❖ GUARDIANSHIP, ADULT

Only a circuit court judge can rule on whether or not a person needs a guardian. The decision is based on information provided from various sources, family members and caregivers as well as professional evaluations. The court may appoint a family member, close friend, an attorney or a volunteer. In Virginia, if no other person is available, an officer of the court may be appointed as guardian. Persons who have a guardian are known as wards.

It may be difficult under some circumstances as a family member or primary caregiver to know when someone for whom you care may need to be protected by a guardianship. The following checklist was developed to help you measure the functions that would be considered by state social services and the courts. If you can answer yes to some of these critical statements about the person for whom you are concerned — especially the ones that concern his/hers or others personal safety — it may be appropriate for you to seek the advice of an attorney, ask for professional assistance from your local social services office and/or speak with your family's physician. You may wish to show him or her your completed CHECKLIST FOR GUARDIANSHIP to help demonstrate your concerns.

✓ CHECKLIST FOR GUARDIANSHIP

- ❒ Person makes decisions that could harm him/her
- ❒ Person creates frequent safety hazards for self or others; for example, cooking, driving, taking medications
- ❒ Person refuses or is unwilling to accept assistance, support services or medical treatment that would be in his/her best interest
- ❒ Current assistance is insufficient to needs
- ❒ Person has not chosen someone to act in his/her behalf (that is, power of attorney, representative payee)
- ❒ Person's health and general well being are often in imminent danger

- ❒ Decisions about medical treatment, placement, are required; person uncooperative
- ❒ Person is suffering from malnutrition or does not eat properly on regular basis
- ❒ Person is unable to care for basic hygiene and health needs
- ❒ Person is being exploited financially or has been subjected to real attempts to do so
- ❒ Person appears unable to manage personal funds; household bills are not being paid on time or at all

FOR MORE INFORMATION

➧ SEE VIRGINIA, CODE OF
VIRGINIA, STATE OF
SOCIAL SERVICES, DEPARTMENT OF
AGING, DEPARTMENT FOR THE
AREA AGENCIES ON AGING

LEGAL AID OF CENTRAL VIRGINIA
101 West Broad Street, Suite 111
Richmond, VA 23220
Phone: 1 (804) 648-1012

VIRGINIA COALITION FOR THE
PREVENTION OF ELDER ABUSE (VCPEA)
730 East Broad Street
P.O. Box 10166
Richmond, VA 23240
Phone: 1 (804) 828-1525

NATIONAL SENIOR CITIZENS LAW CENTER (NSCLC)
On the web: www.nsclc.org
NSCLC analyzes ADA requirements affecting older clients and traditional procedures governing the creation of guardianships and conservatorships. Emphasizes due process protections for persons who are subjects of such proceedings and least restrictive alternatives available to achieve necessary results.

❖ HOME CARE

TO LOCATE FACILITIES AND SERVICES:
➧ SEE VHI'S LONG-TERM CARE PROVIDER DIRECTORY

✓ HOME CARE CHECKLIST

PROVIDER BEING CONSIDERED: _____
LOCATION _____
PHONE _____
❒ SPACE AVAILABLE ❒ SPACE NOT AVAILABLE
SPACE AVAILABLE ON _____
WAITING LIST _____

ABOUT THE PROVIDER
Obtain a written statement outlining the home care provider's
❒ services ❒ fees
❒ licensing ❒ payment procedures

❒ Ask about employee qualifications and qualifications of personnel who will be entering home

❒ What are facility's limitations (procedures they can't perform)

Provider carries ❒ malpractice ❒ liability insurance
Only limited services are available. Other home/community care services if needed are the responsibility of
❒ patient ❒ primary home care service provider ❒ caregiver

If second provider becomes necessary, will secondary provider's charges be
❒ billed to patient through primary provider
❒ separate billings from each sub-contract provider

❒ Obtained three references from provider
❒ Called each reference
Reference one:
❒ No ❒ Some ❒ Many problems.
Reference two:
❒ No ❒ Some ❒ Many problems.
Reference three:
❒ No ❒ Some ❒ Many problems.

ABOUT THE ASSESSMENT AND CARE PLAN
❒ Can perform a patient assessment
❒ Can develop a care plan from previous assessment
❒ Can update a previous assessment
❒ Cannot update previous assessment

Plan of care to be developed with
❒ patient ❒ caregiver ❒ family members
❒ primary physician ❒ specialists ❒ therapists
❒ pharmacist ❒ other

Care plan is written out with copies given to
❒ patient ❒ responsible family member/caregiver
❒ personal physician ❒ all medical specialists
❒ local pharmacy where patient/family is known/has account

❒ Plan includes all medications and dosage schedules to eliminate any cross-medication problems or drug-related allergic reactions
Medication changes are provided in writing on order sheet:
❒ Yes ❒ No
and a copy is given
❒ to supervisor ❒ to aides ❒ to family/caregiver
❒ to all physicians treating patient

❒ Charges for assessment ❒ Does not charge for assessment
❒ Charges ❒ Does not charge for assessment updates
❒ Charges for care plan development
❒ Does not charge for care plan development

ABOUT THE HOME CARE SERVICES PERSONNEL

References are required by the agency or provider and on file for all personnel ❒ Yes ❒ No

Training ❒ is ❒ is not required for aides who are not licensed or certified.

If training is required, it is provided ❒ by provider
❒ by technical educational source ❒ by medical/nursing school

Aides are ❒ supervised in the home
❒ Weekly ❒ Monthly ❒ Other
❒ not supervised
❒ Substitute aides provided if aide is absent

Supervisor can be reached by patient or family caregiver
❒ directly on cell phone ❒ through paging system
❒ through answering service/home care services main office
❒ during fixed daytime hours
❒ 24 hours a day ❒ 7 days a week

All holidays billed at ❒ standard rate ❒ higher rate

ABOUT CHARGES AND PAYMENT

Home care provider bills services
❒ weekly ❒ bi-weekly ❒ monthly

Home care provider files claims with
❒ Medicare ❒ Medicaid
❒ Medigap plans ❒ Public funding
❒ Private insurer ❒ Other

Some services/charges are covered by a
❒ federal ❒ state ❒ local program

❒ Obtained printed hourly fee schedule on/in service provider's stationery/brochure

Has an ❒ hours-per-week minimum ❒ overall minimum charge

Home Care Service workers operate as
❒ independent agents ❒ hourly ❒ salaried employees

A travel time fee ❒ is ❒ is not charged.
Mileage costs (¢ per mile) ❒ are ❒ are not billed to care recipient.

Has ❒ 30 day ❒ 60 day ❒ 90 day account

Charges interest rate fee of % on all costs not paid after
❒ 15 days ❒ 30 days ❒ 60 days ❒ 90 days

Accepts credit cards
❒ MasterCard® ❒ American Express® ❒ VISA®
❒ Optima® ❒ Discover® ❒ Other

ABOUT THE SERVICES CONTRACT

Requires written agreement that includes
❒ schedule of costs ❒ payment arrangements
as well as expectations about time allowed for
❒ full ❒ partial payments

Discounted rates available if contracted on
❒ weekly ❒ monthly basis

FOR MORE INFORMATION

NATIONAL ASSOCIATION FOR HOME CARE
228 7th St., SE
Washington, DC 20003
Phone: 1 (202) 547-7424, Fax: 1 (202) 547-3540
www.nahc.org

HOME CARE — MEDICATION SERVICES

➧ SEE VIRGINIA, CODE OF
REQUIRED QUALIFICATIONS FOR
ADMINISTRATION OF MEDICATIONS IN VIRGINIA

OTHER RESOURCES

➧ SEE VIRGINIA, STATE OF
SOCIAL SERVICES, DEPARTMENT OF
AGING, DEPARTMENT FOR THE
➧ SEE MEDICARE
MEDICAID
SOCIAL SECURITY
LONG-TERM CARE INSURANCE
CAREGIVER GRANTS

❖ HOSPITALS

AMERICAN HOSPITAL ASSOCIATION'S PATIENT'S BILL OF RIGHTS

In 1973 AHA member hospitals voted to adopt a Patient's Bill of Rights. Revised in 1992, this pledge is a commitment by AHA hospitals to provide quality health care that respects the patient's human needs as well as medical needs.

In turn the patient accepts the responsibility to provide information needed for quality care and to behave in a way that supports the hospital's professional efforts in their behalf. These mutual responsibilities are summarized on the following pages*. To obtain a copy of the complete document as drafted by the AHA, ask for one at an AHA hospital near you.

HOSPITAL'S RESPONSIBILITIES TO PATIENT

- Considerate and respectful care
- Current, complete, and understandable information about the diagnosis, treatment, prognosis, specific procedures and any risks and identity of the caregivers
- The financial implications of your treatment
- Protect patient's right to refusal of treatment as well as inform patient of medical consequences of refusal as well as any policies that might affect patient choice
- Allow patient to have any advance directives honored to the extent permitted by law
- Maintain privacy and confidentiality, including medical records; allow patient to review his or her records and have the information explained
- Provide example and explanation of financial charges
- Respond to patient's medically indicated care and service requests
- Provide information on other institutions involved in the patient's care; gain patient's approval (when capable) of a transfer to another facility

*By permission of the American Hospital Association, Copyright 1992.

- Provide information concerning any business relationship between the hospital and other entities that might affect his or her care
- Protect patient's right to accept/refuse participation in a research project
- Provide continuity of care, including information concerning care options available following hospital care
- Provide information on hospital policies and practices concerning patient care and charges
- Provide resources for grievance resolution

PATIENT'S RESPONSIBILITIES TO HOSPITAL

- Provide information about past illnesses, hospitalizations, medications and any other information important to proper treatment
- Take responsibility for requesting clarification of condition or treatment
- Provide health care facility with any written advance directives
- Inform health care facility staff about any problems concerning ability to follow prescribed treatments
- Be aware of need to share hospital staff with others in the hospital and community and make an effort to keep service demands reasonable
- Provide all information necessary to insurance claim process and make appropriate payment arrangements
- Take responsibility for personal behaviors that affect his/her health

FOR MORE INFORMATION

AMERICAN HOSPITAL ASSOCIATION (AHA)

On the web: www.aha.org

The national organization that represents and serves all types of hospitals, health care networks, their patients and communities.

AMERICAN HOSPITAL ASSOCIATION
Chicago Headquarters
One North Franklin, 27th Floor
Chicago, Illinois 60606-3421
Phone: 1 (312) 422-3000

ASSOCIATION OF AMERICAN MEDICAL COLLEGES (AAMC)
On the web: www. aamc.org
A nonprofit association comprised of course-accredited medical schools/teaching hospitals.

AAMC
2450 N Street, NW
Washington, DC 20037-1126
Phone: 1 (202) 828-0400

VIRGINIA HOSPITAL AND HEALTHCARE ASSOCIATION (VHHA)
On the web: www.vhha.com
The VHHA represents Virginia hospitals and publishes information on health care providers in Virginia.

VIRGINIA HOSPITAL AND HEALTHCARE ASSN.
4200 Innslake Drive
Glen Allen, VA 23060
Phone: 1 (804) 965-1210
Mailing Address:
P.O. Box 31394
Richmond, VA 23294-1394

❖ INSURANCE, HEALTH • TYPES OF

BASIC PLANS, ALSO CALLED INDEMNITY OR FEE-FOR-SERVICE PLANS, offer hospital-surgical coverage, major medical coverage and, as a combination of these two under one plan, comprehensive coverage. Benefits offered under each type of coverage vary. Comprehensive plans will more typically offer a wider range of benefits. Any of these plans may be offered as group coverage or as individual coverage. These plans are designed primarily to help cover costs related to illnesses that require hospital inpatient and outpatient care.

DISEASE-SPECIFIC INSURANCE is designed to provide benefits for the costs associated with medical care relative only to the disease

named in the policy — for example, cancer. Benefits are usually limited to per-day amounts or to a one-time payment and are intended only to supplement, not replace, other medical insurance.

HEALTH MAINTENANCE ORGANIZATION PLANS (HMOS) have two recognizable features. First, a provision usually exists for you to select a primary care physician from the plan's list of medical service providers. This physician usually coordinates your care, and, therefore, will see you first. If necessary, your primary care physician will refer you to a specialist. There is usually no deductible when this provision is followed. Secondly, in an HMO, emphasis is usually placed by the plan on preventive care through routine check-ups and health screenings. These may be available for a flat out-of-pocket fee, also referred to as a co-payment.

MANAGED CARE health insurance plans involve a group of medical providers that offer comprehensive medical services. In some managed care plans a primary care physician, or gatekeeper, is chosen by the patient from a list provided by the plan. There is no primary care physician requirement in some managed care plans.

There are basically three managed care options:

- a Health Maintenance Organization or HMO
- a Preferred Provider Organization or PPO and a
- Point of Service feature or POS.

Insurance companies give their own brand names to these various programs. If you are not sure whether you are covered under a managed care program, ask your employer or insurance agent or broker for a careful explanation of your coverage as it pertains to HMOs, PPOs and POS plans and features.

POS HEALTH PLAN FEATURES — Some HMO plans offer a feature called point of service or POS. A POS may allow you to select a non-network provider and/or to receive coverage for some preventive care services. Typically, however, using this option could result in higher costs.

PPO PLANS — PPOs are formed to provide a large medical care network that offers its services to insured members for a set fee — an allowable charge. PPO members receive a list from which they choose medical care providers. A gatekeeper is usually not required. A PPO generally allows its members to receive care outside its network of providers, although usually at a somewhat higher cost.

FOR MORE INFORMATION

➧ See LONG-TERM CARE INSURANCE
MEDICAID
MEDICARE

VIRGINIA ASSOCIATION OF HEALTH PLANS
On the web: www.vahp.org
Represents Virginia's Managed Care Health Plans. Publishes Directory of Virginia Health Maintenance Organizations. Profiles Virginia's HMO plans.

VIRGINIA ASSOCIATION OF HEALTH PLANS
118 North Eighth Street
Richmond, VA 23219
Phone: 1 (804) 648-8466

VIRGINIA HEALTH INFORMATION (VHI)
On the web: www.vhi.org
Represents all health care stakeholders including businesses, consumers, providers and the state. Makes health care information available to assist businesses and consumers make better informed health care decisions. Call for your free HEALTH INSURANCE OPTIONS: A CONSUMER'S GUIDE, a 32-page full-color booklet.

VIRGINIA HEALTH INFORMATION
1108 E. Main Street, Suite 1201
Richmond, VA 23219
Phone: 1 (804) 643-5573
☎ Toll Free: 1-877-844-4636 (1-877-VHI-INFO)

J

JOINT COMMISSION ON ACCREDITATION OF HEALTH CARE ORGANIZATIONS (JCAHO)

On the web: www.jcaho.org

Accredits hospitals/health care organizations for administrative, medical, facility and quality of care issues. Has active complaint department to assist consumers.

JCAHO
One Renaissance Boulevard
Oakbrook Terrace, Illinois 60181
Phone: 1 (630) 792-5000

JCAHO
Complaint Operations Unit:
Phone: 1-800-994-6610

K

❖ KIDNEY DIALYSIS, TRANSPLANTATION

(ALSO OTHER VITAL ORGANS)

➧ SEE MEDICAID
MEDICARE

L

❖ LEGAL ASSISTANCE

LEGAL AID OF CENTRAL VIRGINIA

101 West Broad Street
Richmond, VA 23220
Phone: 1 (804) 648-1012

➧ SEE VIRGINIA, CODE OF

NATIONAL SENIOR CITIZENS LAW CENTER (NSCLC)
On the web: wwwnsclc.org
NSCLC analyzes American Disabilities Act requirements and traditional procedures governing the creation of guardianships and conservatorships. It studies and can source contacts needed for due process protections for persons who are subjects of such proceedings. Provides guidance on least restrictive alternatives available to achieve necessary protection for them.

❖ LICENSING/REGULATION AUTHORITIES

HEALTH, DEPARTMENT OF
On the web: www.vdh.virginia.gov
OFFICE OF HEALTH FACILITIES REGULATION
Licenses hospitals and other health care facilities, conducts routine compliance inspections, provides information on licensed health care facilities and investigates consumer complaints and grievances.
Phone: 1 (804) 367-2100
☎ Toll Free: 1-800-955-1819
also
CENTER FOR QUALITY HEALTH CARE SERVICES
CONSUMER PROTECTION
CERTIFICATE OF QUALITY ASSURANCE
On the web: www.vdh.state.va.us/quality
Regulates quality of health care services provided by managed care health insurance plans in Virginia. Beginning July 2000, managed care health insurance plans are required to maintain a Department of Health Certificate of Quality Assurance. Consumers can address their concerns with the Center.
Phone: 1 (804) 367-2102
☎ Toll Free: 1-800-955-1819
For services listed above:
VIRGINIA DEPARTMENT OF HEALTH
109 Governor Street
Richmond, VA 23219
☎ Toll Free: 1-800-955-1819

FOR PROFESSIONAL LICENSING:
➧ SEE VIRGINIA, STATE OF
LICENSING BOARD, STATE

➧ SEE UNITED STATES GOVERNMENT

SOCIAL SERVICES, DEPARTMENT OF (DSS)
On the web: www.dss.state.va.us
Has responsibility for regulation and oversight of licensed or agency-approved adult day care facilities and assisted living services provided in Virginia.

VIRGINIA DEPARTMENT OF SOCIAL SERVICES
Division of Licensing Programs
730 E. Broad Street
Richmond, VA 23219
Phone: 1 (804) 726-7156

Division of Family/Adult Services
Phone: 1 (804) 692-1299

FOR LICENSING OF

- NURSING HOME ADMINISTRATORS
- NURSES
- PHYSICIANS

STATE BOARD OF EXAMINERS:
VIRGINIA DEPARTMENT OF HEALTH PROFESSIONS
6606 W. Broad Street, 5th Floor
Richmond, VA 23230-1717
☎Toll Free: 1-800-533-1560

STATE CORPORATION COMMISSION (SCC)
BUREAU OF INSURANCE
On the web: www.state.va.us/scc
Licenses all health insurance companies, HMOs and health services plans that wish to operate (sell insurance) in Virginia. Also assists consumers in resolving disputes with insurance companies or underwriters, plans and agents who sell insurance in Virginia. Also provides addresses and telephone numbers of companies licensed to sell insurance in Virginia.

SCC BUREAU OF INSURANCE
Life and Health Division
Consumer Services Section
P.O. Box 1157
Richmond, VA 23218
☎ Toll Free: 1-800-552-7945

OFFICE OF MANAGED CARE OMBUDSMAN
☎ Toll Free: 1-877-310-6560
e-mail: ombudsman@scc.state.va.us

❖ LONG-TERM CARE INSURANCE

HOW IT'S DIFFERENT

Long-term care insurance is a relatively new insurance product to many people. Other forms of health insurance are designed to pay for the services that help keep you well and, when ill or injured, to pay for the facilities and services you need to return to health. Long-term care insurance is designed to provide coverage for the services you may need if you become chronically ill or disabled.

WHAT IT COVERS

Most long-term care insurance policies are designed to cover the *large expenses that are not covered by*

- standard health insurance plans
- Medicare or
- medigap plans
- or when personal asset levels do not meet Medicaid qualification requirements

and to cover *two primary types of care*

- skilled care — for example professional therapists or registered nurses ordered by a physician and
- personal assistance and custodial care which includes help with such Activities of Daily Living (ADLs) as toileting, eating, dressing, etc.

WHEN IT COVERS YOU

Typically, benefits are payable

- when a pre-specified number of Activities of Daily Living (ADLs) — eating, dressing, toileting, transferring or continence — are no longer possible without assistance
- if your cognitive impairment requires substantial supervision or
- if a level of disability is reached that affects your ability to perform ADLs without assistance.

SERVICES AND FACILITIES

Coverage may include long-term care services provided

- in a nursing home
- in an assisted living facility
- through a hospice center or counselors
- in an adult day care center
- through community adult services and/or
- in your home by home care professionals or by personal care aides.

Coverage is something you want to compare carefully. *Where* and *When* vary from policy to policy.

COVERAGE

ABOUT TIME AND/OR DOLLAR LIMITS — Long-term care insurance plans are available that provide coverage

- for a set number of years or a maximum dollar amount or
- for as long as you live or an unlimited dollar amount.

ABOUT ALZHEIMER'S DISEASE — Typically, insurance companies do not pay benefits for care that may involve issues such as attempted suicide, intentional self-wounding, alcohol or drug addiction, injuries related to acts of war and treatments previously covered by state or federal insurance coverage. And, many long-term insurance policies along with other forms of health insurance may exclude mental or nervous disorders or diseases such as Alzheimer's disease.

Long-term care insurance offered in Virginia must include cove rage for Alzheimer's; however, the cove rage offered may vary within the limits of the policy. Check any policies you are considering for coverage limitations.

ABOUT FACILITIES AND PROVIDERS — Much like Medicare and Medicaid, the positive effect of owning a long-term care insurance policy depends not only on what services are covered by the plan you choose but also on what type of facility or providers are covered. For example, long-term care policies often exclude rest homes, personal care homes — some even exclude assisted living facilities unless licensed by the state to provide personal care services. Some plans

specify a limit to the coverage by size of facility. And some even specify special types of nursing supervision.

WHAT IT COSTS, WHAT IT CAN HELP PROTECT

According to most reported national averages, home care for a year — assuming a skilled care nurse three times a week and a licensed practical nurse three times a week for two hours — costs well in excess of $12,000. That's an average of $1,000 a month. A home health aide for 6 hours a week has been estimated to cost in excess of $8,000 a year. And a skilled care nursing facility is estimated to cost over $38,000 a year. These are the expenses that most long-term insurance is designed to cover.

WHO SELLS LONG-TERM CARE INSURANCE

Most long-term care insurance is underwritten and sold by large insurance companies. You may recognize many of the names as companies associated with health and life insurance plans. It can be offered as individual or group coverage. Long-term care insurance can be sold in Virginia

- in person by an insurance agent or broker or
- from an insurance company by direct mail to you or
- through a third party marketer (for example, an association, a residential facility or an employer).

Regardless of how insurance is offered — in person, by direct mail or through a third-party marketer — any insurance company offering insurance to Virginians is required to be licensed to do so by the State Corporation Commission. If you have questions about an offeror of insurance in Virginia, you can contact the SCC Bureau of Insurance about your questions.

IMPORTANT: Check your residential care contract and/or seek legal advice should you be offered long-term care insurance by a facility in which you already reside — an Assisted Living facility or CCRC for instance — or by an independent outside source. If you already have a contract for lifetime health care with a CCRC — that is, you have paid a lifecare entrance fee to a CCRC — you already have a form of long-term care "insurance" in place. Assisted Living services in other types of facilities may or may not be covered. Because coverages and

facilities vary, you would want to understand totally how the policy being offered would help you financially.

LONG-TERM CARE INSURANCE QUALIFIED PLANS

QUALIFIED VS. NON-QUALIFIED PLANS — Some long-term care insurance policies allow tax deductibility of premiums and/or have benefit payments that are can be received by the policy holder as non-taxable income. The companies offering these policies must meet certain federal guidelines under the IRS code. When they have been approved by the IRS they can be sold as qualified plans.

Because qualified policy terms vary and prove beneficial to some people but are not necessarily beneficial to others, it is wise to have knowledgeable assistance when comparing qualified policies and when comparing qualified policies with non-qualified policies. Your tax advisor and/or a financial planner should be consulted to help you decide what is best for you as well as answer questions about medical necessity requirement issues.

SWITCH AND REVERSE SWITCH

Ask your agent/financial planner about the possibility to switch from non-qualified to qualified, and/or the reverse, and back again. Some companies offer this option and you may want to ascertain that the policy you are considering lets you reserve the right to do so. If you purchased a LTC policy prior to January 1, 1997, that policy is probably a qualified policy. You may also want to examine the advantages and disadvantages of trading a "grandfathered" policy for a new policy.

PARTNERSHIP PROGRAMS

A few states* have enacted or have pending special long-term care insurance programs that form a cooperative partnership in that state with the state's Medicaid program. At the time of this publication, Virginia does not participate in a program of this type; therefore, at publication no program-related long-term care insurance is offered in Virginia. Even though Virginia is not a Partnership Program state, under the federal Omnibus Reconciliation Act of 1993 (see Sec 1917(b)¶ 1, sub¶ C: , Sec 1917(b)¶ 3:, and Sec 1917(b)¶ 4, sub¶ B for details and definitions) your assets, brought with you to Virginia from a Partnership

Program state where you purchased long-term care insurance, might be affected. Here's why: If you move to another state (Virginia, for example) and your long-term care policy benefits and personal assets become exhausted, and you must apply for Medicaid, you may be required to apply for Medicaid in the state in which your partnership policy was written. Obtain advice from a legal counsel ❧ or financial advisor prior to making any decisions.

IMPORTANT: If you have a parent or relative who currently lives in a partnership program state and has purchased long-term care insurance in that state some understanding of partnership programs could be important to you and your parent. You also need to understand some of the qualifications that could apply to his/her coverage at a later date. Contact your insurance company, the department of aging and the insurance commission in the partnership state you are leaving well before making a decision.

Some states are exempted from Omnibus requirements. Again, seek advice from your home state and/or Virginia regulatory agencies before you make a final decision.

ACCELERATED BENEFITS LIFE INSURANCE AS LONG-TERM CARE COVERAGE

You may be offered long-term care coverage by your life insurance agent as an accelerated benefit provision of a life insurance policy — that is, the insurance company is willing to write a life policy that allows the death benefit bought to be paid out to you by the insurance company before your death to cover long-term care needs. The cash value of the life insurance will have been used off to pay for long-term care. However, if you have multiple life policies and one includes this feature option or you wish to add a policy that provides this feature, you may wish to explore it as your answer to long-term care cost protection.

*NOTE: At publication date the following states have in place or have pending enabling Long-Term Care Participating Programs: Colorado, Maryland, Massachusetts, Michigan, Illinois, Iowa, and Washington state.

✓ A CHECKLIST OF LTC INSURANCE GUIDELINES

❒ **READ THE FINE PRINT** — Get assistance in reviewing a long-term care policy — before you sign. In all likelihood, the company is being forthright; the goal is to determine whether or not the coverage will meet your objectives for financial protection. VICAP personnel, a lawyer or trusted tax specialist or financial advisor can help you read and decide.

❒ **TAKE ADVANTAGE OF FREE-LOOK PERIODS** — Virginia requires all licensed insurance companies to provide a 30-day "free look" period to a potential insurance buyer. That means, you get to study the actual policy for 30 days to decide if it's right for you. If not, you get back any money you have sent the insurance company. If you request a change in degree of coverage, you may receive a partial refund or be asked to ante-up the difference.

❒ **ALWAYS USE A CHECK OR MONEY ORDER; NEVER USE CASH** — even when a receipt is offered. These special reminders do not apply only to long-term care insurance. Every insurance policy or plan you consider deserves the same careful attention and payment procedure.

❒ **LOOK CLOSELY AT FINANCIAL STABILITY AND REPUTATION** when comparing Long-Term Care insurance companies and plans. Over the next 10-20 years, long-term care insurers will feel the financial crunch created by a growth in claims. Selecting a policy on price and discounting an insurance company's financial reserves — an important stability factor — may not be a wise dollar-saver over the long term. There are over 100 companies selling long-term care insurance in the U.S. Most of them have built their reputations on life insurance related products. Less than 20 of them control the market share. Some very reliable health care insurers are also getting into the market. As long-term insurance grows in popularity, your options will increase. So will competitive offers. Weigh the differences when you shop.

❒ **EARLY SHOPPING** — If you are considering buying long-term care insurance as an early measure (in your 40s or 50s), look at the companies you are considering as they might predictably be

ABOUT THE UNDERWRITER...

How long has the insurance company been in business?

COMPANY:	YEARS	MONTHS
COMPANY:	YEARS	MONTHS
COMPANY:	YEARS	MONTHS

How do their reserves compare to the minimum reserves required for licensing in Virginia? _____

How are they rated with national financial analysts? Ask for highest rating; lowest rating with each call you make — not all insurance analysts use the same rating systems. If you're not sure how to compare the rating you receive, ask the analyst who answers your call to give you a comparison of his rating system with competitive ratings you have obtained (list them for him/her).

COMPANY:	HIGHEST RATING	LOWEST RATING
COMPANY:	HIGHEST RATING	LOWEST RATING
COMPANY:	HIGHEST RATING	LOWEST RATING

AGENT/BROKER...

How many long-term care policies have they written in Virginia in the last 2 years? _____ 4 years? _____

What are the broker's professional credentials?

_____

What is the broker's background for selling long-term care insurance? _____

Do they have prior experience selling
health insurance Yes ❒ No ❒
life insurance Yes ❒ No ❒
long-term care
insurance? Yes ❒ No ❒

in 10 to 20 years. Check out their track record to date with other types of insurance they have offered. You may also find that your premium is considerably lower when you buy coverage in your 40s or 50s. Many companies feature early programs with no

increase in premium as you age unless you add coverage for inflation.

❒ **YOUR INSURANCE COMPANY AND YOUR TAX ADVISOR**
Inclusion as an offerer of qualified insurance is not promissory to any offeror's qualification for tax deductibility. Questions concerning these products relative to annual or estate tax considerations should be directed to the insurance company offering the product and to your personal tax advisor.

❒ **ASK QUESTIONS ABOUT THE INSURANCE COMPANY AND THE BROKER OFFERING THE INSURANCE**
Look at the facts about the company before you decide. Then look at the facts about the insurance policy or program they have to offer.

❒ **COMPARE PLAN BENEFITS**
As you shop long-term care policies you may note that some benefit categories will be covered up to a stipulated percentage of the highest monthly or daily benefit you can receive under the policy.

Maximum Monthly Benefits as Base for Calculating Other Benefit Amounts — For example: The policy you are considering pays $2,000 a month in benefits for as long as you need care.

- In a nursing home, it pays 100% of this amount.
- In an assisted living facility it pays 100% of this amount.
- However, for home care and adult day care it pays up to 50% per month of the $2,000 monthly benefit.

Therefore, in long-term care insurance, nursing home care — or your maximum monthly benefit — is your 100% base benefit for calculating your home care benefit levels and any other care costs that are payable by the insurance as a percentage.

Informal Care An exception in calculating benefits against your 100% base benefit occurs in plans that cover informal care — the care you receive from a friend or relative. Typically, this coverage has a benefit payment that is a percentage of your standard home care benefit. For example: a policy may pay 30% of the home care monthly benefit for informal care expenses.

❒ **CALCULATE YOUR LTC INSURANCE COVERAGE NEEDS**
The percentage of payment typically involved in long-term care insurance is not like traditional health insurance plans that pay a portion of each expense. Long-term care insurance pays all of or a percentage of the total services received for a certain period of time, such as a month or a day, depending on the policy terms. Therefore, in a way, you can control how much you pay out of your personal assets for long-term care with the selection of the monthly or daily amount you elect for coverage. All policies must provide at least 12 months of coverage. For example: You have $1,500 a month in income. You cannot afford to spend any of your monthly income on long-term care costs. Your medigap plan and medicare will pay for some medical expense, but only for a limited number of days. Therefore, if you wish to be covered totally for nursing home care — assuming $3,000 per month for that cost — you might elect a policy that pays $3,000 per month for your care in a residential care facility.

❒ **COMPARE PAYMENT STRUCTURES OF LTC PLANS** — You will also find that long-term care policies vary in how they structure their payment arrangements for different types of services. For example: Some policies may pay benefits on a per day basis for nursing home care but pay home care benefits on a weekly basis. These variations require that you seek good advice since some service providers have minimum hour or day requirements that might not necessarily fit with the insurance you are considering. If you have providers in mind, it might be worth your time to check on how some of them charge and wish to be paid as you consider various long-term care insurance products.

	Policy 1	Policy 2	Policy 3
Person One: **Monthly Premium**			
Person Two: **Monthly Premium**			
Discount (%) for 2 People/Household			
Monthly Benefit			
Daily Benefit			
Lifetime Maximums In Dollars	$	$	$
In Years			
No Dollar Limit			
No Time Limit			
Covered Services **Nursing Home** % of Benefit			
Assisted Living % of Benefit			
Home Care % of Benefit			
Pays Family/Friend for **Informal Care? Y/N**			
If so, based on which Base Benefit?			
% of Benefit Paid			
Number of ADLs To Trigger Benefits			
Waiting Period? Y/N			
If so, how long?			
One time only? Y/N			
Other Benefits:			
care planning visit			
transition expense			
hospice services			
respite services			

✓ LONG-TERM CARE INSURANCE POLICY COMPARISON CHECKLIST

◀ This work sheet may be helpful to you in comparing long-term care insurance policies. Making copies of this form before you begin will allow you to keep a fresh copy in the book for future use.

FOR MORE INFORMATION

FOR FINANCIAL RATINGS:

A.M. Best Company (908) 439-2200
For ratings on the web: *www.ambest.com*
Fitch Investors Service, Inc., 1-800-893-4824
For ratings on the web: *www.fitchratings.com*
Moody's Investor Service, (212) 553-1653
For ratings on the web: *www.moodys.com*
Standard & Poor's (212) 438-7280
For ratings on the web: *www.standardandpoors.com*
☎Weiss Research, Inc. 1-800-289-9222
For ratings on the web: *www.weissratings.com*

For more information on LTC insurance in Virginia and other states:
NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS (NAIC)
On the web: www.naic.org

NAIC
P. O. Box 220
Royal Oak, MI 48068
(816) 842-3600

For information on insurance companies licensed to sell non-qualified or qualified plans in Virginia or to ask for *A Shopper's Guide to Long-Term Care Insurance*, contact :

STATE CORPORATION COMMISSION (SCC)
On the web: www.state.va.us/scc

SCC Bureau of Insurance, Life and Health Division
Consumer Services Section
P.O. Box 1157
Richmond, VA 23218
☎Toll Free: 1-800-552-7945

❥ SEE LEGAL ASSISTANCE

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❖ MEDICAID

Medicaid is a program mandated by Title XIX of the Social Security Act. It became law in 1965. It is jointly funded by our federal and state governments. Medicaid is the largest program currently providing health care to eligible Americans and is the largest insurer of long-term care. The federal program paid approximately 57 percent of the annual national expenses covered by Medicaid in the last reporting year, leaving 43 percent for the states to pay. Medicaid is shifting its support with other insurers to home care services and to community-based services.

Medicaid benefits are divided into two categories:

THOSE MANDATED BY THE FEDERAL GOVERNMENT

- Inpatient, Outpatient and Emergency Hospital Services
- Nursing Facility Care
- Rural Health Clinic Services
- Federally Qualified Health Center Clinic Services
- Laboratory and X-ray Services
- Physician Services
- Home Health Services (Nurse, Aide, Supplies and Treatment Services)
- Family Planning, Supplies and Nurse-Midwife Services
- Medicare Premiums/Hospital Insurance Part A and
- Supplemental Medical Insurance Part B for the Categorically Needy
- Transportation Services

and those that are optional, left up to each state.

Under Title XIX Virginia is allowed to establish eligibility requirements, the type and duration of services, the rate of payment for those services and to operate its program. Optional services may include prescription drugs, hospice care, personal care services, skilled nursing facility care, intermediate care facilities for the developmentally disabled and home and community-based services. Freedom-of-choice waivers allow States to enroll Medicaid beneficiaries in cost-effective managed care programs.