANHR seeks to educate consumers and to advocate for their rights and remedies under the law and to create a united voice for long term care reform and viable alternatives to institutionalization.

For more information about CANHR or about Long Term Care Medi-Cal, call CANHR at (800) 474-1116 or visit our web site (www.canhr.org).

Copies of this booklet are also available in Spanish and Chinese. Contact the CANHR office for additional copies or bulk orders.

CANHR

Long Term Care Justice and Advocacy

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Preface

This book is intended as a resource for consumers who have questions about Long Term Care Medi-Cal, i.e., those who are in a nursing home or who may need nursing home care. *The information in this book is up to date as of September 2012, and any changes in the law will be posted immediately on CANHR's Web site at www.canhr.org.*

On February 8, 2006, President Bush signed the Deficit Reduction Act (DRA) of 2005 (S. 1932), which includes numerous provisions aimed at denying Medicaid benefits to current and prospective long term care beneficiaries. Although SB 483 was signed by the Governor in 2008 to implement the DRA in California, none of the statutory provisions will become effective until final regulations are filed with the Secretary of State.

Please note that, until the regulations are final and counties have been instructed otherwise, the policies and practices as outlined in this booklet are based on current law.

Planning for long term care sometimes involves complex evaluations and may require extensive estate planning. You may need to change your will or your trust, provide for substitute decision making (durable powers of attorney, advance directives or conservatorships) or transfer assets through a court order.

Be Aware: This booklet is not a substitute for an attorney. It is important to consult with someone who is current on the Medi-Cal laws. We strongly advise that consumers needing estate planning for Medi-Cal purposes consult an attorney who is experienced in estate planning for long term care and Medi-Cal. If you already have an attorney, ask if he/she is familiar with the law in this area. If not, contact your legal services program or CANHR's hotline for up-to-date information on Medi-Cal or call CANHR's Lawyer Referral Service for a referral to an attorney experienced in estate planning for long term care and Medi-Cal.

CANHR's Lawyer Referral Service

The California Advocates for Nursing Home Reform (CANHR) Lawyer Referral Service is certified by the State Bar of California and specializes in issues related to long term care. Clients are referred to panel attorneys who are experienced in the following areas: Estate Planning for Long Term Care (Medi-Cal, wills, trusts, asset preservation, special needs trusts and protective services); Residents' Rights Violations; Elder Fiduciary Abuse; and Personal Injury/Medical Malpractice in nursing homes and residential care facilities. Contact CANHR's Lawyer Referral Service Program at (800) 474-1116.



MEDI-CAL ELIGIBILITY

Medi-Cal is California's version of the Medicaid program that is funded jointly by the state and federal governments. It is designed to help pay for medical care for low income persons and others with limited resources and high medical bills. Although Medi-Cal recipients often receive Medicare, the Medi-Cal program is not related to Medicare Insurance. Medi-Cal is a need-based program: that is, eligibility primarily depends on the amount of income and resources a person has.

Who is Eligible?

If you are 65, blind or disabled and on SSI, you are automatically covered by Medi-Cal. Even if your income is too high to qualify for SSI, you may still be eligible for Medi-Cal if:

- you meet the Medi-Cal resource limits (\$2,000 for an individual, \$3,000 for a couple);
- you are aged 65 or older, blind, or disabled;
- payment of your medical bills would leave you with less than the available "need standard" for your other living expenses;
- you qualify for the Aged & Disabled Federal Poverty Level Program (*see page 10*).

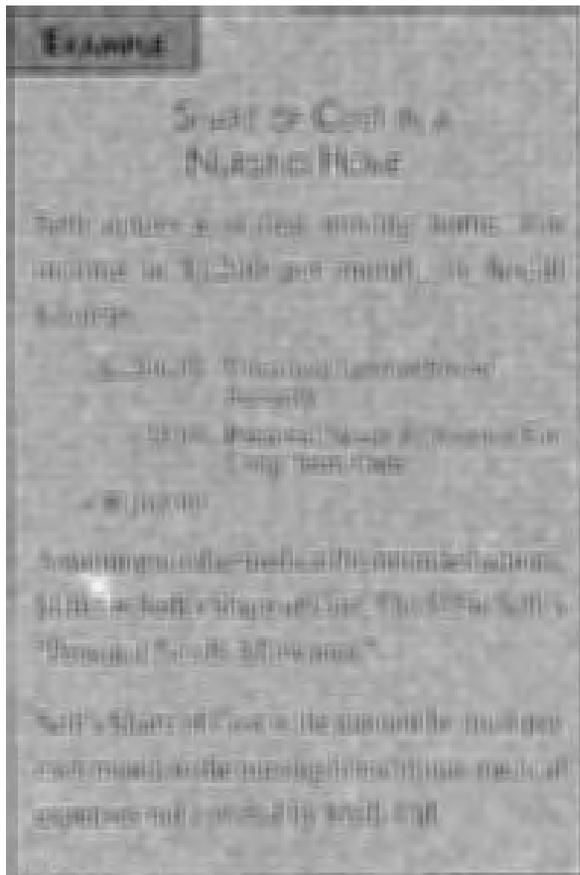
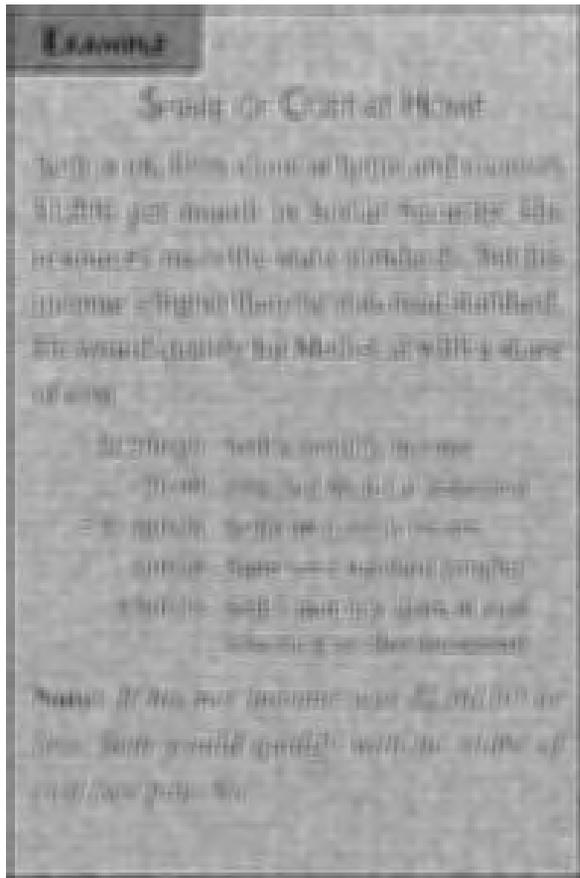
Note: *There are a number of other Medi-Cal programs for special categories of consumers. This book focuses on long term care Medi-Cal.*

What are the Income Limits?

California law has a fixed maintenance need standard for those who are living at home, i.e., the amount of monthly income the state has determined you need for necessary monthly expenses, not including medical bills. The need standard for a single elder (over 65) or disabled person is \$600 per month; for an elder/disabled couple it is \$934 per month, unless you qualify for the Aged & Disabled Federal Poverty Level Program. (*see page 10*)

Generally, if your monthly income is higher than the need standard, or above the aged and disabled level, you will have a "share of cost" for your medical bills each month. Once you pay or agree to pay your monthly "share of cost" towards your medical bills, you will receive a Medi-Cal card, which you can use to pay for Medi-Cal covered services you receive in that month.

The share of cost works much like an insurance deductible and is determined by the Medi-Cal office. The amount of the share of cost is equal to the difference between your gross monthly income, minus deductions, such as insurance premiums (Medicare and/or private insurance), and the need standard.



Are Nursing Home Residents Eligible for Medi-Cal?

Due to the high cost of nursing home care, a majority of California's nursing home residents have part or all of their care paid for by the Medi-Cal program. If your income and resources meet the Medi-Cal standard, you will be eligible for Medi-Cal. *For information on spouses qualifying for Medi-Cal, please see Chapter 2.*

Nursing home residents with outside income may keep \$35 per month for personal needs. Residents whose only income is Supplemental Security Income/State Supplemental Program (SSI/SSP), will receive a payment of \$50 per month as a personal needs allowance.

What Are the Resource Limits?

Medi-Cal classifies property as "exempt" and "non-exempt." Exempt property is not counted in determining eligibility; non-exempt property is counted.

The following property is generally exempt and, therefore, not counted in determining eligibility:

- ❑ **The Home:** totally excluded, if it is the principal residence. Includes mobile home, houseboat, or an entire multi-unit dwelling, as long as any portion serves as the principal residence of the applicant. The property remains exempt if a person in a nursing home or the person's representative expresses an intent to return home on the current Medi-Cal Application and Statement of Facts (*see Chapter 3, "Your Home"*).
- ❑ **Other Real Property:** can be exempt if the net market value of the property is \$6,000 or less and if the beneficiary is "utilizing" the property, i.e., receiving yearly income of at least 6% of the net market value.
- ❑ **Business Property:** may be excluded if it is used in whole or in part as a business or means of self-support. It must meet business property guidelines in order to be considered exempt.

- ❑ **Household goods and personal effects:** totally exempt.
- ❑ **Jewelry:** for a single person, wedding, engagement rings and heirlooms are totally exempt and other items of jewelry with a total net market value of \$100 or less are exempt; for spouses (when one spouse is in a nursing home) there is no limit on exempt jewelry for determining institutionalized spouse's eligibility.
- ❑ **One car** is exempt if used for the benefit of the applicant/beneficiary or if needed for medical reasons.
- ❑ **Whole Life Insurance** policies with a total face value of \$1,500 or less. If the total face value of the policy or policies is over \$1,500, then the entire cash surrender value is counted toward the cash reserve (limited to \$2,000 for a nursing home resident).
- ❑ **Term Life Insurance:** totally excluded.
- ❑ **Burial plots:** totally excluded.
- ❑ **Prepaid irrevocable burial plan of any amount and \$1,500 in designated burial funds:** the designated funds must be kept separate from all other accounts. Accumulated interest on burial funds is also exempt.
- ❑ **IRAs and work-related pensions:**
 - In the applicant's or beneficiary's name: the cash surrender value or balance, regardless of value, shall be considered unavailable if the applicant or beneficiary receives periodic payments (of any amount) of interest and principal. (Title 22, §50402(e)) These do not need to meet the Medi-Cal requirements for annuities. The payments will count toward the monthly share of cost.
 - In the community spouse's name: totally exempt from consideration, regardless of value; nor is the cash surrender value included in the CSRA. (Title 22, §50458) However, any income the community spouse receives will be counted in determining the community spouse's allocation from the nursing home spouse, if he or she receives such an allocation.
- ❑ **Non work-related annuities:**
 - Annuities purchased prior to 8/11/93: the cash surrender value or balance of the annuity is considered unavailable if the applicant/beneficiary is receiving periodic payments (of any amount) of interest and principal. (Title 22, §50402(e)) Remember, this is the old law, so annuities purchased before the new federal law will be treated under the old law.
 - Annuities purchased between August 11, 1993 and March 1, 1996: annuities purchased between 8/11/93 (the date the federal law changed) and 3/1/96 (the date the state regulations went into effect) must meet the new regulations, which can be waived for hardship. Once the individual or spouse takes steps to receive periodic payments of interest and principal, the balance is considered unavailable. However, the payments must be scheduled to exhaust the balance at or before the end of the annuitant's life expectancy.

For example, under the actuarial table used for Medi-Cal, an 85-year-old female has a life expectancy of 6.63 years. Thus, the annuity must be structured to pay out the balance of the annuity at or before 6.63 years. If the annuity is scheduled for longer than that, 10 years for example, it will be considered to be a transfer of assets, and a period of ineligibility could be imposed.

- **Hardship:** annuities purchased during this period that cannot be restructured to meet the new requirements will continue to be treated under the old rules (§50402). Written verification that the annuity cannot be restructured must be obtained from the company or agent who issued or sold the annuity.
- **Annuities purchased on or after March 1, 1996:** must meet the new requirements, no annuity hardship provisions apply. The individual or spouse must take steps to receive periodic payments of interest and principal, scheduled to exhaust the balance of the annuity at or before the end of the annuitant's life expectancy. Annuities structured to exceed the life expectancy of the annuitant will result in denial or termination of benefits due to transfer of assets.
- **Annuities purchased on or after September 1, 2004:** the Department of Health Services has promulgated emergency regulations effective August 2, 2004, pertaining to recovery on annuities. Annuities purchased by the beneficiary on or after September 1, 2004, will now be subject to recovery regardless of whether the annuity is designed to pay a lump sum or periodic payments upon the death of the decedent.

Note to Consumers: be cautious of annuity sales agents who state that annuities are the "only" way to become eligible for Medi-Cal without losing all your assets. There are many exceptions in the Medi-Cal rules, and buying an annuity is not a substitute for responsible estate planning.

- ❑ **Cash Reserve:** applicant/beneficiary may retain up to \$2,000 in liquid assets, e.g., savings, checking, excess cash surrender value of life insurance policies.
- ❑ **Community Spouse Resource Allowance (CSRA):** community (at-home) spouse may retain up to \$113,640 as of 1/1/2012 in liquid assets, not including the home, IRAs and other exempt assets (*see Chapter 2 for spousal rules*).
- ❑ **Trusts:** assets held in revocable living trusts will be considered available, depending on the asset. Assets held in certain types of trusts created after August 11, 1993, will no longer be considered exempt and the corpus and income from these trusts will be counted. See your attorney if you have questions about whether your trust meets the Medi-Cal guidelines.

Any assets **above** the property reserve limit of \$2,000 or any asset that is not exempt will be counted by Medi-Cal in determining eligibility. These include cash, savings, stocks, the cash surrender value of whole life insurance if the face value exceeds \$1,500, and any other nonexempt resource. Note that, with the exception of the spousal protection provisions, these same exemptions apply to those who receive Medi-Cal who are not in nursing homes.

Treatment of Reverse Mortgage Payments/Home Equity Payments

Although the new federal law encourages individuals to reduce the equity value of their homes by using reverse mortgages or home equity loans, keep in mind that any equity borrowed from your home in the form of a lump sum or a line of credit may be counted as an asset for the purposes of Medi-Cal eligibility.

Lines of credit, if not drawn down, are not included in the property reserve and therefore do not count as countable assets. If the line of credit is drawn down, it is counted as a loan requiring repayment and included in the property reserve, i.e., counted as part of the assets. However, most lines of credit are drawn down for a specific purpose - to repair a roof, for example - and are spent down at the same time they are drawn down.

Annuities: some organizations will advise that a lump sum equity loan be used to purchase an immediate annuity or even that a reverse mortgage be used to fund an annuity. Not only are the periodic proceeds from these annuities counted as income and toward the share of cost, but annuities purchased on or after September 1, 2004, are subject to estate recovery. RAMs are reverse annuity mortgages. If the lender (the bank) purchases an annuity to fund a stream of payments to the borrower from the equity in the home, then the payments to the borrower are treated as income in the month received, because they are annuity payments. However, the annuity is owned by the lender and is not subject to the state's annuity rules. If the borrower purchases the annuity, then it is also treated as income in the month received, but must meet the state's annuity rules and it will be subject to the recovery provisions.

Other Reverse Mortgage Lump Sums/Stream of Payments: reverse mortgages may also be made in a stream of income from the lender directly to the borrower or the payment may be in the form of a lump sum payment. In either case, since an annuity has not been purchased, these payments would be considered property in the month of receipt, and any excess would have to be spent down in order to avoid being disqualified for excess property.

California law mandates that potential borrowers receive financial counseling from a Department of Housing and Urban Development (HUD) approved counselor before applying for a reverse mortgage. The law also prohibits lenders from requiring a borrower to purchase an annuity as a condition of obtaining a reverse mortgage loan.

While reverse mortgages can be a beneficial option for some homeowners, they are rarely beneficial to those individuals who are likely to enter a nursing home in the near future.

There are many reputable reverse mortgage lenders. However, consumers should beware of phone and mail solicitations and always seek third party professional advice before signing any loan documents. For more information on reverse mortgages, see CANHR's web site.

Can You Spend Down Resources?

You may spend down your resources to the \$2,000 limit in order to become eligible for Medi-Cal. Resources must be reduced to the \$2,000 level by the end of the month in which you want to be eligible. If, for example, you apply for Medi-Cal on January 3, 2012, your resources must be reduced to \$2,000 by January 31, 2012.

Considering the average cost of nursing home care is \$7,000+ per month, assets can be spent down rather quickly. You may spend down your assets on any item for your own benefit: to remodel or repair the home, buy new furniture or pay off a mortgage or car loan, pay off other bills and debts, buy new clothing, or medical equipment. You can also convert nonexempt assets into exempt assets, e.g., using nonexempt cash reserves to buy a burial plot and/or create a prepaid burial fund. You must provide evidence regarding these expenditures to Medi-Cal, so keep receipts and check stubs.

While spending down is usually easy to do and document, it may be difficult to find a nursing home if you have no resources and must find a bed in a Medi-Cal certified facility. The longer you can pay as a private pay resident, the more options you will have when looking for a nursing home. Medi-Cal pays less per day than the amount a facility will charge a private pay resident.

Although "duration of stay" requirements (i.e., making a resident pay privately for a set period of time) are illegal, nursing homes are legally permitted to review potential residents' finances prior to admission. In some cases, even though Medi-Cal discrimination is illegal, facilities are unwilling to accept residents who are eligible for Medi-Cal upon admission. However, since Medi-Cal rates have increased substantially over the past year, this may not be as much of a problem as in the past.

Keep in mind that, once you have been admitted to a Medi-Cal certified facility for 30 days, you cannot be transferred or evicted simply because of a change from private pay to Medi-Cal payment status even when a (illegal) duration of stay contract has been signed. This applies while the Medi-Cal application is pending, as well.

Can You Give Away Assets and Still Be Eligible for Medi-Cal?

The Medi-Cal application includes a question that asks if you gave away or gifted any non-exempt (countable) assets in the previous 30 months. This 30-month "look-back" period is used to determine if an institutionalized Medi-Cal applicant made a transfer or gift of nonexempt assets to a third party, excluding the spouse. If such a transfer is determined, a period of ineligibility may be imposed. An "improper" transfer is basically giving away property in order to qualify for Medi-Cal, without receiving something of equal value in return. This does not mean that every gift you made in the previous 30 months will result in a penalty. You can still give away (gift) or transfer property and be eligible for Medi-Cal depending on *when* you gave away the asset, *how much* you gave away and whether or not you enter a nursing home. The new federal laws under the DRA require a 60-month look-back for transfer of assets. However, California has not implemented the federal laws yet, and **Medi-Cal offices are still required to use the 30-month look-back period.**

The transfer rules will be applied to transfers made **during the 30 months prior to the date** when a nursing home resident **applies** for Medi-Cal or when a Medi-Cal recipient enters a nursing home. In addition, current Medi-Cal beneficiaries who are nursing home residents can also be penalized for transfers made for less than fair market value. There are no restrictions on gifting until or unless the applicant enters a nursing home.

How is the Transfer Rule Triggered?

The transfer rule is only triggered when you enter a nursing home and apply for Medi-Cal. The Medi-Cal application (called the Statement of Facts) will ask if you transferred any property or made any gifts within the prior 30 months. The Eligibility Worker will ask to review all of your bank statements, etc., for that period. The transfer rules apply only to non-exempt (countable) assets.

An improper transfer can result in a period of ineligibility, which is the lesser of 30 months or the value of the transferred asset divided by the monthly average nursing home private pay rate at the time of application. For 2012, this amount is \$7,092.

EXAMPLE	Illustration of Asset
John transferred \$50,000 to his wife in March 2012. He plans to enter a nursing home and apply for Medi-Cal in September 2012.	
Because John gave the cash money within 30 months before applying for Medi-Cal, he could be found ineligible for a period of time. The period would be the lesser of 30 months or \$50,000 divided by the monthly average nursing home private pay rate in California.	
The rate will be the rate in effect for the 2012 rate of \$7,092 per month. The period would be the lesser of 30 months (ending from the month of transfer, March 2012, and ending June 2012) or \$50,000 divided by \$7,092 = 7.05 months. The final period would be 7 months.	
Because John will not apply until September 2012, he will be eligible for Medi-Cal because his penalty period will have already expired. That a period of ineligibility will not be imposed.	
It is very important to wait until the penalty period has expired before you apply for Medi-Cal.	
In January 2012, John transferred \$50,000 to his wife. He plans to apply for Medi-Cal in September 2012. He will not be eligible for Medi-Cal.	

Non-Penalized Transfers

Transfer restrictions apply only to persons who are in or are going into nursing homes and who are on or applying for Medi-Cal. **There are currently no transfer restrictions for beneficiaries who receive Medi-Cal at home.** Not all transfers are subject to the new transfer rules, and not all transfers result in a period of ineligibility. Transfer penalties *will not apply* if the transfer was made:

- with the intent to dispose of the resource either at fair market value or for other valuable consideration;
- exclusively for a purpose other than to qualify for Medi-Cal;
- to a spouse (*see Chapter 2*);
- to a blind or totally disabled child of any age;
- if the asset was exempt; or
- if denial of eligibility would result in undue hardship.

You can make a gift of any exempt property, (e.g., a wedding ring, car, etc.,) at any time without affecting Medi-Cal eligibility. You can also transfer anything at any time to a blind or disabled child of any age. Because of tax issues and other restrictions, it is wise to check with your attorney if you would like to make a gift of some part of your resources.

Joint Accounts

If an applicant has unrestricted access to a checking or saving account, the entire amount of the account will be included in the property reserve, unless it can be shown that all or a portion of the funds do not belong to the applicant. Thus, if you keep your mother's name on your savings account to avoid probate, this could be a problem if your mother applies for Medi-Cal, unless you can clearly establish that all or a portion of the funds are yours.

Share of Cost

If you meet the eligibility requirements and if there is authorization from a doctor or health care provider, your nursing home care will be covered. You must be admitted on a doctor's order and the stay must be "medically necessary."

If you have income, you must pay a "share of cost" of the nursing home charge, and Medi-Cal will pay the rest of the costs. The share of cost is calculated by the Medi-Cal office, and you will receive a Notice of Action from the Medi-Cal office informing you: a) whether the application has been approved; and b) the amount of the share of cost. Once you pay the share of cost, Medi-Cal will pay the facility the difference between the share of cost and the Medi-Cal per diem rate.

Old Medical Bills: if you have unpaid medical bills (going back as far as four years), you can ask the Eligibility Worker to deduct the payments for these from current and future share of cost. Ask the Eligibility Worker about *Hunt v. Kizer* deductions.

If you qualify for Medi-Cal, you may not need private insurance, though if other insurance is carried, the premiums are deducted from income when computing the share of cost.

Gross v. Net Income: since the "gross" income rather than the "net" income is used, some beneficiaries end up having to pay a share of cost that is higher than their net incomes. One way to avoid this problem is to terminate tax liability, i.e., have the pension fund stop deducting taxes from the beneficiary's pension. You can change the amount of taxes deducted by filing a Form W-4P. Contact your accountant or a tax specialist for this and to determine how payments made for nursing home care can be tax deductible.

Always Pay SOC: if the resident receives Social Security or other monthly income, he/she will usually have a share of cost. Do not let that income accumulate in the resident's account, as this could potentially jeopardize Medi-Cal eligibility. It is usually best to pay a monthly "estimated" share of cost to the facility if approval of Medi-Cal is delayed. This will avoid accumulating more than the \$2,000 asset limit and avoid an unpaid share of cost later.

Signing the Admission Agreement

If you are signing the admission agreement on behalf of a resident, be careful to sign as an "agent" and not as a "responsible party," which can make you personally liable for unpaid charges in the facility. Facilities are prohibited from requiring that you sign as a "responsible party" for the resident. However, some admission agreements are misleading. Note that an agent under a power of attorney, a conservator or a representative payee is not a responsible party even if the admission agreement is signed as such.

If you are an agent for the resident, i.e., you manage or have control over the resident's income or assets, be sure to use the monthly income to pay the share of cost. Willful shirking of this duty can be a misdemeanor. An agent is only responsible for the amount of the resident's funds received but not distributed to the facility as required and does not assume personal responsibility for the resident's debts.

Expenses Not Covered By Medi-Cal

Residents of nursing homes may deduct the costs for uncovered medical expenses, such as certain drugs, hearing aid batteries, extra eye glasses, dentures, etc., and other medical equipment and supplies not covered under the Medi-Cal program from the monthly share of cost. A current physician's prescription is necessary and must be put in the resident's record at the facility. This prescription must be a part of the physician's plan of care. Ask the facility about this.

When and Where to Apply

You should apply for Long Term Care Medi-Cal as soon as you know your (or your spouse's) assets will be \$2,000 or less by the end of the month of application. If you are a single individual, you need to have long term care status, i.e., inpatient medical care which lasts for more than the month of admission and is expected to last for at least one full calendar month after the month of admission. For spousal impoverishment rules to apply, the spouse must have a continuous period of institutionalization, i.e., when the spouse has remained or is expected to remain in a medical institution or nursing facility for 30 or more consecutive days. Contact the county welfare or social services department (Medi-Cal Eligibility Unit) to apply for Long Term Care Medi-Cal benefits. If you are on Medi-Cal at home, you still need to apply for Long Term Care Medi-Cal if you need Medi-Cal in a nursing home. See CANHR's web site for a list of local offices.

What If Your Application is Denied?

You can file for a fair hearing if you think your application for benefits was improperly denied. The Notice of Action must tell you why you were denied and the applicable regulations or laws. The reverse side of the Notice of Action will inform you as to your rights to a hearing. You can also file for a hearing when the county takes more than 45 days to process your application (as long as the delay is not your fault) or to contest the share of cost. It is important to file for a hearing within the time limits.

If you are *not* already on aid and you win the hearing, the benefits could be retroactive to the month of application. If you *are* already receiving Medi-Cal, a timely appeal will ensure that your Medi-Cal is not terminated until the outcome of the hearing. Contact your local legal services office for assistance with Fair Hearings.

Aged and Disabled Federal Poverty Level Program

As of April 1, 2012, an aged or disabled person with countable income at or below \$1,161 or couples with an income at or below \$1,571 could be qualified for the Aged & Disabled Medi-Cal Program (A&D FPL) and pay no share of cost. Qualified individuals must be aged 65 or older or disabled and **not in long term care**. Therefore rates will remain the same. For more information, contact your county Medi-Cal office and see A&D FPL fact sheet at www.canhr.org.

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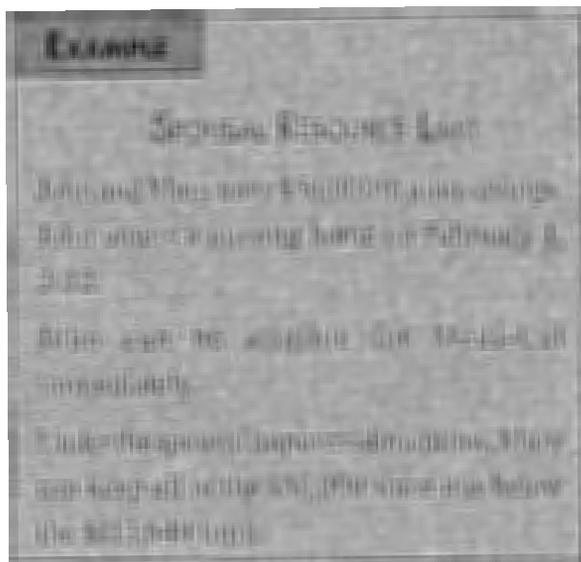
IF YOUR SPOUSE MUST ENTER A NURSING HOME

What is the Law?

Federal laws enacted in 1988 included provisions to prevent the impoverishment of the at-home spouse when one spouse entered a nursing home. California implemented these "spousal impoverishment" provisions in January 1990. Although the federal laws were amended by the August 10, 1993, passage of the federal OBRA 93 Medicaid amendments and again by the federal Deficit Reduction Act of 2005, California has not yet implemented the new federal laws.

Resources

The California law allows the community spouse (i.e., the at-home spouse) to retain a certain amount in nonexempt resources available to the couple at the time of application. This Community Spouse Resource Allowance (CSRA) increases every year according to the Consumer Price Index. For 2012, the at-home spouse can keep up to \$113,640 and the institutionalized spouse can keep up to \$2,000 in a separate account (*see Chapter 1*).



What If You Have Separate Property?

Separate property, i.e., money from an inheritance or bequest or from a previous marriage, will be counted in the total resources and subject to the \$113,640 CSRA limit for the community spouse, with the exception of IRAs and work-related pensions in the at-home spouse's name.

What Resources are Counted?

Only nonexempt resources are counted in the spouses' combined countable resources at the time of application for Medi-Cal. Assets such as household goods, personal effects, jewelry, the principal residence, one car, burial plots, burial trusts, and term life insurance are all totally excluded, regardless of their value (*See Chapter 1, "Resource Limits"*).

Work-Related Pensions and IRAs

Pension funds and IRAs *do not have to be liquidated* in order to qualify for Medi-Cal. Under California law, the cash surrender value, or balance, of pension funds and IRAs, regardless of value, are considered unavailable if the applicant or beneficiary is receiving periodic payments of both interest and principal. A “periodic” payment can be weekly, monthly, annually, etc. There is no minimum amount of periodic payment required for Medi-Cal purposes. Any income received, however, will be counted toward the share of cost.

Pension funds or IRAs in the name of the community spouse are totally exempt from consideration and do not have to be generating income. These funds are not counted as part of the CSRA, either.



Non Work-Related Annuities

Annuities purchased prior to August 11, 1993, are treated like work-related pensions and IRAs, and only have to generate periodic payments of interest and principal. However, effective March 1, 1996, the expected return on the annuity must be commensurate with the life expectancy of the beneficiary (See Chapter 1, “Resource Limits” for details). **Be careful:** a non-qualifying annuity can result in a denial of eligibility and, if the annuity is purchased by the beneficiary on or after September 1, 2004, it will be subject to recovery.

After Your Spouse is Eligible for Medi-Cal

Resources you acquire *after* your spouse is institutionalized *but before* she or he goes on Medi-Cal *are not protected* and will be counted at the time of application for Medi-Cal. However, once your spouse is eligible for Medi-Cal, any resources acquired by you will not affect your spouse’s Medi-Cal eligibility.

Mary, for example, could inherit \$100,000 after John is found eligible for Medi-Cal, and this will not affect John’s eligibility. If you are thinking of selling an asset like your home, for example, it is best to wait until after your spouse is on Medi-Cal. You must also remove your spouse’s name from the home before you sell it or half of the proceeds will be considered available to the institutionalized spouse, disqualifying him or her from Medi-Cal.

Physical Separation of Assets/Recordkeeping

Once the resource limit has been reached, the institutionalized spouse must transfer to the community spouse any ownership interest she or he maintains in the community spouse resource allowance. Whenever possible, that which can be physically separated should be (e.g., a joint account with the nursing home spouse to pay the share of cost; a separate checking account for the at-home spouse and a savings account in the at-home spouse's name alone), keeping accurate records for each of you. Medi-Cal allows a 90-day period from the date of application to separate spousal assets, so it's important to apply for Medi-Cal if you want coverage for this period.

When your spouse applies for Medi-Cal (or if you apply for him/her), you will need to show the total amount of separate and community assets you have as of the date of application.

Once your spouse is on Medi-Cal, you don't have to account for your own assets, except to the extent that any changes in income may affect the share of cost. However, any assets the Medi-Cal spouse receives may affect his or her eligibility. Changes in either of your incomes or an increase in your spouse's assets must be reported to Medi-Cal within 10 days.

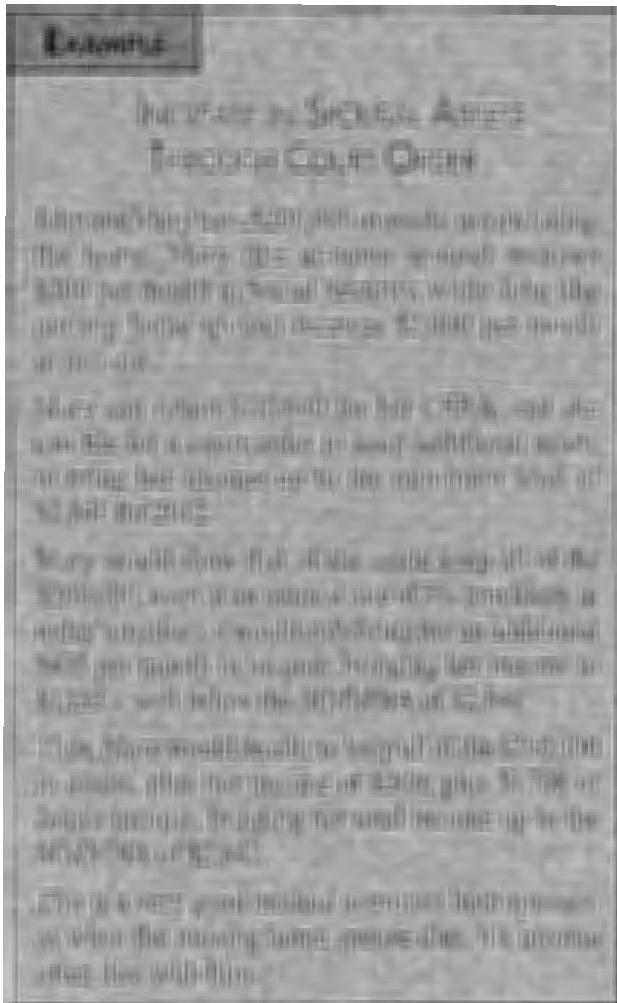
Spending Down Resources

Your spouse can always spend down resources by purchasing an exempt asset (see Chapter 1, "Resource Limits"). In addition, your spouse can spend down resources on anything, whether or not it is for her or his "own benefit." For example, the nursing home spouse could pay off the mortgage on the home even if the home is later transferred to the at-home spouse.

How is Your Income Divided?

California law has established a floor of income for the at-home spouse called the "minimum monthly maintenance needs allowance" (MMMNA). This allowance is adjusted annually by a cost of living increase. The 2012 MMMNA is \$2,841. If the at-home spouse's income is in his or her name only, under the "name on the instrument" rule, he or she will be able to keep it all.

Example	COMMUNITY SPOUSE MAKES <u>LESS THAN \$2,841</u>
<p>John and Mary own a home in California. Mary lives in the nursing home and John lives at home. Mary's income is \$2,841 per month and John's income is \$2,841 per month.</p> <p>John's income is \$2,841 per month and Mary's income is \$2,841 per month.</p>	<p>John's income is \$2,841 per month and Mary's income is \$2,841 per month.</p> <p>John's income is \$2,841 per month and Mary's income is \$2,841 per month.</p>
<p>John and Mary own a home in California. Mary lives in the nursing home and John lives at home. Mary's income is \$2,841 per month and John's income is \$2,841 per month.</p> <p>John's income is \$2,841 per month and Mary's income is \$2,841 per month.</p>	<p>John's income is \$2,841 per month and Mary's income is \$2,841 per month.</p> <p>John's income is \$2,841 per month and Mary's income is \$2,841 per month.</p>
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Fair Hearings

Either spouse can file for a Fair Hearing to allow the at-home spouse to keep additional income-generating resources. This is one way to increase the CSRA above the \$113,640 limit if the spouse at home has limited income, i.e., income below the \$2,841 level and if the nursing home spouse's income, when added to the at-home spouse's income, would still not be enough to meet the \$2,841 MMMNA level.

A Fair Hearing can also be filed to allow the at-home spouse to retain additional income if it can be shown that exceptional circumstances exist that are the cause of extreme financial distress. For example, extraordinary medical expenses for the at-home spouse could result in extreme financial distress warranting a Fair Hearing to increase the income allocation (MMMNA) above the \$2,841 level.

Court Orders

A court order can be obtained to allow the community spouse to retain assets over the community spouse resource allowance of \$113,640 or to retain income over the \$2,841 MMMNA:

- If you (the at-home spouse) receive less than \$2,841 per month in income, and you need to retain resources to generate additional income.
- If your spouse is mentally incapacitated and you need to transfer the home, transfer other assets or gain access to accounts.

Contact your attorney or CANHR's LRS for an attorney if you need a court order.

3

YOUR HOME

Transfer of Interest in Your Home

It is strongly suggested that you consult with an attorney experienced in Medi-Cal and Estate Planning for Long Term Care before any transfer is made. There could be legal issues, as well as tax considerations, that will affect your decision.

Under federal law, title to the principal residence may be transferred at any time to the following persons:

- a spouse;
- a son or daughter under age 21 or who is blind or permanently disabled;
- a sibling who has equity in the home and who was residing there for at least one year immediately prior to the individual's admission to a nursing home;
- a son or daughter who was living in the home for at least two years immediately prior to the individual's admission to a nursing home and who provided care which enabled the parent to live at home;
- to anyone, so long as the home was exempt at the time of transfer.

When Your Home is Exempt

Your home is exempt from consideration as a resource (and remember, you can transfer an exempt resource) when you are on Medi-Cal under any of the following circumstances:

- If the beneficiary's spouse, child under age 21, or "dependent relative" continues to reside in the home.
- The residence is inhabited by the recipient's sibling or son or daughter who has resided there continuously for at least one year prior to the date the recipient entered the nursing home.
- There are legal obstacles preventing the sale of the home, and the applicant/beneficiary provides evidence of attempts to overcome such obstacles.
- The home is a multiple dwelling unit, one of which is the principal residence of the beneficiary.
- If during any absence, including nursing home stays, the beneficiary intends to return home, and states so in writing. If the beneficiary is mentally incapacitated, a family member or someone acting on her or his behalf may state this intent. The Medi-Cal

application simply asks whether or not the applicant intends to return home. **Always indicate "yes."** Under California law, it is not necessary to show that the applicant can actually return home.

If your home is exempt under one of the above circumstances, you can transfer your home without affecting Medi-Cal eligibility. If your home is exempt on the basis that you "intend to return home," you need a declaration from the person to whom you are transferring the home stating that you "...can return to live there at any time."

Just because your home is exempt for the purposes of Medi-Cal eligibility while you are alive, it does not prevent the state from placing an estate claim on the property *after your death*; the manner in which you transfer your home is equally important.

Transfer of the Home to a Spouse

The law allows the spouse in the nursing home to transfer his or her interest in the home to you, the at-home spouse. This applies whether the transfer occurs prior to or after your spouse enters a nursing home. *If the nursing home spouse no longer has any interest in the home*, you can do anything you want with the home without worrying about affecting the Medi-Cal eligibility of your spouse. You can move out of the home, rent it, sell it (and retain all of the money from the sale), all without affecting your spouse's Medi-Cal eligibility. **Note:** *A transfer of the home while the nursing home spouse is alive will also prevent a later estate claim after the at-home spouse dies.*

However, if you sell the home *before* your spouse applies for Medi-Cal, even if the home is in your name alone, the assets from the home will be considered with all the other nonexempt assets held by both of you, and you will still be limited to the community spouse resource allowance of \$113,640. If you intend to sell the home, it is best to wait until after your spouse is on Medi-Cal and the home is in your name only, because assets acquired by the at-home spouse after Medi-Cal eligibility is established are not counted.

Life Estates, Occupancy Agreements and Other Options

Nursing home residents, in particular, tend to be concerned about losing their family homes. Most nursing home residents transfer property to avoid probate and to avoid future Medi-Cal estate claims that would force the sale of the property. Tax issues are also considerations, as inter vivos (during life) transfers of property can result in substantial capital gains taxes.

At the same time, nursing home residents, already stripped of most of their independence, are often reluctant to completely relinquish control of their property. Although living trusts, joint tenancies and tenancies in common are no longer protected from estate claims, there are still a number of ways in which nursing home residents can transfer their homes and 1) avoid probate; 2) avoid capital gain consequences; 3) avoid Medi-Cal estate claims; and 4) retain some control over their property.

- **Life Estates:** allow you to transfer title to the home while retaining control over the property during your life; avoid tax consequences attached to an outright transfer; avoid probate; and, if the transfer is current and irrevocable, avoid an estate claim. Under the Medi-Cal recovery rules, claims on irrevocable life estates are waived, but the state is placing claims on “revocable” life estates. For example, if you retain a life estate and, “upon death the remainder to the children,” this would not be considered a transfer and your home could be subject to recovery. However, if you make an irrevocable transfer of the property and retain a life estate, neither the life estate nor the remainder interest is subject to recovery.
- **Occupancy Agreements:** allow you to transfer title to the home, while retaining a current right of occupancy; avoid probate; avoid tax consequences; and avoid estate claims.
- **Other Options:** there are a number of other legal options, such as irrevocable trusts, available to meet some or all of the above considerations. If you are considering any real estate transfer, you should consult a qualified attorney who is knowledgeable about Medi-Cal and property transfers.

Note: *You should always check with legal services or an experienced estate planning attorney if you are considering transferring your home or an interest in your home.*

4

LIENS & ESTATE CLAIMS

Consumers often confuse liens and estate claims. Both have been used by the state in attempts to reimburse the Medi-Cal program for payments made to beneficiaries. Liens are imposed on living beneficiaries' estates to "hold" the property until the beneficiary dies. Estate claims are claims made against the estate of the deceased Medi-Cal beneficiary.

Your home, for example, may be an exempt asset while you are alive and is not counted for Medi-Cal eligibility purposes. However, *if the home is in your name when you die*, the state can make a claim against your estate for the amount of Medi-Cal benefits paid. In 1993, California greatly expanded the ability of the state to recover on the property left by deceased Medi-Cal beneficiaries. The information below can assist you in understanding the recovery laws and your rights regarding recovery.

Can the State Place a Lien on Your Home?

For a brief period of time, California law permitted liens against the homes of nursing home Medi-Cal beneficiaries who were not "reasonably expected" to return home, and against the real property of the surviving spouse of a deceased nursing home beneficiary.

California is no longer permitted to impose liens against the homes of nursing home residents or their surviving spouses except in cases where the home is not exempt and is being sold or where the heirs or survivors have signed a "voluntary" lien for Medi-Cal recovery purposes after the beneficiary has died.

Estate Claims

After the beneficiary's death, the state can make a claim against the estate of an individual who was 55 years of age or older at the time he or she received Medi-Cal, or an individual of any age who received Medi-Cal in a nursing home, unless there is a surviving spouse or a surviving minor, blind or disabled child (of any age). Thus, if there are any assets left in the estate of the deceased beneficiary, Medi-Cal will seek to be reimbursed for benefits paid, whether or not the beneficiary was in a nursing home.

California now seeks recovery from any real or personal property or any other assets in which the individual had any legal title to or interest in at the time of death. This means that the state can place a claim against joint tenancies, tenants in common, living trusts, or revocable life estates. This includes assets received by a surviving spouse by distribution or survival, e.g., assets left by a will or in community property. Thus, the state could recover after the surviving spouse dies, if the property has not been transferred to the well spouse during life. The state can also recover from annuities purchased on or after September 1, 2004.

Right to a Hearing / Hardship Claims

Once the Medi-Cal beneficiary has died, the estate (the estate attorney, the personal representative or the person in control of the property) is required to send notice of death and a copy of the death certificate to the Director, Department of Health Care Services, Estate Recovery Unit, Mail Stop 4720, P.O. Box 997425, Sacramento, CA 95899-7425. Registered or certified mail is recommended so you have proof of date of mailing. You do not have to complete any estate recovery “questionnaires,” as your only legal obligation is to send notice of death and a death certificate.

If the estate is subject to probate or trust administration, the state has four months from receipt of notice in which to file a claim. If a claim is not filed within this time, it is forever barred.

However, many estates are not subject to probate or trust administration. In these cases, the Department must file a claim within three years of receipt of the notice of death.

You have the right to file for a waiver of the claim, to contest the amount of the claim and to appeal any denials of hardship waivers. For more information on Medi-Cal Recovery, see the *Medi-Cal Recovery Frequently Asked Questions* on CANHR’s web site at www.canhr.org.

How Can You Avoid an Estate Claim?

The best way to avoid an estate claim is not to have anything in your estate when you die. Medi-Cal applicants who have a home they would like to leave to their spouse or to their children and who wish to avoid Medi-Cal recovery should consider transferring the interest in the home in some way before death (See Chapter 3, “Your Home,” for options). If you have a spouse in a nursing home and are concerned about an estate claim, you might consider having the institutionalized spouse’s interest in the home transferred to you—the at-home spouse.

Any transfers of real property should be reviewed with a qualified Medi-Cal knowledgeable estate planning attorney. Real property transfers usually involve tax consequences, which need to be considered.

CANHR SERVICES

- ❁ **Consumer Information Service:**
Provides pre-placement counseling, including information on choosing a nursing home, Medi-Cal, residents' rights, services and quality information on California's nursing homes and residential care facilities; assistance with complaints; and community education on long term care issues. Please contact us at (800) 474-1116 (consumers only).
- ❁ **Lawyer Referral Service:**
Provides referrals to qualified attorneys in California specializing in estate planning, conservatorships, special needs trusts, residents' rights, elder financial abuse and elder abuse in nursing homes and other institutions.
- ❁ **Family Council Organizing:**
Assists relatives and friends of nursing home residents in forming Family Councils in individual facilities.
- ❁ **Legal Information Network:**
Provides legal services and private bar attorneys with training and information in the areas of estate planning and long term care issues.
- ❁ **Legal Services Support:**
Provides training, technical assistance and advocacy support to Legal Services Projects throughout California.
- ❁ **Legislative and Administrative Advocacy Support:**
Develops corrective legislation and clarification of current regulations and policies related to long term care issues.
- ❁ **Social Worker Advocacy Program (SWAP):**
Designed specifically for long term care social workers, geriatric case managers, admission and discharge planners and other community-based service providers to keep up to date on long term care issues.

CANHR is supported primarily through donations, fees for services and foundation grants. If you have a loved one in a nursing home or residential care facility or have found our services helpful, we urge you to become a "CANHR Advocate." You will receive our quarterly newsletter, *The Advocate*, which provides news on long term care, Medi-Cal, and pending legislation, as well as our Citation Report, detailing citations received by nursing homes statewide. Through your donation, you help CANHR bring information and support to California's nursing home residents and their loved ones. See www.canhr.org for more information.

www.canhr.org

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SAN FRANCISCO, CA 94107

MEMORANDUM

DATE	December 12, 2013
TO	Education Subcommittee Members Professional Fiduciaries Bureau
FROM	Professional Fiduciaries Bureau
SUBJECT	Agenda Item #7 – Practical Component and Increasing Prelicensing and continuing Education Hours Requirements – Kevin Urbatsch, Subcommittee Vice Chair

Attachment #5: Board asks for next steps in competency training plan Article

- Including a Practical Component within the Required Education Hours
- Specify within the Hours Requirement the Number or Percentage of Hours Required in Each Subject
- Increase the Number of Required Hours

Public Comment:

Attachment #5

Board asks for next steps in competency training plan

By Amy Yarbrough
Staff Writer

With the goal of better preparing new lawyers to enter the profession, the State Bar's Board of Trustees gave the go-ahead last month to new competency training requirements as well as a committee that will decide how to carry them out.

Chaired by former State Bar President Jon Streeter, the new committee will develop a timeline and plan for implementing the three recommendations – competency training for new lawyers, a pro bono legal services requirement and additional Minimum Continuing Legal Education (MCLE) hours.

Streeter, who also chaired the task force that developed the new training requirements, told trustees prior to their Oct. 12 vote that the proposal dates back to 2011 and addresses the fact that more and more students coming out of law school have been unable to find a job. The Internet has made it easier for them to start solo practices, but they often lack mentors or fundamental knowledge, such as budgeting or running a law practice.

The competency training proposal calls for 15 units of practice-based, experiential course work or an apprenticeship equivalent during law school, 50 hours of legal services devoted to pro bono or modest means clients prior to admission or in the first two years of practice and 10 additional MCLE hours focused on law practice competency training. Under the current plan, the implementation committee would develop a roadmap to phase in the MCLE hours starting in 2015, the pro bono or modest means requirement in 2016 and the law school competency training in 2017.

"I must say in the course of what we have done there has been overwhelming support," Streeter told trustees at their Oct. 12 meeting. But some people still have reservations about the proposal.

One concern is that implementing the new requirement will increase the already staggering cost of a legal education.

In one of roughly 30 letters the State Bar received commenting on the proposal, Pepperdine Law School student Levi Lesches wrote that it is "inherently unjust" to require 50 hours of pro bono service.

"The cards are stacked so heavily against a legal education turning into a rewarding career, whether financially or emotionally, that merely suggesting additional bar passage requirements is akin to walking over to a soldier who is laying mortally wounded on a battlefield and asking him to do some good for his country," Lesches wrote in a Sept. 4 letter to the board. "With the amount of unpaid hours law students already put in, the dismal career opportunities awaiting them at the end, it is plain wrong, if not offensive, to place restraints on those sparse opportunities that exist for law students to earn money while in school."

But Streeter cited a study done by commenter Robert R. Kuehn, associate dean of clinical education at Washington University School of Law in St. Louis, which found, among other things, that 90 percent of the American Bar Association-accredited law schools in California already have the capacity to ensure that their students can graduate with clinical education experience.

Streeter called the recommendations, "a fairly gentle nudge toward what law schools should be doing" to add value.

"What we are doing here in California has the attention of the entire country," he added. "I think this is something you will be proud to be associated with in the future."



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MEMORANDUM

DATE	December 12, 2013
TO	Education Subcommittee Members Professional Fiduciaries Bureau
FROM	Professional Fiduciaries Bureau
SUBJECT	Agenda Item #9 – Future Agenda Items



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BUSINESS, CONSUMER SERVICES, AND HOUSING AGENCY
GOVERNOR EDWARD G. BROWN JR.

MEMORANDUM

DATE	December 12, 2013
TO	Education Subcommittee Members Professional Fiduciaries Bureau
FROM	Professional Fiduciaries Bureau
SUBJECT	Agenda Item #10 – Future Meeting Dates

Next Meeting Date:



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MEMORANDUM

DATE	December 12, 2013
TO	Education Subcommittee Members Professional Fiduciaries Bureau
FROM	Professional Fiduciaries Bureau
SUBJECT	Agenda Item #11 – Adjournment

Time of Adjournment: