

Understanding Residential Care Options for People with Alzheimer's 2018



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When is home no longer the best place?

Although most of us want to stay home as long as possible, it's not always the best place to be. If your loved one has Alzheimer's and has lost critical independent living skills that place her safety at risk — or if you are feeling overwhelmed—it's time to re-evaluate your options.

First, find out if there's more help you can get in the home. Can other family members help? Does your loved one qualify for any in-home programs such as respite, sitter, and personal care services?

To find out what in-home programs are available in your community, call the Alzheimer's Association at 1-800-272-3900, your Area Agency on Aging at 1-800-252-9240, your Texas Information and Referral Network at 2-1-1, or your Aging and Disability Resource Center at 1-855-YES-ADRC (1-855-937-2372).

If your loved one can't get enough help in the home to meet her needs, then it's time to consider residential care.

This booklet will discuss the two most common types of residential care settings — assisted living facilities and nursing homes — including tips for choosing the best facility, licensing regulations, and programs to help pay for residential care. It's written particularly for family members of people with Alzheimer's or related dementias.

How do I choose the facility that's best for my loved one?

When you're choosing a residential care facility, it's important to do your research. You can't draw conclusions about facilities' quality of care by looking at their buildings. It's important to gather as much information as you can from several sources of information, including facility staff members, families of residents, facility regulators, and facility ombudsmen.

As you gather information from staff, ask about the building, regulatory history, services, resident rooms, resident care, dining and meal service, activities, staffing, and costs.

The following questions have been prepared by the West Virginia Chapter of the Alzheimer's Association and serve as a good checklist for comparing facilities.

Building

- How many beds do you have? How many beds are available?
- What are your visiting hours?
- Am I allowed to visit at any time?
- Are your exterior doors kept locked?
- Is there a secure outside area that would be accessible to my loved one?
- What security measures do you have in place to make sure my loved one doesn't wander away from the building?
- Are pets allowed in the building?

Regulatory History

- May I see a copy of your most recent inspection by the state? (Note: facilities are required to post the surveys in a public place, for anyone to see).
- What were the major findings of the most recent inspection? Were any fines assessed? If so, for what reason?

Services

- What services can my loved one get in the building? Dental care? Vision care? Podiatry services? Hearing services? Beauty salon? Physical therapy? Occupational therapy? Speech therapy? Who pays for these services? May I get a price list for all of the services that would be paid for out-of-pocket?
- Do people with Alzheimer's live in a separate part of the building, or are living spaces shared with people who don't have Alzheimer's?
- Under what circumstances would I have to move or transfer my loved one? How long would I have to make other arrangements? How much help would the facility give me in making other arrangements?
- What types of behavioral issues are you able to handle?
- What is your process, in case your staff has problems handling a resident's behavior?

- Are you able to meet the needs of people with Alzheimer's who wander?
- What's your policy on using physical restraints, such as bed rails and geriatric chairs?
- What's your policy on using psychotropic medications?
- Is your facility a certified Alzheimer's facility? (For more information on certification requirements, see page 8).
- What services do you provide that aren't available at other facilities?
- Do you have transportation that would be available to my loved one? If so, what are the fees?
- What is your smoking policy?
- What is your policy on replacing items that are lost or stolen?
- Who will do my loved one's laundry? Do I have the option of doing it myself?

Rooms

- How would my loved one's room be selected? Can we pick the room?
- Would my loved one's room be private or semi-private?
- If my loved one would share a room, how would a roommate be chosen?
- What happens if roommates don't get along?
- Will I be able to decorate my loved one's room? Will we be able to bring our own furniture?



Resident Care

- What kind of schedule would my loved one be on? Would he/she be allowed to sleep in? Would he/she be allowed to bathe, get dressed, and eat meals at different times if the scheduled times aren't convenient?
- How often would my loved one's teeth get brushed?
- How would you manage my loved one's care if he/she is incontinent?
- Would you allow my loved one to choose between a bath and a shower?
- How do you care for residents who don't like taking baths or showers?
- How do you care for residents who need help eating? Are they fed in the dining room or their own rooms?
- What does the facility do to make sure residents who spend most of their time in bed don't get bed sores?

Dining and Meal Service

- Can my loved one choose where she/he eats? With whom she/he eats?
- Will my loved one get to help plan the menu?
- What options will my loved one have if she/he doesn't like the food that's served?
- When are meals served?
- What kinds of snacks are provided?
- Can I bring snacks to my loved one?
- Can you accommodate special dietary needs?
- Can I join my loved one for meals?

Activities

- Do you have a recreational therapist on staff?
- Do you provide special activities for people with dementia?
- Can you give me a copy of your activity calendar?
- What activities do you conduct on evenings and weekends?
- Do you coordinate and provide transportation to community outings?
- What activities do you provide people who can't leave—or don't want to—leave their rooms?

Costs

- Do you accept Medicaid? Do you have any Medicaid beds available? If not, how soon might a bed become available?
- Do you accept Medicare? VA? Private insurance?
- What are your rates? What do the rates include? What items are extra? Can you give me a price list for extra items?
- Do you have different rates for different levels of care? For example, if my loved one is able to take a bath by herself when she enters the facility and later needs help, will her cost of care go up? If so, how are the levels of care determined, and what's the cost of the highest level of care?
- How many times have your rates increased in the past year? How much have your rates increased during the past year?
- How much notice will I receive before rates are increased?

Staffing

- How many aides and nurses are on duty during the day? Evenings? Nights? Weekends? For how many residents? How many staff are on the wing that my loved one might be on?
- Do you have a full-time social worker?
- Do you have a full-time activity director?
- Is the facility accessible by public transportation, for the benefit of staff and visitors who rely on public transportation?
- What special training have employees received? Who provides the training?
- Does the nursing home have a doctor? If so, does he/she come to the facility?
- Can my loved one use her/his own doctor?
- How long has the administrator been at the facility? What about other key staff, such as the director of nurses, director of dietary services, and social worker and activities director?



If you're interested in a particular facility, it's a good idea to visit — and more than once, at different times of the day and/or days of the week. Most facilities have more limited staffing at nights and on weekends.

While tours are helpful, ask if you can spend some time on your own in the facility, observing resident care. Notice how staff members treat residents and visitors. Are they friendly? Do they greet you? Do they respond to call lights promptly?

As you visit, talk to family members to see how satisfied they are with the care. Are residents treated with respect? Is the staffing adequate to meet residents' needs? Are staff members responsive to concerns or complaints? What do they like best about the facility? What do they like least about the facility?

In addition to gathering staff members' and family members' opinions, you should get as much objective information as you can. Two important sources of objective information are the State regulatory agency and the Long-Term Care Ombudsman Program.

In Texas assisted living facilities and nursing homes are regulated by the Texas Health and Human Services' Long-Term Care Regulatory Division. You can see for yourself how a particular facility did during its most recent survey. You can get survey data directly from the facility, since it's required to post the findings in a place that's visible to residents and the public. Or you can access survey results on-line, at:

<https://apps.hhs.texas.gov/LTCSearch/>

You can also speak with a long-term ombudsman by calling 1-800-252-9240. Ombudsmen are resident advocates who make regular visits to nursing facilities and assisted living facilities. They can let you know about their observations and experiences at facilities you're considering.

What types of residential facilities are available?

This booklet will discuss two types of residential care facilities that are designed to provide supervision and help with personal care: assisted living facilities and nursing homes. There are other housing options, but they are not widely available.

Also, be aware that some facilities (particularly "board and care" homes) operate in violation of Texas law. Any facility that provides care for three or more unrelated individuals — and provides personal care services and/or administers medication — is required to have a license (or be seeking a license, in the case of new facilities). Avoid facilities that are unlicensed since they have little or no oversight.

What are the differences between assisted living facilities and nursing homes?

Assisted living facilities are intended for people who may need supervision and/or help with their daily care but don't require skilled nursing care on an on-going basis.

In Texas there are three types of assisted living facilities:

- Type A: serve residents who are able to leave the building without assistance from staff in case of an emergency, don't need routine assistance during the night, and are capable of following directions in case of an emergency
- Type B: serve residents who may need assistance from staff in case of an emergency, may need routine assistance during the night, and may need assistance transferring from bed to a wheelchair
- Type C: have no more than four beds and are classified as adult foster care facilities

Under Texas regulations, facilities may admit people who show signs of mental or emotional problems, as long as they don't pose a threat to themselves or others; need help with walking, bathing, dressing, eating, and grooming; need reminders to toilet; need assistance taking medications; require encouragement to eat; are incontinent, as long as they don't have pressure sores; and require a special diet. However, assisted facilities can refuse to admit anyone if they don't have the ability to meet the individual's care needs.

Some people prefer assisted living facilities for loved ones with early- and mid-stage Alzheimer's since residents tend to be more alert and able to care for themselves. However, be aware that your loved one may be asked to leave the facility when her condition worsens. For this reason, you may want to consider residential care providers who offer a range of care options, including nursing home care.

Nursing homes are able to care for people with need for skilled care.

What must facilities do in order to be certified as an Alzheimer's facility?

Although most assisted living facilities and nursing homes care for residents who have Alzheimer's or related dementias, not all are equally equipped. Facilities vary widely in their ability to provide specialized facilities, activities, and staffing.

If a facility advertises itself as providing specialized care for persons with Alzheimer's, it must be certified with the Texas Health and Human Services' Long-Term Care Regulatory Division as an Alzheimer's facility. However, if the facility advertises itself as providing "memory care," "reminders," "escort service," or other non-disease specific services, it is not required to be certified as an Alzheimer's facility. When in doubt, ask if the facility is a certified Alzheimer's facility.

What sets an Alzheimer's certified facility apart from any other facility? The major differences are related to staff training, activities, and building design.

- **Staff training:** All staff of nursing facilities and assisted living facilities must receive training. However, staff of certified Alzheimer's facilities must receive a higher level of training that is specific to caring for people with Alzheimer's; and all direct care staff must annually complete at least 12 hours of in-service education regarding Alzheimer's disease.
- **Activities:** For people with Alzheimer's, structured activities are important—to help separate day from night, avoid boredom, and slow memory loss. For this reason, certified Alzheimer's facilities are required to meet a higher standard with their activity programs. Specifically, they must provide activity programs that incorporate cognitive activities (i.e., activities that stimulate your loved one's mind, such as story-telling, reminiscence, and arts and crafts), recreational activities (i.e., activities that promote social relationships, such as exercise classes and board games), and self-care activities (e.g., tasks such as dressing, eating, and cooking).

Non-Alzheimer's certified facilities are required to provide an activity and/or social program, but at a lesser frequency than certified facilities.



What type of care can I expect the residential care facility to provide my loved one?

One of the keys to getting quality care in any residential setting is making sure staff members are aware of your loved one's needs. As you're considering a residential facility, be open and honest with staff regarding any medical conditions that require close monitoring or behaviors that require accommodation.

Both assisted living facilities and nursing homes are required to assess all residents and develop care plans that are based on their medical needs, physical abilities, behaviors, decision-making abilities, preferred activities, and ability to communicate, among other things. In doing so, they must involve the resident to the extent possible. Once the care plan is developed, the facility is obligated to follow it.

Care plans must be updated at least once a year, in addition to whenever the resident experiences a significant change in his/her condition.

If your loved one is not getting the care he/she needs, ask that the facility schedule a care plan meeting and update the care plan as needed.

What type/level of staffing are facilities required to provide?

There are significant differences between staffing requirements for assisted living facilities and nursing homes.

Licensing standards for assisted living facilities do not require that any staff be licensed nurses. Attendants — who provide most direct care services — aren't required to have medical backgrounds or college degrees. They are required to be at least 18 years of age and have graduated from high school.

Texas regulations for assisted living facilities do not specify ratios of staff to residents. Rather, they require that facilities have “sufficient” staff to ensure that the physical environment is safe and clean, and that residents receive supervision and care required to meet their basic needs.

Even though assisted living facilities are not bound by staffing ratios, they must provide prospective residents and their families with their normal 24-hour staffing pattern and post a copy each month in a conspicuous space.

Texas regulations for staffing of nursing homes are more rigorous. In most cases nursing homes must have a registered nurse on duty for at least eight consecutive hours a day, seven days a week.

In addition, facilities must have at least one licensed nursing staff person for each 20 residents — or meet a ratio of .4 licensed-care hours per resident day. Licensed-care hours per resident is determined by multiplying the number of licensed nurses by the hours they work in a day, and dividing the product by the number of residents in the facility. For example, if a facility has two licensed nurses who work eight hours per day (16 hours) and 30 residents, then its licensed-care hours per resident is $16/30$, or .53—above the minimum requirement of .40.

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What are my loved one's rights?

Regardless of whether your loved one enters an assisted living facility or nursing home, he/she is entitled to certain rights.

Residents' rights include:

- To be free from physical and mental abuse;
- To participate in social, religious, or community activities, unless these activities interfere with the rights of others;
- To practice the religion of his/her choice;
- To be treated with respect;
- To live in a safe and decent living environment;
- To be allowed to communicate in his/her native language for the purpose of getting any type of treatment, care or services;
- To complain about his/her care of treatment;
- To send and receive unopened mail;
- To communicate with people of his/her choice;
- To manage his/her financial affairs;
- To access his/her medical record;

- To choose his/her own doctor;
- To be involved in his/her individual service plan;
- To refuse medical treatment or services;
- To have privacy while making a phone call;
- To have privacy while taking care of personal needs or receiving visitors, unless this interferes with other residents' rights;
- To keep and use personal possessions;
- To decide his/her dress, hair style, and other personal effects, as long as he/she maintains personal hygiene;
- To keep and use personal property;
- To be informed by the facility no later than the 30th day after admission whether the resident is entitled to Medicare or Medicaid benefits;
- To not be transferred or discharged without 30 days' notice, unless necessary for health or safety reasons, non-payment, improvement in the resident's condition; or the facility's inability to meet the resident's needs;
- To leave the facility temporarily or permanently; and
- To have access to a Long-Term Care Ombudsman.



Who can help resolve a problem?

If your loved one is a resident in an assisted living facility or nursing home and you're not satisfied with the care he/she is receiving, speak to the director of nurses or administrator. Be as specific as possible, and offer any solutions you might have.

If you're unable to get the issue resolved by working with staff, you can contact the Long-Term Care Ombudsman Program or the Texas Health and Human Services' Long-Term Care Regulatory Division. These two programs have unique roles and responsibilities, although they often work together to improve care. The Long-Term Care Ombudsman advocates for residents' rights, helps protect the health, safety, welfare and rights of residents, resolves residents' complaints, and provides information to the public. The Long-Term Care Regulatory Division licenses and regulates nursing homes and assisted living facilities. It conducts inspections on at least an annual basis and investigates complaints.

You can reach a Long-Term Care Ombudsman by calling 1-800-252-9240. You can reach the Long-Term Care Regulatory Division by calling 1-800-458-9858.

If you're not satisfied with the care your love one is getting — or if she requires more help than the residential care facility can provide — you can move her to another facility. However, be aware that moves are disruptive under the best of circumstances; and people with Alzheimer's tend to have trouble adjusting to new environments. For this reason, try to avoid a move unless it's necessary.

Which programs pay for residential care?

Medicare

Medicare does not pay for care in an assisted living facility.

Although Medicare can pay for skilled care in a nursing home, it's unlikely to do so if your loved one has a primary diagnosis of

Alzheimer's and requires custodial care only. Custodial care includes help with personal care tasks such as getting dressed, walking, taking a bath, eating, getting out of a chair, and using the toilet. Medicare will pay only if your loved one requires skilled care, such as physical therapy or monitoring by a nurse related to a significant change in medications.

In order for Medicare to pay for nursing home care, your loved one must meet all of the following criteria:

- He/she has been a hospital inpatient for at least three days in a row during the past 30 days and goes into a skilled nursing facility within 30 days of leaving the hospital;
- His/her doctor has ordered skilled care, such as nursing, physical therapy, occupational therapy, or speech therapy;
- He/she needs skilled care on a daily basis; and
- He/she enters a skilled nursing facility that is certified by Medicare.

During the first 20 days in a skilled nursing facility, people who qualify for Medicare coverage don't have to pay for the care, since Medicare covers all of the cost. From day 21 through day 100 in the skilled nursing facility, people who qualify for Medicare must pay \$167.50 per day, either out of pocket, through private insurance (e.g., Medicare supplement), or public insurance (e.g. Medicaid). After 100 days, Medicare coverage for that benefit period ends.

Medicaid

Medicaid may pay for your loved one's care in a nursing home or assisted living facility, as long as certain conditions are met.

Specifically, Medicaid may pay for your loved one's nursing home care if he/she has a low income, limited resources, and a medical need for nursing home care.

- **Income:** Your loved one can make up to \$2,250 per month from all sources (or more, if he/she has established a Qualifying Income Trust, explained on pages 17-18). If your loved one is married and his/her spouse also needs nursing home Medicaid, their combined income can be no

more than \$4,500 per month. Government checks, paychecks, interest and rental payments, annuities, mineral rights, and gifts are considered income.

- Resources: If your loved one is not married, he/she can have no more than \$2,000 in resources. If your loved one is married and his/her spouse also needs Medicaid to pay for care in a nursing home, their combined resources can be no more than \$3,000. Resources include cash in checking and savings accounts, certificates of deposit, other liquid assets, and property other than your homestead or burial plot. In most cases homesteads that are worth less than \$572,000 are not considered. However, if your loved one owns a home that's worth more than \$572,000, he/she cannot qualify for Medicaid. One vehicle, life insurance policies, and burial policies may not be counted as resources.
- Medical Need for Nursing Home Care: To qualify for nursing home Medicaid, your loved one must have specific medical needs. How do you know, or prove, that your loved one meets the medical requirements? A nurse or other health care professional (often the director of nurses at the nursing home) assesses his/her health, using a Resident Assessment Instrument. Then, he or she sends the assessment form to the Texas Medicare and Healthcare Partnership for review.

Your loved one must also be a United States citizen or a qualifying alien, as well as a Texas resident.

In order to apply for nursing home Medicaid, your loved one must be in a nursing facility for at least 30 consecutive days. If he/she leaves the facility before 30 consecutive days, Medicaid will not pay for the care. Your loved one will be responsible for the charges.

Applications for nursing home Medicaid are submitted to the Texas Health and Human Services Commission (HHSC), which has up to 90 days to make a decision. If HHSC approves the

Medicaid application, the Medicaid program will pay for the nursing home care retroactively to the first day of nursing home care. If HHSC denies the Medicaid application, you will be given an opportunity to appeal the decision. However, you will need to appeal within 90 days of getting the notice of denial.

If you need help with a Medicaid appeal, you can contact your Area Agency on Aging at 1-800-252-9240. Its ombudsmen and benefits counselors can explain your options and, in many cases, connect you with an attorney.

If your loved one qualifies for nursing home Medicaid, he/she will be allowed to keep only \$60 per month for incidental items.

Most people who receive nursing home Medicaid qualify after they've been in a facility for some time and "spend down" their resources. Even if your loved one doesn't qualify for Medicaid now, he/she may qualify later. And if there's a possibility he/she may qualify later, ask the facility: 1) whether it participates in the Medicaid program; and 2) whether it will guarantee that a Medicaid bed will be available to your loved one, if and when he needs it. Facilities have limited numbers of Medicaid beds and may maintain waiting lists for them — even if there are other, non-Medicaid beds that are empty.

What if your loved one's monthly income is over the Medicaid limits?

Single people who make more than \$2,250 per month and married couples who make more than \$4,500 may qualify for nursing home Medicaid if they set up a qualifying trust, and/or are protected under the Spousal Impoverishment law.

If your loved one has too much income to qualify for Medicaid, you might consider a Qualifying Income Trust (or QIT). This trust should be set up by a lawyer. It creates a special account where some of your loved one's monthly income can be placed.

Although your loved one doesn't have to put all of his/her income into the QIT, he/she does have to put all of his/her income from the same source into the QIT. For example, if your loved one is single and receives a monthly Social Security check of \$900 and a monthly annuity of \$1,500, the Social Security check of \$900 can be deposited into the QIT. Then, your loved one's monthly income would be considered \$1,500 a month — which is below the Medicaid resource limit. Each month, money that is deposited into the QIT is taken out to help pay the costs of your loved one's nursing home care.

Keep in mind that the QIT must be irrevocable (i.e., you can't alter or change it). And after your loved one dies, the State will take money out of his/her QIT that's equal to the amount that Medicaid paid for his/her care while he/she was living.

If your loved one is married and his/her spouse does not need nursing home Medicaid, it may be possible to divert some of your loved one's income to his/her spouse. The Spousal Impoverishment law allows the spouse who lives in the community to keep more of the couple's combined income and more of the couple's combined resources than Medicaid otherwise allows.

The spouse who lives in the community gets to keep up to \$3,090 per month in income. If the community spouse's monthly income is less than \$2,030 and if the nursing home spouse's income is sufficient, the community spouse's income may be increased to meet the minimum state standard of \$2,030.

What if my loved one's resources are over the Medicaid limit?

The Spousal Impoverishment law also protects resources held by couples when one spouse applies for nursing home Medicaid and

the other spouse lives at home. The spouse who stays at home gets to keep half of the couple's countable resources, or \$24,720, whichever is more. The maximum protected amount for spouses is \$123,600. Remember, the homestead, one car and a burial policy are usually not counted as resources.

Let's look at a few examples to see how these protections work. Mr. and Mrs. Smith have \$60,000 in combined resources, and Mrs. Smith applies for nursing home Medicaid. Mr. Smith, who continues to live at home, would be allowed to keep \$30,000 in resources, or half of the Smiths' combined resource amount.

Mr. and Mrs. Jones have \$35,000 in combined resources, and Mr. Jones applies for nursing home Medicaid. Half of their combined resources is \$17,500. But Mrs. Jones, who remains at home, would be allowed to keep \$24,720 in resources, since that is the minimum resource amount protected under the Spousal Impoverishment law.

In contrast, Mr. and Mrs. Anderson have \$400,000 in combined resources, and Mr. Anderson applies for nursing home Medicaid. Half of their combined resources is \$200,000. Mrs. Anderson, at home, would be allowed to keep \$123,600 since that is the maximum resource amount protected under the Spousal Impoverishment law.

In all of these cases, the spouse who goes into a nursing home must still "spend down" his or her portion of the assets to the \$2,000 limit.

In most cases, if your loved one is single, or your loved one is married and has a spouse who also requires nursing home Medicaid, it will be necessary to spend down resources until they are at or below the Medicaid limits (i.e., \$2,000 for a single person, and \$3,000 for a couple). Spending your loved one's resources on his/her own care is the best and safest way to "spend down."

If your loved one gives money away as gifts to other people and applies for Medicaid, eligibility for Medicaid may be delayed.

This is called the transfer penalty. In 2018, you can divide the amount of the gift (or gifts) by \$172.65 to determine the number of days that Medicaid eligibility is delayed. For example, let's assume that your loved one is single and has \$12,000 in resources. He gives \$10,000 to a family member. Two years later he applies for Medicaid. Even if he meets the income and resource requirements, he will have to wait before he becomes financially eligible for Medicaid. Take \$10,000 and divide it by \$172.65, for a quotient of 57.92. Your loved one will have to wait for 58 days before Medicaid will start paying.

Federal law states that gifts made within five years of applying for Medicaid are reviewed to see if an asset transfer penalty applies. The period of time reviewed is called the look-back period.

Will my loved one have to give up his/her home in order to qualify for Medicaid?

Your loved one can own a home with equity of up to \$560,000 and still qualify for Medicaid. However, the State may have the right to recover some or all of the money that Medicaid has paid for your loved one's care after he/she dies, under the federal Medicaid Estate Recovery provisions.

Medicaid Estate Recovery applies to people age 55 and over who apply for Medicaid long-term care services (i.e., care in a nursing home, and in certain community-based programs) after March 1, 2005. However, the State may not ask for money from your loved one's estate, even if he/she is over the age of 55 and has applied for Medicaid long-term care after March 1, 2005. There are a number of exemptions that can protect your estate from recovery.

Your loved one is likely to be exempted from Medicaid estate recovery if he/she has a surviving spouse, a surviving child who is under the age of 21; a surviving child of any age who is blind or disabled; a surviving, unmarried adult child who lived in your loved one's homestead for a year prior to his/her death; and/or if estate recovery would cause undue hardship for his/her survivors. In addition, the State will not ask for any money back from your loved one's estate if his/her home is valued at less than \$10,000, or if recovery would not be cost effective. For more information about Medicaid Estate Recovery, call 1-800-458-9858.



How does Medicaid pay for assisted living?

Texas has a Medicaid waiver program called STAR+PLUS that can pay for care in assisted living facilities. In order to qualify for STAR+PLUS services — and help with the costs of assisted living — an individual must meet all of the following criteria:

- Qualify financially for the Medicaid program, including having low income and limited resources;
- Qualify medically for nursing home care;
- Be approved for Medicaid waiver services; and
- Go into an assisted living facility that has a Medicaid waiver contract, in effect with the managed care organization that's assigned and has a Medicaid bed available.

People who aren't already receiving Medicaid benefits may have to wait several months between applying for STAR+PLUS and being assessed for eligibility. For this reason, it's important to apply in advance of need, if possible.

Will the Veterans Administration pay for residential care?

The Veterans Administration (VA) can pay for short-term and long-term nursing home care. To see if your loved one qualifies, contact the VA Health Benefits Regional Office at 1-800-827-1000.

Veterans are considered according to priority, such as having a service-connected disability, having been prisoners of war, having been exposed to toxic chemicals in Vietnam or in the American occupation of Hiroshima and Nagasaki, having served in World War I, World War II, the Korean conflict, or Vietnam, and/or receiving a VA pension that is not adequate to cover the cost of nursing home care. Other veterans are considered on a case-by-case basis.

The VA owns some nursing homes that are for veterans only. In addition, the VA can pay for a veteran to receive care at a non-VA nursing home.

The VA may also help pay for the cost of care in an assisted living facility through the Aid & Attendance program. Aid & Attendance benefits are available to veterans who: 1) need regular help with feeding, dressing, bathing, grooming, toileting, and/or taking medicines; 2) are confined to bed; 3) are residents

of nursing homes; or 4) are blind. Aid & Attendance can pay up to \$1,829 per month to eligible veterans, up to \$1,176 per month to eligible spouses, and up to \$2,170 per month to veterans who are married to veterans for care received in the home, assisted living facility, or nursing home.

The Aid & Attendance program takes assets into consideration. In general, qualifying veterans have less than \$80,000 in assets. Assets do not include the homestead, a car, and household goods and personal effects.

People who qualify for Aid & Attendance usually pay the provider and get reimbursed from the VA. However, the VA can designate a family member or facility as fiduciary if the qualifying person has Alzheimer's. In such cases, payment is made directly to facilities.

Some businesses charge a fee to help qualify people for Aid & Attendance benefits. It's not necessary to pay someone to qualify for Aid & Attendance — or any other VA benefits. The county veterans service officer can provide information and help with applying for benefits at no charge.

Will a long-term care insurance policy pay for residential care?

Many long-term care insurance policies pay for care in assisted living facilities and nursing homes. Unfortunately, policies are not standardized, and you must read each policy carefully to understand what kind of care it covers, how it pays, how you qualify for coverage, and what the limits on coverage are.

Here are questions to ask of any insurer:

- What types of care are covered, and in what setting? Will the policy pay for home health care, adult day care, care in an assisted living facility, and care in a nursing home? What about hospice and respite care?
- How will my loved one qualify for benefits? Must he/she need help with at least two or three activities of daily living

(i.e., bathing, dressing, grooming, toileting, transferring, walking, and feeding)? What if he/she is in good shape physically but has memory problems? Will the policy pay if he/she needs reminders and supervision, rather than hands-on care?

- How long is the elimination period, or time between qualifying for benefits and getting the insurance company to start paying for care? Some policies will make you wait 30 or 60 days after you qualify for benefits before the policy will start paying.
- How much is the daily benefit for each type of care? Is the daily benefit set at a certain dollar amount, or will it go up as costs increase?
- How long will benefits be paid? Is there a certain dollar limit on coverage, such as \$100,000 in benefits? Or does the policy provide lifetime coverage?
- Does the policy have a pre-existing waiting period? If so, how long must one wait before the policy starts to pay?

If you need more information about long-term care insurance policies and the companies that offer them, you can call the Texas Department of Insurance at 800-252-3439.

The content was prepared by the North Central Texas Aging and Disability Resource Center, in collaboration with the Alzheimer's Association—North Central Texas chapter, the Texas State Long-term Care Ombudsman Program, the Texas Health and Human Services Commission, the Senior Source, the Alzheimer's Association—West Virginia Chapter, and the Alzheimer's Association—Orange County chapter. To provide feedback on its content, contact **Doni Green** at **(817) 695-9193** or **dgreen@nctcog.org**.

Helpful Resources for Long Term Care Planning:

Alzheimer's Association: 1-800-272-3900

Area Agency on Aging Benefits Counseling Program:
1-800-252-9240 (*general information and counseling about public and private benefits*)

Centers for Medicare and Medicaid Services: 1-800-633-4227
(*information about Medicare coverage and claims*)

National Clearinghouse for Long-Term Care Information:
www.longtermcare.gov
(*a U.S. sponsored website about long-term care planning*)

Own Your Future, Texas: www.ownyourfuturetexas.org
(*a State-sponsored website about long-term care*)

Texas Aging and Disability Resource Centers:
1-855-YES-ADRC (1-855-937-2372)

Texas Department of Health and Human Services'
Long-term Care Ombudsman: 1-800-252-2412

Texas Department of Insurance: 1-800-252-3439
(*information about insurance products and companies*)

Texas Health and Human Services Commission: 2-1-1
(*information about Medicaid*)

Texas Legal Services Center: 1-800-622-2520 (*legal information and advice about public and private benefits*)

