Waiver & Care Management 2007 Enrichment Symposium

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1. The Deficit Reduction Act (DRA): New Problems for Families and Nursing Homes - 1 Hour

New Medicaid Rules Hit Seniors and Nursing Homes:
Deficit Reduction Act is Implemented in Pennsylvania

Written By: Jeffrey A. Marshall, CELA*

Seniors and nursing homes will have to cope with drastic new Medicaid rules that take effect this week (March 3, 2007). The rules make it much harder to qualify for government aid in meeting nursing home costs. The children of nursing home residents may also be affected.

Under the new rules, people who made a gift after February 8, 2006 may be ineligible for Medicaid nursing home benefits when they run out of other funds. For applications filed after March 3, 2007, the penalty for making a gift will not begin to run until the nursing home resident has no other funds to pay for care. This means nursing homes are likely to be stuck with beds filled with people who cannot pay.

The new penalties on gifts are part of a law, called the Deficit Reduction Act (DRA), passed by the last Congress and signed into law by President Bush in February 2006. The DRA forces Pennsylvania to deny Medicaid long-term care benefits to applicants who made a non-exempt gift.

Approximately two thirds of nursing home residents receive some assistance from the Medicaid program. Nursing home residents who are already on Medicaid should not be affected unless they make a gift in the future, but new applicants will find it much harder to qualify. Because the Medicaid ineligibility period will no longer begin to run until the nursing home resident is out of funds, there will be a period of time during which neither the nursing home resident nor Medicaid can pay for needed care. The Congressional Budget Office estimates that this will affect about 15% of individuals who are admitted to nursing homes each year.

Why the DRA Means Trouble

Unmarried individuals usually don't qualify for Medicaid financial assistance with the cost of nursing home care until they have exhausted all but $2,400 of their cash and investments. $2,400 is not enough to pay for even one month in a nursing home. Therefore, in order for the nursing facility to get paid, help from Medicaid is needed.

The problem arises if the nursing home resident has made a gift with a value of more than $500 after February 8, 2006 and within 60 months of applying for Medicaid.

Under long-standing Medicaid program rules, gifts make an individual ineligible for Medicaid help with long-term care costs for a period of time. In the past, state examiners would look back for 3 years to see if you had made any gifts. Under the old law, the ineligibility period began when you made the

gift. So, for most nursing home residents, the penalty period had run long before any application for Medicaid was filed.

For example, under the Pre-DRA rules, assume John gave his grandson $20,000 for college in December 2005. By April 2006 the penalty period would have expired and Medicaid would ignore the gift. If John needed nursing home care after that, Medicaid would help pay the nursing home when John spent his remaining funds down to $2,400.

Under the DRA, the look back period is expanded to 5 years, and most importantly, the penalty period doesn't begin until John is in the nursing home and has spent down his funds to $2,400. So, if John gives his grandson $20,000 for college in December 2006 and then applies for Medicaid Assistance 50 months later in February 2011, he will be ineligible for financial help for approximately 3 months. Who pays for that 3 months? Not, John - he has already spent down his assets to $2400 or less. Not the state - the DRA doesn't allow it. Not the grandson - the money is likely long gone. The nursing home is left holding the bag.

Special rules apply if you are married. But, gifts by either spouse make both ineligible for Medicaid nursing home benefits. Gifts can also make seniors ineligible for some other Medicaid long term care benefits, like home and community-based waiver services.

In some cases, a nursing home that isn't getting paid may decide to sue the children of the nursing home resident. Under Pennsylvania's recently enacted family support law (Act 43 of 2005), children can be liable for the parent's unpaid medical and nursing home expenses if the parent can't pay. This rule applies even though the child never received any gifts from the parent.

The DRA law is so complex that it has taken Pennsylvania more than a full year to figure out how to comply with its requirements. The rules are extremely confusing and there are numerous exceptions. Waivers are possible in some cases.

More details of the DRA law and Pennsylvania's rules are available on the Marshall, Parker & Associates website at www.paelderlaw.com.

What You Should Do Now

Seniors:

Seniors should anticipate that they will someday need long-term care, either at home or in a nursing home. The new law places a premium on planning well in advance of the onset of illness.

- Seniors who are healthy and have sufficient financial means may want to consider the purchase of long-term care insurance.
- Seniors who are unlikely to need long-term care within the next five years may want to make gifts now, rather than waiting. There are many ways to give away assets, including irrevocable trusts and retaining reserved interests. Don't make large gifts without advice from a lawyer who understands the DRA.
- Keep records of any gifts made for at least five years. This includes regular gifts such as church or other charitable contributions.

- Get an asset protection power of attorney that will allow your family to plan for you in the event you become incapacitated. An asset protection power of attorney allows your family to try to protect the things you own if you ever need to qualify for Medicaid.
- If illness strikes, get the best possible planning advice as soon as possible. Make sure your lawyer is an expert in the DRA. Don't try to do-it-yourself. Mistakes can cost you and your family much more than the cost of good planning advice.

Family Members of Seniors Who Need Care:

Under Pennsylvania law, children can be held liable for a parent's nursing home costs, if the parent is out of money, but doesn't qualify for Medicaid. Encourage your parents to plan early and get good legal advice before making any large gifts.

Be careful when signing documents for a parent, especially admission paperwork at the nursing home. Understand what you are signing. Sign as power of attorney for your parent, not on your own behalf. Don't make personal guarantees. Make sure your parent gets the best advice possible if they ever need long-term care. Mistakes can cost you dearly.

You might also want to contact your state representative and senator and tell them to repeal the family support law – Act 43 - that makes children financially responsible for their aging parents' health care costs.

Nursing Homes:

Nursing Homes may end up being the largest victims of the DRA. The American Health Care Association, a group representing nearly 11,000 long-term care providers, said the change in the penalty rule "leaves the nursing facility (not the state) to collect from individuals who have no funds to pay privately and are not Medicaid eligible during their penalty phase."

Nursing home administrators need to understand how the DRA is likely to affect their facility. Facilities are at risk if their residents have made ineffectively planned gifts within 5 years of Medicaid application. These residents may be ineligible for Medicaid payment when they run out of other funds. Nursing homes should work closely with a certified elder law attorney or other lawyer who understands the DRA.

Even small gifts of under $1,000 which were made years prior to admission can create a penalty. Administrators need to avoid the transfer penalty payment gap. A facility is much better off with a resident on Medicaid than with a resident who has no source of payment and who cannot be discharged. A lawyer who understands the DRA may be able to help the facility avoid the transfer/non-payment trap if contacted before the resident's private funds are exhausted.

In the past, some nursing homes have viewed elder law attorneys as enemies. Nursing home administrators must come to recognize that knowledgeable elder law attorneys are their allies in making sure residents always have a payment source for their care.

More Information

Extensive resources on the DRA are available on Marshall, Parker and Associates' website at www.paelderlaw.com.

- **Understanding the Deficit Reduction Act-** http://www.paelderlaw.com/DRA.html
- **Selected Provisions of the DRA-** http://www.paelderlaw.com/pdf/DRA_Provisions.pdf
- **DPW Operations Memos-** http://www.paelderlaw.com/Draft_memos.html
- **Act 43 Filial Responsibility-** http://www.paelderlaw.com/pdf/Act_43_of_2005.pdf
- **Children Can be Liable for Parents' Nursing Home Costs-** http://www.paelderlaw.com/budd.html

Elder care professionals may also be interested in attending Marshall, Parker & Associate's Annual Professional Update for an in-depth discussion on the DRA and how these laws affect consumers and providers. Please contact Melissa Bottorf at mbottorf@paelderlaw.com for more information.

Spousal Issues in Medicaid Planning

Prepared by: Attorney Kevin R. Grebas

Marshall, Parker & Associates

I. Overview

The standards for determining Medicaid eligibility for married applicants are found in the "spousal impoverishment" provisions of the Medicare Catastrophic Coverage Act of 1988 (MCCA). The purpose of MCCA was to help insure that non-institutionalized community spouses have enough income and resources to avoid poverty. To accomplish this goal, MCCA established minimum income and asset allowances for the community spouse.

Pursuant to Federal law, all states must adhere to the MCCA rules. However, states were given some discretion as to whether the spousal impoverishment provisions should be applied to home and community based services, provided under a Medicaid waiver.

II. Treatment of Income

The general rule under MCCA is that marital income is attributed to the individual whose name appears on the check. Where both spouses receive income from a single source, such as rental property, each spouse will be considered to receive one half of the income.

Under MCCA, the community spouse is entitled to keep all of his or her individual income. The community spouse's income may not be considered available to pay for the care of the institutionalized spouse. Most income attributed to the institutional spouse, on the other hand, must normally be used to pay toward the cost of his or her care. Once qualified for Medicaid benefits, the institutionalized spouse will be permitted to keep $40.00 per month from his or her income as a personal needs allowance and an additional amount for payment of health insurance premiums.

If the community spouse's income is insufficient to meet his or her minimum needs, some (or all) of the institutionalized spouse's income may be diverted to the community spouse. All community spouses are entitled to a base amount of income known as the Minimum Monthly Maintenance Needs Allowance (MinMMNA). The amount of the MinMMNA is established by MCCA and all states must adhere to it. For a married couple, the MinMMNA must be at least 150% of the federal poverty level, with an allowance for excess shelter costs. Currently this base amount is $1,650 per month plus an increased amount for certain housing related expenses.

In order to determine if the community spouse is entitled to an increased shelter allowance, add 1) the community spouse's expenses for rent or mortgage payment, taxes and insurance and 2) the standard allowance for utilities (or the actual utility expenses). From this number, subtract an amount equal to 30% of 150% of the federal poverty level for a family of two. The sum is equal to the amount of excess shelter allowance. If the sum is zero or less, no excess shelter allowance will be authorized.

If the community spouse needs more income than is permitted by the MinMMMA plus the excess shelter allowance, he or she can seek a judicial order to increase his or her income allowance. The community spouse may seek the increase through judicial court ordered support under 42 U.S.C. §

1396r-5(d)(2)(B) or by requesting an administrative fair hearing pursuant to 42 U.S.C. § 1396r-5(d (5) and 55 Pa. Code § 181.452(d)(2)(ix). The increase should be allowed, especially if the community spouse can show exceptional circumstances resulting in significant financial duress. Due to their complexity and uncertainty few spouse seek judicial or administrative increases in their allowance.

The MinMMMA plus any increases allowed due to excess shelter costs or court or administrative order is called the Community Spouse Monthly Maintenance Needs Allowance (CSMMNA). If the community spouse lacks sufficient income to equal his or her CSMMNA he or she will have an income shortfall. To make up for this shortfall the community spouse may have a portion of the institutionalized spouses income diverted to him or her. This income would otherwise have been used for the institutionalized spouse's care. If the community spouse's income is still insufficient to meet the CSMMNA, he or she may be able to keep additional resources to generate income sufficient to make up the shortfall.

III. Treatment of Resources

Under the MCCA spousal impoverishment rules, most of couple's countable resources, whether owned jointly by the couple or individually, are first combined and reported to the County Assistance Office (CAO) on a Resource Assessment Form. (Some assets excluded from the calculation of countable resources, notably the home, household goods, a motor vehicle, and the community spouses IRA or other retirement plan).

Where a married individual is seeking Medicaid payment for nursing facility care, the Resource Assessment is based on countable assets owned by the couple as of the date of admission to the nursing facility. For those seeking eligibility for the PDA 60 + Waiver Program, the Resource Assessment is

based on assets owned by the couple on the date the applicant was determined to meet the Waiver Program's medical requirements.

Next, a determination is made as to what amount of countable resources the community spouse is permitted to keep. This protected share is known as the Community Spouse Resource Allowance (CSRA). The community spouse's CSRA is generally equal to one half of all countable resources owned by the couple on the date of nursing facility admission, or in the case of the PDA 60 + Waiver Program, the date the applicant was determined to meet the medical requirements.

The CSRA is, however, subject to a floor and a ceiling. For 2007 the maximum CSRA is $101,640 and the minimum CSRA is $20,328.

In all situations, the institutionalized spouse is also permitted to keep a small amount of countable resources ($2,400 or $8,000 depending on his or her income). This is known as the institutionalized spouse's personal allowance. Once the institutionalized spouse is qualified for Medicaid benefits, the personal allowance must at all times remain at or below either the $2,400 or the $8,000 limit.

Countable resources in excess of the combination of the CSRA and the institutionalized spouse's personal allowance will render the institutional spouse ineligible for Medicaid benefits. These assets must be spent on the institutionalized spouse's care or otherwise disposed of before Medicaid benefits will be awarded.

Below are three examples of how spousal shares are calculated:

<u>Example 1</u>: *On the date the institutionalized spouse is admitted to the nursing facility, the couple has $95,000 in countable resources and a home. The institutionalized spouse's income consists of Social Security and a pension totaling $1,200 per month. The community spouse's CSRA is calculated to be $47,500, or one half (1/2) of the couple's countable resources. In addition, the institutionalized spouse is permitted to retain $8,000 in countable resources. The institutionalized*

spouse will qualify for Medicaid benefits when the Couple's total assets have been reduced to $55,500 ($47,500 CSRA + $8,000 allowance). The couple's excess resources amount to $39,500.

<u>Example 2</u>: *On the date the institutional spouse was first admitted to the nursing facility, the couple had $175,000 in countable resources and a home. The institutionalized spouse has a fixed monthly income $1,950. In this situation, the community spouse is entitled to keep the maximum CSRA of $95,100 and the institutionalized spouse is permitted to retain $2,400 in countable resources. The institutionalized spouse will not qualify for Medicaid benefits until the couple's combined assets have been reduced to $97,500 ($95,100 CSRA + $2,400 allowance). This couple is over-resourced by $77,500.*

<u>Example 3</u>: *This couple has a total of $25,000 in countable resources and a home as of the date the institutionalized spouse was determined to be medically qualified for the PDA 60 + Waiver Program. The institutionalized spouse has a fixed monthly income of $975. In this case, the community spouse will be entitled to keep $19,020 of the countable resources (minimum CSRA) and the institutionalized spouse may retain $8,000 for a total of $27,020. Since this is greater than the amount of the couple's total countable resources, the institutionalized spouse will qualify immediately for Medicaid/LTC (including Waiver) benefits.*

Act 43 - Children Can Be Liable for their Parent's Nursing Home Costs

Written By: Attorney Jeffrey A. Marshall , CELA*

Pennsylvania has re-enacted a law that makes children liable for their parent's nursing home costs and other care-related expenses. Children can be sentenced to jail if they fail to comply with a court order to support their parent. The law, Act 43 of 2005, also allows state agencies to become guardians of the person and the estate of indigents.

Under the law, any person, public body, or public agency having an interest in the care, maintenance or assistance of the indigent person may sue any child who has sufficient financial ability to support the parent (unless the child was abandoned by the parent). A child who fails to comply with a support order can be sentenced to up to 6 months imprisonment.

Act 43 also gives any public body or public agency caring for any indigent person the right to petition to become legal guardian of the PERSON and property of the indigent. The law does not specify that the indigent person must be incapacitated. The guardianship, if granted, is not terminated until the public body or agency has been fully reimbursed for the expense of that person's care or assistance.

Here is what the Governor's press release says about Act 43 (formerly known as SB. 86):

Senate Bill 86 – includes changes to the Support Law and is a companion bill to the changes that were made to the Welfare Code that enable the commonwealth to seek reimbursement for medical assistance costs already paid for by the commonwealth recipient if there is any action, claim or settlement associated with the recipient's estate. It also updates provisions requiring that immediate family members contribute to the cost of care, thus decreasing the burden on the Medical Assistance program, when possible.

An Overview of the Long-Term Care Provisions of the Deficit Reduction Act of 2005 (DRA)

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On February 8, 2006, President Bush signed the Deficit Reduction Act of 2005 (the "DRA")[2] into law. The DRA includes a number of significant changes to the Federal Medicaid rules particularly in regard to the effects of a transfer of assets on eligibility.

The DRA represents an attempt to shift more of the financial cost of long-term care onto the individuals in need of that care and their families. Most Pennsylvania nursing home residents rely on Medicaid to cover part of the cost of their care. The new law will make it more difficult for many of these residents to obtain this government financial aid.

In particular, the DRA places new restrictions on those persons who want to give their home, farm or other assets to their children or others. Under prior law, seniors who transferred assets within three years of applying for Medicaid long-term care benefits were barred from coverage for a length of time beginning at the date of transfer. Under the DRA, the standard three-year "look-back" period is extended to five years, and the start date for the disqualification period is moved from the transfer date to the date when an application would be approved but for the transfer. (Transfers made before the date of enactment are treated under prior Medicaid law).

The DRA does not make it impossible to transfer assets and still qualify for Medicaid, but planning has become more uncertain, complicated, and difficult. Effective dates for implementation are unclear. Until the DRA is implemented, pre-DRA eligibility procedures continue to be utilized by County Assistance Offices. It is difficult to advise clients under these transitional circumstances.

Here is a short summary of the Medicaid long-term care provisions of the DRA. References are made to the related sections of the Act which are reproduced in Part 2.

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[2] Public Law 109-171 (2/8/2006). For history and related information see http://thomas.loc.gov/cgi-bin/bdquery/z?d109:S.1932: http://thomas.loc.gov/cgi-bin/bdquery/z?d109:h4241:See also, Conference Report on S. 1932, Deficit Reduction Act of 2005 -- (House of Representatives - December 18, 2005) http://thomas.loc.gov/cgi-bin/query/R?r109:FLD001:H12642.

- Lengthening the Look-Back Period [Sec. 6011 (a)][3]

The general look-back period on non-exempt transfers of income and assets by an individual or spouse is lengthened to 60 months in the case of dispositions of assets made on or after the date of the enactment of the Deficit Reduction Act of 2005.

- **Change in the Beginning Date for Period of Ineligibility** [Sec. 6011(c)]

If an individual (or spouse) transfers an asset for less than fair market value on or after the look-back date, the individual is ineligible for medical assistance for long-term care nursing facility services and home or community-based waiver services. The duration of the ineligibility is determined based on the uncompensated value transferred and the average monthly cost to a private patient receiving nursing facility services.

The DRA changes the way the ineligibility start date is calculated. For transfers occurring after the date of enactment, the ineligibility period starts on:

> (1) the first day of a month during or after which assets have been transferred for less than fair market value, or
>
> (2) the date on which the individual is eligible for medical assistance under the State plan and would otherwise be receiving institutional level care based on an approved application for such care but for the application of the penalty period,

whichever is later, and which does not occur during any other period of ineligibility under this subsection.[4]

- Hardship Waivers [Sec. 6011(d) and (e)]
Federal law contains a number of exceptions to the application of a penalty to uncompensated transfers.[5] One exception specifies that the transfer penalty is not to be imposed in situations where the denial of eligibility would work an undue hardship.[6]

Section 6011(d) represents a clarification rather than a change of this prior law. Each state is required to specify the criteria by which an application would be approved for an undue hardship waiver from the imposition of the asset transfer provisions. Section 6011(d) directs states to provide a hardship waiver procedure in accordance with 42 U.S.C. § 1396p(c)(2)(D) that includes a potential hardship imposed by the application of the transfer of asset provisions.

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[3] Section citations are to Sections of the Deficit Reduction Act of 2005, Public Law 109-171. These Sections of the Act are reproduced below in Part 2.

[4] 42 U.S.C. § 1396p(c)(1)(D)(ii).

[5] 42 U.S.C. '1396p(c)(2).

[6] 42 U.S.C. § 1396p(c)(2)(D).

Approval of a hardship waiver will require a finding that the imposition of an ineligibility period would deprive the individual of medical care such that the individual's health or life would be endangered or that the individual would be deprived of food, clothing, shelter, or other necessities of life. States are required to provide: (A) notice to recipients that an undue hardship exception exists; (B) a timely process for determining whether an undue hardship waiver will be granted; and (C) a process under which an adverse determination can be appealed.

Section 6011(e) permits facilities in which institutionalized individuals reside to file undue hardship waiver applications on behalf of the individual, with the institutionalized individual's consent or the consent of his or her guardian. If a nursing facility's application for undue hardship for a resident meets criteria to be specified by the Secretary, the state will have the option of providing payments for nursing facility services to hold the individual's bed at the facility while an application is pending. Such payments can not be made for longer than 30 days.

- Treatment of Annuities [Sec. 6012]

The DRA codifies certain requirements for the treatment of annuities.

<u>Disclosure.</u> To be eligible for Medicaid financed long-term care services, the applicant must disclose any interests the applicant or spouse has in an annuity (or in similar financial instruments to be specified by the Secretary of Health and Human Services). Reporting is required regardless of whether the annuity is irrevocable or is treated as an asset.

<u>State Interest in Annuities.</u> The DRA creates a state interest as a remainder beneficiary in annuities purchased post-DRA or modified post-DRA. The Medicaid application (or re-certification) form must specify that the state will become a remainder beneficiary under such annuities and similar financial instruments. This requirement applies to any annuity interest owned by either the Medicaid applicant or spouse.

The position that the state's remainder interest must be given is also defined. "Under the DRA an annuity must name the State as the remainder beneficiary in the first position for the total amount of medical assistance paid on behalf of the annuitant, unless there is a community spouse and/or a minor or disabled child. . . . If there is a community spouse and/or any minor or disabled child, the State may be named in the next position after those individuals."

<u>Treatment as a Transfer of Assets</u>.

· State Remainder Requirement. If the state is not named as a remainder beneficiary in the correct position, the purchase of the annuity by the applicant (or spouse) must be treated as a transfer of assets for less than fair market value.

· Additional Requirement where Annuity is purchased by an Annuitant who has applied for Medicaid. An annuity purchase by or on behalf of an annuitant who has applied for Medicaid long-term care benefits will be treated as a transfer of assets unless an additional requirement is met. The annuity must qualify as either a retirement annuity or as an actuarially sound annuity:

    (1) Retirement Annuity Requirement- the annuity is held in an IRA retirement plan specified in various subsections of section 408 of the Internal Revenue Code).

(2) Actuarially Sound Annuity Requirement. An actuarially sound annuity must meet three tests:

(I) be irrevocable and nonassignable ;
(II) be actuarially sound,which means that the average number of years of expected life remaining for the individual must be no longer than the life of the annuity ; and
(III) the annuity must provide for payments in approximately equal amounts during the term of the annuity, with no deferred or balloon payments.

- Income-First Mandate [Sec. 6013]

States will no longer be allowed to use a resource-first methodology to allow low-income community spouses to keep additional financial resources to avoid delayed spousal impoverishment. The DRA requires states to use an income-first methodology in determining the base Community Spouse Resource Allowance. This income-first mandate applies to transfers and allocations made on or after the date of enactment by individuals who become institutionalized spouses on or after such date. Current Pennsylvania law (Act 42 of 2005) appears to conflict with this mandate. Pennsylvania currently offers an optional modified resource-first methodology as a means of determining the Community Spouse Resource Allowance.

- Limit on Home Equity [Sec. 6014]

Under the DRA, individuals with substantial home equity may not be Medicaid eligible for nursing facility or other long-term care services. Under prior law, home equity was not deemed available to pay for a Medicaid applicant's care so long as the homeowner evidenced an intent to return home. Applicants with substantial home equity were not required to borrow against their homes.

The DRA places a new $500,000 ceiling on the home equity exemption (Pennsylvania may elect to increase the exemption up to $750,000). However, individuals will not be excluded from eligibility due to excess equity if they have a spouse, a child under age 21, or a child who is blind or disabled who lawfully resides in the individual's home.

The new home equity limitations apply to applications for benefits made on or after January 1, 2006.

- **Enforceability of CCRC Provisions** [Sec. 6015]

Section 6015 clarifies that Continuing Care Retirement Communities (CCRCs) and Life Care Community Admission Contracts may require that residents spend resources declared for the purpose of admission on their care before they apply for Medicaid. It also provides that entrance fees for CCRCs or life care communities are generally countable resources, and thus available to the applicant, for purposes of the Medicaid eligibility determination.

- Inclusion of Certain Notes and Loans [Sec. 6016(c)]

Section 6016(c) specifies that the purchase of a promissory note, loan, or mortgage is a transfer of assets unless the note, loan, or mortgage (i) has a repayment term that is actuarially sound, (ii) provides for payments to be made in equal amounts during the term of the loan, with no deferral and no balloon

payments made, and (iii) prohibits the cancellation of the balance upon the death of the lender. The countable value of a promissory note, loan, or mortgage that does not satisfy these requirements is the outstanding balance due as of the date of the individual's application for Medical Assistance.

- Inclusion of Transfers to Purchase Life Estates [Sec. 6016(d)]

Section 6016(d) specifies that the purchase of a life estate interest in another individual's home constitutes a transfer of assets unless the purchaser resides in the home for at least one year after the date of purchase.

- Other Changes

The DRA makes several revisions to the asset-transfer rules that are consistent with already existing Pennsylvania policy regarding partial months of ineligibility and multiple transfers of assets.[7]

The Act authorizes states to amend their Medicaid state plans to provide for state long-term care insurance partnership programs, and sets forth requirements for partnership policies.[8] This type of program is designed to encourage the purchase of private long-term care insurance. Prior to the DRA, partnership policies could be sold in only four states -- California , Connecticut, Indiana, and New York. If Pennsylvania decides to authorize a partnership program, policyholders who buy a designated private long-term care insurance policy which is used to pay for long-term care services will be allowed to protect additional resources from Medicaid spend-down requirements. Individuals must still meet Medicaid income requirements. Existing long-term care insurance policies are not grand-fathered.

Documentation of proof of citizenship standards are tightened by Section 6036.[9] The new standards will be effective for eligibility determinations (including re-certifications) made on or after July 1, 2006.

The DRA also includes a number of provisions intended to facilitate the financing of long-term care services in home and community settings. The DRA establishes home and community-based services as an optional Medicaid benefit that does not require a waiver for individuals whose income does not exceed 150 percent of the federal poverty level. The recipient will not need to be nursing facility

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[7] See Sections 6016(a) and 6016(b) below. See also, *Heffelfinger v. Department of Public Welfare*, 789 A2d 349 (Pa. Cmwlth. 2001.)

[8] See Act Section 6021 below. For more information on long term care partnership insurance policies see Government Accounting Office report on The Long Term Care Partnership Program available at http://www.gao.gov/new.items/d051021r.pdf. See also, Daniel C. Vock *New law pushes long-term care coverage,* February 16, 2006, Stateline.org., www.stateline.org/live/ViewPage.action?siteNodeId=136&languageId=1&contentId=89158.

[9] The Congressional Budget Office (CBO) has estimated that 35,000 Medicaid recipients would lose coverage because of new, more stringent requirements for them to prove United States citizenship. Most of those losing coverage would be illegal immigrants, but some would be citizens unable to supply the necessary documents, the CBO report said. *Budget to Hurt Poor People on Medicaid, Report Says,* by Robert Pear, New York Times, January 30, 2006.

clinically eligible. Beginning in 2007 states will have increased latitude to use Medicaid money to provide community services, in-home aides, or other community care.[10]

The state will have the option to provide Medicaid payment for the cost of self-directed personal assistance services (other than room and board) based on a written plan of care to individuals for whom there has been a determination that, but for the provision of such services, the individuals would require and receive personal care services under the Medicaid state plan or home and community-based services under a HCBS waiver. Self-directed personal assistance services may not be provided to individuals who reside in a home or property that is owned, operated, or controlled by a provider of services, not related by blood or marriage.[11]

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[10] The state may provide this option to individuals without determining that, but for the provision of such services, the person would require the level of care provided in a hospital, nursing home, or ICF–MR. See DRA Sections 6086 and 6087 below.

[11] Conference Report on S. 1932, Deficit Reduction Act of 2005 -- (House of Representatives - December 18, 2005), page 300 http://thomas.loc.gov/cgi-bin/query/R?r109:FLD001:H12642.

DRA Annuities:
Understanding The Federal and Pennsylvania Rules

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(Adapted from the Author's article appearing in the *Medicaid Annuity Report*, www.paannuity.com)

As a result of the Deficit Reduction Act of 2005 (DRA), annuities have become an increasingly useful planning tool for clients seeking to protect their resources from the costs of long-term care. The new law effectively authorizes the use of annuities to gain immediate eligibility for Medicaid if the transfer and remainder interest provisions of the law are met.

The Department of Public Welfare's Operations Memorandum on Annuities may be open to criticism, but it clearly authorizes the use of annuities to accelerate Medicaid/LTC eligibility.

Federal and state approval of annuity-based planning means lawyers need to understand how annuities can be used to benefit clients who are in need of long-term care. This article is intended to provide the Pennsylvania lawyer with a basic overview of the federal and state treatment of DRA compliant annuities.

Prior to the DRA, annuities were frequently employed to protect the assets of married couples. Annuities would convert the excess resources of a community spouse to exempt income. On the other hand, annuities were rarely used in planning for unmarried individuals. For unmarried persons, assets could usually be better protected through the use of "half a loaf" transfer planning or other techniques.

Under the DRA, annuities continue to be a vital planning option for married couples. And, due to the DRA's strict new restrictions on asset transfers, annuity-based planning has now become more significant for unmarried individuals.

1 Federal Law

Congress and Federal regulators have historically given preferential treatment to annuities. In OBRA 93, Congress delegated the Medicaid treatment of annuities to the Secretary of HHS. Transmittal 64 to the State Medicaid Manual contained the Secretary's determination as to when an annuity purchase involves a transfer of assets.

Annuities, although usually purchased in order to provide a source of income for retirement, are occasionally used to shelter assets so that individuals purchasing them can become eligible for Medicaid. In order to avoid penalizing annuities validly purchased as part of a retirement plan but to capture those annuities which abusively shelter assets, a determination must be made with regard to the ultimate purpose of the annuity (i.e., whether the purchase of the annuity constitutes a transfer of assets for less than fair market value). If the expected return on the annuity is commensurate with a reasonable estimate of life expectancy of the beneficiary, the annuity can be deemed actuarially sound.

Transmittal 64 established that an actuarially sound immediate annuity could be purchased without a transfer penalty. The DRA continues this rule subject to several modifications:

(1) It clarifies and codifies the rules regarding when an annuity transaction is to be treated as a transfer for less than fair value.

(2) It requires that the state be named as remainder beneficiary (subject to the preferred interest of the community spouse and minor and disabled children) to the extent of benefits paid.

(3) It requires that applicants for Medicaid funded long-term care disclose their interest in annuities.

The DRA also gives special treatment to annuities purchased with the proceeds of certain retirement plan accounts. The new law's asset transfer provisions do not apply to such "qualified annuities." However, retirement plan qualified annuities are still subject to the DRA's disclosure and remainder beneficiary provisions.

The new annuity rules apply to any annuity purchased after February 7, 2006 or involved in a transaction after that date. A copy of the annuity sections of the DRA, as amended by the Tax Relief and Health Care Act of 2006, are posted at www.paannuity.com. (Click on "News and Events" on the left hand side of the home page).

In July, 2006, CMS issued a letter to state Medicaid Directors which provided some guidance regarding CMS interpretation of the transfer and annuity provisions of the DRA. The CMS letter is available at http://paannuity.com/pdf/cms_transfer_of_assets.pdf.

2 State Guidance

DPW's Operations Memorandum ("Ops Memo") on the subject of annuities is available at http://paannuity.com/_ops_memo.html. The Ops Memo lays out DPW's interpretation of the rules regarding when the purchase of an annuity will be penalized as a transfer. The Ops Memo also addresses the issue of when an annuity is to be treated as a resource rather than as income.

A denial of Medicaid long-term care ("Medicaid/LTC") benefits may result if an annuity is treated as either a transfer or as an available resource. Thus, for Medicaid planning purposes, the ideal annuity is one which will not be an available asset and whose purchase will not involve a penalized transfer of assets. The Ops Memo sets out the path to be followed to meet these objectives.

The DPW annuity policy applies to applicants, recipients and spouses of applicants and recipients who purchase an annuity or make a transaction involving an annuity on or after February 8, 2006.

State Transfer Rules - DRA Compliant Annuities

Under the Ops Memo, DPW will treat an annuity as a transfer of assets for less than fair market value unless the annuity meets all of the following DRA requirements:
(1) The annuity is irrevocable and non-assignable;
(2) The annuity is actuarially sound;
(3) The annuity provides for payments in equal amounts, with no deferral and no balloon payments made; and
(4) The annuity names DPW as the beneficiary in the first position for at least the total amount of medical assistance paid on behalf of the applicant/recipient (or 2nd position if the applicant has a community spouse, a minor child, or a disabled child).

We refer to annuities that meet these requirements as ”DRA Compliant Annuities.” An annuity that meets these four tests is deemed to have been purchased for fair market value with no transfer penalty applied.

2.2 State Resource Rules

The Ops Memo also provides guidance as to when the state intends to treat an annuity as an available resource.

A. Annuity Owned by the Applicant/Recipient of Medicaid/LTC:

A DRA compliant annuity owned by an applicant/recipient for Medicaid/LTC that names DPW as the beneficiary in the first position will be counted as income (and not as a resource) to the applicant/recipient. There is no limit on the purchase price of the annuity.

B. Annuity Owned by the Community Spouse.

A DRA compliant annuity of the community spouse will be treated as either income or a resource depending upon the aggregate income of the community spouse.

(1) If the annuity provides the community spouse with monthly income that, when combined with all the other available income to the community spouse, is no greater than the Community Spouse Monthly Maintenance Needs Allowance (CSMMNA), the annuity is to be treated as income to the community spouse.

(2) If the annuity provides the community spouse with monthly income that, when combined with all the other available income to the community spouse, exceeds the CSMMNA, the annuity is to be treated as an available resource.

Acting in compliance with the Ops Memo, a Medicaid/LTC applicant (and spouse, if applicable) should be able to purchase one or more annuities that will allow immediate eligibility for benefits. Some conservative strategies are clearly permissible under the Pennsylvania rules. Other techniques, such as combining annuities with divestments, may be more aggressive. The client, with advice from legal counsel, can decide which approach is most appropriate to that client’s particular goals and circumstances.

2. Break- 10 minutes

3. Pennsylvania's New Health Care Decisions Law - 30 minutes

Complicated New Advance Directive Law Requires Study by Health Care Professionals and Lawyers

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Who will make life and death decisions for you?

Advance health care directives, such as living wills and health care powers of attorney, allow us to maintain some control over who will someday make health treatment decisions for us. They can provide a voice for us when we cannot speak for ourselves.

For many years, Pennsylvania was criticized for having out-of-date laws regarding advance directives, a deficiency that contributes to poor end-of life care. Finally, the problem has been addressed. Pennsylvania's long-awaited new law governing the use of advance health care directives becomes effective on January 29, 2007.

The new law, Act 169, is lengthy and complex. It creates opportunities for effective advance health care planning but creates traps as well. It is particularly important that health care providers and lawyers study the new law. To assist these professionals, Marshall, Parker & Associates has put together a comprehensive guide to the new law. The Guide is available on the Marshall, Parker & Associates' website at **http://www.paelderlaw.com/PA_Attorneys_Guide_to_AD.html**.

Act 169 should make an authorized medical proxy decision maker available for most adults.
The Act authorizes a qualified individual, referred to as the "principal," to appoint a surrogate decision maker ("agent"). The agent can be authorized to make any health-care decision, including those concerning end-of-life treatment. The law provides a list of default decision makers for persons who lack an available agent.

Act 169 is sweeping in its scope. Some key aspects of the new law include:

(1) Medical decision making by family members and close friends (representatives) is authorized for incompetent adults who have no appointed agent;

(2) Agents and representatives are given the authority to make almost any decision a competent patient could make;

(3) The decision making process to be followed by agents and representatives is set out in detail;

(4) An example advance directive is included. This optional form emphasizes the document as only one step in a planning process that should include frank discussions with family members and health care providers;

(5) Prior living wills and health care powers of attorney remain valid;

(6) Responsibilities are placed on physicians and other health care providers;

(7) The Department of Health is directed to provide oversight to ensure the law's surrogate decision making process is followed.

Act 169 was the result of years of discussion, lobbying, and negotiation by many interest groups. The Act shows the effects of its collective parentage - it is lengthy and intricate and occasionally inconsistent. Unfortunately, its complexity increases the potential that its provisions will be either misunderstood or disregarded by lawyers and health care providers.

What You Should Do Now

Consumers should understand that their prior living wills and powers of attorney remain valid. Nevertheless, this may be a good time to re-evaluate your planning documents, especially if you have only a living will. (See the discussion of the inadequacy of living wills in the **Guide**). Most people should have a comprehensive advance directive that combines end-of-life instructions with a health care power of attorney. *(**Note to Marshall, Parker & Associates clients:** Virtually all clients who have had their advance directives prepared by Marshall, Parker & Associates over the last 15 years already have the kind of comprehensive advance directive which is encouraged by the new law.)*

Advance directives should be reviewed and updated as your circumstances and preferences change. Your choice of the person to serve as your agent is of particular importance. Consumers may want to review **Section 3-1.2.1 of the Guide** for some tips on choosing the right agent.

Lawyers should study the provisions of the new law to make certain that the Advance Directives they prepare meet its requirements. They should also counsel their clients as to the importance of engaging in an ongoing advance planning process. The preparation of the document is just one step in the process.

Health Care Providers should study the new law and be cognizant of the requirements it places on them. These requirements are outlined in **Section 1.5 of the Guide** (1-5 Duties and Protection of Health Care Providers).

Professional Resources on Marshall, Parker & Associates' Website:

-Understanding Act 169: A Professional's Guide to Living Wills and Health Care Powers of Attorney in Pennsylvania

-Act 169: Updated Advance Health Care Directive Law

The following sample form of advance directive for healthcare is included in Act 169.

DURABLE HEALTH CARE POWER OF ATTORNEY
AND HEALTH CARE TREATMENT INSTRUCTIONS
LIVING WILL
PART I
INTRODUCTORY REMARKS ON
HEALTH CARE DECISION MAKING

You have the right to decide the type of health care you want. Should you become unable to understand, make, or communicate decisions about medical care, your wishes for medical treatment are most likely to be followed if you express those wishes in advance by:

(1) naming a health care agent to decide treatment for you; and
(2) giving health care treatment instructions to your health care agent or health care provider.

An advance health care directive is a written set of instructions expressing your wishes for medical treatment. It may contain a health care power of attorney, where you name a person called a "health care agent" to decide treatment for you, and a living will, where you tell your health care agent and health care providers your choices regarding the initiation, continuation, withholding, or withdrawal of life-sustaining treatment and other specific instructions.

You may limit your health care agent's involvement in deciding your medical treatment so that your health care agent will speak for you only when you are unable to speak for yourself or you may give your health care agent the power to speak for you immediately. THIS COMBINED FORM GIVES YOUR HEALTH CARE AGENT THE POWER TO SPEAK FOR YOU ONLY WHEN YOU ARE UNABLE TO SPEAK FOR YOURSELF.

A living will cannot be followed unless your attending physician determines that you lack the ability to understand, make, and communicate health care decisions for yourself and you are either permanently unconscious or you have an end-stage medical condition, which is a condition that will result in death despite the introduction or continuation of medical treatment. You, and not your health care agent, remain responsible for the cost of your medical care.

If you do not write down your wishes about your health care in advance, and if later you become unable to understand, make, or communicate these decisions, those wishes may not be honored because they may remain unknown to others.

A health care provider who refuses to honor your wishes about health care must tell you of its refusal and help to transfer you to a health care provider who will honor your wishes.

You should give a copy of your advance health care directive (a living will, health care power of attorney or a document containing both) to your health care agent, your physicians, family members, and others whom you expect would likely attend to your needs if you become unable to understand, make, or communicate decisions about medical care.

If your health care wishes change, tell your physician and write a new advance health care directive to replace your old one. It is important in selecting a health care agent that you choose a person you trust who is likely to be available in a medical situation where you cannot make decisions for yourself. You should inform that person that you have appointed him or her as your health care agent and discuss your beliefs and values with him or her so that your health care agent will understand your health care objectives.

You may wish to consult with knowledgeable, trusted individuals such as family members, your physician, or clergy when considering an expression of your values and health care wishes. You are free to create your own advance health care directive to convey your wishes regarding medical treatment.

The following form is an example of an advance health care directive that combines a health care power of attorney with a living will.

NOTES ABOUT THE USE OF THIS FORM

If you decide to use this form or create your own advance health care directive, you should consult with your physician and your attorney to make sure that your wishes are clearly expressed and comply with the law.

If you decide to use this form but disagree with any of its statements, you may cross out those statements. You may add comments to this form or use your own form to help your physician or health care agent decide your medical care.

This form is designed to give your health care agent broad powers to make health care decisions for you whenever you cannot make them for yourself. It is also designed to express a desire to limit or authorize care if you have an end-stage medical condition or are permanently unconscious.

If you do not desire to give your health care agent broad powers, or you do not wish to limit your care if you have an end-stage medical condition or are permanently unconscious, you may wish to use a different form or create your own. You should also use a different form if you wish to express your preferences in more detail than this form allows or if you wish for your health care agent to be able to speak for you immediately. In these situations, it is particularly important that you consult with your attorney and physician to make sure that your wishes are clearly expressed.

This form allows you to tell your health care agent your goals if you have an end-stage medical condition or other extreme and irreversible medical condition, such as advanced Alzheimer's disease. Do you want medical care applied aggressively in these situations or would you consider such aggressive medical care burdensome and undesirable?

You may choose whether you want your health care agent to be bound by your instructions or whether you want your health care agent to be able to decide at the time what course of treatment the health care agent thinks most fully reflects your wishes and values.

If you are a woman and diagnosed as being pregnant at the time a health care decision would otherwise be made pursuant to this form, the laws of this Commonwealth prohibit implementation of that decision if it directs that life-sustaining treatment, including nutrition and hydration, be withheld or withdrawn from you, unless your attending physician and an obstetrician who have examined you certify in your medical record that the life-sustaining treatment:

(1) will not maintain you in such a way as to permit the continuing development and live birth of the unborn child;
(2) will be physically harmful to you; or
(3) will cause pain to you that cannot be alleviated by medication.

A physician is not required to perform a pregnancy test on you unless the physician has reason to believe that you may be pregnant. Pennsylvania law protects your health care agent and health care providers from any legal liability for following in good faith your wishes as expressed in the form or by your health care agent's direction. It does not otherwise change professional standards or excuse negligence in the way your wishes are carried out. If you have any questions about the law, consult an attorney for guidance.

This form and explanation is not intended to take the place of specific legal or medical advice for which you should rely upon your own attorney and physician.

PART II
DURABLE HEALTH CARE POWER OF ATTORNEY

I,___________________, of_______________County, Pennsylvania, appoint the person named below to be my health care agent to make health and personal care decisions for me.

Effective immediately and continuously until my death or revocation by a writing signed by me or someone authorized to make health care treatment decisions for me, I authorize all health care providers or other covered entities to disclose to my health care agent, upon my agent's request, any information, oral or written, regarding my physical or mental health, including, but not limited to, medical and hospital records and what is otherwise private, privileged, protected or personal health information, such as health information as defined and described in the Health Insurance Portability and Accountability Act of 1996 (Public Law 104-191, 110 Stat. 1936), the regulations promulgated thereunder and any other State or local laws and rules. Information disclosed by a health care provider or other covered entity may be redisclosed and may no longer be subject to the privacy rules provided by 45 C.F.R. Pt. 164.

The remainder of this document will take effect when and only when I lack the ability to understand, make or communicate a choice regarding a health or personal care decision as verified by my attending physician. My health care agent may not delegate the authority to make decisions.

MY HEALTH CARE AGENT HAS ALL OF THE FOLLOWING POWERS SUBJECT TO THE HEALTH CARE TREATMENT INSTRUCTIONS THAT FOLLOW IN PART III (Cross out any powers you do not want to give your health care agent):

1. To authorize, withhold or withdraw medical care and surgical procedures.

2. To authorize, withhold or withdraw nutrition (food) or hydration (water) medically supplied by tube through my nose, stomach, intestines, arteries or veins.

3. To authorize my admission to or discharge from a medical, nursing, residential or similar facility and to make agreements for my care and health insurance for my care, including hospice and/or palliative care.

4. To hire and fire medical, social service and other support personnel responsible for my care.

5. To take any legal action necessary to do what I have directed.

6. To request that a physician responsible for my care issue a do-not-resuscitate (DNR) order, including an out-of-hospital DNR order, and sign any required documents and consents.

APPOINTMENT OF HEALTH CARE AGENT

I appoint the following health care agent:

Health Care Agent ____
(Name and relationship)

Address:____

Telephone Number: Home____________________Work_________________________

E-MAIL:____________________________________

IF YOU DO NOT NAME A HEALTH CARE AGENT, HEALTH CARE PROVIDERS WILL ASK YOUR FAMILY OR AN ADULT WHO KNOWS YOUR PREFERENCES AND VALUES FOR HELP IN DETERMINING YOUR WISHES FOR TREATMENT.

NOTE THAT YOU MAY NOT APPOINT YOUR DOCTOR OR OTHER HEALTH CARE PROVIDER AS YOUR HEALTH CARE AGENT, UNLESS RELATED TO YOU BY BLOOD, MARRIAGE OR ADOPTION.

If my health care agent is not readily available or if my health care agent is my spouse and an action for divorce is filed by either of us after the date of this document, I appoint the person or persons named below in the order named. (It is helpful, but not required, to name alternative health care agents.)

First Alternative Health Care Agent:____
(Name and relationship)

Address:____

Telephone Number: Home_________________________ Work______________________

E-MAIL:____

Second Alternative Health Care Agent:____
(Name and relationship)

Address:____

Telephone Number: Home_________________________ Work_______________________

E-MAIL:____

GUIDANCE FOR HEALTH CARE AGENT (OPTIONAL)

GOALS

If I have an end-stage medical condition or other extreme irreversible medical condition, my goals in making medical decisions are as follows (insert your personal priorities such as comfort, care, preservation of mental function, etc.)

SEVERE BRAIN DAMAGE OR BRAIN DISEASE

If I should suffer from severe and irreversible brain damage or brain disease with no realistic hope of significant recovery, I would consider such a condition intolerable and the application of aggressive medical care to be burdensome.

I therefore request that my health care agent respond to any intervening (other and separate) life-threatening conditions in the same manner as directed for an end-stage medical condition or state of permanent unconsciousness as I have indicated below.

Initials________I agree Initials_________I disagree

PART III

HEALTH CARE TREATMENT INSTRUCTIONS IN THE EVENT OF END-STAGE MEDICAL CONDITION OR PERMANENT UNCONSCIOUSNESS (LIVING WILL)

The following health care treatment instructions exercise my right to make my own health care decisions. These instructions are intended to provide clear and convincing evidence of my wishes to be followed when I lack the capacity to understand, make, or communicate my treatment decisions:

If I have an end-stage medical condition (which will result in my death, despite the introduction or continuation of medical treatment) or am permanently unconscious such as in an irreversible coma or irreversible vegetative state and there is no realistic hope of significant recovery, all of the following apply (cross out any treatment instructions with which you do not agree):

1. I direct that I be given health care treatment to relieve pain or provide comfort even if such treatment might shorten my life, suppress my appetite or my breathing, or be habit forming.

2. I direct that all life prolonging procedures be withheld or withdrawn.

3. I specifically do not want any of the following as life prolonging procedures: (If you wish to receive any of these treatments, write "I do want" after the treatment)

   - heart-lung resuscitation (CPR) ____
   - mechanical ventilator (breathing machine) ___________________________
   - dialysis (kidney machine) ____
   - surgery ____
   - chemotherapy radiation treatment ___________________________________
   - antibiotics ____

Please indicate whether you want nutrition (food) or hydration (water) medically supplied by a tube into your nose, stomach, intestine, arteries, or veins if you have an end-stage medical condition or are permanently unconscious and there is no realistic hope of significant recovery.

(Initial only one statement.)

TUBE FEEDINGS

_____I want tube feedings to be given.

OR

NO TUBE FEEDINGS

_____I do not want tube feedings to be given.

HEALTH CARE AGENT'S USE OF INSTRUCTIONS

(INITIAL ONE OPTION ONLY.)

_____My health care agent must follow these instructions.

OR

_____These instructions are only guidance.

My health care agent shall have final say and may override any of my instructions. (Indicate any exceptions)

If I did not appoint a health care agent, these instructions shall be followed.

LEGAL PROTECTION

Pennsylvania law protects my health care agent and health care providers from any legal liability for their good faith actions in following my wishes as expressed in this form or in complying with my health care agent's direction. On behalf of myself, my executors and heirs, I further hold my health care agent and my health care providers harmless and indemnify them against any claim for their good faith actions in recognizing my health care agent's authority or in following my treatment instructions.

ORGAN DONATION (INITIAL ONE OPTION ONLY.)

_____ I consent to donate my organs and tissues at the time of my death for the purpose of transplant, medical study or education. (Insert any limitations you desire on donation of specific organs or tissues or uses for donation of organs and tissues.)

OR

_____ I do not consent to donate my organs or tissues at the time of my death.

Having carefully read this document, I have signed it this_____day of______________________, 20__, revoking all previous health care powers of attorney and health care treatment instructions.

SIGNED: ____

(SIGN FULL NAME HERE FOR HEALTH CARE POWER OF ATTORNEY AND HEALTH CARE TREATMENT INSTRUCTIONS)

WITNESS: ____

WITNESS: ____

Two witnesses at least 18 years of age are required by Pennsylvania law and should witness your signature in each other's presence. A person who signs this document on behalf of and at the direction of a principal may not be a witness. (It is preferable if the witnesses are not your heirs, nor your creditors, nor employed by any of your health care providers.)

NOTARIZATION (OPTIONAL)

(Notarization of document is not required by Pennsylvania law, but if the document is both witnessed and notarized, it is more likely to be honored by the laws of some other states.)

On this_____day of _________________, 20____, before me personally appeared the aforesaid declarant and principal, to me known to be the person described in and who executed the foregoing instrument and acknowledged that he/she executed the same as his/her free act and deed.

IN WITNESS WHEREOF, I have hereunto set my hand and affixed my official seal in the County of________________, State of______________________ the day and year first above written.

____

Notary Public

My commission expires ______________________

4. Question and Answer - 20 minutes

5. List of Certified Elder Law Attorneys in Pennsylvania

The following listing of Certified Elder Law Attorneys (CELAs) in Pennsylvania is current as of March 19, 2007. For convenience, the CELAs are listed by the general geographic regions of their offices. CELA's are certified as elder law attorneys by the National Elder Law Foundation in accordance with the rules of the Pennsylvania Supreme Court.

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