Deciding "What if?"

A Legal Handbook for Hawai‘i’s Caregivers, Families and Older Persons

All Counties of Hawai‘i Edition

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INTRODUCTION

DECIDING "WHAT IF?"— A Legal Handbook For Hawai'i's Caregivers, Families and Older Persons will guide you in a simplified way through several areas of legal concerns facing caregivers and the persons they care for. It incorporates some of the recent changes to the law, updates the amount of some public benefits for 2006, adds some cautionary advice about identity theft and expands the list of resources of organizations and public agencies that can assist caregivers and persons who are cared for. Remember laws change constantly, so it may be wise to check before you act. We are most pleased to publish this all counties edition for the first time. We urge readers to contact your Area Agency on Aging (AAA) for further information about services for older persons and caregivers in a particular county. The AAAs in Hawai'i are the City & County of Honolulu Elderly Affairs Division, the Hawai'i County Office on Aging, the Kaua'i County Agency on Elderly Affairs, and the Maui County Office on Aging. They are all listed in the "Resources for Caregivers" section at the end of this handbook. We thank all the counties for funding the publication.

Portions of this handbook, and in particular the materials pertaining to health care decisionmaking, were adapted with permission from *The Akamai Kupuna* (Pietsch) and *The Elder Law Hawai'i Handbook*, (Pietsch & Lee, 1998) published and copyrighted by the University of Hawai'i Press. Also, some materials in this handbook were adapted from federal and state publications.

Caution: While this handbook contains practical and helpful information, it is not intended to serve as a "do-it-yourself" legal guide nor as a substitute for professional legal advice. It provides a basic introduction to various legal concerns of caregivers, families and the elderly and is intended to assist individuals in recognizing problem areas, in finding resources and in obtaining appropriate referrals. If you have legal questions you should seek the advice of an attorney. For information about caregiving resources in other states, call the National Eldercare Locator at 1-(800) 677-1116 or visit their website at http://www.eldercare.gov/.

The University of Hawai'i Elder Law Program (UHELP) is especially grateful for the continuing support provided by the Elderly Affairs Division, Department of Community Service, City and County of Honolulu. For those of you who have access to the Internet, please visit their website at www.elderlyaffairs.com. You can also visit our website at www.hawaii.edu/uhelp. Special thanks go to this year's UHELP Law Clerks, Holly McPherson, John-Anderson Meyer and Christy Matsuba for their assistance.

WITH ALOHA,
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CHAPTER 1

PLANNING FOR THE FUTURE: INCAPACITY, GUARDIANSHIP, ALTERNATIVES TO GUARDIANSHIP, AND PROTECTIVE SERVICES

Frailty, illness, mental incapacity, fear, language barriers and poverty are just a few of the reasons why some elders are unable to manage their own affairs and may need the assistance of a caregiver. They need someone to take care of them and many have no one to help. To make matters worse, some of our senior citizens are being abused, neglected, or exploited by families, acquaintances, or strangers. Often older persons, caregivers, and persons who are cared for are faced with the "what if something happens" question when their health, wealth or wellbeing is threatened. This chapter outlines a few plans of action to help you decide, "What If?"

Lifetime Planning

One way to plan for the future is to utilize a "lifetime planning" approach. Lifetime planning is a continual and comprehensive approach to financial and estate planning that also encompasses additional concerns including personal, social and health care needs. Financial and estate planning issues are beyond the scope of this handbook but are, nevertheless, important. Although there are many fine financial and estate planning books available, this handbook focuses on other aspects of lifetime planning, including powers of attorney, financing health care and health care decision-making, government benefit programs, protective services, guardianship and related issues of planning for incapacity. You will see that some tools in planning for the future such as powers of attorney and trusts can be used for a variety of purposes. Usually, the key to a secure future is prior planning and prevention. Often knowing what to look out for can help prevent problems and start you on the way to a satisfying future.

Incapacity

Although adults are presumed to be "competent," it is a "rebuttable" presumption. In working with clients, the question often arises as to whether the individual has the "capacity" to make decisions. Judicial declarations of incompetency are infrequent and usually not required. The most common court cases where capacity is an issue involve guardianship, conservatorship, adult protective

services and civil commitment. The concept of capacity, or incapacity, is more activity specific. To be considered legally valid, each decisional activity (e.g., provision of informed consent for medical treatment, execution of a will, completion of an advance health care directive, etc.) may require a different level of decisional capacity.

Decisional Capacity

An individual is usually considered to have decisional capacity when he or she is sufficiently able (capacitated) to receive, understand and evaluate information and to communicate a particular choice. This means, at minimum, that he or she has the ability to understand the nature of the problem or activity he or she is facing, to understand available alternative courses of action (including no action), to understand the possible risks and benefits attached to each alternative, and that he or she is able to express a choice. Note that decisional capacity is different from "undue influence" which can be exerted by one person over another person.

Whether a person is considered to have decisional capacity depends on each specific situation. For example, a judge may declare a person legally incapacitated to manage his or her own affairs and appoint a guardian or conservator for that person. However, that person may still be deemed to have sufficient mental capacity to execute a will. Likewise, while that person has the capacity to execute a will, he or she may not have the mental capacity to enter into a contract.

Guardianship and Conservatorship

When a person is incapable of making the necessary decisions for handling his or her own affairs due to mental retardation, mental incapacity or certain other conditions, and effective alternatives have not been set up, it may be appropriate to seek guardianship or conservatorship for that individual. In 2005, a new Uniform Guardianship and Protective Proceedings Act went into effect in Hawai'i. It took the place of the old "guardian of the person" and "guardian of the property" provisions under the previous law. Under the new law, the term, "guardian of the property" is changed to "conservator" and the term, "guardian of the person" is now simply "guardian." In some instances, a guardian or conservator will be appointed even when an alternative, such as a power of attorney, is in existence.

Guardianship and conservatorship involve processes through which a person is appointed by the court to take care of the person or property of an individual who is determined to be incapable of handling his or her affairs. Hawai'i courts have jurisdiction over guardianships for people domiciled or present in the state and over conservatorships for people who are domiciled and own property in Hawai'i. Court hearings for guardianships of incapacitated persons can be heard in Circuit (Probate) Court or in Family Court. This is what is called "concurrent jurisdiction." Hearings for

conservatorships are in the Circuit (Probate) Court. Cases involving the guardianship or conservatorship of the same person can be consolidated in either court at the court's discretion. The petitioner, (the individual who asks the court to be the one to care for another person) can act both as the guardian and as the conservator of an incapacitated person. Finally, transfer of jurisdiction is permissible if it is determined to be in the best interest of the ward or protected person.

To obtain a guardianship or a conservatorship for a person or his or her property, that person must be, for reasons other than being a minor, unable to "receive and evaluate information or make or communicate decisions to such an extent that the individual lacks the ability to meet essential requirements for physical health, safety, or self-care, even with appropriate and reasonably available technological assistance."

The appointment of a guardian or a conservator usually requires rather lengthy and often expensive procedures. The petitioner, that is, the person who appears before the court to be appointed as guardian or conservator, will need to be prepared to provide medical and personal information about the incapacitated person and information about the incapacitated person's spouse, parents, children, other close relatives, current custodian or guardian and the proposed guardian or conservator. The court will require confirmation of the incapacitated person's condition, usually through a written report from a doctor. The court must also find that it has jurisdiction over the person and property if a conservatorship is required, that the appointment is in the incapacitated person's best interest and that it is necessary or desirable to continue the care and supervision of the incapacitated person.

A guardianship or conservatorship will last until the death, resignation, or removal of the guardian or conservator or when the court terminates the guardianship. The ward (under a guardianship) or protected person (under a conservatorship) can also petition the court to terminate the guardianship or conservatorship when he or she regains the capacity or ability to take care of his or her person and property again.

GUARDIANSHIP

A guardian can be appointed by a parent, spouse, or reciprocal beneficiary by means of a will or other signed writing. Upon the death or incapacity of the appointing parent, spouse or reciprocal beneficiary, if there is no objection by the ward or other interested person and if the guardian accepts the appointment, the guardianship will become effective.

The will or writing can specify any limitations on the power of the guardian and is freely revocable until the court appoints a guardian. A guardian who is appointed by such writing must file an acceptance with the court within 30 days of appointment.

A guardian can also be appointed by a judge based on a petition that meets certain statutory requirements and which complies with other measures required by the court, such as proper notice to the interested parties. Except as otherwise limited by the court, a guardian has the duty to make decisions regarding the ward's support, care, education, health and welfare. The guardian should only exercise his or her authority as necessitated by the ward's limitations and, to the extent possible, should encourage the ward to participate in making decisions for himself or herself. The guardian should also encourage the ward to regain the capacity to manage his or her own affairs.

Among other powers, the guardian will generally have the authority to take custody of the ward and establish the custodial dwelling within this state (or outside the state with court's authorization). The guardian will also be authorized to consent to medical or other care, treatment or service for the ward, to take action to compel support for the ward and to apply for and receive moneys for the support of the ward. A guardian, without authorization of the court, may not revoke any health care directions set forth in any medical directive or health care power of attorney of which the ward is the principal. However, the appointment of a guardian automatically terminates the authority of any agent designated in the medical directive or health care power of attorney.

CONSERVATORSHIP

Conservatorship may be determined to be necessary for the protection of the property (sometimes called estate) of an incapacitated individual under different circumstances. The court may determine that the individual is unable to manage property and business affairs because he or she cannot receive and evaluate information or make or communicate decisions even with help or because the individual is missing, detained, or unable to return to the United States. The court may also decide that unless management is provided, the property will be wasted or dissipated. Further, the court may decide that a conservatorship is necessary or desirable when money is needed for the support, care, education, health, and welfare of the individual or of individuals who are entitled to the individual's support.

Generally, without the necessity for further court approval, a conservator may authorize, direct, or ratify any transaction necessary or desirable to provide for the security, service, or care of the ward. The appointment of a conservator vests title in the conservator as trustee to all property of the ward or to the part of the property specified in the court order. Upon notice of the appointment of a conservator, all agents acting under a previously created power of attorney by the ward must take no further actions without the direct written authorization of the conservator, promptly report to the conservator as to any action taken under the power of attorney and promptly account to the conservator for all actions taken under the power of attorney.

CONSERVATORSHIPS FOR ESTATES LESS THAN $10,000

When the value of all of the incapacitated person's assets (his or her estate) is less than $10,000, the Clerk of the Circuit Court may be appointed to act as conservator and is responsible for all actions. For estates of this size, often most of the clerk's work as conservator will involve managing the person's bank account. To have the Clerk of the Circuit Court establish conservatorship of an incapacitated person with assets of less than $10,000, a family member, social worker or other interested person may call the Small Estates and Guardianship Office to start the process.

The Small Estates and Guardianship Office will ask for a letter from a physician stating that the person is incapable of managing his or her financial affairs. To help determine if the incapacitated person is qualified to have the Clerk of the Circuit Court become his or her conservator, the Small Estates and Guardianship Office will require names and addresses of family members and other information, such as bank accounts, to determine the value of the person's assets.

After the necessary information has been gathered, the Small Estates and Guardianship Office prepares a petition for conservatorship. After the probate judge approves the petition, the ward's bills and checks can be sent directly to the Small Estates and Guardianship Office for payment. The conservatorship will continue until the ward dies, becomes capable of handling his or her own financial affairs, or until a successor guardian is appointed.

PUBLIC GUARDIAN

As a state-funded program at the Judiciary, the Office of the Public Guardian (OPG) serves as guardian for mentally incapacitated adults if there is no willing and suitable person, family member, relative, or close friend to serve as his or her guardian.

The OPG also provides temporary guardianship of the person in emergency situations. While the OPG can be appointed guardian of the ward, another organization, legal services agency or private practice attorney or person must be the one to file the petition with the court and obtain the appropriate documents to name the OPG as guardian. With the assistance of a "pro se packet," you can file your own petition on behalf of the incapacitated person. Information about such "do-it-yourself" packets is available through the OPG.

TRUST COMPANIES AND ATTORNEYS AS CONSERVATORS

Being a conservator can be complicated, time consuming and require a great deal of responsibility. For these reasons, friends and family members are not the only ones who can be appointed conservator. Where substantial assets are concerned (usually in excess of $100,000), private trust

companies and private attorneys are usually willing to be conservators for incapacitated wards. To establish a conservatorship, the trust company or attorney must go through the same proceedings as a private individual.

Alternatives to Guardianship and Conservatorship

A guardianship or a conservatorship involves time delays, costs, and loss of privacy. Obtaining the required documents, such as birth certificates, marriage certificates and a doctor's assessment and going through the judicial process, giving notice to the interested parties and attending the court proceedings normally take several months. Filing fees and attorneys' fees and costs are incurred with each proceeding. Further, guardianship documents and proceedings are matters of public record and, accordingly, the financial affairs of the ward may become public knowledge.

With proper advance planning, guardianship or conservatorship proceedings may not be necessary. Less restrictive alternatives can serve the purpose of providing necessary assistance. Executing an advance directive for health care, obtaining a power of attorney, establishing a trust, becoming a representative payee, or maintaining a joint account to pay bills are a few of the frequently used alternatives.

Powers of Attorney

A power of attorney is a powerful tool that can be used in planning for incapacity. As such, it can be an important alternative to guardianship or conservatorship. A power of attorney is a written instrument through which a person designates another person to be his or her agent (or "attorney-in-fact") and grants that person authority to act or to perform certain acts on his or her behalf. Powers of attorney can be drafted to take effect immediately or on a future date and can be made for a specific period or to last indefinitely until death. Springing powers of attorney "spring" into effect upon some subsequent future event. You should realize that there is generally no requirement for an individual or organization to accept a power of attorney. To be certain whether your power of attorney will be accepted by a particular organization or financial institution, you should check this out with them in advance. Ask your attorney for advice about this common problem.

The two basic types of powers of attorney are the general power of attorney and the special power of attorney. A general power of attorney is a very broad and sweeping grant of authority and should be used with extreme caution. Unless prescribed by law or regulation, this instrument authorizes another person to do any legal act, which you, the "principal," might do for yourself. In contrast, a special power of attorney grants authority to an individual to act on your behalf in specific matters. Since it is limited in scope, the use of a special power of attorney reduces the

risks involved in giving another person power. You have the right to revoke, terminate, or modify a power of attorney at any time.

Powers of attorney are important legal documents, which can affect the management of your property and your personal affairs. You should know and trust the person to whom you grant such power. Generally speaking, it is wise to limit the powers granted and the duration of those powers as much as possible. Remember, once an individual (your agent) acts on your behalf with permission (your power of attorney), it may be impossible to undo what he or she has done. You may wish to ask your lawyer to include a "self-executing revocation date" if you do not want your agent to have power indefinitely. Keep track of to whom you give your power of attorney and where it is. You can revoke (or cancel) a power of attorney orally or in writing. To be safe, you may wish to do it in writing and give the revocation to your agent and to any person or organization your agent may have had dealings with. Death automatically terminates the power of attorney.

DURABLE POWERS OF ATTORNEY

Mental disability of the principal terminates a power of attorney unless the instrument contains a provision that states that the power will not be terminated by such disability. There are certain words that need to be included in the power of attorney in order for the power to be considered to be "durable."

WORDS NECESSARY TO CREATE DURABLE POWER OF ATTORNEY

Phrases to the effect that "these powers will not be affected by my disability or incapacity" or "these powers will only be effective upon my incapacity or disability" would serve to create a durable power of attorney. The latter phrase would create a springing durable power of attorney which would be useful for individuals who do not want to grant powers to be effective immediately but who do want somebody to have powers in the event of incapacity.

CAUTION

You should know that, generally speaking, no person or organization must accept a power of attorney and many organizations have their own forms or required formats. For example, the Internal Revenue Service has its own Power of Attorney Form 2848, which contains information and authority the IRS requires in designating an agent. It is especially important for you to "tailor" your power of attorney regarding real estate. It may require a more detailed and formal way of describing the property may be necessary for the document to be legally sufficient.

Powers of attorney can be dangerous in the wrong hands. In Hawai‘i, as across the nation, there are increasing reports of financial abuse, exploitation and theft through the use of powers of attorney. Be especially careful when you give a power of attorney to someone to handle your property or real estate. Be sure that you trust the person to whom you give a power of attorney and read the document before you sign it. If you have doubts, trust your instincts and don't sign it until you are satisfied that the person is trustworthy or that your attorney has built in sufficient protections in your document.

Note that durable powers of attorney can include health care powers if such power is specifically stated in the document. Such "Durable Powers of Attorney for Health Care" are discussed in detail in Chapter 2.

TRUSTS

A trust is simply an arrangement you (the "settlor") make to give your property to a trustee (it could be yourself), who holds it for you or your beneficiaries. Trusts are very useful as estate planning tools and can be used in planning for incapacity. If a person should become incompetent or incapable of handling his or her own affairs, the trust can be a very useful alternative to guardianship. The trust can be used to manage any property you place in it. This can include your home, rental properties, vehicles, bank and savings accounts, stocks, bonds, and virtually anything you can hold title to. Your trustee can use and manage your assets in accordance with your instructions and can be held fiduciarily responsible for his or her actions. Under this framework you can be a little more assured that your assets will be used for your care and for the payment of your bills in the event you are not able to do so. A court-appointed guardian could accomplish the same thing but guardianship actions take time and money and many matters could remain undone while the guardianship action is being pursued.

One of the most important considerations in setting up a living trust is proper transfer of the property you want to be managed by the trust into the trust. It is not automatic. Please see Chapter 3 for more information about the relationship of trusts to "Medicaid Planning."

REPRESENTATIVE PAYEES

When a person has memory loss, is incompetent, or does not understand the process of paying bills, a representative payee can be appointed to handle his or her benefit check. The representative payee then receives checks from the Social Security Administration, the Department of Veteran's Affairs or other agencies, and must use the money for the needs of the beneficiary. Different agencies have different procedures for designating a representative payee.

As a representative payee, you need to keep informed about the needs of the person you care for so that you can decide how benefits can best be used for his or her personal care and well being. The Social Security Administration has made it clear that any money left after meeting the beneficiary's current and reasonably foreseeable needs must be saved and maintained on behalf of the beneficiary. Periodically, the Social Security Administration will ask you to complete a form to account for the funds you have received. As a representative payee, you will need to keep Social Security informed of changes that may affect the beneficiary's eligibility for benefits.

Direct Deposit, Joint Accounts and Money Management

One of the most common reasons that an older adult becomes the subject of a guardianship proceeding is that the individual is experiencing difficulty in depositing checks, writing checks, and paying bills or otherwise managing his or her financial affairs. Direct deposit is a program that allows you to have your incoming checks delivered directly to your personal checking, or savings account at whichever bank you designate. To sign up, just take your next check to wherever you do your banking and tell them you want to sign up for direct deposit. They can tell you whether your checks can be directly deposited and answer any questions.

A joint account can be useful for a person who needs help in writing checks and in depositing funds into an account because it permits another person to have complete access to the funds. While this is a very simple and often useful tool to help pay bills, it is very important to note that this alternative can be very risky because the person whose name is added to the account is generally considered a co-owner of the account and can withdraw all of the money!

Money management is a catchall term for a wide range of services provided by individuals and organizations to help people manage their financial affairs. Money management includes such things as check writing, bill paying, depositing money, balancing check books, claims preparation and filing, tax preparation and financial counseling. Services can be provided for free or on a fee basis and are usually commenced by signing a contract for services. Either you or the service provider can terminate these services at any time. If you use these services, make sure that your money manager is insured and bonded to protect you from theft or loss of funds.

Protective Services

The term "protective services" encompasses a wide range of services and actions to help persons who experience difficulty or who are incapable of managing their own personal affairs. These services can include providing health, nutrition, transportation, nursing and chore services, representative payeeships, governmental intervention, guardianship, and civil commitments. Protective services are often used to address incidents of elder abuse.

ELDER ABUSE

Abuse and neglect of the elderly is a serious problem, which, until recently, has not received the same attention or resources as child abuse or domestic violence. Elder abuse has been described as a "hidden epidemic" in our society. Elder abuse can be defined as physical or mental mistreatment or injury or neglect that harms or threatens an elderly person. Elder abuse is often distinguished from ordinary crimes directed against the elderly by the repetitive character of the acts, often committed by a relative or other caregiver. While there is no specific Hawai'i law that addresses elder abuse, there are various laws that provide protection to vulnerable and dependent adults, including the elderly.

EXAMPLES OF THE TYPES OF ELDER ABUSE

The National Center on Elder Abuse defines seven different types of elder abuse:

- Physical Abuse is the use of physical force that may result in bodily injury, physical pain or impairment.
- Sexual Abuse is non-consensual sexual contact of any kind with an elderly person.
- Emotional Abuse is the infliction of anguish, pain, or distress through verbal or non-verbal acts.
- Financial/Material Abuse is the illegal or improper use of an elder's monies, funds, property (including an elder's home or other real estate), or assets.
- Neglect is the refusal or failure to fulfill any part of a person's obligations or duties to an elderly person.
- Abandonment is the desertion of an elderly person by an individual who has physical custody of the elder or by a person who has assumed responsibility for providing care to the elder.
- Self-Neglect is a behavior that threatens the elder's health or safety.

SOME OF THE CAUSES OF ELDER ABUSE

There are many causes of abuse. Some abusers purposefully hurt an older person, especially if the older person is defenseless. These abusers may be evil, violent, mentally disturbed, or abuse drugs or alcohol. Others use abuse as a means of control over the older person. Some use abuse as revenge or a "pay back" for abuse that the older person may have committed in the past. Poverty or greed can cause abusers to steal money or property from their victim.

Abuse and neglect of the elderly take place most commonly in the victim's home and in institutions such as nursing and care homes. In the home setting, the abuser is often a caregiver who often has repeated contact with the victim and has the opportunity to commit the abuse. Spouses, children, grandchildren, nieces and nephews, siblings, neighbors, friends and hired caregivers are examples of people who may be abusers. In an institution, abuse is most often committed by employees on those who are physically or mentally incapacitated. Abused elderly often endure the abuse for fear of losing whatever support the abuser may be providing. They may feel helpless and feel they have nowhere to go or no one to turn to. If you feel you are being abused or know someone who is being abused, help is available. Some resources are listed in the back of this booklet.

FINANCIAL ABUSE

Financial abuse can happen to anyone. Abusers can be charming. They often pretend to be your friend and pressure you into giving them gifts. They may even say they're doing you a favor. Trust your instincts. Don't be fooled. Ask questions. Don't sign anything you don't understand. Get advice from your bank, an attorney, or financial advisor before you commit yourself.

Financial exploitation includes abuse of a power of attorney, misuse of ATM or credit cards and joint bank accounts, misappropriation of pension and benefit checks, illegal property transfers and a variety of frauds and scams.

IDENTITY THEFT

Identity theft occurs when someone uses your personal information without your permission to commit fraud and other crimes. When thieves steal and use your personal information such as your name, Social Security Number, credit card number, checking account number or other identifying information, you may be refused credit, housing, bank loans or you may even be accused of a crime you did not commit. You may have to spend much time and money to clear up your name and credit record even when it is not your fault.

HELPFUL TIPS

- Do not give out your Social Security Number without a good reason.
- Shred your personal bank checks and credit card receipts before disposing them.
- Be suspicious and careful if unsecured websites ask you for personal information which may lead to identity theft.
- Close any accounts that you think may have been tampered with.
- File your complaint with the Federal Trade Commission (FTC) 1-(877) 438-4338.
- Visit their website at www.consumer.gov/idtheft/ to obtain ID theft Affidavits.
- If you are a victim of identity theft, contact the three major credit bureaus to place a fraud alert or to obtain a copy of your credit report (fees may be incurred):
  - Equifax 1-(800) 525-6285
  - Experian 1-(888) 397-3742
  - TransUnion 1-(800) 680-7289

CAREGIVER ABUSE

Caring for an older person or a disabled person (or both) can be difficult, stressful and, sometimes, thankless. You may be caring for more than one person. The person you are caring for may not appreciate what you are doing, may be demanding, abusive toward you or may not even recognize you. He or she may need constant supervision. Other family members may not be willing or able to help. You may not have enough time to sleep much less take care of your own personal matters. If you do not have the proper tools, training, finances, support and respite, you risk neglecting yourself as well as the person (or persons) you care for. This can lead to actual abuse of the person you are caring for, allegations of abuse filed against you, or even abuse to you. Some caregivers who are "at the end of their ropes" will even abandon the person they are caring for if they do not know what else to do.

DANGER SIGNS THAT YOU MAY NEED HELP:

- You are often angry at your situation.
- You are being abused by the person you are caring for.
- You are overwhelmed by the care that needs to be provided.
- You are having financial problems.
- You are always tired and you neglect yourself.
- You are turning to alcohol or drugs to deal with the situation.
- You resent that you are not getting enough support from other family members.

Although each situation is different, try to get help or share some of your burdens with others rather than to risk "caregiver abuse." Take care of yourself first, get some rest and perhaps, a physical checkup.

The local county offices on aging, which are the Hawai'i County Office on Aging, the Kaua'i County Agency on Elderly Affairs, the Maui County Office on Aging and on O'ahu, the Elderly Affairs Division of the City and County of Honolulu, may be able to provide information about various social services. They can put you in touch with services that include Kupuna Care for elders and respite services for caregivers, help in bathing, transportation and shopping, Meals on Wheels, Home Health Services, hospice care for the terminally ill and legal services for socially or economically needy elders. Phone numbers for the county offices on aging are listed in the "Resources for Caregivers" section at the end of this handbook.

SELF-NEGLECT

Certain people may be forced into or may choose lifestyles that may seem strange to you. Many older persons are too poor to take proper care of themselves. Others may exhibit unusual behavior due to a mental illness, over or under medication, malnutrition, psychological changes, depression, substance abuse or poverty. Sometimes people reach the stage where they appear to be causing harm to themselves appear to need some kind of protection. Deciding whether to intervene into a person's life because of his or her eccentricity or self-neglect is filled with legal, ethical and practical considerations. Issues of statutory limitations, civil rights, autonomy and self-determination very often limit the ability of concerned individuals and agencies to intervene. Sometimes the only recourse is to offer social or legal services and to attempt to persuade individuals to change their lifestyle.

TIPS TO AVOID BEING ABUSED

Abuse can happen to anybody.
You can apply the following tips to yourself or to the person you may be caring for:

- Avoid isolation. Surround yourself with trusted family, friends and advisors.
- Track your assets, and be mindful of changes you didn't initiate.
- Safeguard your credit cards, checkbooks and bankcards.
- Use direct deposits for Social Security, pension and other income.
- Be careful when using joint accounts.
- Develop a plan for managing your assets if you become unable to manage them yourself.
- Contact authorities if you suspect a problem. Don't be ashamed if you become a victim.

Laws to Protect Abused Elderly

While there are no specific laws in Hawai‘i that address elder abuse, there is a wide range of laws that can be used to protect abused older persons. The Hawai‘i Penal Code provides criminal penalties for crimes against all persons in Hawai‘i. Much of the abuse directed against the elderly can be considered criminal. There are even enhanced penalties for certain crimes directed against older or disabled individuals.

There are other laws that establish agencies to investigate and prevent further abuse. The State of Hawai‘i Office of the Long-Term Care Ombudsman has the power to investigate incidents of alleged abuse in long-term care facilities such as nursing homes and care homes. The Medicaid Investigations Division of the Department of the Attorney General of the State of Hawai‘i has the power to investigate and prosecute alleged incidents of abuse in health care facilities that receive Medicaid funding. The Attorney General also has the authority under the Elder Justice Act to seek damages from institutional caregivers who abuse or neglect their residents.

Dependent Adult Protective Services

The most comprehensive law providing protection is the Dependent Adult Protective Services law, which recognizes that the elderly and the mentally or physically impaired form a significant and identifiable segment of the population which is particularly subject to risks of abuse, neglect, and exploitation. The law also recognizes that a person's dependency status, not age, is often encountered in cases of abuse, neglect and exploitation. The Dependent Adult Protective Services law requires certain persons who, in the performance of their professional or official duties, know or have reason to believe that a dependent adult has been abused and is threatened with imminent abuse to promptly report the matter orally to the Department of Human Services (DHS). The Adult Protective Services (APS) Unit of the DHS takes reports of suspected abuse. On O‘ahu, you can call the APS Hotline by dialing 1-(808) 832-5115. Please see the "Resources for Caregivers" section at the end of this booklet to reach APS on the neighbor islands. APS is required to investigate reports of alleged abuse against a dependent adult and has the authority to take steps to prevent further abuse, including legal action in the Family Court, which has overall jurisdiction over cases of dependent adult abuse.

Action Upon Receiving a Report

Upon receiving a report that abuse of a dependent adult has occurred and is imminent, APS investigates. By law, APS is entitled to have access to the allegedly abused dependent adult and may seek the assistance of the police to gain access. If abuse is discovered, DHS must take action to prevent further abuse. It should be noted that DHS can only act with the consent of the victim, unless it obtains court authorization to provide necessary services.

LONG-TERM CARE OMBUDSMAN

As previously mentioned, Hawai‘i has a Long-Term Care Ombudsman/Advocate Law which grants investigative and access authority to the Long-Term Care Ombudsman. As an independent and politically neutral examiner, the Ombudsman receives and investigates complaints against long-term care facilities and the agencies. Personal data relating to a complaint is treated as confidential and will not be released by the Ombudsman without written permission of the patient/resident or his or her legal representative.

A complaint can be lodged by anyone, including organizations, friends, staff, or anonymous persons. It is a crime to retaliate against any patient or resident who files a complaint with the Ombudsman. Persons in residential long-term care facilities, care homes, and boarding homes in Hawai‘i are protected by this law. Investigation begins as soon as possible after the complaint is received. If verified, the facility's staff is asked to make corrections or provide a prompt response. The Ombudsman may also involve other responsible agencies.

OTHER INTERVENTIONS AND REMEDIES

The Hawai‘i Disability Rights Center may be able to assist certain disabled victims. Also, domestic violence organizations may be able to assist victims who are abused by household members. Private legal remedies, including actions for breach of contract, tort and civil fraud, may also be pursued.

You can protect yourself from an abusive individual by obtaining a "Temporary Restraining Order" (TRO) from the District or Family Court. The Family Court will hear cases in which the abuser is a relative, former spouse, dating partner, someone with whom you have had a child or someone with whom you have lived. Otherwise, the District Court may be able to hear the case. In all instances, you will need to fill out specific forms (available from the Clerk of the respective Courts) to give the Court information on the alleged abuse and certain contact information. You will also need to participate in a hearing on the matter and may need to pay a filing fee. The TRO will be effective when it is served.

If you are in danger or feel threatened, leave your home if it is unsafe. Get medical attention if you have been injured. Report abuse to Adult Protective Services to help with your safety and protection. In an emergency, call 911 for help. Be calm and clear about the location of the emergency.

CHAPTER 2

PLANNING FOR THE FUTURE: MEDICAL TREATMENT AND HEALTH CARE DECISIONS

As medical science continues to make progress toward permitting people to live healthier and longer lives, many individuals are now deciding to take charge of their own medical decisions in consultation with physicians, family members, clergy, and close friends.

MEDICAL TREATMENT AND INFORMED CONSENT

In Hawai‘i and all other states, competent individuals have the fundamental right to control the decisions relating to their own medical care. This includes decisions whether to have life sustaining medical or surgical means or procedures to prolong their lives provided, continued, withheld, or withdrawn. The basis for making decisions center around the concept of informed consent. In Hawai‘i, the State of Hawai‘i Board of Medical Examiners establishes standards for health care providers to follow in giving information to a patient or to a patient’s guardian, if the patient is not competent to give an informed consent. The standards include provisions which are designed to reasonably inform a patient, a patient’s guardian or legal surrogate of the following:

- The condition to be treated;
- A description of the proposed treatment or surgical procedure;
- The intended and anticipated results;
- The recognized possible alternative forms of treatment;
- The recognized alternative treatments or procedures, including the option of not providing these treatments or procedures;
- The recognized material risk of serious complications or mortality associated with the proposed treatment, recognized alterative treatments, not undergoing treatment, and recognized benefits of the recognized alternative treatments or procedures.

PATIENT SELF DETERMINATION ACT

All states and most health care facilities must comply with Medicare and Medicaid rules regarding patients' right to control their health care treatment under a federal law commonly referred to as the "Patient Self-Determination Act" (PSDA). It requires all Medicare and Medicaid organizations, specifically, hospitals, nursing facilities, home health agencies, hospices and prepaid health care organizations to do five things:

1. Provide written information to patients at the time of admission or initial provision of services about patients' rights under state law to make decisions about what medical care they want or do not want, including their right to accept or refuse life-sustaining or life-prolonging medical treatment;
2. Maintain written policies and procedures regarding advance directives, and provide written information to patients about what those policies are;
3. Document in the patients' medical records whether they have executed advance directives;
4. Ensure compliance with state law at each health care organization which is subject to the new federal law;
5. Provide (individually or with others) for the education of the staff and community on issues concerning advance directives.

HEALTH CARE DECISIONS

More and more people have decided to face the question of how health care decisions will be made when they are no longer able to make these decisions for themselves. No matter what an individual desires, it is important to communicate those desires so that health care providers will know what to do when that person can no longer make decisions. In determining how he or she wishes to be treated, an individual may want to discuss these matters with family, friends, clergy and other advisors. Individuals should make sure that these personal desires are made known to concerned individuals and especially to health care providers.

Health care encompasses much more than medical treatment and decisions about end-of-life issues. Under a relatively new law in Hawai‘i, the Uniform Health Care Decisions Act (Modified), health care means any care, treatment, service, or procedure to maintain, diagnose, or otherwise affect an individual's physical or mental condition, including:

- Selection and discharge of health care providers and institutions;
- Approval or disapproval of diagnostic tests, surgical procedures, programs of medication and orders not to resuscitate; and
- Direction to provide, withhold, or withdraw artificial nutrition and hydration, provided that

withholding or withdrawing artificial nutrition or hydration is in accord with generally accepted health care standards applicable to health care providers or institutions.

HEALTH INFORMATION AND HIPAA

For the most part, with a few exceptions, patient records belong to the patient and such information is considered confidential. A federal law, the Health Insurance Portability and Accountability Act of 1996 (HIPAA), among many other things, requires that "covered entities" such as health plans, health care providers (e.g., hospitals and nursing facilities), or health care clearinghouses verify a person's identity to ensure that it is the patient or a delegated or authorized "personal representative" who is requesting the patient's medical records. Due to the complexity and confusion of the HIPAA statute, an individual who needs access to medical records on behalf of an incapacitated patient may have a difficult time gaining access to those records unless they can produce evidence of their authority to receive medical information, including reviewing the medical file, on behalf of the patient.

State or other law determines who is authorized to act as a personal representative for purposes of HIPAA. In Hawai'i, this would usually include an individual who 1) has been delegated such authority by the patient in writing, or 2) has been appointed by the court to act as guardian, or 3) has been appointed by the patient as an agent in a power of attorney for health care or 4) has been selected as a "designated surrogate" by consensus of "interested persons" or 5) has been appointed as a non-designated surrogate acting on behalf of the patient. For deceased patients, the personal representative or executor of the patient's estate may qualify. More detailed information about the roles and authority of these individuals, as well as sample language regarding the release of health care information, is included later in this chapter.

ADVANCE HEALTH CARE DIRECTIVES

The term "Advance Health Care Directive," (sometimes shortened to "Advance Directive"), applies to all directives, instructions, or even desires that a person may communicate in writing, orally or in some other fashion concerning decisions about medical treatment and health issues relating to his or her body and life. The term "Living Will" was popular for many years but was confusing to many. In 1999 the Uniform Health Care Decisions Act (Modified), or UHCDA, was enacted in the state of Hawai'i. This law does not use the term "living will" but several other states still use the term. In Hawai'i, the term "individual instruction" has taken its place. This and other information about the UHCDA will be discussed in greater detail later in this chapter.

Although advance directives are generally used in the context of making end-of-life decisions, the laws of the state of Hawai'i cover a broad range of advance directives and make it easy for

individuals to have their instructions followed. Accordingly, directions such as declining cardio-pulmonary resuscitation in advance or donating organs may be considered in a broad sense to be advance directives. Another example is a recently enacted law which specifically addresses making decisions in advance with respect to mental health conditions. Most commonly, advance directives are thought of as those written documents which provide health care providers with information about a patient's desires concerning medical treatment and which contain a designation of an agent to make health care decisions for the patient. Although written advance directives concerning lifesustaining medical treatment are encouraged and preferred under Hawai‘i law, they are not required. An adult or emancipated minor may give an individual instruction regarding health care. The instruction may be oral or written. The instruction may be limited to take effect only if a specified condition arises.

Although Advance Health Care Directive formats generally following the optional form used in Hawai‘i under the UHCDA should be adequate for use in most other states, some health care facilities may still be reluctant to recognize out-of-state documents. While there continues to be a strong movement toward creating uniformity among the states, it is still best to take preventive measures and check out the laws in another state ahead of time. For example, a person who is traveling to another state may be concerned about the "portability" of his or her advance directive. Some of this homework can be accomplished by calling a family member or friend living in that area to find out from a health care provider or elder law attorney about advance directive guidelines there.

DO NOT RESUSCITATE (DNR) CODES

DNRs are orders not to provide cardio-pulmonary resuscitation (CPR) attempts to a person who has stopped breathing or whose heart has stopped beating. There are two basic types of DNRs, "in-hospital" and "out-of-hospital" DNRs. Out-of-hospital DNRs, often referred to as "Comfort Care Only (CCO-DNR)" or "Rapid Identification Documents," will be discussed a bit later in this chapter.

In-hospital DNRs are placed by a physician with the patient's (or patient's legally authorized decision-maker's) consent in the patient's treatment chart. The normal action when a patient suffers cardiac or respiratory arrest in a hospital or other health care facility is called a "code." It is important to know that, in such an emergency, the patient may routinely be resuscitated unless there is a written "DNR" (do not resuscitate) order in the medical record. This order is sometimes called a "Do Not Attempt to Resuscitate" or "No Cardiopulmonary Resuscitation (CPR)" order. The DNR order is only an order to forego the otherwise automatic initiation of CPR and it does not alter other treatment decisions. CPR can include such emergency medical interventions as artificial breathing, chest compressions, cardiac defibrillation (using electric shocks), and certain drugs.

A patient can designate an agent under a health care power of attorney to make such decisions. The decision to refuse CPR may also be made orally by a mentally competent patient to the treating physician. This can also serve as the basis for the DNR order, which is usually signed by your attending physician or supervising health care provider. DNR orders (or "no codes") are placed in the patient's medical chart and, thereafter, emergency procedures to resuscitate the patient will not be carried out. DNR codes are often written if it is felt that future resuscitation efforts would be futile.

INDIVIDUAL INSTRUCTIONS

A good way to make your desires known concerning health care decisions, including lifesustaining medical treatment is to make an "individual instruction" in accordance with Hawai'i's Uniform Health Care Decisions Act (Modified) (UHCDA). As previously mentioned, the individual instruction takes the place of what was commonly called the "living will" under old law. Individual instructions may be made orally or in writing and can cover virtually all aspects of health care. If made orally, it may be best for you to provide the instruction directly to your attending physician and ask him or her to "chart" your discussions by placing the information you provide in your medical file. You can provide an individual instruction in writing, for example by writing a letter to your physician which includes information you want him or her to know about your desires for health care in the future.

An individual instruction can also be incorporated into an advance directive document, which can also include the designation of an agent through a health care power of attorney, directions concerning organ donations and the designation of a health care provider among other matters. The UHCDA provides an optional sample form with an accompanying explanation. Sample forms (long and short) are found at the end of this chapter. In the long form, choices are provided for you to express your wishes regarding the provision, withholding, or withdrawal of treatment to keep you alive, including the provision of artificial nutrition and hydration, as well as the provision of pain relief medication. Space is provided for you to add to the choices you have made or for you to write out any additional wishes. This form may be modified to suit your needs, or you may use a completely different form. A sample short form is also included at the end of this chapter.

HEALTH CARE POWER OF ATTORNEY

In addition to the "individual instruction" for health care, you should consider making a health care power of attorney (also called a durable power of attorney for health care or medical power of attorney). This can be done in the advance health care directive under the UHCDA. Do not confuse the durable power of attorney for health care, which expressly addresses health care decisions and which has different execution requirements, with the durable powers of attorney discussed in Chapter 1, which may or may not include health care decisions. Samples are included in the

advance directive sample forms at the end of this chapter. If you are confused about the type of power of attorney you have, make sure to ask an attorney for advice and guidance. Delegating the authority to carry out your individual instructions, or to make health care decisions in the absence of such instructions, is becoming a common method of planning for the future.

You can choose to have the health care power of attorney take effect when you become incapable of making your own decisions or have it take effect immediately even though you are still capable. You may also name an alternate agent to act for you if your first choice is not willing, able, or reasonably available to make decisions for you. This is a very important consideration since you cannot always be sure if your primary agent will be available to make decisions when you need him or her.

Unless related to you, your agent may not be an owner, operator, or employee of a health care institution where you are receiving care. Unless the form you sign limits the authority of your agent, your agent may make all health care decisions for you. Practically speaking, a physician normally will not want to act or, perhaps will not be able to act as your agent, unless you are related to the physician or if the physician is a close friend and is not your treating physician.

Powers of attorney for health care must be witnessed or notarized. For the power of attorney to be valid for making health care decisions, you must sign it:

- Before two "qualified" adult witnesses who are personally known to you and who are present when you sign. These witnesses must also sign the document.
- OR before a notary public in the state that acknowledges your signature.

A witness for a power of attorney for health care cannot be:

- A health care provider,
- An employee of a health care provider or facility, or
- The agent.

At least one of the individuals used as a witness for a power of attorney for health care must be someone who is neither related to the principal by blood, marriage, or adoption, nor entitled to any portion of the estate of the principal upon the principal's death under any will or codicil the principal may have made prior to the execution of the power of attorney for health care or by operation of law then existing.

What To Do With Your Advance Health Care Directive

When you complete an advance directive, which includes individual instructions and a power of attorney for health care, or make just a power of attorney for health care or provide individual instructions for health care, give a copy of any signed and completed forms to your physician, to any other health care providers you may have, to any health care institution at which you are receiving care and to any health care agents you have named. You should talk to the person you have named as agent to make sure that he or she understands your wishes and is willing to take on the responsibility. Once again, make sure that you consider designating alternate attorneys-in-fact in case your first choice is unwilling or unable to act on your behalf.

Make certain that a copy of your executed document is placed in your medical file or files. This is your responsibility. In case of an emergency that requires a decision concerning your health care, make sure that you keep a copy where it is immediately available to your agent.

You can ask to have "AHCD" (short for Advanced Health Care Directive) placed on your driver's license or state identification card so the fact that you have made an advance directive will be known in an emergency. This will encourage people to look for the advance directive if, for some reason, you have not had it placed in your medical file. You can also "register" your advance directive with an electronic document bank for advanced health care directives, such as Healthcare Directive Partners at http://www.myhealthdirective.com, for a small fee. Individuals may also deposit their advance directives at the Healthcare Directive Partners and give permission for participating health care facilities to obtain them in the event of incapacitating illness or accident.

Revocation of Advance Health Care Directive

The UHCDA makes it clear that you may revoke an advance directive, including a health care power of attorney. However, you may revoke the designation of an agent only by a signed writing or by personally informing the supervising health care provider. You may revoke all or part of an advance health care directive, other than the designation of an agent, at any time and in any manner that communicates an intent to revoke. A decree of annulment, divorce, dissolution of marriage, or legal separation revokes a previous designation of a spouse as agent unless otherwise specified in the decree or in a power of attorney for health care.

Comfort Care Only, DNR Directives

Advance directives are not generally used to make emergency resuscitation decisions although they may be used as the basis to withhold cardio-pulmonary resuscitation (CPR) attempts in cases where a person has been determined to be in a condition as stated in their advance directive.

Traditionally, DNR codes only applied in situations when you are a patient in a health care facility. However, if you are terminally ill, a Hawai‘i law which has been in effect since 1995, will allow you to obtain a special bracelet or necklace which would tell “first responders” not to resuscitate you in an emergency. The Department of Health has adopted rules for emergency medical services which include uniform methods of rapidly identifying an adult person who:

- Has been certified in a written “comfort care only” document by the person’s physician to be a terminally ill patient of that physician; and,
- Has certified in the same written “comfort care only” document that the person who directs emergency medical services personnel, first responder personnel, and health care providers has been informed not to administer chest compression, rescue breathing, electric shocks, or medication, or all of these, given to restart the heart if the person’s breathing or heart stops, and directs that the person is to receive care for comfort only, including oxygen, airway suctioning, splinting of fractures, pain medicine, and other measures required for comfort; and,
- The written document containing both certifications must be signed by the patient with the terminal condition, by the patient’s physician and by any one other adult person who personally knows the patient.

As of the date of this printing, the legislature was considering a bill (Physician Orders for Life-Sustaining Treatment or POLST) which would amend the rapid identification documents law by deleting the requirement that the Comfort Care Only-Do-Not-Resuscitate document only be recognized in the form of a bracelet or necklace. It would also allow a lawfully appointed guardian, agent, or surrogate to act on a patient’s behalf when directing medical staff to provide comfort care only.

Surrogate Decision-Making

Who will make health care decisions for an individual who is no longer capable of making decisions, has not made an advance health care directive and does not have a guardian? Historically, health care providers have turned to family members to provide informed consent in these situations. Since 1999, Hawai‘i’s UHCDA (Modified) has provided a mechanism for surrogates to make decisions for incapacitated individuals. A surrogate is a person who is not a guardian or health care agent but has the authority to make decisions for the patient.

Under the UHCDA surrogate provisions, a patient may designate or disqualify any individual to act as a surrogate by personally informing the supervising health care provider. In the absence of such a designation, or if the designee is not reasonably available, a surrogate may be appointed to make a health care decision for the patient. A surrogate may make a health care decision for a patient who is an adult or emancipated minor if the patient has been determined by the primary

physician to lack capacity and no agent or guardian has been appointed or the appointed agent or guardian is not reasonably available. The process of appointing a surrogate is somewhat complicated under Hawaii's modified version of the UHCDA.

Upon a determination that a patient lacks decisional capacity to provide informed consent (or refusal) for medical treatment, the primary physician or the physician's designee first needs to make "reasonable efforts to notify the patient of the patient's lack of capacity." The primary physician, or the physician's designee, then must make reasonable efforts to locate as many "interested persons" as practicable. The primary physician may rely on such individuals to notify other family members or interested persons. Under this new law "interested persons" means the patient's spouse, unless legally separated or estranged, a reciprocal beneficiary, any adult child, either parent of the patient, an adult sibling or adult grandchild of the patient, or any adult who has exhibited special care and concern for the patient and who is familiar with the patient's personal values.

Upon locating the interested persons, the primary physician, or the physician's designee, must inform such persons of the patient's lack of decisional capacity and that a surrogate decision-maker should be selected for the patient. The interested persons are to make reasonable efforts to reach a consensus as to who among them shall make health care decisions on behalf of the patient. The person selected to act as the patient's surrogate should be the person who has a close relationship with the patient and who is the most likely to be currently informed of the patient's wishes regarding health care decisions.

If any of the interested persons disagrees with the selection or the decision of the surrogate, or, if after reasonable efforts the interested persons are unable to reach a consensus as to who should act as the surrogate decision-maker, then any of the interested persons may seek guardianship of the patient by initiating guardianship proceedings. Only interested persons involved in the discussions to choose a surrogate may initiate such proceedings for the patient.

A surrogate who has been designated by the patient may "make health care decisions for the patient that the patient could make on the patient's own behalf." In other words, a "designated surrogate" may make all decisions for the patient. A surrogate who has not been designated by the patient "may make all health care decisions for the patient that the patient could make on the patient's own behalf, except that artificial nutrition and hydration may be withheld or withdrawn for a patient upon a decision of the surrogate only when the primary physician and a second independent physician certify in the patient's medical records that the provision or continuation of artificial nutrition or hydration is merely prolonging the act of dying and the patient is highly unlikely to have any neurological response in the future." This particular provision is subject to interpretation and reinforces the notion that an individual should appoint an agent through a health

care power of attorney or designate a surrogate if the person wishes to grant another person the power to make health care decisions for the patient that the patient could make on the patient's own behalf. In other words, a "non-designated surrogate" has certain restrictions on making health care decisions about tube feeding.

The surrogate who has not been designated by the patient shall make health care decisions for the patient based on the wishes of the patient, or, if the wishes of the patient are unknown or unclear, on the patient's best interest. The decision of a surrogate who has not been designated by the patient regarding whether life-sustaining procedures should be provided, withheld, or withdrawn shall not be based, in whole or in part, on either a patient's preexisting, long-term mental or physical disability, or a patient's economic status. A surrogate who has not been designated by the patient must inform the patient, to the extent possible, of the proposed procedure and the fact that someone else is authorized to make a decision regarding that procedure.

Whether the surrogate is a "designated" or "non-designated" surrogate, a health care decision made by a surrogate for a patient is effective without judicial approval. Further, the supervising health care provider will require a surrogate to provide a written declaration under the penalty of false swearing, stating facts and circumstances reasonably sufficient to establish the claimed authority.

The legislature's enactment of unique requirements and restrictions governing the surrogate provisions of this "uniform" law in Hawai'i makes it even more crucial for an individual to consider designating an agent in a health care power of attorney or, at a minimum, designating a surrogate by informing the supervising health care provider.

Donations of Organs and Bodies

The Uniform Anatomical Gift Act permits any individual eighteen years of age to give all or any part of his or her body for medical or dental education, research, advancement of medical science or dental science, therapy or transplantation. The gift becomes effective upon death without waiting for probate. Evidence of an intent to donate organs can be made by a will or by a document other than a will, such as a donor card, or document imprinted on a driver's license. The potential donor, the next of kin, or another person in accordance with the statute, can make the gift.

The John A. Burns School of Medicine at the University of Hawai'i has a program through which it accepts bodies for scientific purposes. However, it does reserve the right to refuse bodies, for example, when it does not need any more or when the body is not in appropriate condition for the school's purposes or if the body is not located on O'ahu.

Contact the Organ Donor Center for more information about organ donation. In Hawai‘i you can designate “Organ Donor” on your driver’s license but permission will still need to be obtained from your next of kin or other recognized survivor before your organs can be used.

AUTOPSIES

Autopsies can be authorized under the provisions of the Uniform Anatomical Gift Act, previously discussed. In addition, under other provisions of Hawai‘i law, “if, in the opinion of the coroner, or of the coroner’s physician, or of the prosecuting attorney, or of the chief of police (in the City and County of Honolulu), an autopsy of the remains of any human body appearing to have come to death under circumstances that would indicate that the death was a result of violence, or as the result of any accident, or by suicide, or suddenly when in apparent health, or when unattended by a physician, or in prison, or in a suspicious or unusual manner, or within twenty-four hours after admission to a hospital or institution, or if it is necessary in the interest of the public safety or welfare, that person shall cause to have performed such an autopsy.”

FORMS

We have included the following forms:

- CHECKLIST FOR MAKING AN ADVANCE HEALTH CARE DIRECTIVE
- SAMPLE LONG FORM FOR ADVANCE HEALTH CARE DIRECTIVE
- SAMPLE SHORT FORM FOR ADVANCE HEALTH CARE DIRECTIVE

CHECKLIST FOR MAKING AN ADVANCE HEALTH CARE DIRECTIVE

- ❑ Talk with family members, friends, spiritual advisors, physicians, other health care providers and other trusted persons about what would be important to you if you become terminally or irreversibly ill or injured and you can no longer communicate your health-care decisions or other wishes.

- ❑ Ask someone you trust and whom you can count on to be your health care agent and discuss your wishes with this person. Select an alternate health care agent in case your agent is unable to serve.

- ❑ Complete either one of the enclosed simplified forms, change or cross out provisions or make an entirely different document. Add pages if you like.

- ❑ Have two qualified witnesses or a notary witness your signature.

- ❑ Inform family members, your spouse, parents, children, siblings, friends, physicians and other health care providers that you have executed an advance health care directive and that you expect them to honor your instructions. Keep them informed about your current wishes.

- ❑ Give copies of the document to your health care agent, health care providers, family, close friends, clergy or any other individuals who might be involved in caring for you.

- ❑ Place the executed document in your medical files.

- ❑ When you renew your driver's license or state I.D., you may designate that you have an advance directive by putting "AHCD" on it.

- ❑ Make plans to review the document on a regular basis. If necessary, make a new document and keep people informed of any changes.

- ❑ Do it today!

SAMPLE LONG FORM FOR ADVANCE HEALTH CARE DIRECTIVE

MY NAME IS: _____

MY ADDRESS IS: _____
(Address) (City) (State) (Zip code)

PART 1
DURABLE POWER OF ATTORNEY FOR HEALTH CARE DECISIONS

(1) DESIGNATION OF AGENT: I designate the following individual as my agent to make health care decisions for me:

_____
(Name of individual you choose as agent)

_____
(Address) (City) (State) (Zip code)

_____
(Home phone) (Work phone) (E-Mail or other means of contact)

OPTIONAL: If I revoke my agent's authority or if my agent is not willing, able, or reasonably available to make a health care decision for me, I designate as my first alternate agent:

_____
(Name of individual you choose as first alternate agent)

_____
(Address) (City) (State) (Zip code)

_____
(Home phone) (Work phone) (E-Mail or other means of contact)

OPTIONAL: If I revoke the authority of my agent and first alternate agent or if neither is willing, able, or reasonably available to make a health care decision for me, I designate as my second alternate agent:

_____
(Name of individual you choose as second alternate agent)

_____
(Address) (City) (State) (Zip code)

_____
(Home phone) (Work phone) (E-Mail or other means of contact)

(2) AGENT'S AUTHORITY: **(Strike through any of the following provisions you do not want. You can add provisions on the form or attach additional pages.)**

My agent is authorized to make all of the following health care decisions for me:

- To consent or refuse consent to any care, treatment, service, or procedure to maintain, diagnose, or otherwise affect a physical or mental condition, including admission to or discharge from a health care facility or program, approval or disapproval of diagnostic tests, medical or surgical procedures, programs of medication, the use of alternative or complementary therapies as well as decisions to participate in education, research and experimental programs.
- To make decisions regarding orders not to resuscitate, including out-of-hospital "Comfort Care Only—Do-Not-Resuscitate" (CCO-DNR) documents, as well as decisions to provide, withhold, or withdraw nutrition and hydration, and all other forms of health care to keep me alive.
- To request, receive, examine, copy, and consent to the disclosure of medical or any other health care information, including medical files and records. I also grant my agent the power to authorize, or to revoke any authorization for, the release, disclosure and use of any of my health and medical information, including, but not limited to, my entire medical record, my medical bills, all information in my medical records relating to Acquired Immune Deficiency Syndrome (AIDS) or HIV, alcohol and/or drug abuse treatment, or behavioral or mental health services, and any written opinion relating to my capacity, my competency, or my ability to manage my own affairs or to make my own decisions, and such power shall apply to any information governed by the Health Insurance Portability and Accountability Act of 1996 (also known as HIPAA), 42 USC 1320d and 45 CFR 160-164, and any other applicable federal, state or local statute or regulation. In addition, my agent shall have the power to pay any fee charged for duplication of records, and to release health care providers and other entities from all liability and claims whatsoever pertaining to the disclosure of information as contained in the records released pursuant to such authorization.
- To communicate with, select and discharge health care providers, organizations, institutions and programs, including hospice programs and to make and change health care choices and options relating to plans, services, and benefits.
- To apply for public or private health care programs and benefits, to include Medicare, Medicaid, Med-Quest or other federal, state, local or private programs without my agent incurring any personal financial liability.

To make all other health care decisions for me, except as I state here:

_____

_____

_____

(Consult with a mental health professional and/or attorney for appropriate language if you wish to give your agent additional information or instructions about decisions regarding mental illness. You may make a separate mental illness advance directive or include such provisions in this advance directive. Use additional sheets if needed.)

(3) WHEN AGENT'S AUTHORITY BECOMES EFFECTIVE: My agent's authority becomes effective when my primary physician determines that I am unable to make my own health care decisions unless I mark the following box.

____ ❑ If I mark this box, my agent's authority to make health care decisions for me takes effect immediately. However, I always retain the right to make my own decisions about my health care and to revoke this authority as long as I am mentally capacitated.

(4) AGENT'S OBLIGATION: My agent shall make health care decisions for me in accordance with this power of attorney for health care, any instructions I give in Part 2 of this form, and my other wishes to the extent known to my agent. To the extent my wishes are unknown, my agent shall make health care decisions for me in accordance with what my agent determines to be in my best interest. In determining my best interest, my agent shall consider my personal values to the extent known to my agent. My agent shall not be obligated to assume any personal financial responsibility when making decisions in accordance with this document.

(5) NOMINATION OF GUARDIAN: If a guardian of my person needs to be appointed for me by a court, I nominate my agent. If another person is appointed as guardian and my agent is willing and able to act, I would prefer my agent to have precedence in making health care decisions for me.

PART 2
INSTRUCTIONS FOR HEALTH CARE

If you are satisfied with allowing your agent to determine what is best for you in making end-of-life decisions, you need not fill out this part of the form. If you do fill out this part of the form, you may strike through any wording you do not want.

(6) END-OF-LIFE DECISIONS: I direct that my health care providers and others involved in my care provide, withhold, or withdraw treatment in accordance with the choice I have marked below: **(Check only one of the two following boxes. You may cross out any unwanted provisions.)**

____ ❑ (a) Choice **Not To** Prolong Life

I do not want my life to be prolonged if

- I am close to death and life support would only postpone the moment of my death or I have an incurable and irreversible condition that will result in my death within a relatively short time; OR
- I am in an unconscious state such as an irreversible coma or a persistent vegetative state and it is unlikely that I will ever become conscious again; OR
- I have brain damage or a brain disease that makes me permanently unable to interact and make and communicate health care decisions about myself and the likely risks and burdens of treatment would outweigh the expected benefits.

OR

____ ❑ (b) Choice **To** Prolong Life

- I want my life to be prolonged as long as possible within the limits of generally accepted health care standards.

(7) ARTIFICIAL NUTRITION AND HYDRATION: Artificial nutrition and hydration must be provided, withheld or withdrawn in accordance with the choice I have made in paragraph (6) unless I mark the following box.

____ ❑ If I mark this box, artificial nutrition and hydration must be provided regardless of my condition and regardless of the choice I have made in paragraph (6)

(8) RELIEF FROM PAIN: If I mark the following box,

____ ❑ I direct that treatment to alleviate pain or discomfort should be provided to me even if it hastens my death.

(9) OTHER WISHES: (If you do not agree with any of the optional choices above and wish to write your own, or if you wish to add to the instructions you have given above, you may do so here. Examples of additional instructions include preferences to receive Hospice Care and/or to die at home.) I direct that:

_____

_____

PART 3
DONATION OF ORGANS/BODY AT DEATH (OPTIONAL)

(10) Upon my death: (Mark applicable box(es).

____ ❑ (a) I give any needed organs, tissues, or parts, OR

____ ❑ (b) I give the following organs, tissues, or parts only

_____

____ ❑ (c) My gift is for the following purposes
(Strike through any of the following you do not want)

- Transplant
- Therapy
- Research
- Education

____ ❑ (d) I give my body to the John A. Burns School of Medicine for its research and education purposes. **(Obtain information/forms from the medical school Department of Anatomy.)**

PART 4
PRIMARY PHYSICIAN/HEALTH-CARE FACILITY (OPTIONAL)

(11) I designate the following physician as my primary physician:

(Name of physician)

(Address) (City) (State) (Zip code) (Phone)

OPTIONAL: If the physician I have designated above is not willing, able, or reasonably available to act as my primary physician, I designate the following physician as my primary physician:

(Name of physician)

(Address) (City) (State) (Zip code) (Phone)

(12) I have the following preference of hospitals and/or nursing homes if I require such care:

(You may name a facility, or you may indicate a preference for hospice care administered at home or in a hospice facility, a preference not to be institutionalized, a preference to remain at home, etc.)

PART 5
RELIGIOUS OR SPIRITUAL INFORMATION (OPTIONAL)

(13) I identify with the following church, temple, or other spiritual group:

(14) I would like to receive my spiritual care from:

(Name of individual or group)

(Address) (City) (State) (Zip code) (Phone)

(15) EFFECT OF COPY: A copy of this form has the same effect as the original.

SIGNATURE: **Sign and date the form here**:

_____ _____

(Sign Your Name) (Date)

_____

(Print Your Name)

WITNESSES: The power of attorney portion of this document will not be valid for making health care decisions unless it is either (a) signed by two qualified adult witnesses who are personally known to you and who are present when you sign or acknowledge your signature; or (b) acknowledged before a notary public in the state.

ALTERNATIVE NO. 1

FIRST WITNESS

I declare under penalty of false swearing pursuant to section 710-1062, Hawai‘i Revised Statutes, that the principal is personally known to me, that the principal signed or acknowledged this power of attorney in my presence, that the principal appears to be of sound mind and under no duress, fraud, or undue influence, that I am not the person appointed as agent by this document, and that I am not a health care provider, nor an employee of a health care provider or facility. I am not related to the principal by blood, marriage, or adoption, and to the best of my knowledge, I am not entitled to any part of the estate of the principal upon the death of the principal under a will now existing or by operation of law.

_____ _____

(Signature of Witness) (Date)

_____ _____

(Printed Name of Witness) (Address of Witness)

SECOND WITNESS

I declare under penalty of false swearing pursuant to section 710-1062, Hawai‘i Revised Statutes, that the principal is personally known to me, that the principal signed or acknowledged this power of attorney in my presence, that the principal appears to be of sound mind and under no duress, fraud, or undue influence, that I am not the person appointed as agent by this document, and that I am not a health care provider, nor an employee of a health care provider or facility.

_____ _____

(Signature of Witness) (Date)

_____ _____

(Printed Name of Witness) (Address of Witness)

ALTERNATIVE NO. 2

State of Hawai‘i)
) SS
County of _____)

On this _____ day of _____, in the year _____ , before me, _____ (Insert name of notary public) appeared _____ , personally known to me (or proved to me on the basis of satisfactory evidence) to be the person whose name is subscribed to this instrument, and acknowledged that he or she executed it.

Notary Seal

_____
(Signature of Notary Public)

My Commission Expires:_____

SAMPLE SHORT FORM FOR ADVANCE HEALTH CARE DIRECTIVE

MY NAME IS _____.

PART 1: HEALTH CARE POWER OF ATTORNEY DESIGNATION OF AGENT:

I designate the following individual as my agent to make health care decisions for me:

_____

(Name and relationship of individual designated as health care agent)

_____

(Address) (City) (State) (Zip code) (Home phone) (Work phone) (E-Mail)

If I revoke my agent's authority or if my agent is not willing, able, or reasonably available to make decisions for me, I designate the following individual as my alternate agent:

_____

(Name and relationship of individual designated as alternate health care agent)

_____

(Address) (City) (State) (Zip code) (Home phone) (Work phone) (E-Mail)

WHEN AGENT'S AUTHORITY BECOMES EFFECTIVE:

My agent's authority becomes effective when my primary physician determines that I am unable to make my own health care decisions unless I mark the following box.

____ ❑ If I mark this box, my agent's authority to make health care decisions for me takes effect immediately. However, I always retain the right to make my own decisions about my health care and to revoke this authority as long as I am mentally capacitated.

AGENT'S AUTHORITY AND OBLIGATION:

I intend my agent's authority to be as broad as possible subject only to any instructions and limitations I may state in Part 2 of this form or as I may otherwise provide orally or in writing. To the extent my wishes are unknown, my agent shall make health care decisions for me in accordance with what my agent determines to be in my best interest. In determining my best interest, my agent shall consider my personal values to the extent known to my agent. If a guardian of my person needs to be appointed for me by a court, I nominate my agent.

PART 2: INDIVIDUAL INSTRUCTIONS FOR HEALTH CARE

A. END-OF-LIFE DECISIONS:

I wish to provide instructions regarding end-of-life decisions based on different possible situations I may face in the future. (Strike through any of the following provisions you do not want)

- If I am close to death and life support would only postpone the moment of my death, **OR**
- If I am in an unconscious state such as an irreversible coma or a persistent vegetative state and it is unlikely that I will ever become conscious again, **OR**
- If I have brain damage or a brain disease that makes me permanently unable to interact and to make and communicate health care decisions about myself and the likely risks and burdens of treatment would outweigh the expected benefits:

THEN

(Check only <u>one</u> of the three following boxes. You may also initial your selection)

____ ❑ (a) Choice <u>Not</u> To Prolong Life—I do not want my life to be prolonged. **OR**

____ ❑ (b) Choice To Prolong Life—I want my life to be prolonged as long as possible within the limits of generally accepted health care standards. **OR**

____ ❑ (c) Choice To Be Made By Health Care Agent—I want my agent who is designated in Part 1 of this document or in a separate document to make end-of-life decisions for me.

B. ARTIFICIAL NUTRITION AND HYDRATION – FOOD AND FLUIDS:

Artificial nutrition and hydration must be provided, withheld or withdrawn in accordance with the choice I have made in the preceding paragraph A unless I mark the following box.

____ ❑ If I mark this box, artificial nutrition and hydration must be provided regardless of my condition and regardless of the choice I have made in paragraph A.

C. RELIEF FROM PAIN:

____ ❑ If I mark this box, I direct that treatment to alleviate pain or discomfort should be provided to me even if it hastens my death.

D. OTHER MATTERS:

A copy of this form has the same effect as the original.

My agent shall not be obligated to assume any personal financial responsibility when making decisions in accordance with this document. My agent has the authority to request, receive, examine,

copy and consent to the disclosure of medical or any other healthcare information, including medical files and records. This includes my delegated authority for my agent to act as my personal representative for release of all individually identifiable health information concerning me by both covered and non-covered entities under the provisions of the Health Insurance Portability and Accountability Act (HIPAA) and/or other Federal and State laws pertaining to healthcare and healthcare information.

(My Signature)	(Date)
(My Printed Name)	(My Address)

WITNESSES:

This document must either be signed by two qualified adult witnesses who witness or acknowledge the signature; or be acknowledged before a notary public in the state.

ALTERNATIVE NO. 1

FIRST WITNESS*

*I am not the person appointed as agent by this document, and that I am not a health care provider, nor an employee of a health care provider or facility. I am not related to the principal by blood, marriage, or adoption, and to the best of my knowledge, I am not entitled to any part of the estate of the principal upon the death of the principal under a will now existing or by operation of law.

(Signature of Witness)	(Date)
(My Printed Name)	(Address of Witness)

SECOND WITNESS**

**I am not the person appointed as agent by this document, and I am not a health care provider, nor an employee of a health care provider or facility.

(Signature of Witness)	(Date)
(Printed Name of Witness)	(Address of Witness)

ALTERNATIVE NO. 2

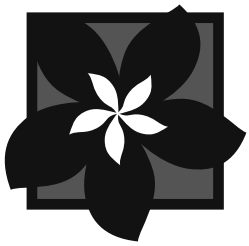
State of Hawai‘i)
) SS
County of _____)

On this _____ day of _____, in the year _____ , before me, _____ (Insert name of notary public) appeared _____ , personally known to me (or proved to me on the basis of satisfactory evidence) to be the person whose name is subscribed to this instrument, and acknowledged that he or she executed it.

Notary Seal

_____
(Signature of Notary Public)

My Commission Expires:_____



CHAPTER 3

FINANCING HEALTH CARE, INCLUDING LONG–TERM CARE

Good health is one of the most important gifts one can receive. Unfortunately, health care can become quite expensive and, thus, out of reach for many. Planning ahead is important and you should know what health care coverage is available and what you can afford. Try not to sell yourself short when it comes to health care coverage. Also, be sure to take advantage of the various federal and state initiatives for seniors in the area of health care. Be aware that new prescription drug benefit plans will be offered under Medicare and Medicaid. Medicare beneficiaries with limited incomes may qualify for extra help in paying for prescription drugs effective January 1, 2006.

MEDICARE

The Medicare program is a federal health insurance program for people 65 or older and certain disabled people. There have been significant changes recently made by Congress through the Medicare Modernization Act (MMA) and you can expect more in the years to come. Medicare is run by the Centers for Medicare and Medicaid Services, or CMS (formerly Health Care Financing Administration), of the U.S. Department of Health and Human Services. Social Security Administration offices across the country take applications for Medicare and provide general information about the program. Currently Medicare has no resource limitations for eligibility, although there may be certain categories of individuals who may be eligible for subsidies or who may benefit more from the new Medicare Part D—prescription drugs than others. Medicare helps pay health care bills for people 65 and over and for those under 65, who have been entitled to disability benefits for 24 months. Also, insured workers and their dependents who have permanent kidney failure or Lou Gerhig's Disease may be entitled to Medicare coverage.

MEDICARE COVERAGE

There are two important rules to remember when Medicare coverage is an issue. First, Medicare can cover care that is "reasonable and necessary" for the diagnosis or treatment of an illness or injury. Care is not considered reasonable and necessary, for example, if a doctor places you in a hospital or skilled nursing facility when the kind of care you need could be provided elsewhere. Also, Medicare will not cover your stay in the hospital or skilled nursing facility longer than you

need to be there. Medicare coverage will end when further inpatient care is no longer reasonable and necessary.

Second, Medicare generally does not pay for long-term care. Medicare also does not pay for help with activities of daily living or other care that most people can do themselves. Some examples of activities of daily living include eating, bathing, dressing and using the bathroom. Medicare will help pay for skilled nursing or home health care if you meet certain conditions.

Eligibility for Medicare is determined by the Social Security Administration (SSA). The Centers for Medicare and Medicaid Services (CMS), a federal agency within the Department of Health and Human Services (HHS), is responsible for the overall administration of the program. Medical bills and claims are handled by private insurance companies under contract with HHS and monitored by the government.

MEDICARE PART A

There were two major parts to the original or "traditional" Medicare program. These two parts (Part A and Part B) continue to this day under the original program and two additional parts were added more recently (Part C and Part D). Hospital Insurance (Part A) helps pay for inpatient hospital care, some inpatient care in a skilled nursing facility, home health care, and hospice care. All persons age 65 and over who are receiving Social Security are automatically enrolled in Part A of Medicare.

Private insurance companies that handle Part A are known as "fiscal intermediaries." They are chosen by the Part A providers of services (hospitals, nursing homes, and home health agencies which participate in the Medicare program). Insurance companies, which administer payments to participating Part B providers (physicians and other practitioners), are called "carriers." In addition to paying claims, fiscal intermediaries and carriers are responsible for setting payment rates and charges and assisting providers in complying with Medicare requirements and standards.

EXTRA HELP FOR MEDICARE BENEFICIARIES

Under the federal Medicare Qualifying Individuals (QI), Qualified Medicare Beneficiary Program, (QMB) and Specified Low-Income Medicare Beneficiary Program (SLMB) programs the Hawai‘i Department of Human Services (DHS) Medicaid Program can help pay for your Medicare Part A and Part B Insurance deductibles and premiums. (Information about Medicaid is contained in section later on in this handbook.) QMB pays Medicare Part A premiums, Part B premiums, and Medicare deductibles and coinsurance amounts for Medicare services. SLMB pays for Medicare Part B premiums for individuals who have Medicare Part A, a low monthly income,

and limited resources. QI pays all or part of the Medicare Part B premium for people with income higher than allowed for the SLMB Program. These are relatively underutilized programs and can be of significant benefit to many individuals. Information is readily available through Medicare or the Hawai‘i Department of Human Services.

Financed primarily through payroll tax deductions, Part A covers expenses incurred during periods of acute illness that requires inpatient hospital care. Following a hospital stay, Part A also covers the expense of inpatient care in an extended care facility. Benefits available under Medicare Part A primarily consist of payments to qualified participating hospitals and skilled nursing facilities for expenses incurred by persons as inpatients.

After payment of an insurance deductible ($952 in 2006) reasonable hospital costs are covered for 90 days in any single “spell of illness” (also referred to as a “benefit period”). This is defined as a period of consecutive days that begins the first day a patient receives inpatient hospital or post-hospital extended care services and ends 60 days after the patient is no longer in the hospital or extended care facility. Again, the Medicare eligible patient is responsible for an insurance deductible ($952 in 2006) for each spell of illness. A patient may pay more than one deductible amount per year if he or she has more than one “spell of illness.” A patient will also have to pay a co-insurance amount per day ($238 in 2006) for the 61st through the 90th day of care, and coinsurance charges ($476 per day in 2006) for “lifetime reserve” days used. After these days are used, the patient or his or her insurer is responsible for the entire bill. Currently each eligible Medicare Part A enrollee is entitled to a total of 60 reserve days to draw upon.

Medicare Part A has very limited coverage for skilled nursing facility (SNF) care. Generally, a physician must order care. There is a requirement for a three-day hospitalization immediately prior to or within 30 days following entry into an SNF. Co-insurance payments are also required ($119 per day in 2006) for days 21–100. Coverage is limited to 100 days per spell of illness and custodial care is not covered. Note that most individuals in nursing homes do not require skilled care and are thus not eligible for Medicare coverage.

Medicare Part A can pay for home health services if a homebound patient requires “intermittent skilled nursing care,” or physical, occupational, or speech therapy. There is no limit to the number of home health services visits but the services must be prescribed by a doctor and must not be performed on a daily basis.

A certified terminally ill patient may elect hospice benefits under Medicare. In obtaining Medicare coverage for hospice benefits, the attending physician needs to certify that the patient is terminally ill at the beginning of each period of care, which is limited to two 90-day periods and unlimited 60-day periods for the patient’s lifetime. Hospice care includes medical and supportive services

intended to provide comfort to the individual who is terminally ill. Hospice care provides palliative care to manage illness and pain but does not treat the underlying terminal illness. Special co-payment rules apply for hospice care.

MEDICARE PART B

Medical Insurance (Part B) helps pay for medically necessary doctors' services, outpatient hospital services, home health care and a number of other medical services and supplies that are not covered by the hospital insurance part of Medicare. It is voluntary and enrollees pay a monthly premium. It includes coverage for medically necessary physicians' service, outpatient hospital services, outpatient physical therapy and speech pathology services, home health services, diagnostic tests and medical appliances (durable medical equipment). Part B benefits are designed to supplement and extend the benefits provided by the Part A program. Under Part B, payment can be made for medical and health services and for home health services for up to 100 visits per year. (Remember that Part A can pay for unlimited visits.)

As under Part A, there are certain deductible and co-insurance amounts the Part B recipient must pay. The Part B annual deductible (for 2006) consists of the first $124 of covered services plus the first three pints of blood. After application of the annual deductible, payment under Part B will be made for 80 percent of the remaining reasonable charges or costs of covered services. The Part B recipient pays the remaining 20 percent co-insurance amount. However, there is no coinsurance requirement for home health services under Part B and no deductible or co-insurance for certain inpatient radiological and pathological services rendered by a physician and diagnostic laboratory tests. Also, the co-insurance payment is waived if the recipient purchases used durable medical equipment. Under current law, all bills under Part B must be submitted directly by the physician or supplier to the carrier. The Part B premium is currently $88.50 per month (2006).

MEDICARE PART C—MEDICARE ADVANTAGE (FORMERLY CALLED MEDICARE+CHOICE)

In addition to the original Medicare Plan, there are several Medicare option plans to choose from. These options are collectively known as Medicare Advantage (formerly called Medicare+Choice) or Medicare Part C. These options include Medicare Managed Care Plans provided by Health Maintenance Organizations (HMOs), and newer private fee-for-service plans. If you decide to join a Medicare Advantage Plan, you must be enrolled in Medicare Part A and Part B. Accordingly, you will have to pay the monthly Medicare Part B premium of $88.50 (2006). In addition, you may have to pay a monthly premium to your Medicare Advantage Plan for the extra benefits that they may offer.

Currently, in Hawai‘i, examples of managed care plans that are available include the various plans offered by HMSA's 65C, the Kaiser Foundation Health Plan and the United Healthcare Insurance Company. Enrollment in these plans may be limited. Most plans are limited to certain geographic areas. Some plans limit the number of people who can be enrolled. All plans have limited enrollment periods.

If you have End-Stage Renal Disease (ESRD), you usually cannot join a Medicare Advantage plan. However, if you are already in a plan, you can stay in the plan you are in or join another plan offered by the same company in the same state. If you have had a successful kidney transplant, you may be able to join a plan.

What you pay out-of-pocket depends on whether the plan charges a monthly premium in addition to your monthly Part B premium, how much you pay for each visit or service ("co-payments"), the type of health care you need, the types of extra benefits you use and whether the plan covers them.

In sum, if you are enrolled in Medicare, you can join a Medicare Advantage plan if:

- You have both Medicare Part A (Hospital Insurance) and Medicare Part B (Medical Insurance).
- You live in the service area of the plan.
- You do not have End-Stage Renal Disease (permanent kidney failure requiring dialysis or a kidney transplant).

MANAGED CARE PLANS (HEALTH MAINTENANCE ORGANIZATIONS – HMOS)

While many individuals still participate in the original Medicare fee-for-service program, a growing trend among Medicare beneficiaries is to look into "managed care" plans through health maintenance organizations (HMOs). Managed care plans for Medicare recipients can be seen as a collaboration between insurers and health care delivery systems. Medicare HMOs provide you with coverage for Parts A and B and, except for the HMOs contracted co-payments, you do not have to pay the Medicare deductibles or the Medicare co-payments.

When you join an HMO, some of your options may be more limited than in a fee-for-service plan. Your choice of doctors and coverage outside of your HMO service area may be limited to urgent care. The doctor who has treated you all your life and knows your medical history may not belong to the HMO. In some instances, you may see a different doctor each time you go. However, you can often choose a primary care physician from available doctors within the HMO.

Even though the cost for HMOs may be less than fee-for-service plans, there is some criticism that older or disabled individuals enrolled in an HMO may not get all the medical services they need. There is a fear that because HMOs are reimbursed differently by Medicare and because these individuals may require expensive and extensive medical care, HMOs may not provide the highest level of care for them. To be fair, some studies point out that care does not change for the worse when a person enrolls in an HMO. Since it is to the HMOs advantage to keep the patient healthy and away from using up costly medical services, some suggest that care can even be better. This seems to be especially the case if the person is younger and healthier. Before selecting an HMO, read the contract to find out how conflicts are resolved, what services are covered or not covered, and what the restrictions are if you use an outside doctor.

PRIVATE FEE-FOR-SERVICE PLANS

In private fee-for-service plans, a private company provides health care coverage to people with Medicare who join this plan. It, rather than the Medicare program, decides how much it pays and how much you pay for the services rendered. You can go to any doctor or hospital that accepts the terms of the plan's payment. The private company pays a fee for each doctor visit or service you get and you also may pay a fee. In a private fee-for-service plan, you may pay more if the plan lets doctors, hospitals, and other providers bill you more than the plan pays for services.

MEDICARE PART D—PRESCRIPTION DRUGS

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 created a voluntary outpatient prescription drug benefit, known as Medicare Part D, which began on January 1, 2006. Drug coverage is provided through competing private Part D plans sponsored by health care organizations, which may charge premiums, deductibles, or copayments for drugs. Many Medicare beneficiaries have experienced trouble in figuring out what to do about Medicare Part D and Congress may "tinker" a bit more with this prescription drug benefit as it is fully set in place.

For most Medicare beneficiaries, prescription drug plans offered by insurance companies and other private companies will cover both generic and brand-name prescription drugs. There are two types of Medicare prescription drug plans from which you may choose according to your needs. There are prescription drug plans that add coverage to the Original Medicare Plan. There are also prescription drug coverage that are part of Medicare Health Plans (Medicare Advantage and Medicare Cost Plans). Medicare prescription drug plans provide insurance coverage for prescription drugs. Like other insurance plans, individuals who opt to join will pay a monthly premium and pay a share of the cost of their prescriptions. Costs will vary depending on the drug plan that is chosen.

"Dual Eligibles" and the State Pharmacy Assistance Program

The new law provides extra help for prescription drug costs for eligible individuals whose income and resources are limited. As a result of the Medicare Prescription Drug, Improvement, and Modernization Act, on January 1, 2006, drug coverage for "dual-eligible beneficiaries" transitioned from Medicaid to Medicare Part D. Dual-eligible beneficiaries are Medicare beneficiaries that receive full Medicaid benefits for services not covered by Medicare. Prior to 2006, state Medicaid programs paid for drugs provided to dual-eligible beneficiaries using a combination of state Medicaid funds and federal matching funds. As of January 1, 2006, Medicaid no longer provides coverage for Part D covered drugs for these beneficiaries. Instead, Medicare provides coverage. Under Part D, dual-eligible beneficiaries will pay reduced co-payments and receive a low-income subsidy to cover their entire deductible and help cover any Medicare prescription drug plan premiums.

The State Pharmacy Assistance Program (SPAP) is a state-funded program that will pay for Medicare Part D co-payments for certain Hawai'i residents. You may be eligible to enroll if you meet the following criteria:

- You are a resident of Hawai'i;
- You are age 65 years or older or disabled and receiving and eligible for Medicare;
- You are not enrolled in PACE (Program of All Inclusive Care for the Elderly);
- You are not a member of a retirement plan who is receiving a benefit from Medicare Part D;
- You are not enrolled in a public assistance program, other than the Hawaii Rx Plus program, that provides drug benefits other than those provided by Medicare Part D;
- You are not enrolled in a private sector plan or insurance providing payments for prescription drugs;
- Your household income (before deductions, not take home pay) does not exceed 100% of the Federal Poverty Level (FPL):
- Your assets are within the limits set by federal law for applicable family size.

For information about SPAP you may call them at (808) 692-7989.

There has been quite a bit of confusion surrounding the implementation of Medicare Part D and one of the best resources for trying to figure out what to do is the Sage Plus Office located at the Executive Office on Aging. Their telephone number is (808) 586-7299 or 1-888-875-9229.

PROGRAM OF ALL INCLUSIVE CARE FOR THE ELDERLY (PACE)

PACE is an optional benefit program under both Medicare and Medicaid that focuses entirely on older people, who are frail enough to meet their state's standards for nursing home care. It features comprehensive medical and social services that can be provided at an adult day health center, home, and/or inpatient facilities. For most patients, the comprehensive service package permits them to continue living at home while receiving services, rather than be institutionalized. A team of doctors, nurses and other health professionals assess participant needs, develop care plans, and deliver all services which are integrated into a complete health care plan.

MEDICARE COVERAGE FOR ALZHEIMER'S DISEASE

Several years ago, Medicare extended coverage to people with Alzheimer's Disease and other forms of dementia. In the past, patients were often automatically denied services when they were diagnosed with dementia on the theory that treatment was not considered "to improve functioning". These patients often did not receive such services as physical, occupational and speech therapy and home care. Under the new policy, such services can now be covered as long as they are determined to be reasonable and medically necessary. Unfortunately, Medicare still will not provide assistance for custodial in-home care or adult day care.

HEALTH CARE AND MEDIGAP INSURANCE

As we have seen, Medicare covers many but certainly not all health costs for eligible persons. Supplemental coverage at an additional cost is available. Shopping for supplemental coverage can be confusing and difficult. A Medicare Supplemental Insurance Policy, or "Medigap" Policy, is a health insurance policy designed to supplement Medicare. It is sold by private insurance companies to fill in certain "gaps" in the federal Medicare program. These supplemental policies are designed primarily to supplement Parts A and B of Medicare. Medigap policies generally supplement the amount of Medicare eligible expenses but usually do not supplement the types of medical expenses covered. No Medicare Supplemental Insurance policy will cover everything which Medicare does not cover. Medigap insurance is regulated by federal and state law. Accordingly, insurance companies offer ten standard Medicare supplement benefit plans. Each of the 10 plans has a letter designation ranging from "A" to "J". Plan A is the most basic and Plan J is the most comprehensive. Each of the other nine includes plan A plus a different combination of benefits. As of January 1, 2006, Medigap plans H, I, and J cannot be sold, issued or renewed to any Medicare beneficiary who is enrolled in or eligible for Medicare Part D. The only exception is for persons who are not enrolled in Medicare Part D and who had Medigap plans H, I, or J issued before January 1, 2006.

Insurance companies are not permitted to change these designations or to substitute other names or titles. They may, however add names or titles to these letter designations. While companies are not required to offer all of the plans, they all must make Plan A available if they sell any of the other nine in a state. Check each policy for coverage or exclusion of existing medical conditions.

If you are a potential Medigap policy buyer you should be aware of important facts concerning Medicare and Medicare supplemental policies:

- Medicare does not cover custodial care even if custodial care is provided in what may be called a "skilled nursing facility." Medicare only covers skilled nursing care, which is care which requires ongoing professional supervision and care. Most Medigap policies also do not cover custodial care and may be vague on the entire subject of nursing home care.
- Actual medical charges may not be entirely covered under either Medicare or under Medicare supplemental policies combined with Medicare. The physician's actual charge may be greater than what Medicare considers "medically necessary" or "customary and reasonable" charges.
- If Medicare pays a percentage of these "allowed" charges and a Medigap policy pays the balance of the "allowed" charges there still may be an excess amount, which you must pay.
- You may not need a Medigap policy if you are enrolled in Medicare Advantage. Check with your plan or with Medicare to find out.

Compare the costs and benefits of several policies. Be suspicious of an insurance agent who pressures you to buy immediately. Ask for a copy of the policy and for time to consider before you buy it. Insurance policies are usually complicated, so you should ask a friend or your attorney for advice. When you don't understand a policy that you are considering signing, have someone you trust read it for you. You should also check with other people to see how the company treats its policyholders in general. Do not rely on oral representations.

APPEAL RIGHTS

If you are enrolled in the original Medicare plan, you can file an appeal if you think Medicare should have paid for, or did not pay enough for, an item or service you received. If you file an appeal, ask your doctor or provider for any information related to the bill that might help your case. Your appeal rights are on the back of the Explanation of Medicare Benefits or Medicare Summary Notice that is mailed to you from the company that handles bills for Medicare. The notice will also tell you why your bill was not paid and what appeal steps you can take.

If you are in a Medicare managed care or private fee-for-service plan, you can file an appeal if your plan will not pay for, does not allow, or stops a service that you think should be covered or provided. If you think your health could be seriously harmed by waiting for a decision about a service, ask the plan for a fast decision. The plan must answer you within 72 hours. The plan must tell you in writing how to appeal. After you file your appeal, the plan will review its decision. Then, if your plan does not decide in your favor, your appeal can be reviewed by an independent organization that works for Medicare, not for the plan. See your plan's membership materials or contact your plan for details about your Medicare appeal rights.

MEDICARE INFORMATION

People approaching age 65 should remember that they do not need to retire to get Medicare coverage. The law provides for separate applications for Social Security retirement benefits and for Medicare. The materials discussed above came from the Centers for Medicare and Medicaid Services. If Medicare becomes too confusing, or if you need more information, call 1-800 MEDICARE (1-800 633-4227).

MEDICAID

Medicaid is a program designed to help low-income people pay for certain health care services. This program is financed jointly by the federal government and the state. Because Medicaid is administered by the state and uses state as well as federal funds, its rules and regulations vary from state to state. It is not unusual to confuse Medicaid and Medicare programs since both were started about the same time, deal with health care, and sound similar. The programs are very different, however. It is important to remember that Medicaid is based on financial and other eligibility standards and is run by the State of Hawai'i Department of Human Services (DHS) MedQUEST Division under federal and state guidelines. Medical assistance is provided to eligible residents through several programs.

- The original Medicaid Fee-for-Service (FFS) program is for individuals who are sixty-five years and older, blind or disabled. (The acronym, ABD, is used to describe the eligibility requirements for the aged, blind or disabled.)
- The Hawai'i QUEST program is for individuals and family members who are not ABD.
- The QUEST-Net program provides a limited coverage safety net for FFS or QUEST recipients who become ineligible for assistance due to excess assets or for recipients who voluntarily choose a more limited coverage package. The State is planning to initiate a new program, QUEST II for certain ABD recipients. Essentially this new program would bring the ABD recipients into a managed care program instead of the current fee-for-service program.

The Med-QUEST Division's Eligibility Branch processes and screens the applications for completeness and schedules eligibility interviews for the applicant or the appointed representative. The eligibility worker will process the application and make an eligibility determination, usually within forty-five days or within sixty days if the certification of disability status is involved. If a determination is not made within the proper time frame because of the Department's delay, "presumptive medical assistance" may be provided until a determination is made.

An individual who wishes to qualify for basic Medicaid cannot be receiving more than a certain amount per month in income and cannot have more than a certain limited amount in assets based on federal poverty level guidelines. In 2006, to qualify for the original Medicaid fee-for-service (FFS) program in Hawai'i, a single person could not receive more that $939 in monthly income nor have more than $2,000 in assets. These levels will change every year and will vary depending on the number of people in the household. Coverage for long-term care for married people is an exception to the basic rules and will be discussed later.

Assets such as cash, bank savings, stocks and bonds, investments (including real estate) are totaled and compared against Medicaid's resource levels, which is generally $2,000 for a person and $3,000 for a couple (plus $250 for each additional person). Property held by persons in their own names which is used as the home, clothing, household furnishings and appliances, one wedding and one engagement ring, one burial space per family member, the value of a funeral plan, contract or funeral and motor vehicles are all considered "exempt" assets that a person may keep and still be eligible for Medicaid if he or she meets other eligibility criteria. Note that a home held in a trust is no longer considered an exempt asset and individuals and their advisors need to take this into consideration when planning for the future.

As indicated in the Medicare section of this handbook, if the person's income is insufficient to meet the entire cost of medical care, a person may become eligible for supplementary medical assistance. These persons can apply for and receive extra help for payment of their medical bills from DHS under the Qualified Medicare Beneficiary Program, (QMB), Specified Low-Income Medicare Beneficiary Program (SLMB) programs or Qualifying Individuals (QI) Programs. Through the DHS Medicaid Program, QI, QMB and SLMB, can help pay for your Medicare Part A and Part B Insurance deductibles and premiums. It can pay the balance of qualified hospital and doctor's bills not paid by Medicare.

Medicaid will provide inpatient hospital care, outpatient hospital services, laboratory and x-ray services, skilled nursing facility services, the services of physicians, and home health services to those who meet the standards for a "categorically needy" person. Before Medicaid will pay for these services, however, a physician must have ordered them and the hospital rendering the services must be approved for participation in Medicaid. Medicaid may be able to provide some

benefits not covered by Medicare such as eyeglasses, hearing aids, drugs and other health services. If you need help with your medical bills you should apply for benefits at the state Department of Human Services. Note that Medicaid beneficiaries who are enrolled in Medicare usually do not need to purchase Medigap insurance.

MEDICAID APPEALS

If an application has been denied or not processed within the required period of time or there has been a refusal to pay for medical services or if there is a determination that the person is no longer eligible for Medicaid, under federal law the individual is entitled to written notice of any such decision. This notice should inform you that you have the right to file a request for a "fair hearing" within 90 days from the date of the notice. A decision must be made within 90 days of the request for hearing. If the decision rendered at the hearing is unfavorable, the government is required to provide information on how the decision may be further appealed.

PAYING FOR LONG-TERM CARE

It is very important to note that Medicare does not provide for an unlimited number of days in a hospital. Any Medicare coverage continues only for acute stages of illness or injury and does not cover the needs of most patients who may require an extended stay in a nursing home. Medicare does not pay for "custodial care" and, on average, across the nation, pays for only a very small percentage of nursing home care.

The three most common means of financing long-term care are by direct payment by patients or their families, by long-term care insurance or by the Medicaid program. Coverage under Medicaid requires that individuals have certain limited incomes and assets, as discussed in the previous section. Although most individuals do not qualify for Medicaid, it would be very wise to look into this program to determine eligibility and alternatives. As usual, pre-planning is most important. There are dramatic exceptions for married people.

SPOUSAL IMPOVERISHMENT PROVISIONS (MEDICAID)

Often an individual who is placed in a long-term care facility has a spouse who remains in the community. If the spouse in the long-term care facility does not have sufficient income to pay for his or her nursing home and related medical expenses, (the figure for the average cost of nursing home care in Hawai‘i has been set at over $7,000 per month) Medicaid may be able to help.

Congress set "spousal impoverishment" rules in the Medicare Catastrophic Coverage Act (MCCA). This act provides certain income and resource protection for the spouse who remains in

the community. The institutionalized individual (i.e., a spouse in need of long-term care in a medical institution or nursing facility) with a spouse in the community (i.e., the spouse remaining at home) is permitted to give some of his or her income for the maintenance needs of his or her spouse. The spouse in the community is also allowed to keep a much larger sum of money than under original Medicaid rules. The MCCA rules only apply to long-term care coverage and only to married people. One of the spouses must be receiving long-term care and the other must remain in the community.

As this handbook was being sent to print, Congress had just made significant changes to the existing law and the President signed the new law into effect on February 8, 2006. It was not clear exactly when all the changes take effect. For an update of changes to Medicaid Long-Term Care Spousal Impoverishment provisions, you may wish to call the Federal Center for Medicare and Medicaid Services at 1-(877) 267-2323 (toll-free) or visit their website at www.cms.hhs.gov or ask a qualified counselor such as an elder law attorney or the Executive Office on Aging's Sage Plus Office at (808) 586-7299 or 1-888-875-9229.

Under the MCCA, the income of the community spouse is not considered available to the institutionalized spouse. In 2006, the community spouse can retain up to $2,488.50 monthly, as a minimum monthly maintenance needs allowance (MMMNA). The level of the MMMNA "spousal allowance" varies each year to take into consideration the cost of living factors (this yearly increase takes place on January first). Thus, if the community spouse has income of less than $2,488.50 per month he or she can request an amount of money from the institutionalized spouse that would bring his or her income up to $2,488.50.

The institutionalized spouse gets to keep a $30 allowance per month. The institutionalized spouse can also keep $2,000 in his or her own name and certain other items. The balance of the institutionalized spouse's income would be applied to his or her nursing home expenses.

Income is considered to belong to the spouse in whose name the check or other instrument is made payable. However, if the check or instrument is in the name of both spouses, then one-half of the amount will be considered available to each spouse. This rule is called "attribution." At the time this handbook was being printed, Congress had added a limiting provision with respect to the monthly maintenance needs allowance. This provision provides that all states must now follow the "Income First" rule. This rule mandates that the states must consider all income of the institutionalized spouse that can be allocated to the community spouse, in order to bring the community spouse's income up to the MMMNA, before raising the community spouse's resource allowance to adequately provide for that income.

In addition to changing the rules about income, the MCCA also has rules concerning the amount of resources a couple can keep and still qualify for Medicaid to pay for long-term care. Under 2006 standards, if the couple's "non-excluded resources" exceed $99,540, then only the excess of $99,540 will be attributed to the institutionalized spouse in determining eligibility. In other words, the community spouse will be able to keep up to $99,540 in assets in addition to such "excluded assets" as the family residence, an automobile, household and personal effects. This is dramatically different from basic Medicaid eligibility standards of $2,000 per person or $3,000 for a couple.

At the time this handbook was being printed, Congress had added a limiting provision with respect to the family residence. This new provision provides for a denial of benefits for an individual who has equity in a home that exceeds $500,000. It allows states to increase the $500,000 limit to an amount not greater than $750,000. If a state decides to increase the amount above $500,000, it is allowed to do so without regard to federal statutory requirements that: (i) provisions shall be in effect throughout the state, or (ii) assistance is available in the same amount, duration and scope to all individuals within the state.

However, the new provision does provide exceptions to the general rule denying assistance. Denial of assisstance shall not apply to an individual whose spouse or child under twenty-one, blind or disabled is lawfully residing in the home. Individuals may use a reverse annuity mortgage or home equity to reduce their total equity. The Secretary is required to establish a process to waive the application of the denial of eligibility in cases of demonstrated hardship.

Transfer of Assets Penalties

The transfer of any assets, other than the couple's home (under certain circumstances), for less than fair market value, for the purpose of qualifying for benefits can result in a period of disqualification. If such a transfer occurs, Medicaid eligibility will be denied the applicant for as many months as would have been required to spend the uncompensated value of the transferred asset on nursing home care, based on the average cost of nursing home care in the community.

As mentioned several times, Medicaid rules are subject to change and the most dramatic change recently passed by Congress involved transfer of asset penalties. If a transfer was made before February 8, 2006, there is a 36 month "look-back period" upon application for Medicaid long-term care coverage and there is a 60 month look-back period for assets transferred into an "irrevocable trust." If there was a transfer during the look-back period, a period of disqualification as described above may have occurred commencing on the date of transfer of assets. However, Congress made dramatically different rules as of February 8, 2006. The law gives states some time to pass legislation to meet the new requirements but, as of the date of this printing, it is uncertain when all of the new rules go into effect in Hawai‘i.

As of February 8, 2006, Congress made the look-back period 60 months for all transfers (outright transfers as well as transfers to and from certain Trusts). Further, another provision of the new law provides that the beginning date for the period of ineligibility is the first day of a month during or after which assets have been transferred for less than fair market value, or 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. In other words, the penalty period does not start at the time of transfer of assets but would normally be at the time a person applies for and otherwise qualifies for assistance. You should check with your attorney or Med-QUEST for the implementation date.

If the transferred asset is a home, such a transfer will not be penalized if the transfer is to the individual's spouse, dependent or disabled child, a sibling with equity interest who resided in the individual's home for one year before institutionalization, or the individual's son or daughter who lived in the individual's home for two years prior to the individual's institutionalization and had cared for the individual.

Individuals affected by this provision may ask for an exception based on hardship. In order for such hardship provisions to apply, the application of the transfer of assets provisions would need to deprive the individual of either medical care such that the individual's health or life would be endangered, or of food, clothing, shelter, or other necessities of life. Such procedure must provide for notice to recipients that an undue hardship exception exists, a timely process for determining whether an undue hardship waiver will be granted, and a process under which an adverse determination can be appealed.

SPENDING DOWN AND ANNUITIES

Although the spousal impoverishment provisions continue to make it easier for individuals to qualify for Medicaid, many people must still "spend down" the bulk of their assets before they can qualify for coverage under Medicaid. In the past, the purchase of certain annuities had become a method of trying to maximize the spousal impoverishment provisions. Under the new rules, for purposes of being eligible for long-term care services under Medicaid, the applicant or his or her spouse must disclose any interest in an annuity (or similar financial instrument that may be specified by the Secretary of Health and Human Services). Further, the purchase of an annuity shall be treated as the disposal of an asset for less than fair market value unless:

(i) the State is named as the remainder beneficiary in the first position for at least the total amount of medical assistance paid on behalf of the annuitant under this title; or

(ii) the State is named as such a beneficiary in the second position after the community spouse or minor or disabled child and is named in the first position if such spouse or a representative of such child disposes of any such remainder for less than fair market value.

There are numerous other complex issues regarding annuities and other provisions of the MCCA. An individual would be best served by asking the previously mentioned Med-QUEST or CMS offices or a qualified counselor such as an elder law attorney or the Sage Plus Office for advice regarding the spousal impoverishment provisions of Medicaid, including when all of the provisions go into effect. Again, any transfer made before February 8, 2006 falls under the old transfer rules, but it is not clear when all of the new rules will go into effect in Hawai‘i.

MEDICAID LIENS AND ESTATE RECOVERY PROVISIONS

Besides a period of ineligibility, federal regulations require the state to recover Medicaid payments from medically institutionalized recipients. The state of Hawai‘i now has “lien” and “estate recovery” provisions to seek reimbursement of certain medical costs paid by the state. The state recovery of medical assistance payments is made from the estates of individuals who received assistance while in a nursing facility or from individuals not in nursing facilities who received benefits from the age of 55.

Currently, a lien will not be placed on the home of an individual in a nursing facility if there is a stated intention to return to the property. This provision is, as with everything else, subject to change. If the Medicaid recipient’s stay in the medical institution is likely to be permanent, based on a determination whether the recipient can reasonably be expected to be discharged from the medical institution and return home, the state will send a notice to inform the affected recipients that a lien may be placed on the home. The recipient or the recipient’s authorized representative will have the opportunity to request a hearing if they disagree with the state’s determination to file a lien. After the notice and the opportunity for a hearing, a lien will be filed on the home if there is no request for a hearing or if the outcome of the requested hearing is in the state’s favor.

The state will not impose a lien on the home when the state has determined that the recipient is expected to be discharged from the medical institution and returned home or the following individuals are lawfully residing in the home:

- The recipient’s surviving spouse,
- The recipient’s child under the age of 21,
- Or a child over 21 years of age who is blind or disabled,
- The recipient’s sibling who has an equity interest in the home and who was residing in the home at least one year prior to the recipient’s admission to the medical institution.

The lien will be dissolved when the individual returns to the home property after being discharged from the nursing home. A lien on the home does not change the ownership of the property but secures the asset for future reimbursement to the state for the cost of medical care when the property is sold or transferred. Recovery from the lien on the home will take place when the home is sold or transferred while the recipient is still living. After the death of the recipient, recovery will not be made while:

- The surviving spouse is living,
- Or there is a child who is under 21 years,
- Or a child over 21 years who is blind or disabled,
- The recipient's sibling who has an equity interest in the home and who was residing in the home at least one year prior to the recipient's admission to the medical institution,
- A non-dependent child who resided in the home for a period of at least two (2) years immediately before the recipient's admission to the medical institution and who provided care to the individual that allowed the recipient to reside at home instead of the institution.

These individuals must have continuously lived in the home since the recipient's admission to the medical institution.

Recovery may be waived if it causes hardship under the following conditions:

- The real property is the sole income-producing asset, such as a family farm or other family business;
- The income produced by the property is not greater than one hundred percent of the federal poverty guidelines for the number of family members solely dependent on the real property;
- Or the real property is a home of modest value that is occupied by the family members who lawfully resided in the home for a continuous period that started at least three months immediately before the recipient's admission to the medical institution and provided care that allowed the recipient to reside in at home rather than an institution;
- These family members do not own other real property and have income not greater than one hundred percent of the federal poverty limit.

CAUTIONS REGARDING "MEDICAID PLANNING"

As you can see, there are many rules and exceptions that apply as to how the lien is to be placed and when estate recovery will be pursued. In view of the new look back period, the estate recovery provisions and the risk of liens, it is important to analyze the rules about transferring assets along with potential income, estate and gift tax consequences in attempting to shelter assets.

Nobody knows what the Medicaid rules will be in the future, so do not rely on the information contained in this handbook for purposes of Medicaid planning, and be especially careful if you are considering transferring your home. Some of the saddest cases we have dealt with involved individuals who transferred their homes with the hopes of eventually qualifying for Medicaid long-term care coverage. Some made mistakes in transferring their homes and have been disqualified for many years for Medicaid qualification. Some have been subsequently evicted from their homes by their children, grandchildren or other relatives. Some never needed long-term care and were unable to get their homes back.

We recommend that you consult an elder law or estate-planning attorney before making transfers of any assets for less than fair market value. At the very least, check with Sage Plus or the MedQUEST Division of the Department of Human Services about current transfer penalty provisions when trying to qualify for Medicaid.

Long-Term Care Insurance

With the high cost of nursing homes and other long-term care, more and more individuals are trying to figure out whether they need nursing home or other long-term care insurance or whether they can manage without it. Most people want to be able to control their own finances and long-term care setting.

Several decades ago, insurance companies began offering nursing home insurance. Soon they began to offer optional "riders" to cover the cost of in-home health care and were limited to one-half of the policy's nursing home benefit. What this usually meant was that the insurance policy rider provided some in-home assistance for the activities of daily living but would not pay for full-time care at home. Long-term care insurance coverage may be improving as some of the newer long-term care insurance policies cover at least a portion of the cost of care homes, assisted living facilities, adult daycare centers, and nursing home alternatives. The cost of premiums, however, is still the major factor in most individuals' decisions.

Besides being able to control, at least to some extent, ones' own future there may be other reasons to consider long-term care insurance. For over a decade, premiums for long-term care insurance have been tax deductible, at least theoretically. This tax deduction, however usually works only for those who itemize their deductions and who meet the Internal Revenue Code requirements for taking medical expenses as a tax deduction.

Problems exist. Abuses in the nursing home insurance industry reportedly continue despite governmental oversight. These abuses include post-claim cancellations, arbitrary benefit denials, delays in payment and agent misrepresentation and overselling. When deciding whether or not to

purchase long-term care insurance, there are various items you should consider. First of all, make sure the company writing the policy is licensed in the State of Hawai‘i or the State Insurance Division may not be able to assist you if you run into difficulty. Next, find out whether the policy has a guaranteed renewable provision, which means that as long as you continue to pay your premiums on time, the company cannot refuse to continue your policy. Find out whether the policy requires prior hospitalization before you can receive benefits in a nursing home since many people are not hospitalized before entering a nursing home. Find out about restrictions for coverage for pre-existing conditions which may disqualify you. Find out the number of years of coverage offered.

Costs and coverage are key considerations. Premium costs usually increase with each year of coverage provided. Find out how much money the policy pays per day of nursing home care and how much the policy will pay for care provided at home. For nursing home care, find out the levels of care the policy covers. Traditionally, levels of care include: acute care, skilled nursing care, intermediate care, custodial care and home care. Not all policies cover all levels of care. Find out if there is an "inflation protection" option to protect your benefits from inflation. This option can be expensive, however. It is usually best to avoid policies that are disease specific such as "cancer policies" since you may not be covered for any other conditions. Look at several policies to compare not only their premiums but also their benefits and restrictions. The State of Hawai‘i Department of Commerce and Consumer Affairs can provide you with valuable information in this area. Also, the website of "Nursing Home Compare" at www.medicare.gov/ compares nursing homes in your area.

Veterans Benefits

Persons who have served their country in the military may be entitled to certain benefits. Veterans should apply to the United States Department of Veterans Affairs (VA). If you are a veteran or are caring for a veteran, write, visit, or telephone the nearest VA regional office. The address and toll-free telephone numbers may be found in the white pages of the telephone directory under "U.S. Government." The State of Hawai‘i also has an Office of Veterans Affairs, which can help you get information. Generally, veterans who were honorably discharged can qualify for certain benefits. Holders of undesirable or bad conduct discharges may qualify, depending upon the determination of the VA based on the facts of each case. Dependents and survivors of veterans may also be eligible for certain VA benefits.

One of the benefits includes medical care. VA medical facilities give highest priority to providing medical care to veterans with service-connected disabilities, to those who were discharged from active duty for a disability incurred or aggravated while in military service, to those who are in receipt of a VA pension, to those who are eligible for Medicaid, to those who are former POW's,

and to certain others who were exposed to nuclear tests. Another benefit is nursing home and outpatient care. The VA provides skilled or intermediate type nursing care and related medical care in VA or private nursing homes for convalescents or persons who are not acutely ill and not in need of hospital care. Outpatient care is provided for veterans disabled by age or disease who are not in need of acute hospitalization and who do not need the skilled nursing services provided in nursing homes.

Signing for Others

It is not unusual for a person who needs care, especially long-term care, to be suffering from diminished capacity or to need some assistance. Under those circumstances, health care providers will often seek signatures from other persons indicating approval of the treatment or admission to a facility. If you are signing treatment or admission papers for somebody else as an agent, guardian, surrogate or even as a spouse or child of that person, make sure that you do not unintentionally accept personal financial responsibility for the treatment or admission. Except for spouses, there is normally no requirement for one person to be responsible for the health care bills of another person. However some health care providers will ask a person to "voluntarily" accept personal financial responsibility for the patient even though federal and state law may prohibit requiring acceptance of personal financial responsibility as a condition of treatment or admission to a facility. Read any papers you are asked to sign. If you see something unusual, do not sign and tell the provider that you need to ask for independent advice first. Usually, a good person to ask is an Elder Law Attorney.

CHAPTER 4

PRACTICAL TIPS: HIRING A CAREGIVER, COPING WITH DEATH, FINDING A LAWYER

HIRING A CAREGIVER

Finding good caregivers takes work. Often people are disappointed. Many people have a hard time finding a qualified and trustworthy caregiver at an affordable price. You should know that there are increasing reports of caregiver abuse, neglect, theft and financial exploitation. While troubles can be found with any caregivers, professional home caregiver agencies normally have the resources to provide insured, trained, and pre-checked caregivers. Further, such agencies can usually provide short-notice and continuous care with back-up caregivers as necessary. One major drawback, of course, is the cost. If you hire your own caregiver you may be able to save some money since you will be able to cut out the built-in overhead costs associated with a business enterprise and its profit objective. Even so-called "non-profit" agencies still need to support its structure and make money to continue in existence.

TYPES OF CAREGIVERS

The types of caregivers you need, of course, depends on your own particular situation and the types of services and the levels of services required. You may or may not need round-the-clock services. You may or may not need to have household or chore services. You may or may not need close supervision for a frail or vulnerable or physically or mentally disabled person. You may or may not need to have intensive home health care services.

Even among home health care providers there are differences. For example, Medicare-Certified home health agencies are licensed by the State of Hawai‘i and provide part-time, intermittent skilled nursing services with at least one other therapeutic service (occupational, physical and speech therapy), or medical social services which can be reimbursed by Medicare. Private Duty Service Providers are hired by individuals to provide services that are not reimbursed by Medicare. If you need to hire a home health care provider, one way to get assistance in locating

an appropriate licensed provider is to use the services of a home care association such as the Home Care and Hospice Division of the Healthcare Association of Hawai‘i (www.hahc.org), which is listed in the resource section of this handbook.

Utilizing a Professional Service Agency

If you do utilize a professional service agency check to see if:

- The agency is registered/licensed with the State Department of Commerce and Consumer Affairs;
- The agency is Medicare-certified if you will be seeking Medicare reimbursement;
- The agency has any record of complaints;
- The agency/supervisor is available by phone at all times;
- The agency has written policies and procedures pertaining to patients bill of rights, services, costs, payment plans, malpractice/injury, thefts, unacceptable behavior, and disputes;
- Employees are insured and bonded;
- Employees are trained;
- Employees are screened for health, background and criminal records;
- References for employees are available.

Although the cost of hiring a private caregiver may be significantly lower than utilizing a professional caregiver agency, there are certain drawbacks. For example, Medicare will only provide reimbursement for eligible services provided by a Medicare-certified home health care agency. Private health insurance plans may have the same policies.

Benefits and Burdens of Being an Employer

Hiring your own caregiver may also result in benefits. You become the employer and thus you can demand greater loyalty and can provide greater direction to an employee that you select yourself. While there are advantages to being an employer, you also take on the responsibility for hiring, paying and supervising the caregiver. The responsibilities include those typically associated with running a business which hires people.

- First, you have to find your own qualified caregiver. This may mean advertising in a newspaper or bulletin board, interviewing candidates, checking on references, checking on driver’s licenses and medical records and even performing abuse/criminal record background checks. You will need to get permission/privacy waiver documents for some of these.

- Second, you have to enter into an employment agreement. This usually includes a written contract which contains such matters as the job description, scheduling work, back-up help, time off, wages, meals, use of automobile and other equipment, work rules dealing with such issues as alcohol use, smoking, personal phone use, and termination policy, including prior notification, if any. If you do not have a written agreement, you may be setting yourself up for trouble.
- Third, you have to supervise and manage your caregiver. This usually includes providing necessary introductions, training, orientation, demonstration of preferred techniques, and testing emergency responses. It also includes providing appropriate discipline, including dismissal, reporting to protective services agencies and even bringing criminal charges.
- Fourth, you have to comply with federal, state and local laws, regulations, and ordinances. These include legal eligibility, immigration assurance, wage and hour compliance, employment/labor practices, tax and insurance matters. It also includes obtaining tax identification numbers, withholding federal and state taxes, and paying Social Security/Medicare (FICA) and unemployment taxes. It further includes obtaining workers compensation and liability insurance. You will be required to fulfill federal and state record-keeping requirements on each employee to insure compliance with all of these matters.

Even if you hire a caregiver for a short period of time, you will be required to comply with federal and state "Nanny taxes" which are technically called "Employment Taxes for Household Employees," if wages to any caregiver exceed $1,000 per year.

CHECKLIST

At the end of this overview is a "Checklist for Employers" which will give you a head start in the process of engaging caregivers. The Internal Revenue Service (IRS), Social Security Administration as well as the State Departments of Taxation and Labor can provide you with valuable information, instructions, and required forms for employers. The Immigration and Naturalization Service (INS) can provide information about work registration requirements and legal documentation. A great "one source" to get you started is the Department of Commerce and Consumer Affairs' Consumer Resource Center.

CAUTION

You may be tempted to engage a so-called "independent contractor" to try to get the best of both worlds by avoiding the extra cost of a professional caregiver agency while also avoiding the effort of employing a caregiver. You should be aware that employment and tax laws are written in such a manner to presume that a person is an employee and not an independent contractor if the person engaging him or her can control what is done, when it is done and how it is done. If you have the

right to control the method and result of the service you are probably an employer. It does not matter whether the person is full or part time.

In Hawai‘i, every individual or organization, which becomes “an employing unit” must file a status report (Form UC–1, “Report to Determine Liability”) with the Unemployment Security Division of the State Department of Labor within twenty days after hiring an employee. You may call the Business Action Center of the Department of Commerce and Consumer Affairs which will supply you with forms for registering your business. Also, the Internal Revenue Service has a very helpful guide (Publication 926–Household Employer’s Tax Guide), which you should read before hiring a caregiver. There are agencies that can help you fill out forms and file necessary taxes for a fee. Of course, your attorney can answer your questions and assist you in this matter.

INSURANCE

Whether you engage a professional caregiver agency, hire an employee or perhaps engage an independent contractor, make certain that you check with your insurance agent to ensure that your homeowners, automobile and other liability policies cover the caregiver in your home. If you are going to permit or request the caregiver to drive your automobile, check to make sure that he or she has a valid driver’s license and whether that person has been convicted of serious traffic offenses. Always check with your automobile insurer to see if your policy covers the caregiver. Further look into having the caregiver bonded for your protection.

CAREGIVER CONTRACT

Agreements and arrangements made with a caregiver should be documented in a contract. A contract will set the terms and conditions, including services to be provided, fees and dispute resolution. Contracts can avoid misunderstandings as well as provide documentation of the respective rights and responsibilities of all the parties involved. Consult with an attorney if you have questions about any contract.

CRIMINAL HISTORY RECORD CHECK

It is always a good idea to consider requesting a criminal history record check on prospective employees, especially if they are not well known to you. The Hawai‘i Criminal Justice Data Center (part of the Department of the Attorney General–see resource section) is responsible for the statewide criminal history record information system.

Basically, a criminal history record check is a search of a person’s criminal history by name or fingerprints. It is also known as a “police abstract” or “rap sheet.” Arrest records which have

resulted in convictions (found guilty) are considered public record. Arrest records which have resulted in non-convictions or are still pending, are considered confidential and not available to the general public.

CHECKLIST FOR EMPLOYERS

A. RECRUITING

___Non-discriminatory advertising
___Personal information permission/Privacy waiver
___Prior employment reference check
___Personal reference check
___Credit check
___Medical/health check (including contagious diseases)
___Abuse report check
___Criminal records history check
___Interview questionnaire

B. EMPLOYMENT AGREEMENT

___Enforceable legal contract format
___Job description
___Work schedule
___Back-up help schedule
___Time-off schedule
___Wages
___Meals
___Use of automobile/equipment
___Work rules (e.g. smoking, alcohol, personal phone calls, visitors, etc.)
___Acceptance and exchange of gifts (prohibition with person cared for to avoid theft/undue influence questions)
___Termination policy

C. SUPERVISING

___Introduction to person cared for, family, neighbors, professionals
___Training (content, resources, materials, courses)
___Orientation to job, home, support facilities and responsibilities
___Demonstration of preferred manner of commonly performed tasks
___Testing of emergency notification and substantive procedures
___Performance reports
___Disciplinary options

___Counseling
___Warning
___Reporting to Adult Protective Services Unit, Department of Human Services
___Reporting to Police
___Dismissal

D. TAXES, LAWS, REGULATIONS, INSURANCE

___U.S. Citizenship or legal authorization to work—INS Form I–9
___Minimum wage determination
___Federal Income Tax Withholding—IRS Form W–4
___Federal Wage and Tax Statement—IRS Form W–2
___State Wage and Tax Statement—IRS Form W–2
___Employer Identification Number Form SS–4
___Federal Insurance Compensation Act (FICA) —IRS Form 1040, Schedule H
___Social Security
___Medicare
___Federal Unemployment Tax Act (FUTA)—IRS Form 1040, Schedule H
___State Unemployment Tax—Form UC8–6
___Workers Compensation/Temporary Disability Insurance
___State of Hawai‘i Business Registration—Form UC–1
___Employee Records
Name:
Address:
Phone Number/Cell:
Date and Place of Birth:
Social Security Number:
Driver’s License Number:
Date hired:
Date discharged:
Dates and amounts of wages:
___Copies of contracts, other agreements, records checks, performance reports, termination notice, other communications:
___Copies of Tax, FICA, Insurance documents and filed forms
___Home owners, automobile, liability insurance policies
___Employee bond

Survivors go through different emotional stages when confronted with death and dying. Denial, anger, bargaining, depression, and acceptance are mentioned as stages that a person experiences as a way of dealing with the fear and anxiety associated with dying. Counselors say that a person usually goes through each of these emotional stages in some degree or another before a resolution is made and a person is able to return to a somewhat normal life.

HOSPICE CARE

You may have to make the difficult decision where you or a loved one should die—at home, in a hospital, or in a hospice. Caring for a person, making sure they have comfort care, and dealing with the signs and symptoms of death and dying, may be too much for a person or family to handle on their own. More people are choosing hospice care, which can be either home-based or residential-based. Hospice philosophy is based on a belief that death is a part of life and concentrates on relief from pain and support for the individual's emotional and spiritual needs. Hospice often permits an individual to meet his or her life's end in a more peaceful manner than might otherwise be possible.

Most hospice care is covered completely by insurance or Medicare or Medicaid. Room, board and medications are not covered. Hospice workers and volunteers are trained to help the dying person, relatives, and friends to prepare for the death process as well as the actual death moment. Hospice workers and volunteers can help with the sad but appropriate way to say "good-bye" and to achieve closure and make the final release possible. The death of the hospice patient is not considered an "emergency" and the body does not have to be moved until the family and friends are ready. The hospice program can also provide immediate emotional support for the survivors.

STEPS TO TAKE UPON DEATH

No matter where the death occurs, the survivors will have to make the following decisions:

- Whom to notify,
- What to do with the body,
- What type of ceremony, if any, to have,
- What services and merchandise to purchase.

When Death Occurs at Home

If the patient is not enrolled in a hospice program and if you have not made previous arrangements with the attending physician, call 911. The operator will ask if it is an emergency. Explain that a death has occurred and the circumstances. A medical examiner, paramedic or coroner will be sent to the address to verify that a death has occurred. Make arrangements with a funeral home or mortuary to remove and store the body until it can be buried or cremated. The morgue will normally not store the body unless there is evidence of a violent or suspicious death, the body is unclaimed or the body has a contagious disease.

The police may need to be notified if the death was unattended or unexpected. If the death was expected and a physician was attending the individual, the physician can inform the survivors what to do. Typically, prearrangements will have been made and the survivors call the prearranged contact at the funeral home or mortuary to take the body. If you are a survivor who will be taking charge of making decisions, you may want to notify relatives, close friends and business associates and arrange for funeral or memorial services. If the deceased or his or her spouse is a veteran contact the Department of Veterans Affairs to see if he or she qualifies for benefits.

When the Death Occurs in a Hospice or Medical Facility

If the death occurred in a hospice or medical facility, the hospice and medical personnel and volunteers can help guide the survivors. If death occurs in another type of health care facility, appropriate procedures, including governmental agency notification, will already be in place.

Problems Associated with Disposition of the Body

When a nursing home, hospital, doctor, or police notifies the survivor that a death has occurred, the survivors are usually instructed to contact a funeral home or mortuary to make arrangements for the disposition of the body. Problems have occurred when two different parties have different opinions about who should be in charge of disposing the body or what should be done with the body. Hospitals will generally release the body to the "next of kin" or a family member such as the spouse, reciprocal beneficiary or other closely related family member.

Sometimes, when there is no legal next of kin, funeral homes will not honor the wishes of the unrelated party. Funeral homes will generally follow the directions of the next of kin unless there is evidence specifying another party. To avoid conflicts in an emotionally charged time, it would be best to put into writing a person's choice as to who will make decisions regarding the disposal of the body. This can be done in a will and expanded upon in a letter to the personal representative. Sometimes the directions contained in a power of attorney can be followed.

Funeral and Memorial Plans

Funeral or memorial plans can be very simple or they can be very elaborate. Of course, preplanning, which includes a pre-chosen funeral home or mortuary and pre-paid services, would be helpful in most situations. Many people are choosing to belong to a memorial society which is a non-profit organization dedicated to achieve dignity, simplicity, and economy through preplanning. If you are a veteran, ask the Department of Veteran Affairs for advice concerning advance funeral and memorial arrangements. If you are receiving public assistance, you should also know that the state may pay for certain expenses relating to the disposition of your body. Your plan, accordingly, may be as simple as letting your survivors know to call the Department of Human Services for assistance upon your death. Talk to your social worker about this, if you have one.

Funeral and Memorial Services

There have been highly publicized problems about the funeral industry on the mainland and in Hawai‘i. When you consider that funeral related decisions are usually made in just a few hours, you can see why people are sometimes exploited. Good business practices should be followed by you as a consumer in getting the contract for services in writing, knowing what you are paying for, knowing which services are not necessary, and seeing that all these services are performed as agreed. Beware of such practices as substitution of one casket for another, or charging for services not needed such as thank you cards if you are providing your own, or a flower car if there are no flowers, pallbearers who were not requested, or charging for clothing for the deceased that you are providing. Plans are often made according to the prescribed religious funeral or memorial rites of the deceased and the funeral director, your minister, priest, rabbi, or spiritual advisor can help with the plans.

Funeral plans can include burial, entombment or cremation. Embalming is a method of preserving the appearance of the body for open viewing. Embalming is not always required and is usually unnecessary if the body is to be cremated. Scattering of ashes can be accomplished informally or can involve elaborate ceremonies. While, generally speaking, there is little regulation of scattering of ashes in Hawai‘i, health ordinances may be different in some jurisdictions. The funeral home or mortuary may be able to provide you with information about scattering of ashes. They may discourage such a practice, even if it is legal, if they have their own plan that they may wish to sell to dispose the ashes.

Memorial services differ from funeral services. Traditionally, funeral services are those which are held in the presence of the body and may include a viewing. Memorial services are held without the body and are usually less costly. Often, memorial services are held when friends and family-

cannot immediately meet after a death. Other things to consider for a funeral or memorial are the music, the eulogy, the gathering place, food, readings, obituaries, and pallbearers or attendants.

Making Your Own Preparations

In addition to taking into consideration the issues set forth above, there are some additional considerations you may wish to address, especially if you are planning to buy a funeral plot for your own use:

- Who owns the cemetery and are there any restrictions on who can be buried in them?
- Is the cemetery well maintained and is maintenance included in the price of a plot?
- How many individuals may use a single plot and if multiple uses are permitted, do they have to be related?
- Can you change your mind and get a refund or even re-sell the plot?

Prepayment Plans

While preparing for the future need for funeral services and products, be very cautious about paying in advance (prepayment plans) especially if you do not know the company you are dealing with. While most well-established funeral industry entities are trustworthy, there have been many reports of businesses, which have mismanaged or stolen funds. Also when mortuaries or funeral homes go out of business, the moneys you prepaid may be completely lost. You may also find that your moneys are non-refundable if you move to another location and do not need the services of that particular plan or if for some other reason you want your money back.

Burial at Punchbowl or Other Military Cemeteries

If you are a veteran or a spouse or dependent of a veteran who has served in the uniformed services, you may be entitled to have your remains interred in the Punchbowl or other military cemetery in Hawai‘i or on the mainland. Space is limited at the Punchbowl, especially for burials. Gravesites in Department of Veterans Affairs (VA) national cemeteries cannot be reserved in advance; however, reservations made prior to 1962 will be honored. Families are encouraged to prepare in advance by discussing cemetery options, collecting the veteran’s military information including discharge papers, and by contacting the cemetery where burial is desired. Call the federal Department of Veteran’s Affairs or the state Veteran’s Office for information.

Using and Closing Out Bank Accounts

Of immediate financial concern to many who have a joint account or a joint safe deposit box is

whether the survivor will have access to the account. Usually the bank will not freeze your assets if it is in a joint account. Since each financial institution's policies differ, check with them ahead of time. Not only can joint accounts be used prior to and after a death but they can also be easier to "close out" than one that is not jointly held with rights of survivorship. Also recall that joint accounts can be useful tools in estate planning to give survivors immediate access to funds upon death. To close out an account that was in the deceased's name only, you will need a death certificate and, depending on the amount in the account, an affidavit or letters from the court naming you as the personal representative of his or her estate.

Finding a Lawyer

Throughout this handbook, we have suggested that you may need to utilize the services of a lawyer. Finding a lawyer can be a very time consuming and stressful experience, and especially for caregivers who are already stressed. Whether or not you or the person you are caring for is "old," you may wish to consider a lawyer who practices "elder law."

Elder Law

Elder law is the relatively new and evolving field of law that addresses issues facing older persons. Rather than being defined by technical legal distinctions, elder law is defined by the client to be served. In a sense, most attorneys could think of themselves as elder law attorneys, especially when they are preparing estate-planning documents, or consulting a client on a pension plan or retirement timing or Social Security benefits. Elder law is different from traditional estate planning in that more emphasis is placed on planning for the contingencies of an extended lifetime. This includes planning for the time when finances, health, mental capacity and support structures may change, either rapidly or progressively.

How to Locate a Lawyer

If you do not have a family lawyer, you may find that a colleague, relative or a friend may have one or know of one who has done a good job for him or her. Word of mouth is often a good way to find a lawyer. Also a person may call lawyer referral services which are usually run by state and local bar associations such as the Hawai'i State Bar Association which does do not charge the public for the referral. Usually a person who calls a lawyer referral service will obtain the names and numbers of attorneys who subscribe to the service and who have indicated a special interest in certain areas of the law. You can also check through the "yellow pages" of the telephone book or respond to commercial advertisements.

Free Legal Services

The Legal Aid Society of Hawai‘i and Volunteer Legal Services Hawai‘i provide free legal services for eligible clients in certain civil cases. The Public Defender provides free legal services for eligible clients in criminal cases. There are even specialty non-profit law offices such as the University of Hawai‘i Elder Law Program individuals and caregivers on O‘ahu and the Senior Law Program on Kaua‘i. Finally there are other non-profit organizations, such as the Hawai‘i Disability Rights Center and the Domestic Violence Clearinghouse and Legal Hotline, which utilize attorneys to assist clients.

Attorney Fees

The first question in entering into a relationship with an attorney may very well be, “How much is this going to cost me?” Always ask if your initial conversation will cost you money. It may surprise you that many attorneys do not offer a “free initial consultation” and you will be expected to pay for your time with the attorney even if it is a preliminary meeting and you decide not to retain the attorney. Be especially cautious about “non-refundable” deposits, which can be difficult or impossible to get back if you change your mind about the attorney.

Some attorneys may charge a flat fee for certain services. Even under these circumstances, be careful since any additional tasks, changes or modifications may cost you money. Some attorneys charge on an hourly basis. Under this system, time is truly money. Other attorneys may charge on a “contingent fee basis,” a mechanism through which the attorney will receive a percentage of what he or she is able to recover for the client. Of course, not all cases are suitable for payment under a contingent fee basis and the law prohibits contingent fees for certain kinds of cases, such as criminal cases. Finally, you may wish to “shop around” and get several quotes from different attorneys.

Working With Your Lawyer

When you work with your attorney, be prepared and do your homework. Read this book. Keep your appointments. Show your attorney all of the documents affecting your case, not just selected documents. Make a list of concerns. Remember to bring your written questions with you so you will not forget them and be sure to take notes so that you will remember what your attorney told you. Ask questions. Share your own point of view. Be honest with your attorney. Do not hide facts. Stick to the point when you are talking with him or her since, remember, time is money. Make sure you hear and see as well as possible. If you have a hearing aid, wear it. If you have glasses (including reading glasses) bring them and wear them.

DECIDING WHAT IF?

"Prepare for the worst and expect the best" is a strategy that underlies *Deciding What If?* The more you are prepared for your potential needs and the needs of persons you may be caring for, the more likely you will be able to keep yourselves safe, healthy and happy. Make the legal and financial preparations to prepare for the worst. Don't be afraid or embarrassed to accept help. Take care of yourself and the person or persons you are caring for and expect the best. To help you find the best, a list of resources follows.

RESOURCES FOR CAREGIVERS

AARP 1- (888) OUR-AARP or 1- (888) 687-2277 (toll-free)

www.aarp.org
www.aarp.org/states/hi

AARP National Legal Training Project
http://aarpnltp.grovesite.com

O'ahu	1-866-295-7282 (toll-free)
Hawai'i County Information Center	(808) 334-1212
Hilo	(808) 959-0012
Kaua'i	(808) 246-4500

Administration on Aging, US Department of Health and Human Services
Public Inquiries 1- (202) 619-0724
www.aoa.gov

Adult Protective Services (APS) and Community Care Services Branch
Department of Human Services (DHS)

O'ahu (Adult Protective Service Hotline):	(808) 832-5115
Hawai'i County	
Hilo	(808) 933-8820
Kona	(808) 327-6280
Kaua'i	(808) 241-3432 or (808) 241-3337
Maui	(808) 243-5151
	(808) 243-5150 After Hours

www.state.hi.us/dhs

Aloha United Way 211
Statewide community information and referral service: Dial 211 (free call)
www.auw.org/211

O'ahu	(808) 536-1951
Hawai'i County	
Hilo	(808) 935-6393;
www.hawaiiunitedway.org	
Kona	(808) 326-7400
www.hawaiiunitedway.org	
Kaua'i	(808) 245-2043
www.kauaiunitedway.org	
Maui	(808) 244-8787
www.mauiunitedway.org	

Alzheimer's Association 1-(800) 272-3900 (24 hour contact center, toll-free)
www.alz.org
www.alzhi.org

O'ahu	(808) 591-2771
Hawai'i County	(808) 981-2111
Kaua'i	(808) 821-1776
Maui	(808) 242-8636

American Bar Association (National) 1-(312) 988-5000
http://www.abanet.org

American Hospice Foundation 1-(202) 223-0204
www.americanhospice.org

Centers for Medicare and Medicaid Services (CMS) (Federal)
1-(877) 267-2323 (toll-free)
1-(866) 226-1819 (TTY toll-free)
www.cms.hhs.gov

Credit Reporting Companies:

Equifax

To Order a Credit Report	1- (800) 685-11111 (toll-free)
Fraud Alert	1-(888) 766-0008 (toll-free)

www.equifax.com

Experian

To Order a Credit Report or to Report Fraud	1-(888) 397-3742 (toll-free)

www.experian.com

TransUnion

To Order a Credit Report See Website
www.transunion.com
Fraud Assistance 1-(800) 680-7289 (toll-free)

Criminal Justice Data Center, State of Hawai'i

O'ahu	(808) 587-3100

www.state.hi.us/hcjdc
www.hawaii.gov/hcjdc

Department of Commerce and Consumer Affairs, State of Hawai'i,
Business Action Center
O'ahu (808) 586-2545
On neighbor islands, call the following numbers followed by 6-2545 and the # sign:

Hawai'i County	(808) 974-4000

Kauaʻi	(808) 274-3141
Maui	(808) 984-2400
Lanaʻi & Molokaʻi	1- (800) 468-4644 (toll-free)

www.hawaii.gov/dcca
www.hawaii.gov/dcca/quicklinks/bac

Department of Commerce and Consumer Affairs, State of Hawaiʻi,
Consumer Resource Center (Consumer Protection)

Oʻahu	(808) 587-3222 or (808) 587-3295

On neighbor Islands, call the following numbers followed by 7-3222 and the # sign:

Hawaiʻi County	(808) 974-4000
Kauaʻi	(808) 274-3141
Maui	(808) 984-2400
Lanaʻi & Molokaʻi	1- (800) 468-4644 (toll free)

www.state.hi.us/dcca
www.hawaii.gov/dcca

Department of Human Services (DHS), State of Hawaiʻi
Financial/Food stamps and Medical Information (including Medicaid/Med-QUEST)
General Information:

Oʻahu	(808) 643-1643
Hawaiʻi County	
Kamuela/Hamakua	(808) 775-8850
North Hilo	(808) 933-0331
South Hilo	(808) 981-2754
North Kona	(808) 327-4980
South Kona	(808) 323-7573
Kaʻu	(808) 939-2421
Kohala	(808) 889-7141
Kauaʻi	
Kauaʻi Section Office	(808) 241-3663
Central Kauaʻi	(808) 274-3371
East Kauaʻi	(808) 822-3475
West Kauaʻi	(808) 241-3660
Maui	
East Maui	(808) 984-8300
West Maui	(808) 243-5110
Lanaʻi	(808) 565-7102
Molokaʻi	(808) 553-1715

www.state.hi.us/dhs
www.hawaii.gov/dhs

Department of Human Services (DHS) Med-QUEST Division

O‘ahu Applications Unit	(808) 587-3521
Hawai‘i County	
Hilo	(808) 933-0339
Kona	(808) 327-4970
Kaua‘i	(808) 241-3575
Maui	(808) 243-5780
Moloka‘i	(808) 553-3295
Lana‘i	1- (800) 894-5755 (toll free)

www.med-quest.us
www.hawaii.gov/dhs/Q-Book.html

Department of Labor and Industrial Relations (DLIR), State of Hawai‘i
Forms for employing a caregiver

O‘ahu	(808) 586-8842
Hawai‘i County	
Hilo	(808) 974-6464
Kona	(808) 322-4808
Kaua‘i	(808) 274-3351
Maui	(808) 984-2072

http://hawaii.gov/labor/

Eldercare Locator (U.S. Administration on Aging)

1-(800) 677-1116 (toll-free)

www.aoa.dhhs.gov
www.eldercare.gov

Elderly Affairs Division, City and County of Honolulu (Area Agency on Aging)

Information and Assistance Hotline	(808) 523-4545

www.elderlyaffairs.com

Executive Office on Aging (including Long-Term-Care Ombudsman and Sage Plus)

O‘ahu, General Information	(808) 586-0100

From neighbor islands, dial the appropriate phone numbers, then enter “60100” when prompted.

Hawai‘i County	(808) 974-4000
Kaua‘i	(808) 274-3141
Maui	(808) 984-2400
Moloka‘i & Lana‘i	1- (800) 468-4644 (toll free)

www4.hawaii.gov/eoa

Funeral Consumers Alliance of Hawaii (808) 638-5580
(formerly known as the Memorial Society of Hawaii)

Hawai‘i County Office on Aging (Area Agency on Aging) 808-961-8600
www.hawaii-county.com/

Hawai‘i Disability Rights Center
(Protection and Advocacy System in Hawai‘i) (808) 949-2922
http://www.hawaiidisabilityrights.org

Hawai‘i State Bar Association
O‘ahu (808) 537-1868
www.hsba.org

Home Care and Hospice Division of the Healthcare Association of Hawai‘i
1- (808) 521-8961
www.hahc.org

Hospice
Hawai‘i County
Hospice of Hilo (808) 969-1733
www.hospiceofhilo.org/
Hospice of Kona (808) 334-0334
North Hawai‘i Hospice Waimea (808) 885-7547
www.northhawaiihospice.org/
Kaua‘i Hospice (808) 245-7277
www.kauaihospice.org/
Hospice Maui (808) 2-5555
www.hospicemaui.org/

Kaua‘i County Agency on Elderly Affairs (Area Agency on Aging)
(808) 241-4470
www.kauai.gov

Kaua‘i Seniors Law Program (808) 246-8868
http://www.seniorlaw.com

Legal Aid Society of Hawai‘i
Hawai‘i County Offices
Hilo (808) 934-0678
Kona (808) 329-8331
Kaua‘i Office (808) 245-7580
Maui (808) 242-0724
Moloka‘i (808) 553-3251

Lana‘i (808) 565-6089
O‘ahu Office (808) 536-4302

Maui County Office on Aging (Area Agency on Aging)
(808) 270-7774
www.mauicounty.gov

Medicare
1- (800) 633-4227 (toll-free)
www.medicare.gov

National Academy of Elder Law Attorneys (NAELA)
1- (520) 881-4005
www.naela.com

National Alliance for Caregiving
www.caregiving.org

National Memorial Cemetery of the Pacific (808) 532-3720
www.cem.va.gov/nchp/nchp.htm

National Senior Citizens Law Center
www.nsclc.org/

Office of the Public Guardian of the Judiciary (OPG)
O‘ahu (808) 548-0006
http://www.courts.state.hi.us

Social Security Administration
1- (800) 772-1213 (toll-free)
www.ssa.gov

Tax Records (Property tax)
O‘ahu (City and County of Honolulu) (808) 527-5539
Real Property Office
Treasury Division (808) 523-4856
www.honolulupropertytax.com/
www.co.honolulu.hi.us/

Hawai‘i County
Hilo
Appraisal (808) 961-8354
Clerical (808) 961-8201
Collections (808) 961-8282

Kona

Appraisal	(808) 327-3542
Clerical	(808) 327-3540

www.hawaiipropertytax.com/
www.hawaii-county.com/

Kaua‘i

Real Property Assessmen	(808) 241-6222
Billing & Collection	(808) 241-6555

www.kauaipropertytax.com
www.kauai.gov

Maui

Assessment and Information	(808) 270-7297
Billing & Collection	(808) 270- 7697

www.mauipropertytax.com
www.mauicounty.gov

Temporary Restraining Order (TRO) for abusive family relationships
Family Adult Service Branch of the Family Court

O‘ahu	(808) 538-5959
Hawai‘i County	
Hilo	(808) 969-7798
Kona	(808) 326-1607
Kaua‘i	(808) 482-2330
Maui	(808) 244-2706

http://www.courts.state.hi.us

Temporary Restraining Order (TRO) for non-familial relationships
District Court

O‘ahu	(808) 538-5151
Hawai‘i County	(808) 961-7470
Kaua‘i	(808) 482-2303
Maui	(808) 244-2838

http://www.courts.state.hi.us

Temporary Restraining Order (TRO) Help on Neighbor Islands:

Kaua‘i, YWCA	(808) 245-8404
Domestic Violence Hotline	(808) 245-6362
Sexual Assault Hotline	(808) 245-4144

Maui

Women Helping Women

West Maui	(808) 242-0775
East Maui	(808) 877-6888

www.whwmaui.net/

University of Hawai‘i Elder Law Program (UHELP)

O‘ahu	(808) 956-6544

www.hawaii.edu/uhelp

U.S. Department of Veterans Affairs (VA) (Federal)

VA Benefits	1- 800-827-1000 (toll-free)

www.va.gov

Office of Veterans Services (State Office)

O‘ahu	(808) 433-0420
Hawai‘i County	(808) 933-0315
Kaua‘i	(808) 241-3346
Maui	(808) 873-3145

http://www.dod.state.hi.us/ovs