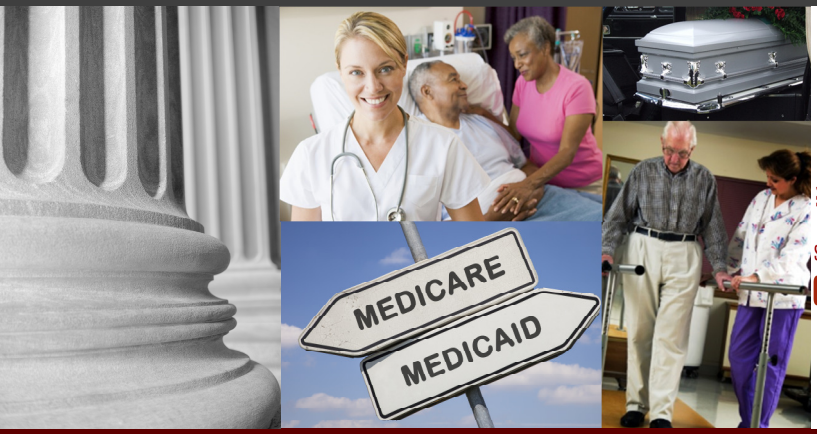

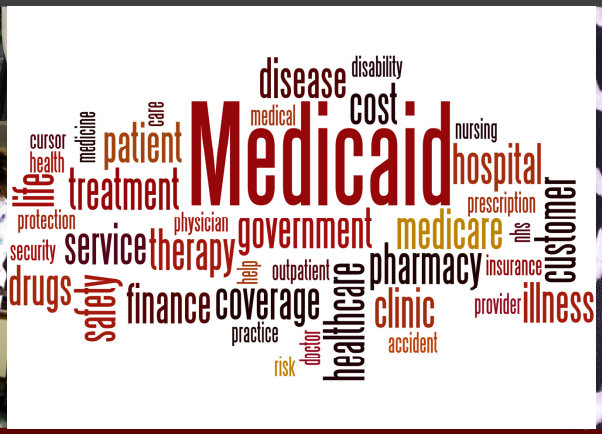

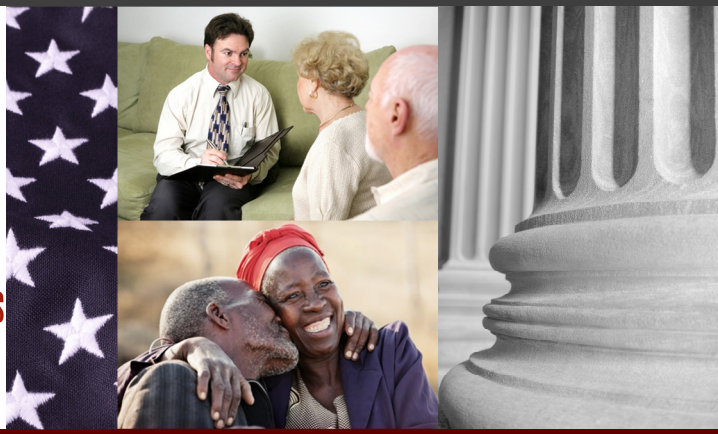

Government Benefits for RESIDENTS of Senior Living Communities

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Government Benefits for Residents of Senior Living Communities

September 2020

Courtesy of:
NCPC

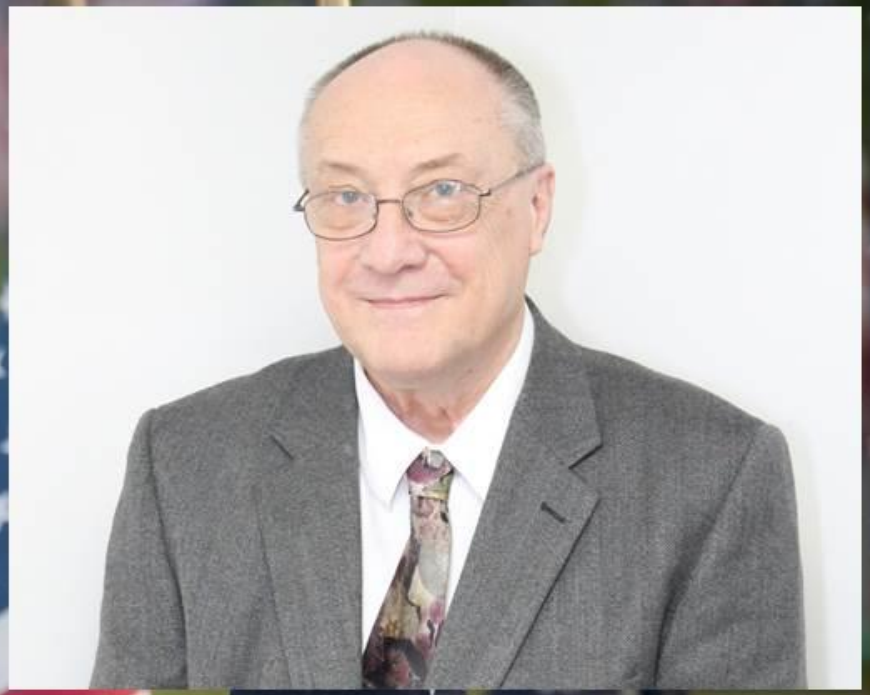
Government Benefits for Residents of Senior Living Communities

Welcome to this educational presentation entitled Government Benefits for Residents of Senior Living Communities. My name is Thomas Day and I have been asked to explain to aging seniors and their family members and other supporters how various government benefits apply to their particular current living situation. Over this time that we are going to be together, I will give you some important insights. I will introduce you to how Medicare covers nursing home services, home care services and hospice. I will also explain to you how Medicaid works and how it is possible to plan in advance to preserve assets from Medicaid spend down.

Let me tell you a little bit about me. I have been working with seniors and their family members and other supporters for over 30 years. I have a great deal of knowledge and experience about the issues facing aging seniors. I am also an educator and writer and have produced 5 popular textbooks on long-term care issues and veterans benefits.

Please note that if you have any questions or need advice on any of the information in this presentation, I will give you instructions at the end on how to receive assistance. In addition to the support that you are entitled to receive by attending this educational presentation, you also have access to a printed workbook containing all of the slides that I will present here. The workbook is important to help you review everything that is discussed. Also, you may have the option of pausing this video presentation and reviewing a particular slide.

GOVERNMENT BENEFITS FOR RESIDENTS OF SENIOR LIVING COMMUNITIES

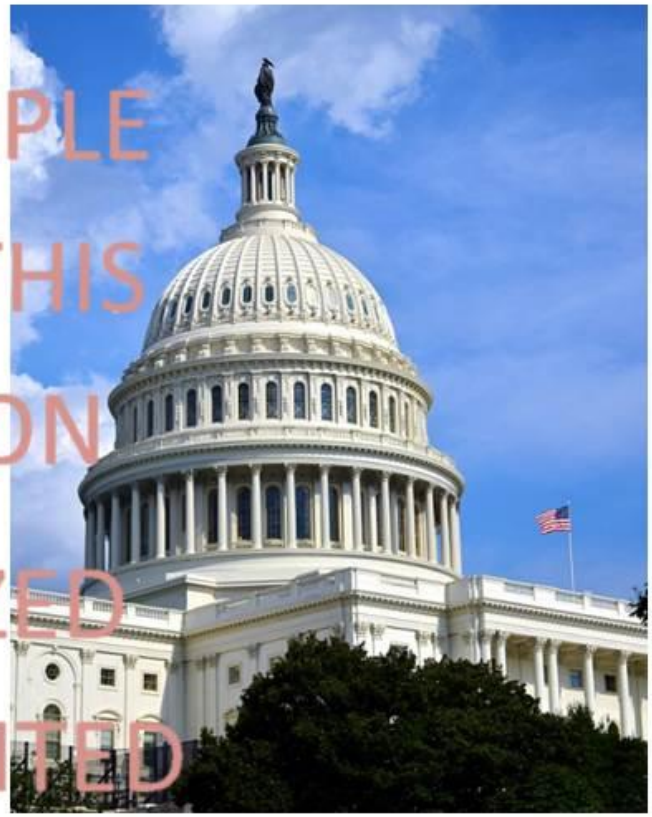


Overview of Government Benefits for Aging Seniors

Here is a list of the topics that I am going to discuss. First on the list is benefits available under Medicare health care coverage for nursing home costs, for home health coverage and for hospice coverage. Next, I will discuss Medicaid and how it affects the income and assets of seniors who need Medicaid assistance. There seems to be a misconception among most people that Medicaid will basically wipe out savings and investments and reduce the healthy spouse of a Medicaid recipient to a poverty level. This is not necessarily true. Planning can be done to avoid the devastation of Medicaid asset rules and income rules. From this list you see that I will discuss at least 3 strategies that can be used to maintain savings and other assets from Medicaid spend down – if this planning is done a reasonable number of years in advance of needing Medicaid. You can either review this slide in your workbook or you may have the option of pausing this video presentation and reviewing this slide.

Overview of Government Benefits for Aging Seniors

- Medicare Nursing Home Coverage
- Medicare Home Health Care Coverage
- Medicare Hospice Coverage
- Understanding Medicaid – Part 1
- Understanding Medicaid – Part 2
- Transferring Assets and Medicaid Eligibility
- Medicaid Planning Strategies
- Example Medicaid Planning Strategy #1
- Example Medicaid Planning Strategy #2
- Example Medicaid Planning Strategy #3
- Strategies For Accelerating Medicaid Payment



Medicare Nursing Home Coverage

Medicare was created as a result of Federal legislation in 1965 that provides universal healthcare to all eligible individuals who pay into the system. Medicare is funded by a payroll tax levied on all working Americans. Nowadays, many older Americans decry the idea of the United States introducing socialized medicine. Medicare **IS** socialized medicine – plain and simple. Most older Americans seem to like it but don't realize that it is government-provided, universal, single-payer health care for those who are eligible. Medicare is available for those who are eligible for Social Security and who have turned age 65. Medicare is also available for individuals younger than age 65 who are receiving Social Security disability.

Medicare was never intended to cover long-term care services, however it does provide some limited support for these services. In particular Medicare will cover the first 20 days of cost in a skilled nursing facility at 100%. Medicare will only partially cover the next 80 days of the cost of a skilled nursing facility. The Medicare recipient must pay a large out-of-pocket coinsurance and Medicare pays the balance. You see here the coinsurance for the current year. For those individuals who buy Medicare supplement insurance, and depending on the plan, the supplement insurance will often partially or fully pay for the out-of-pocket coinsurance for the remaining 80 days in a nursing home stay.

For those seniors who are receiving their Medicare coverage through what is called a Medicare Advantage Plan, nursing home coverage depends on the plan. As a general rule, I have found that Medicare Advantage Plans generally involve more out-of-pocket cost for nursing home coverage than Original Medicare along with a full coverage supplement insurance plan. It must be remembered however that Medicare with or without supplemental insurance does not automatically cover 100 days of nursing home stay. The nursing home must submit a plan of care to Medicare and Medicare will base its coverage on that plan of care. Once Medicare has decided that nursing home coverage is no longer needed, it will not pay any additional cost for the nursing home even if the person needs to stay in a nursing home or transfer to the long-term care wing of that nursing home. Sometimes Medicare will only cover 3 or 4 days of nursing home coverage. Once Medicare stops paying, so does the supplement insurance or the advantage plan stop paying.

In order to receive Medicare nursing home coverage, the patient must have spent at least 3 full days in a hospital and must have a skilled nursing need and a Doctor must order the care. There is generally no other way to get Medicare to cover the cost of a nursing home.

Medicare Nursing Home Coverage

- Original or traditional Medicare will pay for 20 days of a skilled nursing care facility at full cost. After the first 20 days the person insured by Original Medicare pays a coinsurance amount up to $176 (2020) per day of the actual cost for another 80 days. Medicare pays the balance if any.

- Private Medicare supplement insurance often pays the insured's coinsurance of 80 days at $176 per day if a person carries this insurance and the right policy form. However, Medicare often stops paying before reaching the full 100 days. When Medicare stops, so does the supplement coverage.

- To qualify for Medicare nursing home coverage, the individual must spend at least 3 full days in a hospital and must have a skilled nursing need and have a doctor order it. The transfer from a hospital must occur within a certain time period.

- Medicare Advantage Plans handle nursing home coverage differently and as a general rule are not as generous or liberal as Traditional Medicare. Most advantage plans usually require more out-of-pocket cost and usually require preauthorization for nursing home coverage.

Medicare Home Health Care Coverage

Prior to 1997, Medicare used to cover home health care costs almost indefinitely. For example, my mother received Medicare home health care for a medical condition that she had and that included a home health aide who came in five days a week and bathed and attended to her other personal needs. We took care of her in our home for five years. She had received these services for those five years on a daily basis except on weekends. In November 1997, we were informed that she no longer qualified for this benefit. Medicare had changed the rules and if a recipient of home health services was not improving or had recovered, home health services would be terminated.

You see on this slide that home health services from Medicare are authorized typically on a 60 day time frame. After the 60 days, the patient's needs are reassessed and if more health care is needed, another 60 days is granted otherwise the services are terminated. I have found that Medicare Advantage Plans cover home health differently from original Medicare. Some of these plans do not cover home care as adequately as Original Medicare would as there could be co-pays or other out-of-pocket costs associated with home health services under Medicare Advantage.

Medicare Home Health Care Coverage

- Medicare was not intended to pay for never-ending home health care services.
- In 1996, Congress passed the Balanced Budget Act and along with the Health Insurance Portability and Accountability Act of the same year, access to Medicare home health was restricted and the intent of only covering acute care recovering patients was reasserted by these Acts.
- In November 1997, Medicare adopted a Prospective Payment System for home care. PPS greatly restricted eligibility and reimbursements for homebound patients. Under Prospective Payment, a health agency is only reimbursed per patient for each 60 day episode. This does not mean care can be less or more than 60 days since the agency can schedule visits until the prospective payment runs out. There are provisions to cut off reimbursement if the patient recovers early, or to extend payment if the condition worsens or persists.
- Original or Traditional Medicare usually handles home health care more generously than Medicare Advantage Plans. Many Medicare Advantage Plans have more restrictions and out-of-pocket costs on home health care benefits than those available under Original Medicare.

Medicare Hospice Care Coverage

When my mother, whom we cared for in our home for five years, became terminal, Medicare hospice took over. This was prescribed by her attending physician. They would send a nurse or home health aide or a social worker just about every day to check on her condition. They also provided nutritional support and any other medical support for her particular condition. She still received coverage for other medical needs under Medicare but we had to sign an agreement that she would waive all Medicare coverage for the particular condition for which she was receiving hospice. She died in our home with family around her. Hospice had told us not to call an ambulance when she died as they advised us that death in a hospital emergency room was not particularly a desirable event for family members. Her death at home was peaceful and in some respects spiritual. Hospice told us that they would take care of everything after her death and they did including removing her body to the mortuary. They also provided us with bereavement counseling and any other social support that we needed to deal with the death. Medicare has no out-of-pocket co-pays or deductibles for hospice provided in the home. A home would also be considered a senior living community as well.

Medicare Hospice Coverage

Here are the conditions that apply for Medicare Hospice Benefits:

- You must have Medicare Part A (Hospital Insurance)
- Your doctor or the hospice medical director certify that you are terminally ill and have 6 months or less to live if your condition runs its normal course. (Or alternatively you are failing to thrive and death is expected within a certain period of time.)
- You sign a statement choosing hospice care instead of other Medicare-covered benefits to treat your terminal condition.
- You get care from a Medicare-approved hospice program
- You understand that Medicare will still pay for covered benefits for any health problems that aren't related to your terminal condition.

Understanding Medicaid – Part 1

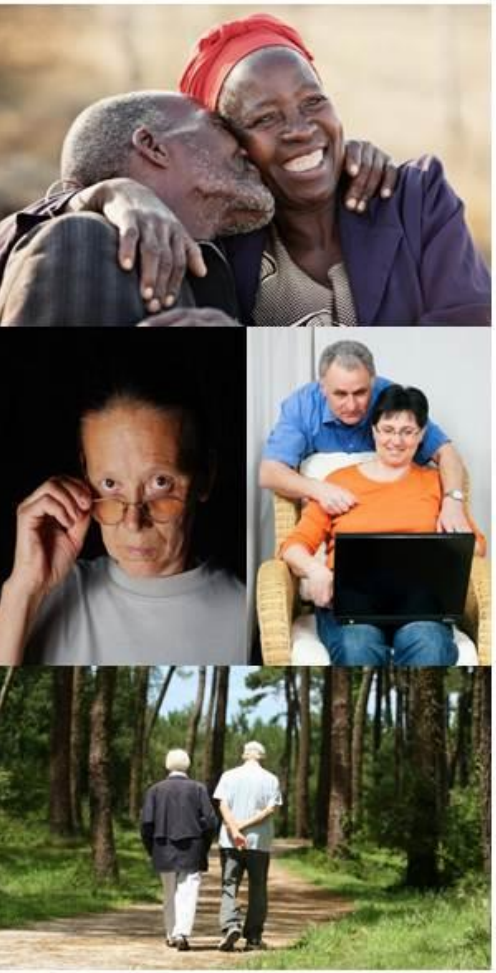
Medicaid was established as Title XIX of the 1965 Amendment to the Social Security Act while Medicare was established at the same time as Title XVIII of the Act. Medicaid is a health insurance program for certain low-income people. These include: certain low-income families with children; aged people 65 and older, blind or disabled people on Supplemental Security Income; certain low-income pregnant women and children; and people who have high medical bills.

Medicaid is funded and administered through a state-federal partnership. Funds for Medicaid are provided jointly by the federal government and the states. On average, the federal government provides about 57% of Medicaid funds and the states provide the other 43%. States with low per capita income receive more from the government for their participation while states with high per capita income, such as Connecticut, Provide more of their share – perhaps up to 83% of their Medicaid costs. Although there are broad federal rules for Medicaid, states have flexibility to design their own programs. Individual states have authority to establish eligibility standards, determine what benefits and services to cover, and set payment rates. For seniors needing long term care, all states must cover skilled nursing and home health services and doctor's services.

An individual needing age 65 long term care must go through an evaluation with a state Medicaid assessment specialist in order to determine a need for care. If the individual fails to meet the minimum level of care needed to qualify for that State's Medicaid coverage, then no Medicaid help is forthcoming. Medical eligibility for home and community-based services covered by Medicaid in some states could be based on different criteria from those for nursing homes.

There is both an income and an asset test to qualify for Medicaid long term care services. In general, these tests are applied for nursing home services but these same tests may also be used to qualify individuals for home or community-based Medicaid services as well. In some states the financial requirements for community-based services may be more stringent than those for nursing homes or they may be less stringent. Some states allow the "medically needy"—those with large medical or long-term care bills -- to deduct these costs from their gross income to reach the required income level and participate in Medicaid. This medically needy program is optional for states. However, a growing list of states, plus the District of Columbia, do not have medically needy programs. These states typically have an income test for Medicaid. If the applicant has an income above the limit established by the state, there is no Medicaid eligibility. These income tests are in conflict with Federal Medicaid rules that states cannot generally exclude Medicaid coverage from any person who otherwise qualifies. As a result, Federal rules allow individuals in states with an income test to meet an alternative eligibility for Medicaid by establishing an income qualifying trust commonly called a Miller trust.

You can look at your workbook or pause the presentation here if your viewing mode allows it in order to see the current income and asset tests for Medicaid.



Understanding Medicaid – Part 1

- Medicaid was established as Title IXX of the 1965 Amendment to the Social Security Act and is a health insurance program for certain low-income people.
- Medicaid is funded and administered through a state-federal partnership.
- An individual needing aged Medicaid long term care must go through an evaluation
- Many states have an income test for eligibility. (In California it is known as Medi-Cal)
- Other states use what is called a medically needy income test for eligibility
- Spouses of Medicaid nursing home beneficiaries are allowed to retain the couple's income for support within a range between $2,113.75 and $3,216 per month in 2020.
- The community spouse is also allowed an excess shelter allowance if household maintenance costs are above certain predetermined limits but in no case may the monthly income allowance exceed $3,216 a month.
- In most states, an individual needing Medicaid nursing home care must have assets less than $2,000 but some states have a higher limit, and certain assets are not counted towards the limit.

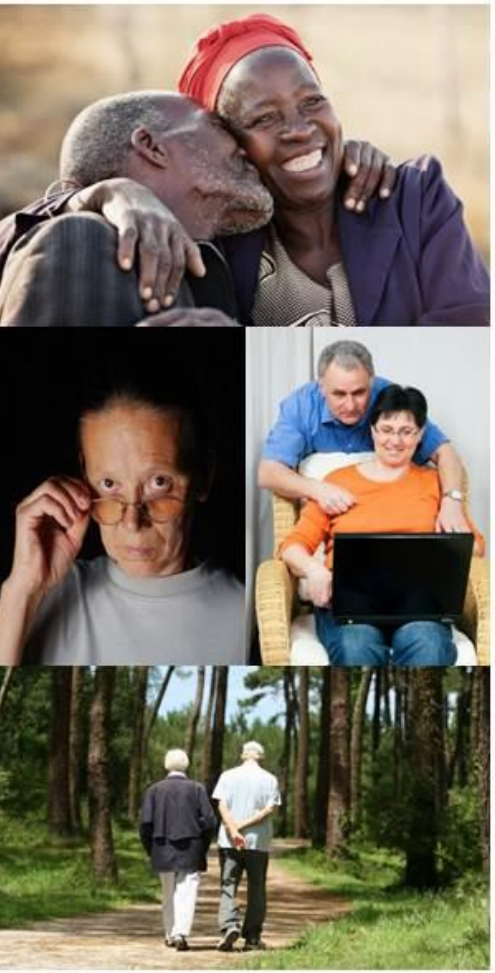
Understanding Medicaid – Part 2

I will now discuss in more detail how the income and asset tests, that are often unique to each state, are applied generally. In most states, when someone is anticipating the need for Medicaid assistance for long-term care, the Medicaid department will take a snapshot of the resources of the potential applicant. Resources are defined as all household assets and other property that can be converted to cash belonging to both the potential applicant and his or her spouse. In most states, a personal residence is not considered part of the resources and is exempt under certain rules defined by that state. On the other hand, when the Medicaid recipient dies and if the house is not occupied by a surviving spouse, in many states, Medicaid will generally put a lien against the property so that it cannot be sold until the debt to Medicaid has been paid off.

This snapshot will freeze the value of those resources for application purposes, even though an application might not be submitted at that point. Medicaid allows couples to split up their resources so that the spouse who does not need Medicaid is allowed to keep a certain amount of the resources. In certain states – called 50% states – the spouse not needing Medicaid who is called the "community spouse" can keep up to half of the amount of resources – not to exceed the limit that you see on this slide for the current year. In all states if the value of the resources is below a certain limit – say $25,000 as an example – the community spouse gets to keep all of those resources and the Medicaid spouse basically keeps only $2,000 or whatever the state uses for its minimum resource amount.

In the remaining states called 100% states the healthy spouse can keep all of the household resources up to a limit determined by the state not to exceed the maximum resource limit which you see on this slide. In both 50% and 100% states the balance of the resources belong to the nursing home spouse, or the spouse receiving community services under Medicaid, and must be spent down to below $2,000 or whatever the minimum asset limit is for that state. As of this date, 34 states and the District of Columbia are 50% states and 17 states are 100% states.

I have already mentioned in a previous slide how the income eligibility test can be met in certain states. Under state rules, the Medicaid spouse must generally spend his or her income for care costs. The community spouse (healthy spouse at home) gets to keep his or her income and not use that towards the cost of care. In all states, once a Medicaid recipient is eligible and if that recipient has a spouse, the state will provide the community spouse with a certain amount of income in order to not impoverish that person. This is called the Minimum Monthly Maintenance Needs Allowance or MMMNA. If the Minimum Needs Allowance of the community spouse is a greater amount than the actual income of that spouse, Medicaid will take income from the spouse receiving Medicaid and give it to the community spouse to meet the minimum needs. Under certain conditions, additional expenses of the community spouse such as taxes, utilities and so forth allow for a higher Minimum Needs Allowance and in some states this could be over $3,000 a month .



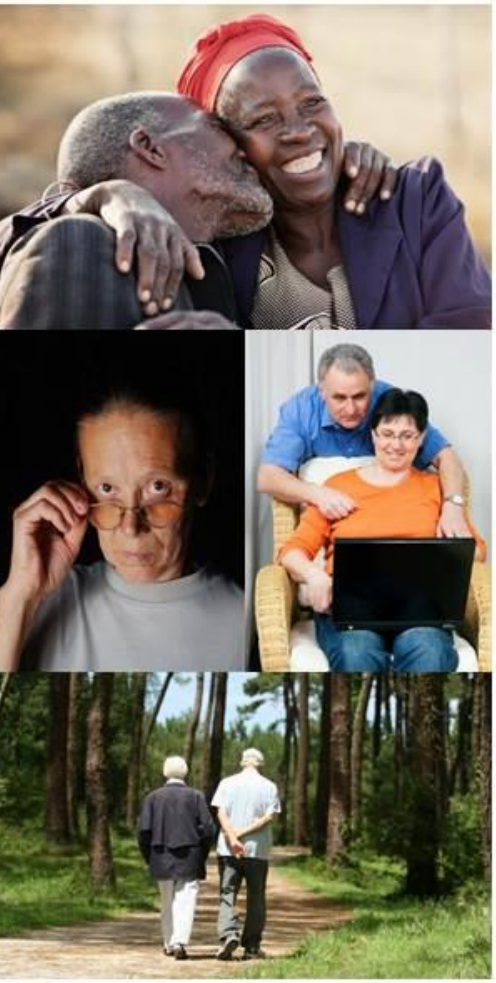
Understanding Medicaid – Part 2

- Medicaid will take a "snapshot" of the couple's combined resources at the point where a nursing home is anticipated prior to an application for Medicaid.
- Combined resources are anything owned between spouses that can be converted to cash to pay for nursing home care. The personal residence is generally exempt.
- In some states – called 50% states – the healthy spouse is allowed to keep up to half of these resources not to exceed $128,640 (for the year 2020).
- In 50% states there is also a minimum amount that the spouse who is at home can keep, disregarding whether it represents half of the resources or not
- In other states – called 100% states – the healthy spouse can keep all of the combined resources up to a maximum of $128,640.
- In 50% and 100% states, the balance of the resources belong to the nursing home spouse and must be spent down to below $2,000 (or whatever the minimum resource allowance is) before Medicaid will start contributing its share of the cost.
- As of now, 34 states and the DC are 50% states and 17 states are 100% states
- Monthly Minimum Needs Allowance (MMNA) to protect the community spouse

Transferring Assets and Medicaid Eligibility

I am not going to read to you the rules that you see here. I would have nothing more to add. Refer to your workbook or pause the presentation if you can to read this slide in more detail. Just be aware that there are penalties for transferring resources prior to or during Medicaid eligibility and the penalties for doing this are quite severe.

Please be aware that I'm not personally offering you any planning strategies as legal advice as I am not authorized to do so. I am simply listing some of the strategies that are currently being used by individuals who are authorized to do Medicaid planning. Do not do any planning on your own, using any of the ideas that I have given you here. Always use someone who is authorized and experienced to do this type of planning



Transferring Assets and Medicaid Eligibility

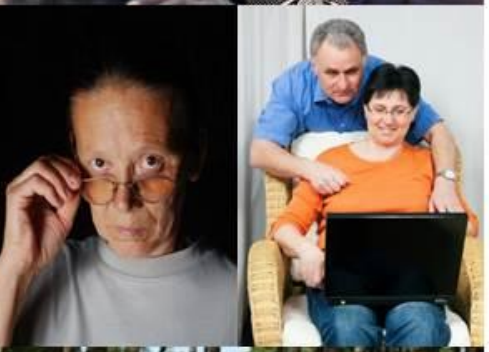
- Any transfer of resources for less than value – whether it is a gift or at a reduced purchase price – is subject to a penalty from Medicaid at any time during 60 months from the date of the gift.
- The penalty is calculated by dividing the less-than-value amount of the transfer by the Medicaid penalty divisor for penalized transfers in the state.
- Each state publishes its monthly Medicaid penalty divisor at least yearly.
- In some states, if a single Medicaid beneficiary is not residing in the personal residence and there is no anticipation that person can return to his or her home, the State may require that the home be sold to pay for Medicaid costs.
- In other states, the home can be left vacant in anticipation of the beneficiary returning whether the beneficiary is medically capable or not but the beneficiary must sign an intent to return home document to keep the home from being sold or counting as an asset for the resource test.
- Transfers of the personal residence may also be made under certain circumstances without Medicaid penalty.

Medicaid Planning Strategies

It is important to understand that if someone is anticipating the need for Medicaid at some future date but does not need it right now, some planning can be done to protect assets from the Medicaid spend down rules. These rules require the Medicaid applicant to spend down all of his or her allotted resources usually to below $2,000 before Medicaid will cover the cost of long-term care. For example, if someone has $250,000 and needs nursing home care, that person would have to spend $248,000 of those resources before Medicaid would cover the cost of a nursing home. Of course all of you have heard of these impoverishment rules and any of you who have any assets at all live in fear of ever needing to reside in a nursing home very long as most of those assets would be dissipated before Medicaid would take over paying the cost.

Fortunately, some planning can be done years in advance to insulate assets from this Medicaid spend down requirement. For example, if assets are gifted in the form of a trust or an outright gift and 60 months or more have expired before the Medicaid application, those assets are free of any penalty from Medicaid. There are some other strategies that are used to protect assets that I will discuss in the next three slides. However, these next three slides are very complex and I am only including them as examples of the kind of planning that can be done. I am not going to take the time to go into detail on verbally explaining how the various strategies were used and why they work. You can stop the presentation if possible or refer to your workbook if you want to study them in more detail. Any planning that you do in advance should be done with someone who understands Medicaid and can help you with this planning. In some states, only attorneys can do this type of planning.

Please be aware that all of the ideas that I discuss do not represent any legal advice from me. Do not do any planning based on the information I am giving you here. I am not authorized to provide this sort of planning. I am only illustrating on the next three slides some of the strategies that are typically used for Medicaid planning. You should not do it on your own. If you need assistance with planning for Medicaid, we can help you find someone to provide that assistance. At the end of this presentation I provide instructions on how to request assistance.



Medicaid Planning Strategies

3 POPULAR STRATEGIES TO ACCELERATE QUALIFICATION FOR MEDICAID AND TO PRESERVE ASSETS FROM MEDICAID SPEND DOWN

- Medicaid funeral trust – Explained in more detail in Planning Strategy #1
- Gift assets and private pay for care from gifted assets while waiting out the remainder of the look back or the penalty – Explained in more detail in Planning Strategy #2
- Community spouse annuity – Explained in more detail in Planning Strategy #3

(The planning strategies discussed in this presentation do not constitute legal advice and you must not initiate any planning based on this presentation without consulting with someone who is authorized to assist you.)

Example Planning Strategy #1

This strategy illustrates the use of Medicaid funeral trusts to preserve assets from Medicaid spend down. On the left is a scenario with no planning where Mary and John have $48,000 in assets. John is in a nursing home and has to go through spend down and then dies and his funeral and burial costs are $11,000. Without planning Mary is only left with $19,000 for her own use. Using Medicaid funeral trusts, Mary gets to preserve $30,000 of their assets for her own use, including her burial and funeral costs. You can pause the slide here if you can or refer to your workbook to understand this planning strategy.

None of this information should be considered legal advice. It is only used for enlightenment as to what may or may not be done. You should always use a Medicaid planning expert to help you with any strategies pertaining to accelerating Medicaid payment. In some states only an attorney can do this type of planning.

PLANNING STRATEGY #1 – PRESERVE ASSETS FROM MEDICAID BY SETTING UP MEDICAID FUNERAL TRUSTS, YEARS AHEAD OF NEEDING MEDICAID

John, age 76, and Mary, age 75 have $50,000 in assets which includes a $10,000 cash value life insurance policy for John's funeral and burial. Mary does not have life insurance.

NO PLANNING

In 5 years, John goes into a nursing home costing $8,000 a month. John needs Medicaid

↓

John applies for Medicaid and Medicaid allows Mary to keep $28,000 of the assets and John must spend down $20,000 of remaining assets before Medicaid will pay his nursing home cost.

↓

A year later, John dies in the nursing home and his funeral and burial cost is $11,000.

↓

Mary has her $28,000 in assets and receives John's remaining $2,000 for a total of $30,000. She pays the $11,000 for his funeral and burial. **Mary is left with only $19,000 for her use.**

PLANNING AHEAD TO PRESERVE ASSETS

John and Mary decide to set aside a portion of their assets for funeral and burial into Medicaid funeral trusts which make those assets exempt for the division of assets which occurs at Medicaid application.

↓

John transfers the $10,000 of cash value in his life insurance policy into a Medicaid funeral trust and adds $1,000 more. They also set up a funeral trust for Mary in the amount of $11,000. They now have $22,000 of assets which are exempt from Medicaid spend down requirements.

In 5 years, John goes into a nursing home costing $8,000 a month. John needs Medicaid

↓

John applies for Medicaid and Medicaid allows Mary to keep $28,000 of the assets and John immediately gets Medicaid to cover his nursing home cost.

↓

When John dies, his funeral and burial of $11,000 are covered. Mary keeps $28,000 and she still has an additional $11,000 set aside to cover her funeral and burial. **They have effectively preserved all $50,000 of their assets for Mary's use.**

Example Planning Strategy #2

This idea uses a strategy to gift assets many years in advance of needing Medicaid. The idea is to wait out the 60 month inclusion period for Medicaid gifting in order for the gift to not be subject to penalty. Even if an application is made for Medicaid within this 60 month inclusion zone, significant assets can still be saved from Medicaid spend down and from penalty by private paying for long-term care services through the end of the 60 month inclusion. This usually results in some assets being saved from spend down. Pause here if you can or refer to your workbook.

Please be aware that I'm not personally offering you any planning strategies as legal advice as I am not authorized to do so. I am simply listing some of the strategies that are currently being used by individuals who are authorized to do Medicaid planning. Do not do any planning on your own using any of the ideas that I have given you here. Always use someone who is authorized and experienced to do this type of planning.

PLANNING STRATEGY #2 – PRESERVE ASSETS FROM MEDICAID SPEND DOWN THROUGH GIFTING, YEARS AHEAD OF NEEDING MEDICAID

Mark, age 81, is single, makes $2,500 a month and has $320,000 in assets

NO PLANNING

Due to dementia, Mark goes into a nursing home 40 months from now and the nursing home costs $6,500 a month.

Mark spends $4,000 a month from his assets to the nursing home and lives 6 more years before he dies.

Mark spends a total of $288,000 of his assets for the nursing home and **leaves only $12,000 to his heirs when he dies.**

PLANNING AHEAD TO PRESERVE ASSETS

Mark gifts $300,000 to a special Medicaid trust and puts $15,000 into a Medicaid funeral trust.

Due to dementia, Mark enters the nursing home 40 months from now which costs $6,500 a month.

Mark's Medicaid penalty for gifting in his state is 50 months. If Mark applies for Medicaid, he has to pay out-of-pocket, $6,500 a month, for 50 months until Medicaid takes over. Mark has only 20 months left on his look back from the date of gifting. If he waits 20 months, Medicaid will pay the nursing home cost forever.

Mark's family decide to wait the 20 months to the end of his 60 month look back and then apply for Medicaid.

The family trustees of his Medicaid trust pay the difference between the nursing home and his income for 20 months– $4,000 a month

In the 21st month, the family applies for Medicaid. Medicaid will now pay his full nursing home cost for the rest of his life. The trustees pay a total of $80,000 towards Mark's nursing home and **the family keeps $220,000 of his $300,000 that he put into the trust.**

Example Planning Strategy #3

This idea is currently being used by Medicaid planners as a strategy to transfer the Medicaid recipients resources to the community spouse through the use of an income annuity. This strategy is used for what is called Medicaid crisis planning were an application for Medicaid is imminent and an attempt is made to save as much of the assets from spend down as possible. Pause here if you can or refer to your workbook for more detail

Please be aware that I'm not personally offering you any planning strategies as legal advice as I am not authorized to do so. I am simply listing some of the strategies that are currently being used by individuals who are authorized to do Medicaid planning. Do not do any planning on your own using any of the ideas that I have given you here. Always use someone who is authorized and experienced to do this type of planning.

PLANNING STRATEGY #3 – PRESERVE ASSETS FROM MEDICAID SPEND DOWN THROUGH A SPOUSAL MEDICAID ANNUITY AT MEDICAID APPLICATION

George, age 85, and Martha, age 79 have $269,000 in assets.
George makes $2,200 a month and Martha makes $2,000 a month.

NO PLANNING

George goes into a nursing home costing $9,000 a month. George needs Medicaid

George applies for Medicaid and Medicaid allows Martha to keep $119,233 of the assets and George must spend $147,767 of remaining assets, before Medicaid pays the nursing home. Martha is allowed $2,800 a month in income.

Three years later, John dies and all $147,767 is gone. His funeral and burial cost is $12,000.

Martha has her $119,233 in assets and receives George's remaining $2,000 totaling $121,233. She pays the $12,000 for his funeral and burial. **Martha is left with $109,233 for her use.**

PLANNING AHEAD TO PRESERVE ASSETS

George and Martha purchase Medicaid funeral trusts of $15,000 each, totaling $30,000.

George goes into a nursing home costing $9,000 a month. George needs Medicaid

George applies for Medicaid and Medicaid allows Martha to keep $119,233 of the countable assets and George must spend down $117,767 of remaining assets, before Medicaid will pay his nursing home cost.

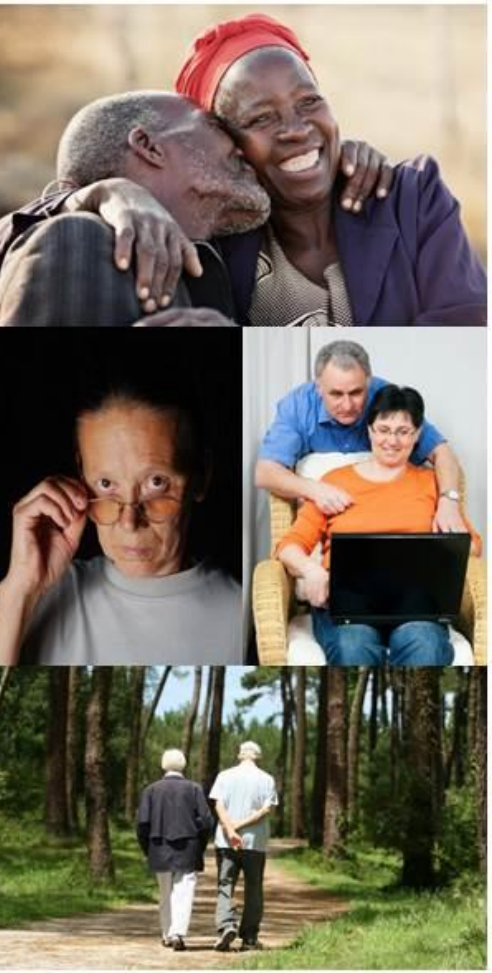
George purchases an immediate income annuity for Martha that pays her $5,100 a month for 24 months. He uses his $117,767 of Medicaid asset division funds to purchase the annuity. Martha's income is now $7,100 a month.

George transfers his spend down of $117,767 to Martha through the annuity. He is now eligible for Medicaid. George dies after 3 years. His final costs are paid by his Medicaid funeral trust. **Including Martha's funeral trust, George and Martha have preserved all $269,000 of their assets for Martha's use.**

A Few of Many More Strategies for Accelerating Medicaid Payment

Here are a few more potential ideas for preserving assets from Medicaid spend down, thus accelerating the point at which Medicaid takes over for paying for long-term care. It would take me way too long to describe each of these ideas in detail. Just be aware that they may or may not be available in your state.

None of this information should be considered legal advice. It is only used for enlightenment as to what may or may not be done. You should always use a Medicaid planning expert to help you with any strategies pertaining to accelerating Medicaid payment. In some states only an attorney can do this type of planning. Pause the presentation here if you can or refer to your workbook for more detail.



A Few of Many More Strategies for Accelerating Medicaid Payment

- Using a promissory note to transfer property
- Converting countable assets to exempt assets by purchasing automobiles, paying for home improvements or purchasing a new home outright
- Reducing assets by investing in a child's home
- Investing assets into exempt income producing property or other trade or business
- Investing assets into exempt tangible personal property
- Using available strategies to maximize the community spouse minimum resource allowance
- Making sure that the community spouse minimum monthly maintenance allowance is being used to its maximum extent
- Never attempt Medicaid planning strategies without consulting someone who understands the rules in your state

Obtaining Help with the Benefits Discussed in This Presentation

If you need any advice or assistance with any of the planning concepts or benefits discussed in this presentation you should contact the sponsor of this presentation and the sponsor can direct you to the right people. Contact information from the sponsor of this presentation is included on the workbook that you receive, or the sponsor may use other methods to allow you to make requests.

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Thank You for Attending

Thank you for attending this presentation. I covered some pretty detailed information and I appreciate that you hung in there with me. I hope it was rewarding for you and I hope that you have received some valuable bits of information that will help you retain assets or provide for additional benefits from the government.

THANK YOU FOR ATTENDING