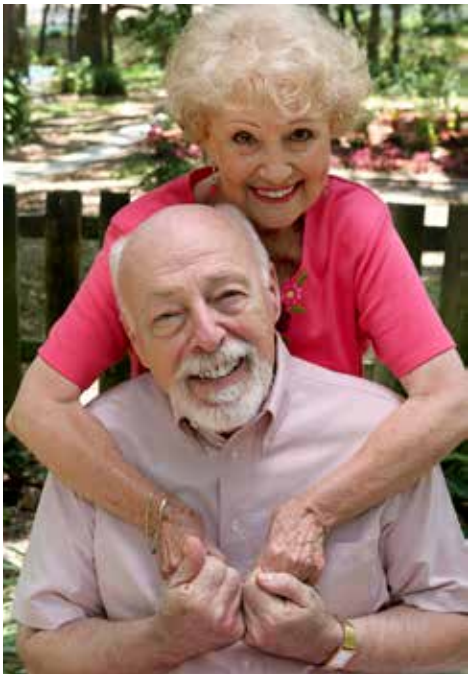
Are You Prepared For Long Term Care? What You Need To Know Today

White Paper

Author, Chris Orestis



Contents

Introduction

Seniors and their families are already struggling with the costs of everyday living, if you add the costs of long term care to the picture it is a back breaking scenario for most Americans. Statistics show that the majority of people do not understand the various forms of long term care, the different means to pay for it, and most do not plan for long term care until they are hit by a health care crisis. Adding to the crisis is the fact that Baby Boomers are now reaching Social Security and Medicare age 65 at a rate of over 10,000 people a day, and 70% of them will need long term care services before they pass away.

When Medicaid was created on July 30th, 1965, the entire GDP of the United States was $791.1 billion, and no one could have predicted that by 2013 the U.S. would spend over $2 trillion on health care in a single year. Today, Social Security, Medicare and Medicaid are all in the red and creating havoc for government budgets at the federal and state levels. According to the Chairman of the Federal Reserve, this has become the number one concern about the future of the U.S. economy.

State budgets have been impacted particularly hard by shrinking tax dollars and growing Medicaid enrollment brought on by the economic crisis and an aging population. Over 10 million Americans now require long term care annually and Medicaid is the primary source of coverage. According to the Kaiser Family Foundation, Medicaid spent $427 billion in 2011, almost doubling since spending $240 billion in 2009. With these numbers increasing every year, the United States has officially crossed the tipping point into the long feared era of the “long term care funding crisis”.

In the midst of growing demand and dwindling resources, the problem for America is the most basic of economic principles-- Supply and Demand: “Demand” of seniors that need (or will need) long term care is growing at a much faster rate than the “Supply” of resources (dollars) to pay for their care. This demographic-economic reality has forced the government to reduce benefit levels and raise barriers to entry for the three primary entitlement programs: Social Security, Medicare and Medicaid. The harsh reality is that more of the responsibility to fund retirement and long term care is being pushed back on the individual (and their family).

The costs of long term care are increasing every year, but most families do not understand what they will be confronting when it is their time to start paying for care. Too many people wait until they are in the midst of a crisis situation before they start trying to figure out how the world of long term care works. Long term care is a very expensive proposition. Families can go broke trying to provide for a loved one. Do you know the differences between Medicare and Medicaid, and what you must do to qualify? Do you know the differences between Home Care, Assisted Living and Nursing Home care? Do you know what is and is not covered? Are you aware of the problems with policy loans? Do you know how long term care insurance works and if you qualify?

Also, did you know that a life insurance policy can be converted to pay for Assisted Living, Home Care and all other forms of long term care? There are literally millions of seniors that are struggling with the costs of long term care who will abandon a life insurance policy without realizing they could be holding the solution to their problem in their hands. The shame is that if a person owns a life insurance policy it can be easily converted to help cover these costs.

Seniors have an overwhelming desire to remain independent, and do not want to become a burden on their family or a ward of the state by entering Medicaid. Unfortunately, the current system to fund long term care has evolved into one that encourages seniors to impoverish themselves and move towards Medicaid as quickly as possible. For the wealthy, long term care costs can be absorbed. For the poor and disabled, government subsidized care is available. But what about the majority of middle class Americans that need access to long term care today? New approaches to fund long term care must be encouraged, and converting life insurance policies into a Long Term Care Benefit Plan is an option that has grown into a mainstream and accepted financial solution.

Genworth Cost of Care Survey 2013

"According to the Genworth 2013 Cost of Care Survey, the national median annual cost for long term care ranges from $41,756 to $83,950 depending on the type of care needed. Assuming the average stay in a nursing home is three years, costs can easily surpass $250,000 for the entire long term care event."

National Average Costs Senior Care

- Nursing Home- $7,000/mo. ($84,000)
- Assisted Living- $3,450/mo. ($41,400)
- Homecare- $6,384/mo. ($76,608)

  *12 hours per day ($19/hr.)

Click here to see check the costs of care in your state: *https://www.genworth.com/long-term-care-insurance/al/make-a-plan/cost-of-care.html*

Congressional Commission on Long Term Care points to Senior Care funding crisis facing all Americans

The Commission on Long Term Care appointed by Congress to study and make recommendations about the rapidly escalating crisis facing Americans and their ability to pay for long term care, met for the first time in Washington, DC on Thursday, June 27th and the Commission's prognosis was dire. It has long been known that once the Baby Boom generation started turning 65 the pressure on our country's ability to fund everyone's long term care needs would become almost impossible. We are now facing a Silver Tsunami of Baby Boomers turning 65 at a pace of 10,000 people every day and Medicare and Medicaid cannot keep up. With 30% of the Medicaid population consuming 87% of Medicaid dollars spent on long term care services (Kaiser Family Foundation, 2011) our country has reached a breaking point that will require more reliance on individuals using their own resources to pay for care—and the Commission agrees!

In an article published by the Kaiser Health News entitled, *Facing A Tight Deadline, Long-Term Care Panel Holds First Meeting*, they provided details from the proceedings: During the Committee hearing, panelists explained to the Committee members that the public safety net can no longer sustain the pressure put upon it and private market alternatives must come forth. According to G. William Hoagland of the Bipartisan Policy Center, "Medicare and Medicaid have become the major source of long-term care, and cannot continue at the current pace," he said. Americans should be encouraged to increase their retirement savings so that these programs are relied on as a last resort.

In addition, using long-term care insurance to pay expenses is not an option for many Americans, as premiums rise and companies that can't make a profit leave the market, said Marc Cohen, an industry consultant. Most of the long-term care policies available are sold by only 12 insurers, he said.

"We know that 70 percent of people over the age 65 will need some form of long-term services and support," said Dr. Bruce Chernof, the commission's chairman. Although government programs provide a significant portion of long-term care, none offer the full range of services people need, said Kirsten Colello, a health and aging policy specialist at the Congressional Research Service.

"The fact is that each of us will need these services and supports at some point in our lifetimes," said Sen. Jay Rockefeller, who added the commission to the fiscal cliff compromise, said in a statement Thursday. "The question is whether most Americans can afford to pay for them."

Public policy, law makers and the realties that every family faces when confronted with the costs of long term care are now intersecting at a very precarious moment in our nation's history. We are experiencing an explosion of aging Baby Boomers and longer life expectancies among seniors, but diminished financial resources across the board which has brought together a perfect storm of factors we must now confront. The simple fact is more responsibility is going to be placed back on the individual and their families to find

the resources necessary to handle the costs of long term care. Private market solutions other than long term care insurance will be required.

What you need to know about the Medicaid crisis and laws to recover LTC expenditures

We see it in the news every day. Seniors are living longer; the costs of Senior Care are rising; Medicare and Medicaid is forced to look for cuts to keep pace; and not enough people understand what they are up against, nor are they prepared to financially handle Long Term Care. Numerous studies have shown that this is a topic people ignore. They are not preparing for the eventuality of Senior Care, and most erroneously assume that whatever they want "will just be covered". For seniors, and the providers of Senior Care services such as Assisted Living or Home Care, this is a big problem. Medicare and Medicaid will continue to be more restrictive in what will be covered and rates will continue to be reduced. Service providers and the people they serve are going to be forced to cope with less government assistance and more reliance on private funding options.

The federal and state governments are looking for alternatives in the private market to pay for long term care. Political leaders across the country understand that it is impossible for Medicare and Medicaid to keep pace with demand for long term care services. "Private Pay" has become the holy grail of long term care, and a powerful combination of industry leadership and political action is opening up access for the consumer to this new funding option. State budgets are under siege from Medicaid costs and law makers are frantically looking for savings measures.

Unexpected and dangerous threats in the form of professional and personal liability have emerged in the wake of the growing LTC funding crisis. Law suits and mandated claw-back actions have been brought against families in attempts to recover monies spent on long term care. Insurance and legal advisors have also been sued by clients in response to fiduciary responsibility issues about options to fund long term care, or how to derive the highest value from a life insurance policy.

These aggressive legal actions take root from State Filial Responsibility Laws and federal Estate Recovery Mandates that have existed for decades. In 1993, the federal government passed a mandate in the Omnibus Budget Reconciliation Act of 1993 (OBRA '93) that requires states to implement a Medicaid estate recovery program, and the Deficit Reduction Act of 2005 (P.L. 109-171, DRA) contained a number of provisions designed to strengthen these rules. OBRA gives states the authority, and the obligation, to sue families via probate court to claw-back Medicaid dollars spent on a loved one's long term care. In this law, states are required to sue the estates of Medicaid recipients, *" to recover, at a minimum, all property and assets that pass from a deceased person to his or her heirs under state probate law, which governs both property conveyed by will and property of persons who die intestate. Such property includes assets that pass directly to a survivor, heir or assignee through joint tenancy, rights of survivorship, life estates, living trusts, annuity remainder payments, or life insurance payouts".*

The government has had the authority to take legal action against families to recover Medicaid dollars for over two decades. In fact, Medicaid recovers hundreds of millions from families every year, but as budget pressures increase estate recovery actions are becoming even more aggressive.

What you need to know about Medicaid eligibility

Medicaid Eligibility and Asset Transfer Rules (Order Code RL33593 *Congressional Research Service (CRS) Report* January 31, 2008) - Eligibility for Medicaid's long-term care services is limited to persons who meet a state's functional level-of-care standards and certain financial standards (i.e., income and asset level tests). Persons qualify for Medicaid in one of the three ways: (1) they have income and assets equal to or below state-specified thresholds; (2) they deplete their income and assets on the cost of their care, thus "spending down"; or (3) they divest of their assets to

meet these income and asset standards sooner than they otherwise might if they first had to spend their income and assets on the cost of their care.

Since the enactment of the Omnibus Budget Reconciliation Act of 1993, Medicaid's rules concerning eligibility, asset transfers, and estate recovery have been designed to restrict access to Medicaid's long-term care services to those individuals who are poor or have very high medical or long-term care expenses, and who apply their income and assets toward the cost of their care. In an attempt to discourage Medicaid estate planning, (a means by which some individuals divest of their income and assets to qualify for Medicaid sooner than they would if they first had to spend their income and assets on the cost of their care), the Deficit Reduction Act of 2005 (P.L. 109-171, DRA) contained a number of provisions designed to strengthen these rules.

The DRA lengthens the look-back period from three years to five years for all income and assets disposed of by the individual after enactment. It does not change the look-back period for certain trusts, which was already five years prior to DRA's enactment. Under this change, asset transfers for less than fair market value of all kinds made within five years of application to Medicaid would be subject to review by the state for the purpose of applying asset transfer penalties.

Medicaid Asset Recovery Rules- Omnibus Budget Reconciliation Act of 1993 (OBRA '93) requires states to implement a Medicaid estate recovery program. OBRA gives states the authority, and the obligation, to sue families via probate court to claw-back Medicaid dollars spent on a loved one's long term care. In this law, states are required to sue the estates of Medicaid recipients, *" to recover, at a minimum, all property and assets that pass from a deceased person to his or her heirs under state probate law, which governs both property conveyed by will and property of persons who die intestate. Such property includes assets that pass directly to a survivor, heir or assignee through joint tenancy, rights of survivorship, life estates, living trusts, annuity remainder payments, or life insurance payouts". http://aspe.hhs.gov/daltcp/reports/estreccol.htm*

State Filial Responsibility Laws- Filial responsibility laws (filial support laws, filial piety laws) are laws that impose a duty upon adult children for the support of their impoverished parents and can be extended to other relatives. These laws can include criminal penalties for adult children or close relatives who fail to provide for family members when challenged to do so. 28 states and Puerto Rico have filial responsibility laws in place: Alaska, Arkansas, California, Connecticut, Delaware, Georgia, Indiana, Iowa, Kentucky, Louisiana, Maryland, Massachusetts, Mississippi, Montana, Nevada, New Hampshire, New Jersey, North Carolina, North Dakota, Ohio, Oregon, Pennsylvania, Rhode Island, South Dakota, Tennessee, Utah, Vermont, Virginia and West Virginia. *(Wikipedia) and http://law.psu.edu/_file/Pearson/FilialResponsibilityStatutes.pdf*

What you need to know about recent Law Suits:

- In 2012, John Pittas, a 47 year old restaurant owner was sued by a nursing home company for $93,000 in expenses incurred by his mother over a six month period after she was denied Medicaid eligibility. The **Superior Court of Pennsylvania** *(Health Care & Retirement Corporation of America v. Pittas* Pa. Super. Ct., No. 536 EDA 2011, May 7, 2012) found in favor of the nursing home based on "filial responsibility law" (which is on the books in 28 states), and the son was forced to re-pay the entire costs for his mother's care. The court finding even granted discretion to the nursing home company to seek payment from any family members it wished to pursue. *(Forbes, 5/21/2012)*
- A Rancho Mirage, Calif., couple filed a class-action lawsuit seeking punitive damages, treble damages, restitution and an injunction against Lincoln on Jan. 9 in U.S. District Court in Riverside, Calif., (*Larry Grill et al v. Lincoln National Life Insurance Company* - California Central District Court) alleging that they may have been able to sell their policy rather than reducing their coverage if their agent had told them about the life settlement market.

We have reached the point that we can no longer ignore the realities of an ever growing population that will require long term care, and the diminishing resources to pay for it. People need to arm themselves with information about their options to fund long term care if they are going to maintain dignity and quality in their lives. Government programs such as Medicare and Medicaid will become more difficult to access and the amount of coverage for long term care will continue to be reduced.

People able to sustain themselves with private pay dollars will benefit from access to higher-end senior living environments and care providers, greater choice, more control, and less financial impact on loved ones. Those unable to pay for long term care at some level on their own through the use of savings and assets (such as a life insurance policy conversion), or with the assistance of family, will be forced to rely on the government. Medicare only covers a brief period of medically necessary "rehabilitation" care, and Medicaid will only cover those that fall below set poverty levels requiring specific, medically necessary long term care services. People finding themselves in this position will quickly need to adjust their expectations about how little choice they actually have about their long term care options.

New approaches to fund long term care must be encouraged or Medicare and Medicaid could face bankruptcy.

What you need to know about "Need for Care"

Many families don't realize a loved one needs long term care or that they are in fact already acting as a care provider for a loved one. We often encounter people who are getting care from friends and family and really should be moving towards professional care—they just don't realize it yet and will say they don't need care. People in need of long term care are not always obvious and can seem to be living independently when they should actually be receiving homecare or assisted living.

For example, we have talked with families and asked about their Activities of Daily Living (ADL's) such as if they can shower for themselves. The response sometimes is "of course they can" but then we will hear more details such as: "but I do help them get in and out of the shower and I stand by while they are in there, and I also turn on the water to make sure it is not too hot"—but other than that they shower on their own". The reality is that this person cannot shower for themselves and is already receiving family based care.

Three areas to find warning signs:

- Memory (verbal Cue)
- Health (physical Cue)
- Condition of home (visual Cue)

Three areas for families to prepare for the move to Long Term Care:

- Siblings and spouses on same page
- Everyone needs an assigned job
- Understand types of care and how to pay

In a recent case, Life Care Funding worked with a family that did not realize the extent of their need for long term care until after we had concluded our review process. The policy owner and his family were not taking into account the long term care related factors of his current health situation. The policy owner was experiencing declining health and had just completed an extended skilled rehabilitation stay of 6 weeks. No one had yet considered the factors contributing to the growing need of long term care assistance.

When Elderly Parents Can No Longer Live Alone: Watch for these key signs that your elderly parent should no longer be living alone.

Re-printed from an article originally posted on Jan. 9, 2014 @ *http://www.cantonrep.com/article/20140109/NEWS/301099970/11038/LIFESTYLE*

If you haven't visited with your elderly parent in a while, you might be shocked to find them increasingly fragile, demonstrating signs of marked decline that weren't evident before. In fact, the holidays and their aftermath are the busiest time of year for long-term senior care admissions, says expert Chris Orestis. "This time of year, families gather together and perhaps haven't seen mom or dad in months," says Chris, senior health-care

advocate and CEO of Life Care Funding. "You might start to suspect that they're no longer equipped to care for themselves."

"Don't Blow Off the Warning Signs"

How can you determine if your aging parent is no longer in a position to live alone? There are a number of telltale warning signs that can suggest your elderly parent requires additional assistance or care. To begin, signs of cognitive impairment—particularly, forgetfulness and confusion—are definite red flags that should never be overlooked, Chris warns. "Dementia often first manifests as forgetfulness," he adds. Additionally, take a look around your elderly parent's home and assess its general appearance. "Evaluate their homes for telling visual cues of mental deterioration," Chris says. "Are items oddly placed? Are objects where they aren't supposed to be? Are there signs of damage or neglect to the house?" If the house isn't as organized or tidy as it used to be, this might signal that your aging parent is no longer able to properly fulfill daily household tasks.

Lastly, be on the lookout for signs of physical deterioration, Chris says. These might include marked weakness, loss of strength and stamina, difficulty balancing or drastic weight loss. If you discern noticeable bruises, this could indicate that your aging loved one is experiencing balance or mobility issues. Lack of personal hygiene—a disheveled, unkempt appearance, for example—is another key warning. Because living alone can pose inherent dangers for elderly individuals struggling with cognitive or physical limitations, it's important that you identify these red flags immediately, no matter how subtle they may seem. "Never ignore a warning sign," Chris says. "If something seems odd, don't blow it off as, "Oh, they're just starting to get older.'"

Create a Plan of Attack

Confronting an elderly parent about the necessity of seeking additional care can be a sticky, sensitive subject. Loss of independence is arguably one of the most feared aspects of aging, so the conversation may provoke varied reactions from your elderly loved one—resentment, anxiety or anger. That's why it's wise to formulate a "game plan" in advance for how to best approach this potentially delicate dialogue.

"This isn't the type of conversation you want to just spring on your parent at the dinner table," Chris notes. "You've got to make a 'plan of attack' first." First and foremost, Chris suggests, the family—the siblings, in-laws, spouses, etc.—must reach a mutual consensus that some sort of senior care is in the parent's best interest. "Nothing will make the process more difficult than if the siblings aren't on the same page," Chris notes.

Once you've discussed the matter with siblings, it might be smart to delegate roles amongst the family. Arranging senior care can be an arduous process—with myriad logistical factors to consider—so it helps to divvy up duties accordingly. "For example, one sibling might be assigned the duty of researching different nursing home or assisted living options," Chris says. "The other might be in charge of handling financial matters, while another might be charged with power of attorney."

Next, you need to understand what financial resources are available to help inform what type of senior care you can afford. "Do mom and/or dad have a long-term care insurance policy? Do they have a life insurance policy? What are their savings? What do they have in the bank? Do they have annuities? What's the situation with their home?" Chris says.

Finally, it's time to sit down with your mother and/or father and address your concerns that it's no longer safe for them to be living alone, based on the various clues you've identified. Depending on the severity of your loved one's symptoms, you might not want to immediately introduce the notion of a nursing home or assisted living facility. "This will scare them. You want to ease them into the concept," Chris suggests. "'Maybe it's time to start considering bringing some extra help into the house,' you might say."

Bottom Line

While there is no one-size-fits-all answer to the question of senior care, prior planning and preparation will ensure as smooth of a process as possible. Ultimately, Chris stresses the importance of adult children rec-

ognizing when it's time for their parents to seek help. Although confronting the parent about the necessity of additional care can be a difficult and taxing experience, it's incumbent upon the adult children to ensure that their parent is safe, healthy and comfortable.

What you need to know about Veterans' Aide & Attendance

http://benefits.va.gov

Supplemental Income for Wartime Veterans

VA helps Veterans and their families cope with financial challenges by providing financial assistance through the Veterans Pension Benefit. Veteran's Aide and Attendance is supplemental income for wartime veterans providing a monthly, *tax-free monetary benefit for veterans' (and their spouses) that served in an active field of combat.

- A single veteran can receive upwards of $1,700/mo. and with a spouse upwards of $2,000/mo.
- The Long Term Care Benefit Plan is a qualified spend-down while an applicant waits for VA Benefit approval.

Eligibility

Generally, a Veteran must have at least 90 days of active duty service, with at least one day during a wartime period to qualify for a VA Pension. If you entered active duty after September 7, 1980, generally you must have served at least 24 months or the full period for which you were called or ordered to active duty (with some exceptions), with at least one day during a wartime period.

In addition to meeting minimum service requirements, the Veteran must be:

- Age 65 or older, OR
- Totally and permanently disabled, OR
- A patient in a nursing home receiving skilled nursing care, OR
- Receiving Social Security Disability Insurance, OR
- Receiving Supplemental Security Income

What Documents are needed to apply for Aid and Attendance?

- Discharge or Separation Documents (DD 214)
- VA Form 21-22 if a Veteran's Service Organization or 21-22a if individual is acting as the claimant's representative
- Form 21-4142: Authorization and Consent to Release Information to the Department of Veterans Affairs
- Letter from the claimant's attending physician VDVA Form 10
- Physician Statement, VA Form 21-2680 or Nursing Home Statement, VA Form 21-0779
- Medical Expenses incurred, VA Form 21-8416

In addition to the VA forms, an applicant will need to gather the following documents:

- Marriage Certificate and Death Certificate (Surviving Spouses only)
- Asset Information (bank account statements, etc.)
- Verification of Income (social security award letter, and statements from pensions, IRAs, annuities, etc.)
- Proof of Medical Premiums (Insurance Statements, Medication or Medical bills that are not reimbursed by Medicaid or Medicare)
- Voided Check for Aid and Attendance Direct Deposit

How to Apply

You may apply for Aid and Attendance or Housebound benefits by writing to the VA regional office where you filed a claim for pension benefits. If the regional office of jurisdiction is not known, you may file the request with any VA regional office. You should include copies of any evidence, preferably a report from an attending physician validating the need for Aid and Attendance or Housebound type care.

- The report should be in sufficient detail to determine whether there is disease or injury producing physical or mental impairment, loss of coordination, or conditions affecting the ability to dress and undress, to feed oneself, to attend to sanitary needs, and to keep oneself ordinarily clean and presentable.
- Whether the claim is for Aid and Attendance or Housebound, the report should indicate how well the applicant gets around, where the applicant goes, and what he or she is able to do during a typical day. In addition, it is necessary to determine whether the claimant is confined to the home or immediate premises.

At least one of the following conditions must be present:

- You require the aid of another person in order to perform personal functions required in everyday living, such as bathing, feeding, dressing, attending to the wants of nature, adjusting prosthetic devices, or protecting yourself from the hazards of your daily environment
- You are bedridden, in that your disability or disabilities requires that you remain in bed apart from any prescribed course of convalescence or treatment
- You are a patient in a nursing home due to mental or physical incapacity
- Your eyesight is limited to a corrected 5/200 visual acuity or less in both eyes; or concentric contraction of the visual field to 5 degrees or less

What you need to know about FHA Reverse Mortgages (HECMs) for Seniors

http://portal.hud.gov/hudportal/HUD?src=/program_offices/housing/sfh/hecm/hecmabou

If you are a homeowner age 62 or older and have paid off your mortgage or paid down a considerable amount, and are currently living in the home, and are eligible, you may participate in FHA's Home Equity Conversion Mortgage (HECM) program. The HECM is FHA's reverse mortgage program that enables you to withdraw some of the equity in your home with limitations or a single disbursement lump-sum payment at the time of mortgage closing.

You can also use a HECM to purchase a primary residence if you are able to use cash on hand to pay the difference between the HECM proceeds and the sales price plus closing costs for the property you are purchasing.

How the Program Works

There are many factors to consider before deciding whether a HECM is right for you. To aid in this process, you must meet with a HECM counselor to discuss program eligibility requirements, financial implications and alternatives to obtaining a HECM and repaying the loan. Counselors will also discuss provisions for the mortgage becoming due and payable. Upon the completion of HECM counseling, you should be able to make an independent, informed decision of whether this product will meet your specific needs. You can search online for a **HECM counselor** or call (800) 569-4287 toll-free.

There are borrower and property eligibility requirements that must be met. You can use the listing below to see if you qualify. If you meet the eligibility criteria, you can complete a reverse mortgage application by contacting a FHA-approved lender. You can search online for a **FHA-approved lender** or you can ask the HECM counselor to provide you with a listing. The lender will to discuss other requirements of the HECM program, the loan approval process, and repayment terms.

Borrower Requirements

You must:

- Be 62 years of age or older
- Own the property outright or paid-down a considerable amount
- Occupy the property as your principal residence
- Not be delinquent on any federal debt
- Have financial resources to continue to make timely payment of ongoing property charges such as property taxes, insurance and Home-owner Association fees, etc.
- Participate in a consumer information session given by a HUD- approved HECM counselor

Property Requirements

The following eligible property types must meet **all** FHA property standards and flood requirements:

- Single family home or 2-4 unit home with one unit occupied by the borrower
- HUD-approved condominium project
- Manufactured home that meets FHA require-ments

Financial Requirements

- Income, assets, monthly living expenses, and credit history will be verified.
- Timely payment of real estate taxes, hazard and flood insurance premiums will be verified

You may be eligible for one of the following payment plans:

- **Tenure** - equal monthly payments as long as at least one borrower lives and continues to occupy the property as a principal residence.
- **Term** - equal monthly payments for a fixed period of months selected.
- **Line of Credit** - unscheduled payments or in installments, at times and in an amount of your choosing until the line of credit is exhausted.
- **Modified Tenure** - combination of line of credit and scheduled monthly payments for as long as you remain in the home.
- **Modified Term** - combination of line of credit plus monthly payments for a fixed period of months selected by the borrower.
- **Single Disbursement Lump Sum** - a single payment at loan closing.

If eligible, you can change your payment plan option for a fee of $20.

Mortgage Amount Based On

The amount you may borrower will depend on:

- Age of the youngest borrower
- Current interest rate
- Lesser of appraised value or the HECM FHA mortgage limit of $625,500 or the sales price; and
- Initial Mortgage Insurance Premium

HECM Costs

You can pay for most of the costs of a HECM by financing them and having them paid from the proceeds of the loan. Financing the costs means that you do not have to pay for them out of your pocket. On the other hand, financing the costs reduces the net loan amount available to you.

The HECM loan includes several fees and charges, which includes: 1) mortgage insurance premiums (initial and annual) 2) third party charges 3) origination fee 4) interest and 5) servicing fees. The lender will discuss which fees and charges are mandatory.

You will be charged an initial mortgage insurance premium (MIP) at closing. The initial MIP will be .5 percent or 2.5 percent, depending on your disbursements. Over the life of the loan, you will be charged an annual MIP that equals 1.25% of the mortgage balance.

1. **Mortgage Insurance Premium**
   You will incur a cost for FHA mortgage insurance. The mortgage insurance guarantees that you will receive expected loan advances. You can finance the mortgage insurance premium (MIP) as part of your loan.
2. **Third Party Charges**
   Closing costs from third parties can include an appraisal, title search and insurance, surveys, inspections, recording fees, mortgage taxes, credit checks and other fees.

3. **Origination Fee**
   You will pay an origination fee to compensate the lender for processing your HECM loan. A lender can charge a HECM origination fee up to $2,500 if your home is valued at less than $125,000. If your home is valued at more than $125,000 lenders can charge 2% of the first $200,000 of your home's value plus 1% of the amount over $200,000. HECM origination fees are capped at $6,000.
4. **Servicing Fee**
   Lenders or their agents provide servicing throughout the life of the HECM. Servicing includes sending you account statements, disbursing loan proceeds and making certain that you keep up with loan requirements such as paying real estate taxes and hazard insurance premium. Lenders may charge a monthly servicing fee of no more than $30 if the loan has an annually adjusting interest rate and $35 if the interest rate adjusts monthly. At loan origination, the lender sets aside the servicing fee and deducts the fee from your available funds. Each month the monthly servicing fee is added to your loan balance. Lenders may also choose to include the servicing fee in the mortgage interest rate.

What you need to know about Medicaid

http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Eligibility/Eligibility.html

Eligibility

Medicaid and CHIP provide health coverage to nearly 60 million Americans, including children, pregnant women, parents, seniors and individuals with disabilities. In order to participate in Medicaid, federal law requires states to cover certain population groups (mandatory eligibility groups) and gives them the flexibility to cover other population groups (optional eligibility groups). States set individual eligibility criteria within federal minimum standards. States can apply to CMS for a waiver of federal law to expand health coverage beyond these groups.

Many states have expanded coverage, particularly for children, above the federal minimums. For many eligibility groups, income is calculated in relation to a percentage of the Federal Poverty Level (FPL). For example, 100% of the FPL for a family of four is $23,550 in 2013. The Federal Poverty Level is updated annually. For other groups, income standards are based on income or other non-financial criteria standards for other programs, such as the Supplemental Security Income (SSI) program.

In accordance with CHIPRA section 213, CMS published a notice in Federal Register on December 18, 2009, (Vol. 74, No. 242) soliciting comments to assist in the development of a model process. CMS invites feedback from stakeholders regarding the viability of the proposal on interstate coordination.

Affordable Care Act of 2010 Expands Medicaid Eligibility in 2014

The Affordable Care Act of 2010, signed by President Obama on March 23, 2010, creates a national Medicaid minimum eligibility level of 133% of the federal poverty level ($29,700 for a family of four in 2011) for nearly all Americans under age 65. This Medicaid eligibility expansion goes into effect on January 1, 2014 but states can choose to expand coverage with Federal support anytime before this date-see related Federal Policy Guidance and states that have expanded Medicaid prior to 2014. See Eligibility Provisions in the Affordable Care Act.

Other Eligibility Criteria

There are other non-financial eligibility criteria that are used in determining Medicaid eligibility. In order to be eligible for Medicaid, individuals need to satisfy federal and state requirements regarding residency, immigration status, and documentation of U.S. citizenship.

Retroactive Eligibility

Medicaid coverage may start retroactively for up to 3 months prior to the month of application, if the individual would have been eligible during the retroactive

period had he or she applied then. Coverage generally stops at the end of the month in which a person no longer meets the requirements for eligibility.

Long-Term Services & Supports

The Medicaid program allows for the coverage of Long Term Care Services through several vehicles and over a continuum of settings. This includes Institutional Care and Home and Community Based Long Term Services and Supports. Information on those topics is below. For more information on additional community based topics, see the link to the right.

Institutional Long Term Care

Medicaid covers certain inpatient, comprehensive services as institutional benefits. The word "institutional" has several meanings in common use, but a particular meaning in federal Medicaid requirements. In Medicaid coverage, institutional services refers to specific benefits authorized in the Social Security Act. These are hospital services, Intermediate Care Facilities for People with Mental Retardation (ICF/MR), Nursing Facility (NF), Preadmission Screening & Resident Review (PASRR), Inpatient Psychiatric Services for Individuals Under Age 21, and Services for individuals age 65 or older in an institution for mental diseases.

Institutional benefits share the following characteristics:

- Institutions are residential facilities, and assume total care of the individuals who are admitted.
- The comprehensive care includes room and board. Other Medicaid services are specifically prohibited from including room and board.
- The comprehensive service is billed and reimbursed as a single bundled payment. (Note that states vary in what is included in the institutional rate, versus what is billed as a separately covered service, for example physical therapy may be reimbursed as part of the bundle or as a separate service.)
- Institutions must be licensed and certified by the state, according to federal standards.
- Institutions are subject to survey at regular intervals to maintain their certification and license to operate.
- Eligibility for Medicaid may be figured differently for residents of an institution, and therefore access to Medicaid services for some individuals may be tied to need for institutional level of care.

Community Based Long-Term Services & Supports

CMS is working in partnership with states, consumers and advocates, providers and other stakeholders to create a sustainable, person-driven long-term support system in which people with disabilities and chronic conditions have choice, control and access to a full array of quality services that assure optimal outcomes, such as independence, health and quality of life.

The programs and partnerships contained in this section are aimed at achieving a system that is:

- **Person-driven:** The system affords older people, people with disabilities and/or chronic illness the opportunity to decide where and with whom they live, to have control over the services they receive and who provides the services, to work and earn money, and to include friends and supports to help them participate in community life.
- **Inclusive:** The system encourages and supports people to live where they want to live with access to a full array of quality services and supports in the community.
- **Effective and Accountable:** The system offers high quality services that improve quality of life. Accountability and responsibility is shared between public and private partners and includes personal accountability and planning for long-term care needs, including greater use and awareness of private sources of funding.
- **Sustainable and Efficient:** The system achieves economy and efficiency by coordinating and managing a package of services paid that are appropriate for the beneficiary and paid for by the appropriate party.
- **Coordinated and Transparent:** The system coordinates services from various funding streams to provide a coordinated, seamless package of supports, and makes effective use of health information technology to provide transparent information to consumers, providers and payers.

- **Culturally Competent:** The system provides accessible information and services that take into account people's cultural and linguistic needs.

What you need to know about Medicare

http://www.medicare.gov/coverage/skilled-nursing-facility-care.html

Skilled nursing facility (SNF) care

How often is it covered?

Medicare Part A (Hospital Insurance) covers skilled nursing care in a skilled nursing facility (SNF) under certain conditions for a limited time.

Medicare-covered services include, but aren't limited to:

- Semi-private room (a room you share with other patients)
- Meals
- Skilled nursing care
- Physical and occupational therapy*
- Speech-language pathology services*
- Medical social services
- Medications
- Medical supplies and equipment used in the facility
- Ambulance transportation (when other transportation endangers health) to the nearest supplier of needed services that aren't available at the SNF
- Dietary counseling

*Medicare covers these services if they're needed to meet your health goal.

If you're in a SNF but must be readmitted to the hospital, there's no guarantee that a bed will be available for you at the same SNF if you need more skilled care after your hospital stay. Ask the SNF if it will hold a bed for you if you must go back to the hospital. Also, ask if there's a cost to hold the bed for you.

People with Medicare are covered if they meet all of these conditions:

- You have Part A and have days left in your benefit period.
- You have a qualifying hospital stay if you re-enter the same or another SNF within 30 days, you dont need another 3-day qualifying hospital stay to get additional SNF benefits. This is also true if you stop getting skilled care while in the SNF and then start getting skilled care again within 30 days.
- Your doctor has decided that you need daily skilled care given by, or under the direct supervision of, skilled nursing or rehabilitation staff. If you're in the SNF for skilled rehabilitation services only, your care is considered daily care even if these therapy services are offered just 5 or 6 days a week, as long as you need and get the therapy services each day they're offered.
- You get these skilled services in a SNF that's certified by Medicare.
- You need these skilled services for a medical condition that was either:
- A hospital-related medical condition.
- A condition that started while you were getting care in the skilled nursing facility for a hospital-related medical condition if while you're getting SNF care for a stroke that was also treated during your qualifying three-day hospital stay, you develop an infection that requires IV antibiotics.

Your doctor may order observation services to help decide whether you need to be admitted to the hospital as an inpatient or can be discharged. During the time you're getting observation services in the hospital, you're considered an outpatient—you can't count this time towards the 3-day inpatient hospital stay needed for Medicare to cover your SNF stay. Find out if you're an inpatient or an outpatient.

Note: If you refuse your daily skilled care or therapy, you may lose your Medicare SNF coverage. If your condition won't allow you to get skilled care (for instance if you get the flu), you may be able to continue to get Medicare coverage temporarily.

Your costs in Original Medicare

You pay:

- Days 1–20: $0 for each benefit period.
- Days 21–100: $152 coinsurance20% per day of each benefit period.
- Days 101 and beyond: all costs.

Note

If you stop getting skilled care in the SNF, or leave the SNF altogether, your SNF coverage may be affected depending on how long your break in SNF care lasts.

- If your break in skilled care lasts more than 30 days, you need a new 3-day hospital stay to qualify for additional SNF care. The new hospital stay doesn't need to be for the same condition that you were treated for during your previous stay.
- If your break in skilled care lasts for at least 60 days in a row, this ends your current benefit period and renews your SNF benefits. This means that the maximum coverage available would be up to 100 days of SNF benefits.

Note

Your doctor or other health care provider may recommend you get services more often than Medicare covers. Or, they may recommend services that Medicare doesn't cover. If this happens, you may have to pay some or all of the costs. It's important to ask questions so you understand why your doctor is recommending certain services and whether Medicare will pay for them.

What you need to know about Long Term Care Insurance

http://www.naic.org/index_ltc_section.htm

1. **Long-Term Care is Different from Traditional Medical Care**
   Someone with a prolonged physical illness, a disability or a cognitive impairment such as Alzheimer's disease often needs long-term care. Long-term care services may include help with daily activities, home health care, respite care, hospice care, adult day care, care in a nursing home or care in an assisted living facility.
2. **Long-Term Care Can be Expensive**
   The cost depends on the amount and type of care you need and where you get it. In 2001, the national average cost of nursing home care was $56,000 per year, assisted living facilities reported $22,476 per year and home care costs ranged from $12,000 to $16,000 per year.
3. **You Have Options When Paying for Long-Term Care**
   People pay for long-term care in a variety of ways. These include using personal resources, long-term care insurance and Medicaid for those who qualify. Medicare, Medicare supplement insurance and health insurance you may have at work usually will not pay for long-term care. Long-term care insurance will pay for some or all of your long-term care.
4. **Decide Whether Long-Term Care Insurance is for You**
   Whether you should buy a long-term care insurance policy will depend on your age, health status overall retirement goals, income and assets. For instance, if your only source of income is a Social Security benefit or Supplemental Security Income (SSI), you probably should not buy long-term care insurance since you may not be able to afford the premium. On the other hand, if you have a large amount of assets but do not want to use them to pay for long-term care, you may want to buy a long-term care insurance policy. Many people buy a policy because they want to stay independent of government aid or the help of family. They don't want to burden anyone with having to care for them. However, you should not buy a policy if you can't afford the premium or are not sure you can pay the premium for the rest of your life.
5. **Pre-Existing Condition Limitations**
   A long-term care insurance policy usually defines a pre-existing condition as one for which you received medical advice or treatment or had symptoms within a certain period before you applied for the policy. Some companies look further back in time than others. Many

companies will sell a policy to someone with a pre-existing condition. However, the company may not pay benefits for long-term care related to that condition for a period after the policy goes into effect, usually six months. Some companies have longer pre-existing condition periods or none at all.

6. **Know Where to Look for Long-Term Care Insurance**
   Long-term care insurance is available to you in several different forms. You can buy an individual policy from a private insurance company or agent, or you can buy coverage under a group policy through an employer or association membership. The federal government and several state governments offer long-term care insurance coverage to their employees, retirees and their families. You can also get long-term care benefits through a life insurance policy. Some states have long-term care insurance programs designed to help people with the financial impact of spending down to meet Medicaid eligibility standards. Check with your state insurance department or counseling program to see if these policies are available in your state.
7. **Check With Several Companies and Agents**
   Contact several companies and agents before you buy a long-term care policy. Be sure to compare benefits, the types of facilities covered, limits on your coverage, what is not covered and the premium. Policies from different insurance companies often have the same coverage and benefits but may not cost the same. Be sure to ask companies about their rate increase history and whether they have increased the rates on the long-term care insurance policies.
8. **Don't be Misled by Advertising**
   Most celebrity endorsers are professional actors paid to advertise, not insurance experts. It is also important to note that Medicare does not endorse or sell long-term care insurance policies, so be wary of advertising that suggests Medicare is involved. Do not trust cards you get in the mail that look like official government documents until you check with the government agency identified on the card.
9. **Make Sure the Insurance Company is Reputable**
   To help you find out if an insurance company is reliable, you can take the following actions: Stop before you sign anything, call your state insurance department and confirm that the insurance company is licensed to do business in your state. After you make sure they are licensed, check the financial stability of the company by checking their ratings. You can get ratings from some insurer rating services for free at most public libraries.
10. **Review Your Contract Carefully**
    When you purchase long-term care insurance, your company should send you a policy. You should read the policy and make certain you understand its contents. If you have questions about your insurance policy, contact your insurance agent for clarification. If you still have questions, turn to your state insurance department or insurance counseling program.

What you need to know about Long Term Care Benefit Plan

http://www.lifecarefunding.com/how-it-works/

Instead of allowing a life insurance policy to lapse or be surrendered; the owner of the policy can convert the policy into a Long Term Care Benefit Plan.

A Long Term Care Benefit Plan is the conversion of an in-force life insurance policy into an irrevocable, FDIC-insured Benefit Account that is professionally administered with *tax-free payments made monthly on behalf of the individual receiving care. Policy owners use their legal right to convert an in-force life insurance policy to enroll in the benefit plan, and are able to immediately direct *tax-free monthly payments to cover any form of senior care they choose: Homecare, Assisted Living, Nursing Home, Memory Care, and Hospice.

This option extends the time a person would remain private pay and delays their entry onto Medicaid. It is a unique, tax-advantaged financial option to pay for care because all health conditions are accepted, and there

are no wait periods, no care limitations, no costs to apply, no requirement to be terminally ill, and there are no premium payments.

What does converting a policy mean? It means the policy is sold for a percentage of the death benefit (the range can be between 20%-60%) and the funds are placed into an irrevocable, FDIC insured Benefit Account held and administered at a nationally chartered and regulated Bank and Trust institution. The entire proceeds from the policy settlement are placed into the account and then at the direction of the family, the monthly, *tax-free payments are made directly to their choice of care provider. If care needs change, and the family wants to change care provider and/or the monthly payment amount all they need to do is provide 30 days' notice to adjust the account instructions. From the time of acceptance of the conversion offer, the account can be established and funded, with payments to the care provider starting within 30 days. In addition to being a Medicaid qualified spend-down inside the look back period, the Benefit Account is *tax-free because the funds are spent on care.

This program is accepted by every care provider in the United States and endorsed by over 5,000 Assisted Living, Homecare and Nursing Home companies. National companies such as Brookdale Senior Living, Sunrise Senior Living, 5-Star Senior Living, Visiting Angels, Senior Helpers, Genesis Healthcare, and thousands more offer this programs to families with life insurance policies that are looking for financial assistance.

What are the requirements to enroll in the Long Term Care Benefit Plan?

1. In-force life insurance policy (Term, Universal, Whole and Group) with a death benefit between $50,000-$1,000,000
2. Current need for Homecare, Assisted Living, Nursing Home Care, Memory Care, or Hospice (within 90 days of enrollment)

Highlights of the Long Term Care Benefit Plan:

- Specifically for people that have an immediate need for Senior Care of any form: Homecare, Assisted Living, Nursing Home, Memory Care, Hospice (usually within 90 days)
- Works for Term (convertible or non-convertible), Universal, Whole and Group policies with death benefit of $50,000-$1,000,000
- Simplified underwriting requirement (review of medical records from last 2 years and phone interview to confirm need for care and type of care to be funded with Benefit Account).
- The entire proceeds from sale of the policy will go into an irrevocable, FDIC insured bank & trust account
  - The account is irrevocable to protect the money for the account holder
  - The account is a Medicaid qualified spend-down so once the account is spent-down the account holder can immediately switch to Medicaid to pay for their care
  - The account is *tax-free because the funds are spent on long term care
  - The Account preserves a *tax-free funeral benefit for the family or it will pay the entire balance to the family *tax-free if the account holder dies before the account has been spent-down.
- The Account pays a monthly benefit directly to the care provider of choice
  - Amount and provider can be changed with 30 day notice
  - Additional amount can be drawn for one-time special need circumstances
- Fast and easy process to apply and enroll in a Long Term Care Benefit Plan
  - Average time to enroll and start receiving first benefit payments is 30 days
  - No costs
  - No obligations
  - No more premiums

**Please note that the tax treatment of the proceeds from the sale of a life insurance policy will depend on many factors, including but not limited to who owns the policy, the health of the insured, the use of proceeds, the size of the estate and the state in which the policy owner lives (for purposes of state taxation). This material does not constitute tax, legal or accounting advice; and it cannot be used by any taxpayer for the purpose of avoiding any IRS penalty. Anyone interested in selling a life insurance policy in order to fund Long Term Care Benefits should seek professional advice based on his or her particular circumstances from an independent tax advisor.*

"Did you Know" Discussion Topics

https://www.youtube.com/watch?v=x2uElJdOoNQ

Did you know that 10,000 Baby Boomers turn 65 every day and that 70% of people over the age of 65 will need long term care in their lifetime?

Families across the United States are struggling with how to pay for the costs of long term care. Not enough people plan for the almost certain eventuality that they will need to pay for long term care for themselves or a loved one. The costs of long term care increase every year. The monthly costs of Homecare or an Assisted Living community can easily reach $5,000 and can last 3-5 years. Long Term Care insurance won't cover this and neither does Medicaid. Almost half of people who will require long term care in their life will end up in a nursing home. But, Medicare will only cover the first 100 days of rehabilitation in a nursing home; after that you either need to have private pay resources or go onto Medicaid if you can qualify. One overlooked solution that is in the hands of millions of Americans is converting a life insurance policy into a Long Term Care Benefit Plan that can pay for any form of Homecare, Assisted Living, Memory Care or Nursing Home Care. Before abandoning a life insurance policy, the owner should always find out what the conversion value of the policy is first. Insurance agents, legal professionals or the staff at an assisted living community, homecare company or a nursing home can help you find out more information on how to use a life insurance policy to help pay for long term care expenses for yourself or a loved one.

https://www.youtube.com/watch?v=ty2mmPJVECc

Did you know that there are four primary forms of long term care?

Long Term Care is not a subject that people spend much time thinking about– unless they need it. Until most people focus on the subject, they have a vague sense for the various forms of care and don't really know the differences between Homecare, Assisted Living, and Nursing Home care. A nursing home– something you visited a long time ago when your grandparents were there? Homecare– is it care at home? Assisted Living– sort of like a really nice nursing home? Here is a simple breakdown of the four primary forms of long term care to help you better understand what they are– and the differences.

Home Health Care: Care at various levels provided at home by licensed or unlicensed workers as well as designated family members. Home health is primarily private pay, but Medicare and Medicaid will reimburse some forms of "medically necessary" home health services provided by licensed practitioners for people meeting specific eligibility requirements.

Assisted Living: Housing for the elderly or persons unable to live independently that will provide mid-level custodial care, medication support, lifestyle activities, transportation, and meals. Assisted Living is a "private pay" environment not covered by Medicare and Medicaid.

Nursing Home: Higher level "skilled care" provided in a licensed facility for people requiring long term medical or nursing care; or short term rehabilitation services for injured, disabled, or sick persons. Private pay is accepted and will allow for more choice such as private rooms, enhanced lifestyle options, and wider selection of locations.

Hospice: A specific form of care for people typically in the final 6 months of life as certified by a physician. Hospice care can be provided at home, in an assisted living community, a nursing home, or a free standing care center. Private pay is accepted and not subject to requirements to be medically re-certified every 60 days.

The Long Term Care Benefit covers all of these forms of senior care by converting an existing life insurance policy from a death benefit that may have been purchased many years ago into a living benefit to meet today's expensive senior care needs.

https://www.youtube.com/watch?v=lvJpfaYCarU

Did you know Medicare and Medicaid will only cover certain types of long term care, but a person that is "private pay" can choose any form of care they want?

People are often confused about the differences between Medicare and Medicaid, how to qualify and what exactly will they pay for. Medicare is for people over the age of 65 that will cover the first 100

days of rehabilitation in a nursing home if a person is discharged from a hospital. Medicaid is for people below the poverty line that meet medical and financial requirements to qualify for care in an approved nursing home. Some Homecare can be covered by Medicare and Medicaid if the person meets the eligibility requirements. Assisted Living is not covered by Medicare or Medicaid.

Private pay means a person is paying for their care with savings, investments, private insurance or a Long Term Care Benefit Plan. When a person is private pay they can choose any form of care that they want. If a person wants to be in Homecare or move into an Assisted Living community they can make that decision without worrying about government approvals. When a person converts a life insurance policy into a Long Term Care Benefit Plan the monthly payments will keep them private pay for as long as possible. Also, there are no more premium payments required, and the amount of the monthly payments is set by the family to cover the costs of care, and can be adjusted as needs change. But, because the Benefit Plan is a Medicaid qualified spend-down, if a person exhausts their Benefit account they can then make a seamless transition over to Medicaid. Finally, the Long Term Care Benefit Plan provides a final expense benefit to help families with funeral expenses and if there is any remaining account balance it will all go to the family.

https://www.youtube.com/watch?v=VtmkgaiDYPs

Did you know any type of life insurance policy can be converted to pay for any form of long term care?

All types of life insurance can qualify to be converted into a Long Term Care Benefit including term life policies, whole life, universal life and group life. Cash value does not matter in a policy conversion because it is the death benefit that is being converted into a "living benefit". There are no costs or obligations to apply for a policy conversion. The underwriting process is simple, and the entire enrollment from beginning to end takes about 30 days. Once a policy has been converted and the Long Term Care Benefit is set up, monthly payments immediately start being made to any form of senior care that is desired.

The Benefit will pay for Homecare, Assisted Living, Memory Care, or Nursing Home and Hospice care. The Benefit Plan is designed to be flexible to meet the changing needs of care. For example, the Benefit could start out at $1,000 a month for Homecare services but then switched at a later time to $5,000 a month to pay for Assisted Living if the person needs for care have changed.

Thousands of senior care providers offer this funding option to help families pay for care, and some of the biggest Assisted Living and Homecare companies in the United States work with Life Care Funding every day to help families in need of care.

https://www.youtube.com/watch?v=3A-5YrovBJA

Did you know every Homecare, Assisted Living and Nursing Home company in the country accepts funding from a Long Term Care Benefit Plan?

Life Care Funding is endorsed by over 5,000 Assisted Living communities, Homecare providers and Nursing Homes across the country that offer the Long Term Care Benefit to families as a way to help the pay for care. Policy owners can also learn more about how to qualify for a Long Term Care Benefit Plan through their financial, insurance or legal advisor who would be happy to assist in a policy conversion.

A Long Term Care Benefit Plan is a protected account that makes monthly payments automatically to the care provider of choice. As long as the Benefit Account is in use, the person receiving care is considered "private pay". Private pay individuals remain in control of their own decisions and do not have to go onto Medicaid. Private pay individuals are also preferred by Homecare providers, Assisted Living communities and Nursing Homes-- and for the most part Homecare and Assisted Living only accept Private pay.

Seniors want to remain financially independent, and do not want to become a burden on their family or a ward of the state by entering Medicaid. Unfortunately, the current system to fund long term care has evolved into one that encourages seniors to impoverish themselves and move towards Medicaid as quickly as possible. For the wealthy, long term care costs are easily covered. For the poor and disabled, Medicaid is available. But what about the majority of middle class Americans that need access to long term care today? One solution available to millions of people is to convert a life

insurance policy instead of abandoning it so they can remain private pay and access any form of care that they want.

https://www.youtube.com/watch?v=9COv3dN0Mb0

Did you know a Long Term Care Benefit Plan is a Medicaid qualified spend-down that helps a policy owner stay private pay as long as possible?

A life insurance policy is an asset of the policy owner and it counts against them when applying for Medicaid. But, by converting an existing life insurance policy to a Long Term Care Benefit plan, the owner is spending down the asset towards their cost of care in a Medicaid compliant manner while still preserving a portion of the death benefit for their family. A Long Term Care Benefit Plan is the conversion of an in-force life insurance policy into an irrevocable, FDIC-insured Benefit Account that makes monthly senior care payments on behalf of the individual receiving care. This option extends the time a person would remain private pay and delays their entry onto Medicaid. When a person is private pay, they can choose the form of care they want and remain financially independent. Assisted Living and Private Duty Homecare do not accept Medicaid or Medicare. Surveys show that people mistakenly think Medicare will cover their long term care needs. The fact is that Medicare will only cover the first 100 days in a nursing home and most often it is Medicaid that will end up covering care in a nursing home. If a person goes onto Medicaid it means they have become a ward of the state because they are below the poverty line and they are not able to choose the form or place of care that they want and the person will typically have to share a room.

People prefer to remain private pay and in control of their health care choices. Converting a life insurance policy into a Long Term Care Benefit Plan is a Medicaid qualified spend-down as it keeps a person private pay and off of Medicaid for as long as possible.

https://www.youtube.com/watch?v=3DF2osXUpXU

Did you know it's your legal right to convert a life insurance policy into a Long Term Care Benefit Plan?

Life insurance is legally recognized as an asset and your property ownership rights are guaranteed by the Supreme Court. The Long Term Care Benefit Plan is a unique financial option for seniors because all health conditions are accepted, and there are no wait periods, no care limitations, no costs to apply, no requirement to be terminally ill, and there are no premium payments or anything to pay back. Policy owners use their legal right to convert an in-force life insurance policy to enroll in the benefit plan, and are able to immediately direct payments to cover their choice of senior housing and long term care costs including homecare, assisted living, memory care and nursing home care.

In recent years, state legislatures and advocacy groups have been working together to introduce laws making sure that policy owners are informed that they can convert their life insurance into a Long Term Care Benefit Plan. Consumer protection disclosure laws championed by Life Care Funding have been introduced in numerous states to make sure people are informed that instead of abandoning a life insurance policy to go onto Medicaid, they have the legal right to convert the policy into a Long Term Care Benefit Plan and choose any form of care that they want. We are proud that these consumer protection measures are based on Life Care Funding's program and we have helped to write the bills and have been invited to provide expert testimony in numerous states. Advocacy organizations such as the American Health Care Association, the Assisted Living Federation of America and the AARP in Florida have all spoken out in favor of this approach to funding long term care.

https://www.youtube.com/watch?v=dt16u1x0Zyk

Did you know a Long Term Care Benefit Plan is not a loan on the policy or Long Term Care Insurance?

A Long Term Care Benefit Plan is not long term care insurance, and it is not a policy loan that costs fees and interest and must be paid back. When a policy owner converts their life insurance policy into a Long Term Care Benefit Plan, there are no fees, no premium payments, no interest charges and nothing ever needs to be paid back. The policy owner is actually obtaining the maximum present day value of the policy and protecting the funds in an irrevocable

Benefit Account that keeps them private pay. The policy is no longer considered an asset that could count against them for future Medicaid eligibility.
In a policy loan, in addition to high fees and interest payments, the policy itself is collateral securing the loan and interest, which means that until the loan is paid back the policy remains an asset that counts against the policy owner for future Medicaid eligibility. With a Long Term Care Benefit Plan, the policy owner will never pay fees, interest, and nothing is ever paid back.

Enrollment in a Long Term Care Benefit Plan can take as little time as 30 days and will start making immediate payments to cover any form of senior care. Long Term Care Insurance is purchased before a person needs senior care. The younger and healthier a person is when they purchase insurance, the lower the premium payments will be and the more option they will have. A person who would qualify to purchase long term care insurance would be too young and healthy to enroll in the Long Term Care Benefit Plan. By comparison, a person who qualifies to convert a life insurance policy into a Long Term Care Benefit Plan would be too old or sick to buy long term care insurance. If a person owns long term care insurance and life insurance they can convert the life policy and use both together to make sure they maximize their senior care options.

https://www.youtube.com/watch?v=JvfJ09tN9y8

Did you know it is quick and easy, and there are no fees to enroll in a Long Term Care Benefit Plan?

Life Care Funding does not charge any fees and there are no obligations to apply for the Long Term Care Benefit Plan. The application is a very short from that takes about 5 minutes to complete. If a person has an in-force life insurance policy with a death benefit range of $50,000-$1,000,000 they could qualify to enroll in the Long Term Care Benefit. Term life, Universal life, Whole life and Group life all qualify to be converted into a Long Term Care Benefit. The entire enrollment process takes about 30 days from start to finish with monthly benefit payments being made to the person's senior care provider of choice. A person can select any form of senior care they want such as Homecare, Assisted Living, Memory Care, Skilled Nursing or Hospice and the Benefit account is flexible so it can be adjusted to move from one care provider to another, or the monthly Benefit amount can adjusted as care needs change. The Benefit Plan will also provide a final expense payment to help with funeral costs and if a person should pass away with any money still in their Benefit account, the entire balance will be paid to their family or designated account beneficiary.
The Long Term Care Benefit Plan is a Medicaid qualified financial option to address an immediate need for long term care services. Instead of lapsing or surrendering a life insurance policy, the owner will get a much higher value that will help them pay for the expensive out-of-pocket costs of long term care.

"Many people who need Assisted Living or Home Care can't afford it, so they drop life insurance policies they've been carrying for years in order to qualify for Medicaid. A system that encourages people to abandon their policies to go onto public assistance is broken and has to change. Seniors and their families lose out from the fact that they have made premium payments for years on a policy that they will end up abandoning. The problem is they don't know it can be converted into a Long Term Care Benefit Plan. It's a secret that's been kept from seniors for decades: Your life insurance policy can be used to pay for all forms of senior care such as Home Care, Assisted Living and Nursing Home expenses. But here's the good news-- it isn't a secret anymore." -Chris Orestis, CEO of Life Care Funding, Senior Care Advocate and former insurance industry lobbyist

Free Resources

To receive a FREE copy of the E-Book, "*Help on the Way: THE BIG INSURANCE SECRET SENIORS AREN'T SUPPOSED TO KNOW*" click here to download from Amazon.com:

http://ebook.lifecarefunding.com/?utm_source=free_paper&utm_medium=lead_gen_referral&utm_campaign=ebook

To download a FREE copy of the White Paper: "Dangerous Liabilities Lurk for Families and Advisors in Long Term Care Planning" **Click Here**

(http://www.lifecarefunding.com/white-papers/dangerous-liabilities-lurk-for-families-and-advisors-in-long-term-care-planning/)

About the Author

Chris Orestis is CEO and co-founder of Life Care Funding; a nationally known senior care advocate and 18-year veteran of both the life insurance and long-term care industries. He is the author of the book "Help on the Way", (http://ebook.lifecarefunding.com/), and is a legislative expert, featured speaker, columnist and contributor to a number of insurance and long term care industry publications. His blog on senior living issues can be found at www.lifecarefunding.com/blog. He can be reached at (888) 670-7773 or corestis@lifecarefunding.com.