

I N D I A N A

Laws of Aging



A Partnership of the
Indiana State Bar Association
and the Indiana Bar Foundation

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Thank You

Thank you to these legal professionals for volunteering their time and knowledge to author and edit this fantastic resource for the older citizens of our state:

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Dedication

In 1981, Mary Harter Mitchell began editing the Legal Reference for Older Hoosiers (the precursor to the Laws of Aging). I met Mary when I was a student in her Law and Aging course—she was teaching the course for the first time and I was working in the Senior Law Project of Indiana Legal Services Organization. Mary asked me to assist her with the book, and we became fast friends. Mary was a well-loved professor at the Robert McKinney School of Law, teaching courses in elder law, law and religion, prisoners' rights, and prison literature. She was a natural for the field of elder law with her great compassion, her promotion of human dignity for all persons, and her commitment to service to others. Her untimely death on November 7, 2009, was a great loss to her family, her friends, the legal community, and the countless people who benefitted from her generous spirit and zest for life. It is with much love and many fond memories that this 2015 edition of the Laws of Aging is dedicated to her.

Claire E. Lewis, Editor

Very special thanks to the Indiana Bar Foundation and the Indiana State Bar Association Sections: Elder Law; Probate, Trust & Real Property; GP, Solo & Small Firm and Family & Juvenile Law for grants without which this project would not have been possible.

To order additional copies contact the ISBA:

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Legal Services

OLDER ADULTS ARE LIKELY TO NEED A LAWYER AT ONE TIME OR ANOTHER. THIS DISCUSSION EXPLAINS BRIEFLY:

- when to seek a lawyer's help
- how to find a lawyer
- how to get help if you cannot afford to hire a lawyer
- help available for older adults
- court appointed legal assistance
- what to expect in dealing with a lawyer

WHEN TO SEEK A LAWYER'S HELP

Throughout this book there are suggestions that you consult a lawyer for particular problems. A lawyer can explain complicated laws, including Social Security, Medicare, Medicaid and pensions. A lawyer can help you cut through the maze of government bureaucracy to get answers about government benefits.

Lawyers have the expertise to draft contracts, powers of attorney, trusts, and other legal documents. A lawyer can help you arrange your finances and property to meet your needs and minimize taxes. He or she can help you plan for the possibility of future disability or long-term care. A lawyer can write your will and make other arrangements so that after your death your survivors are protected and your property is distributed according to your wishes.

A lawyer can help with problems of divorce, child custody, landlord-tenant relations, credit sales, property transactions and represent you in negotiations with persons with whom you have a dispute.

You should consult a lawyer if you plan to sue or if someone is suing you in any court except small claims court. Most small claims courts can resolve disputes where the amount in controversy is \$6,000 or less; however, the amount varies depending on the county in which the claim is brought.

If more is involved, you will need a lawyer to represent you in the proper court. These are only a few of the services that a good lawyer can provide.

HOW TO FIND A LAWYER

If you do not have a family lawyer and do not know whom to consult, ask your friends for recommendations. Some non-profit public interest organizations can suggest attorneys in special subject areas. (See Chapter 16.)

You may also contact the Indiana State Bar Association to get the name of a bar official in your area who can help you find a lawyer. Write or call:

Indiana State Bar Association
One Indiana Square, Suite 530
Indianapolis, IN 46204
317-639-5465 or 1-800-266-2581
www.inbar.org

Also, your local Area Agency on Aging might be able to refer you to a lawyer and your local Social Security office can help you find a lawyer for Social Security matters.

If you qualify as low-income or are on a fixed income and cannot afford to pay a private lawyer, you may qualify for help from Indiana Legal Services or at a local legal aid office.

IF YOU CANNOT AFFORD A LAWYER

Do not hesitate to ask a lawyer ahead of time how much she or he charges. Such questions are not considered rude, and you have the right to know. You may want to shop around to get a good lawyer at a price you can afford.

Some lawyers and law firms work for a reduced fee or for free if the client cannot afford to pay regular rates. Ask before you hire the lawyer. If other people share your legal problem, perhaps all of you could consult a lawyer together and share the legal fees.

Indiana has several legal services and legal aid offices that provide free legal advice and representation to persons whose income and assets qualify them for these services. If you are eligible, you pay no lawyer's fee; however, you may have to pay court filing fees and other costs of the case.

HELP AVAILABLE FOR OLDER ADULTS

There is help from legal service providers, which are funded by the Older Americans Act and coordinated by Area Agencies on Aging, providing free legal assistance to older adults age 60 and older. There are no income or asset eligibility requirements. However, the type of services available varies from area to area.

COURT APPOINTED LEGAL ASSISTANCE

None of these legal services offices or providers handles criminal cases. If you are a defendant in a criminal case, including traffic offenses, and you cannot afford to pay a lawyer, you have the right to have the court appoint a lawyer to represent you for free. The first time you are in court, tell the judge that you cannot afford a lawyer. Ask about getting the free services of a public defender.

WHAT TO EXPECT

Once you have a lawyer, he or she will probably want to get as much information from you as possible. Typically you will meet in person and bring any relevant papers to be reviewed.

It is very important that you be completely honest with your lawyer. Do not withhold information or misrepresent facts. Only if the lawyer knows all the facts can he or she advise or represent you well. With very rare exceptions, what you tell a lawyer is confidential information. It is a lawyer's ethical obligation to keep your secrets.

Some legal problems can be handled quickly; others take a long time. The lawyer should keep you informed about the progress of your case. Although it is the lawyer's job to know the law and to give you advice, you should make the important decisions about how to proceed. Once you have decided, the lawyer's job is to try to put your wishes into effect.

If you have a complaint about a lawyer, you should fill out a grievance form, which you can get from:

Indiana Supreme Court Disciplinary Commission
115 W. Washington Street, Suite 1165
Indianapolis, IN 46204
(317) 232-1807
<http://www.in.gov/judiciary/discipline/>

Income

SOCIAL SECURITY

President Franklin D. Roosevelt signed the Social Security Act into law on August 14, 1935, in the midst of the Great Depression. It created a national safety net with programs like public assistance, unemployment, and retirement benefits. Congress has changed and added to the act many times since then adding Medicare, Medicaid, Unemployment Insurance and others, but this section concerns the Social Security program itself.

Social Security is a social insurance program for workers and their families, not a savings plan. Workers and their employers fund Social Security through a payroll tax which goes into the Social Security trust fund. The trust fund pays benefits to current Social Security beneficiaries. The program is run by the Social Security Administration (SSA), an independent agency of the federal government.

As the Baby Boom generation retires, many fear Social Security will run out of money. While action should be taken to build up Social Security's trust fund, funding will last until 2033 even if nothing is done in the meantime. Even then, future workers will be paying enough into the fund to pay roughly 75% of promised benefits. Social Security tax revenue and interest income will fall below pay out starting in 2019. Correction could be as simple as modestly increasing the Social Security payroll tax and removing the tax exemption on high earnings to balance the fund for the next 75 years or more.

In 2013, nearly 55 million people received Social Security benefits. About 72% were age 65 or older. Just under 15% were under 65 and disabled. Twenty three percent of older couples and 46% of older individuals rely on Social Security for at least 90% of their income. Social Security provides benefits to three categories of persons:

1. Retired workers and their dependents.
2. Survivors of deceased workers.
3. Disabled workers and their dependents.

The Social Security Administration also runs a program called Supplemental Security Income (SSI) that provides income for the needy who are aged or disabled. You can get both Social Security and SSI if you are eligible for both. (See the SSI section later in this chapter.)

Health insurance coverage under Medicare comes with Social Security eligibility. You are automatically eligible for Medicare if you are 65 or over and eligible for Social Security or if you are under 65 and have received Social Security benefits based on a disability for at least two years or are on kidney dialysis or have Lou Gehrig's disease (amyotrophic lateral sclerosis). (See the Medicare section later in this chapter.)

Social Security is a complex and changing program. This chapter is only an overview. For more information, check with your local Social Security office. You can contact SSA through its toll-free number, (800) 772-1213, its deaf or hearing impaired line (TTY), (800) 325-0778 or online at www.ssa.gov. The Online Social Security Handbook is a very good reference tool as well, www.ssa.gov/OP_Home/handbook/handbook.html.

ELIGIBILITY

To qualify for Social Security benefits for yourself or your family, you must be insured. You become insured by working in jobs covered by Social Security. These days very few workers are not covered; however, certain farm and household workers, federal employees hired before 1984, and employees of state and local governments who do not participate in Social Security are not covered.

As you work in a covered job, you earn credits. You need a certain number of credits to be insured. In 2015, you earn a credit for every \$1,220 you receive in employment income. This figure changes every year. You can earn a maximum of four credits per year. Credits used to be called "quarters of coverage" because you had to earn the minimum amount in each calendar quarter to get a credit. Since 1978,

total earnings for the entire year are used to calculate the number of credits earned for that year.

Most workers born after January 1, 1929, need 40 credits to be insured for retirement benefits. To be insured for disability benefits, a worker must have 20 credits in the 10 years before disability began. Workers disabled before age 31 need fewer credits.

Some dependents of a worker can receive benefits based on the worker's earnings record. The circumstances under which spouses, divorced spouses, children, and sometimes parents can receive benefits are described later in this chapter.

There is an important gap in Social Security benefits for dependents. A surviving spouse under age 60 when his or her spouse dies and whose children are older than 16 will receive nothing unless he or she is disabled. If the surviving spouse is disabled, he or she can get disabled widow(er)'s benefits as early as age 50. Even so, benefits can be reduced as much as 28.5% for widowed spouses or surviving divorced spouses who begin drawing benefits before age 65. Therefore, life insurance may be desirable to protect a younger spouse in the event of the death of the worker.

Sometimes one person is entitled to two different benefits. For example, a wife may be eligible for retirement benefits on her own work record and also on her husband's record. Or a worker may be both retired and disabled. Whenever that happens, the person cannot receive both, but would get the higher of the two.

RETIREMENT BENEFITS

To qualify for retirement benefits, you must be at least age 62 and have the required number of credits, usually 40. However, your benefits will be permanently reduced if you start drawing before your full retirement age (FRA). If you turned 65 before 2003, the full retirement age is 65. For workers who reach age 65 after the year 2002, the full retirement age will gradually increase to age 67. If you were born during 1943 through 1954, your FRA is age 66. If you retire at that age, you will receive full monthly benefits.

The earliest age a worker can begin to receive retirement benefits is 62. If you were to start receiving benefits at 62 before reaching FRA, your monthly check would only be 70% to 80% of the amount you would have drawn at your FRA. If you work past your full retirement age and don't draw retirement benefits, you get a bonus for delaying retirement. For

retirees born after 1942, the credit is 8% for each year of delayed retirement up to age 70.

Because retirement benefits are intended to partly replace earnings, you cannot always have both retirement benefits and substantial earnings. Social Security's "retirement test," also called the Earned Income Deduction, limits the income a retired worker can earn and still receive full Social Security benefits. For 2015, these limits are:

- Retired worker under full retirement age – \$15,720 per year
- In year retired worker reaches full retirement age – \$41,880
- Retired worker at, or beyond, full retirement age – No Limit

Also, there is a special monthly limit used in a "grace year," usually the year of retirement. In the grace year, you can still receive full benefits for any month in which you earn less than one-twelfth (1/12) of the annual limit, even though your total earnings for the year may be over the annual limit. These limits increase every year. Social Security has online calculators at www.socialsecurity.gov/planners/benefitcalculators.htm.

If you earn more than the limit, your Social Security benefits are reduced. From age 62 through full retirement age, they are reduced \$1 for every \$2 earned over the limit. In the year you reach your FRA, there is a reduction of \$1 in Social Security benefits for every \$3 earned over the limit. Starting with the month you reach your FRA, there is no reduction for earnings. Part of your Social Security will be subject to federal income tax if you earn enough, e.g., if your income plus half of your Social Security benefits exceeds \$25,000 for singles or \$32,000 for couples filing jointly.

Dependents and survivors benefits are also reduced if they earn over certain amounts. They may also be reduced if the retiree whose account they are paid from earns too much.

If you are under full retirement age and have earnings and receive Social Security benefits in a given year, you must usually report your earnings to Social Security by April 15 of the next year. There may be a penalty if you do not report on time. You can get an extension if you have a good reason; however, you must ask for the extension before the due

date. You must report your actual earnings for the prior year and estimate your earnings for the current year. It is important to make an accurate estimate to avoid being paid too much or too little by Social Security. If you are paid too much, you will be asked to pay it back. If your earnings change after you make the report, you should notify Social Security. Always make these reports in writing and keep copies for your records. Usually an IRS Form W-2 from the employer will suffice. In fact, Social Security will adjust your benefits automatically based on the W-2 filed by your employer or your self-employment income tax report to the IRS. However, if these are incorrect, Social Security still holds you responsible for reporting correct information.

BENEFITS FOR DEPENDENTS OF A RETIRED WORKER

The following dependents of a retired worker are also eligible for benefits if the worker is insured.

Spouse. You must be at least age 62 or caring for the worker's child who is under 16 or disabled before 22. Also, you must either have been married to the worker at least one year, had a child with the worker, or been entitled, or potentially entitled, to certain Social Security benefits in the month before marrying the worker.

Divorced Spouse. You must be at least age 62, have been married to the worker at least 10 years, and not currently remarried. If your ex-spouse is not yet receiving retirement benefits, but is 62 and fully insured, you can still draw benefits if you have been divorced at least 2 years.

Unmarried Child. You must be under age 18, or 18 to 19 and a full-time high school student, or 18 or older and disabled before 22. You must also meet certain dependency requirements.

DEATH AND SURVIVORS BENEFITS

When an insured worker dies, a surviving spouse or child may receive a onetime death benefit of \$255. This death benefit is paid only:

- To the surviving spouse who was living with the worker at the time of his/her death.
- To the surviving spouse not living with the worker, but eligible for monthly survivor benefits on the deceased worker's record.

- If there is no eligible surviving spouse, to surviving children eligible for monthly survivor benefits on the worker's record.

The death benefit cannot be paid to a funeral home or a divorced spouse. Additionally, when an insured worker dies, certain survivors can receive monthly benefits.

Surviving Spouse. You must be at least age 60, or at least age 50 if disabled; or if younger, caring for the worker's child who is under 16 or disabled before 22. You must be unmarried or remarried after turning 60, or at least 50 if disabled. Also you must have either been married to the worker usually at least nine months just before he or she died, had a child with the worker, adopted the worker's child, adopted a child with the worker, had your child adopted by the worker, or been entitled, or potentially entitled, to certain Social Security benefits in the month before marrying the worker. Sometimes the nine month marriage requirement can be waived.

Surviving Divorced Spouse. You must be at least age 60 or at least age 50 if disabled. You must have been married to the worker at least 10 years. You must be unmarried, or remarried after turning 60, or at least 50 if disabled.

If you do not qualify based on these criteria, you may still be able to draw benefits if you are caring for the worker's child under 16 or disabled before 22. The child must also be your natural or adopted child and entitled to benefits on the deceased ex-spouse's earnings record. Also you must have either been married to the worker usually at least nine months just before he/she died, had a child with the worker, adopted the worker's child, adopted a child with the worker, had your child adopted by the worker, or been entitled, or potentially entitled, to certain Social Security benefits in the month before marrying the worker. Sometimes the nine month marriage requirement can be waived.

Unmarried Child. You must be under age 18, or 18 to 19 and a full-time high school student, or 18 or older and disabled before 22. You must also meet certain dependency requirements.

Parents. You must be at least age 62 and have received at least half of your support from your deceased child. You must prove dependency within two years of your child's death, even if you are not yet eligible for a parent's benefit at the time.

DISABILITY BENEFITS

A blind or disabled worker may be eligible for monthly Social Security benefits. There is no age requirement, but the worker must have the required work credits to be insured, i.e., having worked 5 of the prior 10 years.

If you become disabled, you should apply as soon as possible. There is a five month waiting period for which you do not receive benefits. If you delay applying for disability benefits, Social Security can go back no more than 12 months before the date you apply.

When you apply, take the names and addresses of doctors and hospitals that have treated you recently to the Social Security office. The Social Security Administration (SSA) will send for medical reports and may require you to undergo additional examinations by its doctors. Your own doctor's report should be as thorough as possible. It should include your doctor's opinion as to the nature and effects of your condition; how long it will last; the chances of improvement; the extent of your pain; medications you take and their effects; and the effect of your condition and your medications on your ability to sit, stand, walk, lift, carry, and work. If your illness has mental or psychological effects, your doctor should explain how they prevent work.

The state disability determination office will decide whether you are disabled. The worker must show one of these two conditions:

1. Blindness: vision no better than 20/200 even with corrective lenses or a field of vision of 20 degrees or less.
2. Disability: a medically provable physical or mental condition that has lasted 12 months, is expected to last 12 months, or result in death, and that keeps you from working for 12 months.

Usually, it is not enough that you cannot do your old job. If there are a significant number of other jobs you could do, you are not considered disabled. Your age, experience, education, and training are taken into account. Do not be discouraged from applying if you believe you are unable to work. Be prepared to appeal a denial of your claim. Disability claimants are often denied benefits at application but win later at an administrative hearing. (See the Appeals section later in this chapter.) Choosing early retirement may be easier if you are 62 or over, but your benefits will be reduced for the rest of your life. Unlike retire-

ment benefits, disability benefits are not reduced if paid before age 65.

Even if you are not considered disabled for Social Security purposes, you might receive help from another government program or private agency. Contact your Area Agency on Aging for advice, (800) 986-3505. Also, contact your local Office of Vocational Rehabilitation listed under state government in the phonebook. If you are disabled but do not have enough work credits, you might be eligible for SSI benefits. (See the SSI section later in this chapter).

Disability benefits continue only as long as you are disabled. SSA will review your case periodically to make sure you are still eligible. If you work despite your disability, earnings over \$1090 per month in 2015 (\$1820 if you are blind) after a nine month trial work period will usually make you ineligible. This figure increases every year.

Dependents are also eligible when the worker is disabled. Benefits are the same as for dependents of a retired worker.

APPLYING FOR BENEFITS

Contact your Social Security office shortly before you plan to retire. For better preparation, plan ahead and meet with Social Security about a year before you intend to retire to learn about your retirement options. Contact Social Security about three months before your 65th birthday, whether you plan to retire at 65 or not, so you can sign up for Medicare without losing any coverage. Apply for disability benefits as soon as you become disabled and cannot work.

You may apply online, in person, or over the phone. Social Security has a toll-free number, (800) 772-1213, which you can call for information as well as for an application. Applying by phone can save you time and energy. SSA will complete the forms and then send them to you to sign. You can send necessary proofs with your application. SSA will copy them and return them to you. If you cannot apply yourself, someone else can sometimes apply for you. You can also apply through Social Security's website, www.ssa.gov/onlineservices.

If you think you are eligible for benefits, insist on filling out a written application. Then, if SSA wrongly denies you benefits, you can appeal.

When you apply, SSA will assign you a claim number. Use it in all communications with SSA. When

you apply, take your Social Security card or the card or number of the person on whose work record you are claiming benefits.

Take with you documents that prove your eligibility. For example, to prove your age, you should take a birth certificate. If that is not available, take a baptismal certificate. If these documents are not available, take some other proof of your age, such as school records, family bible, insurance policy, marriage license, etc. The best proof is a document made before you were 5 years old. You may need other documents to prove marriage, divorce, parenthood, dependency, disability, or earnings. Do not wait to collect all these documents before you apply. There will be time to collect them while SSA is working on your claim. To avoid delays, however, you should contact SSA before you file your claim. SSA can tell you ahead of time what papers you will need to submit and how to get evidence you do not have. SSA may also help you get the necessary papers.

If SSA decides that you are eligible for retirement benefits, you should receive your first check or notice of award in about three to six weeks. There are occasional delays and snags in any government program as big as Social Security. If you have not received a response from SSA after six weeks, call them.

BENEFIT PAYMENT

Your benefits should arrive about the same time every month. If you filed your claim before May 1997, then you normally receive your benefits on the third day of each month, unless it is a holiday. If you retired in May 1997 or later, then your benefits usually arrive on the second, third, or fourth Wednesday of the month, depending on the birth date of the worker on whose record you are drawing. Social Security pays you benefits in the month after they are due. For example, benefits due for January are paid in February. If your check does not arrive on its usual day, wait three business days and then call Social Security for help.

The amount you receive depends on the worker's earnings, years worked, and age of retirement, among other factors. Dependents drawing on a worker's record are paid a percentage of the benefit paid to the insured worker. There is a maximum family benefit which may limit payments to dependents to a smaller amount in some cases.

A 2013 law requires that you have your benefits direct deposited to your bank account. This can be convenient and secure. Ask your bank for the necessary form, fill it out, and have the bank send it to the Social Security office. If you were born on or before May 1, 1921, you can ask the Treasury Department to waive the direct deposit requirement, and it will automatically be granted without filing an application. You can call 855-290-1545 to request the waiver. Others need to apply for a waiver by calling that number or going online at http://www.fms.treas.gov/godirect/about-faq/FMS_Form_1201W_June_2013.pdf. You will need to show that you have a mental impairment that makes it difficult for you to manage a bank account or that you live in a remote area without access to electronic banking services. If you don't have a bank account, the Treasury Department can offer you a debit card called Direct Express. If you are still receiving paper checks, you will likely be hearing from the Treasury Department, and they may even send you a Direct Express card.

If you get a check that is not yours, send it back and notify Social Security. If you receive too much, notify Social Security. If you keep an incorrect payment, you may later be forced to repay the money. (See the Overpayments section later in this chapter.)

REPRESENTATIVE PAYEESHIP

What is a representative payee? Social Security and SSI benefits are usually paid directly to the beneficiary, the person entitled to receive the benefits. However, sometimes SSA may appoint another person or organization to receive and manage a beneficiary's Social Security or SSI payments. This person or organization is called a representative payee.

When will SSA appoint a payee? SSA can appoint a payee if it decides it is in a person's best interests. If a person is too young or is physically or mentally unable to take care of his or her own benefits, SSA will appoint a payee. SSA will consider court decisions, doctor reports, and statements from others who know the beneficiary.

Who may serve as a payee? SSA must pick a person or organization who can best serve the beneficiary's interests. Usually, that will be a guardian or other legal representative, a spouse, a relative, or a friend. It can also be an agency or institution that

cares for the person, such as a nursing home or mental health center. In some cases, a volunteer might be appointed. SSA must investigate a person or organization before it appoints them as a representative payee. Certain people may not be allowed to serve as payee. A person to whom a beneficiary owes money or who has misused funds in the past usually can't be a payee.

With SSA's approval, certain non-profit agencies can charge a beneficiary for acting as his payee. The fee is usually limited to \$30 or 10% of the person's monthly benefit, whichever is less. No one else can charge a fee for serving as representative payee.

WHAT ARE A PAYEE'S RESPONSIBILITIES?

A payee is responsible for taking care of Social Security or SSI payments for a beneficiary. The payee has no authority over any other funds or income the beneficiary has. A payee must use a beneficiary's Social Security or SSI payment for the beneficiary's best interest. Above all, the payment must be used to meet the beneficiary's current needs for food, clothing, shelter, medical care, and personal comfort. Once those needs are met, the payment may be used to support the beneficiary's legal dependents. A payee may not pay off the beneficiary's debts unless the current and foreseeable needs have been met first. Social Security and SSI benefits cannot usually be attached to satisfy a debt.

Any leftover funds must be invested wisely. SSA prefers savings bonds or interest-bearing, government-insured accounts in banks, savings & loans, credit unions, etc. Any account must clearly show that the funds are invested for the beneficiary by the representative payee. Representative payees of SSI recipients must be careful that any savings don't exceed the resource limits for SSI or other benefit programs the individual may receive.

A payee is responsible for reporting changes which might affect the beneficiary's eligibility for SSI or Social Security benefits. This can include changes in the beneficiary's income, assets, address, room-mates, and marital status; medical improvement; return to work; and admission to hospital or nursing home. A payee must also tell SSA if he or she becomes unable to act as payee.

The payee must show how funds have been spent if SSA requires it. It is important to keep good records

and a separate checking account for this purpose. It should be titled in the payee's name for the beneficiary, i.e., Peter Payee, representative payee for Bill Beneficiary.

CAN A PAYEE BE LIABLE?

If a payee fails to use Social Security or SSI payments in the beneficiary's interest, the payee can be required to pay them back. If the payee intentionally misuses the funds, she or he can be criminally prosecuted.

If a beneficiary is overpaid benefits and the payee is at fault, SSA can require the payee to pay back the incorrectly paid funds. This can happen when the payee fails to report changes in the beneficiary's circumstances.

WHAT ARE THE BENEFICIARY'S RIGHTS?

If SSA decides you need a representative payee, it must tell you in writing before sending benefits to the payee. If you disagree, you can appeal. If you object to the person or organization chosen as your payee, you can appeal that as well.

If you want to end a payeeship, you must show SSA that you are capable of handling your own benefits. A letter from your doctor may be the simplest way. Statements from others who know you well may also help. You can appeal if SSA decides not to end the payeeship.

It is not always easy to find someone to serve as payee. SSA can hold your check for up to 30 days while looking for a payee. After that SSA must pay you directly, even if it thinks you cannot manage your own funds. The only exceptions are for children under age 15 and adults found legally incompetent by a judge.

If your payee does not use your benefits for you, SSA may have to reimburse you. You would have to show that SSA did not properly investigate and monitor your payee. Any misuse of benefits should be reported immediately to SSA.

APPEALS

You have the right to appeal when you think that SSA has wrongly denied, reduced, or stopped your benefits. In the written notice of its decision, SSA should tell you exactly how to appeal. Be sure to meet all deadlines. If you miss a deadline, you may get an extension if you had a good reason for missing the deadline. Sometimes,

Social Security will reopen a decision that you failed to appeal. It is often better to ask for an extension or reopening than to reapply and start over because you may lose benefits by reapplying.

To begin the appeals process:

1. Request a reconsideration of the decision. Do this on SSA's form within 60 days of receiving notice of the action with which you disagree. State your reasons for disagreement and attach any additional evidence you have. SSA will reexamine your case and send you notice of its decision.
2. If you still disagree, request a hearing. Make the written request within 60 days of SSA's decision on reconsideration.
 - a. At the hearing, an administrative law judge from SSA will hear your case. You may be represented at the hearing by a friend, relative, lawyer, or other person. At the hearing, you can present evidence, testify and have other witnesses testify for you, and cross-examine the government's witnesses.
 - b. A lawyer or trained paralegal can be especially helpful at the hearing stage of your appeal. Studies have shown that chances of winning are greater when you are represented. If you do not have a lawyer for your hearing, here is some advice:
 - i. Submit as much evidence as possible to SSA before the hearing.
 - ii. You have the right to look at your government file before the hearing. You should check it to be sure that SSA's information is correct, complete, and current.
 - iii. Make sure your witnesses show up at the hearing. To be sure, you can ask the administrative law judge ahead of time to subpoena any witness, that is, to order the witness to appear and testify at the hearing.
 - iv. If the hearing involves the question whether you are disabled, get a complete medical report from your doctor. This report should discuss all problems resulting from your condition, including psychological problems. Your doctor may also attend and testify at the hearing.
3. If you disagree with the judge's decision after the hearing, you can appeal within 60 days to the Appeals Council.
4. If you still disagree, you can appeal to a federal court. At this stage, if not before, you should seek the assistance of a lawyer. This procedure can take a long time.

During the appeal, you might go without benefits. But if you eventually win, you may receive back benefits to cover the time during which you were appealing.

You have the right to be represented by a friend, relative, lawyer, or anyone else you choose. A lawyer can be a great help in a Social Security appeal. If you cannot afford representation, you may qualify for free help from a legal services or legal aid office.

SSA will set the lawyer's fee and will usually approve a fee of up to 25% of your back award or \$6000, whichever is less. It will usually pay the lawyer directly out of your back award. Most lawyers handle these cases on a contingency fee basis. This means you pay the lawyer only if you win your appeal.

OVERPAYMENTS

Social Security is a complex program. Changes in earnings, age, and other factors can affect the amount of benefits you are due. When SSA pays you too much, it expects you to refund the overpayment. If SSA thinks that you have been overpaid, it must send you a written notice. You may need to ask for a more detailed explanation. Unless you act promptly, SSA will keep all your benefits until the overpayment is repaid. You can request reconsideration and/or waiver as explained later in this chapter. You should do this within 30 days of receiving the notice to avoid an interruption in benefits.

If you think you have not been overpaid, you should request reconsideration. (See the Appeals section earlier in this chapter.) You can appeal a decision that you were overpaid just like any other decision made by SSA.

If you accept that you were overpaid but don't think it was your fault, you might request a waiver of the overpayment. You will need to show why it was not your fault. You will also need to show that you cannot afford to repay it. If your income does not exceed your expenses by more than \$25 and your

assets are under \$3,000, more if you have dependents, SSA will generally consider that you cannot afford to repay. Under some circumstances you will not be required to pay back the overpayment even when you can afford to, if it would be “against equity and good conscience.” Also, if you are not at fault and the overpayment is not over \$1,000, SSA usually waives the overpayment if you ask.

After you request a waiver, SSA will contact you to schedule a meeting to consider your request, unless it decides a waiver can be granted without the meeting. You will be given an opportunity to look at your claims file and to explain why you are not at fault. SSA must consider your physical, mental, educational, and language limitations, if any. If the waiver is denied, you may then appeal. (See the Appeals section earlier in this chapter.)

You may request reconsideration, a waiver or both. While you may request both at the same time, it is usually better to request reconsideration first. Then, if reconsideration is denied, you can request a hearing on that issue and a waiver. This delays recovery of the overpayment as long as possible. SSA will not start recouping from your benefits while you wait for a decision on reconsideration or waiver.

When SSA intends to collect an overpayment, it offers a choice of paying the entire amount at once or having your benefit checks withheld until it is completely paid. However, you can also ask that a smaller amount be withheld from your check. You may be asked to provide information about your income and expenses.

SSA takes a heavy-handed approach to recovering overpayments that is frightening to many people. Do not allow yourself to be pressured into signing a repayment agreement unless you are sure that you must pay back the overpayment. If you are unsure what to do, seek help from an experienced lawyer, advocate, or legal assistance program.

FURTHER INFORMATION

For more specific information about Social Security, call your local Social Security office. Look in the telephone book under Social Security Administration, which is listed with the offices of the United States government. A great deal of information can also be found on SSA’s website, www.ssa.gov.

SUPPLEMENTAL SECURITY INCOME (SSI)

If you have little income and are age 65 or older, or are blind or disabled, the SSI program might help you. If you are eligible, you can receive monthly checks to help you pay for your basic needs. SSI is run by the Social Security Administration (SSA), the same agency that runs the Social Security program. Many persons receive both SSI and Social Security benefits, but you do not have to receive Social Security benefits in order to be eligible for SSI and you don’t need any work history to qualify for SSI.

ELIGIBILITY

To be eligible for SSI benefits, you must meet these requirements:

1. You must be either 65 or older, or are blind or disabled. You are blind if your vision is not better than 20/200 with glasses or you have less than a 20% field of vision. You are disabled if you meet the disability test used for Social Security. (See the Social Security section earlier in this chapter.)
2. If you are blind or disabled, you must accept referral to the Office of Vocational Rehabilitation, if offered.
3. You must have a low income and limited assets.
4. SSA may require you to apply for other benefits for which you might be eligible, including: Social Security, Veterans benefits, Workers Compensation, Railroad Retirement pensions, private pensions, or unemployment compensation.

You do not have to sell your home to get SSI benefits. The government gets no lien on your property and no claim against your estate for SSI benefits it has given you. If you give away money or property before or after applying for SSI, it can make you ineligible for SSI in some cases. You should seek advice from a lawyer or legal assistance program if you are in this situation.

The government may change the way eligibility is calculated, so be sure to ask for current information at your local Social Security office.

INCOME TEST

You are not eligible for SSI if your income is too high. Income includes cash and checks you or your spouse receives plus the value of food and housing

from friends, relatives, or others. Some income, for example, tax refunds and income from volunteer work in an ACTION program, is not counted at all. After all your other income is added together, SSA subtracts certain amounts, including:

- \$20 a month for any income, except Veterans' benefits.
- \$65 a month of earned gross income, earnings from a job or self-employment.
- Half of the rest of your earned income for the month.

If your monthly income after deductions is below the SSI monthly benefit level, you meet the income test. For an individual, that amount in 2015 is \$733; for a couple, both spouses must be age 65 or over, blind, or disabled, it is \$1,100. These amounts change nearly every year on January 1 as the cost of living goes up.

ASSET TEST

Your assets are the property and possessions you own. A single individual cannot receive SSI if his/her countable assets are worth more than \$2,000. A couple cannot receive SSI benefits if their assets are worth more than \$3,000.

In adding up the value of your assets, SSA will not count the value of your house if you live there. SSA will also generally not count the value of your personal effects, i.e. personal jewelry, personal care items, prosthetic devices, books, musical instruments, cultural or religious items; and household goods, i.e. furniture, appliances, personal computers, televisions, radios, carpets, cooking and eating utensils, and dishes. However, if such items are held for investment value, they will be counted as a resource. For example, wedding or engagement rings will be exempt, but a collection of valuable jewelry purchased as an investment and kept in a safe deposit box will be counted.

Starting March 9, 2005, SSA no longer counts one car as a resource, regardless of its value, as long as it is used to transport the individual or a member of his/her family. Other vehicles will count as resources up to their equity value, fair market value minus outstanding loans. A life insurance policy does not count as an asset if the face value is less than \$1,500. However, if the face value is more than \$1,500, the cash surrender value is counted as income.

Even if your resources are worth more than the maximum allowed, you might still be eligible for SSI if you agree to sell the excess nonliquid assets. You must then sell the assets within the time allowed, which is nine months for land or a house and three months for other nonliquid property. You will have to pay back the SSI benefits you received during this time. If it takes more than nine months to sell real estate, you can usually still receive SSI while you try to sell; however, you only have to pay back the SSI received during the first nine months.

WHERE YOU LIVE

When you live in a medical treatment facility for less than one full calendar month, your SSI benefits should not be affected. When you live in a private facility, i.e., hospital, convalescent center, nursing home, etc., for a full calendar month and Medicaid pays more than half your bill, your SSI benefits are reduced to only \$30 a month. Indiana Medicaid should pay you an additional \$22 per month also, if you have Medicaid. If your stay is expected to last no more than 90 days and you want to keep your home or apartment, you can continue receiving your full SSI check. However, you must tell Social Security shortly after you enter the nursing home or other facility. If Medicaid does not pay for your care in the facility, you should receive full SSI benefits. You are not eligible for SSI at all when you are in a public institution such as a veterans' hospital, state hospital, etc., for a full calendar month; however, there are a few exceptions.

If you receive food or shelter from another person, SSA will count what you receive as in-kind income and will reduce your SSI check. If you live in someone else's household and receive both food and shelter from that person, your SSI check will be reduced by one-third, regardless of the value of the food and shelter you receive. For example, in 2015 the federal benefit rate for an individual is \$733. After the one-third reduction, SSI would pay only \$488.61. These figures go up whenever the SSI benefit goes up.

If you receive in-kind income under different circumstances, for example, you live with a friend rent-free but buy your own food, SSA will assume that the food or shelter you receive is worth one-third of the SSI federal benefit rate plus \$20 and will reduce your

SSI check by that amount. For example in 2015 for an individual that would mean a reduction of \$264.33. However, if you show SSA that it is worth less than this amount, they will use the actual value.

The simplest way to prevent your benefits from being reduced for in-kind income if you live with others is to pay your “pro rata” share of food and shelter expenses, including rent, mortgage, property taxes, heating fuel, gas, electricity, water, sewage, and garbage collection. Your pro rata share is the average monthly cost of these items divided by the number of people living in the household. If the value of the shelter you receive is high, you might instead enter into a business arrangement with the person who owns the housing so that you pay monthly rent equal to one-third of the SSI federal benefit rate. If you live in Indiana and pay that amount, you will not have in-kind income from shelter that someone provides you, even if it could be worth more than that.

These rules are complex. If your SSI has been reduced because of in-kind income, consult with an experienced lawyer or legal assistance program.

HOW TO APPLY

Apply for SSI benefits at your local Social Security office. You have the right to file a written application if you think that you might be eligible. If you prefer, you can call SSA and make an appointment for an office or telephone interview at (800) 772-1213 or TTY (800) 325-0778.

When you apply, you should take records and documents that will show you are eligible. For example, to prove your age, unless you are already receiving Social Security, you should take a birth certificate. If you cannot take a birth certificate, take some other proof of age. (See the Social Security section earlier in this chapter.) You must also show your Social Security card.

To show your income, you should take W-2 forms or a copy of your federal income tax return and recent check stubs. You should also take a list of the persons who help to support you and how much each provides. To show ownership of real property, you should take your latest tax bill or an assessment notice and the deed. Also, take documents that show your assets, for example, your bank book and bank statements, motor vehicle registration or title, stock certificates, and bonds. If you are blind or disabled,

take the names of doctors and hospitals that have treated you. SSA might help pay your expenses for gathering these necessary documents.

Having this information with you will speed up processing of your claim. However, it is more important to file your application at the earliest possible date. SSI benefits can be paid no earlier than the month after you apply. So if you cannot find all the documents right away, go ahead and apply anyway. A simple phone call asking about your eligibility for SSI and requesting an application should establish your application date.

BENEFITS

In 2015, an eligible individual with no countable income receives \$733 a month from SSI. An eligible couple with no countable income receives \$1,100 a month. If you live in a nursing home and Medicaid pays most of the bill, your SSI benefit will be only \$30 per month unless your stay is expected to last less than 90 days. (See the section Where You Live previously in this chapter.) These are the maximum SSI benefits; benefits are smaller for persons who have countable income. Some states supplement these basic amounts from the federal government; however, Indiana does not unless you are on Medicaid in a nursing home. These amounts usually increase in January each year, except for the \$30 benefit.

PAYMENTS

Once you have applied, you might not receive your first check for 60 to 90 days. If you are found eligible, however, you will receive benefits that go back to the first month after the month you applied.

In some cases, you can receive benefits immediately. If you need money desperately and can show that you are probably eligible for SSI, you should ask for an emergency advance of up to the full SSI benefit level. Also, if you are obviously disabled, you can get full benefits immediately for up to six months.

The effect of income on SSI benefits can be confusing. SSI benefits are reduced by the amount of income you have that SSA counts. However, your SSI benefits are not adjusted until two months after you actually receive the income. For example, if you receive \$100 in March, it won't affect your SSI benefit until May.

OVERPAYMENT

An overpayment occurs when you receive more SSI money than you should. If SSA thinks that you have been overpaid, they must write you. SSA may then try to get the money back by reducing your SSI checks for subsequent months. If you disagree with this decision, you should appeal. (See the Overpayments section earlier in this chapter.)

SSA cannot take more than 10% of the SSI benefit level to collect an overpayment and you can request that they take less. If you become ineligible for SSI benefits, the SSI overpayment can be collected from Social Security benefits you receive. An overpayment can also be collected from an IRS tax refund or from certain other federal payments you might receive.

APPEAL RIGHTS

You have the right to appeal any decision or action that affects your SSI benefits. The appeals process for SSI is the same as that for Social Security. (See the Appeals section earlier in this chapter.)

If SSA proposes to stop or reduce your SSI check, you may continue to receive the same benefit amount if you appeal within 10 days of receiving the notice. However, if you lose the appeal, SSA may ask you to repay benefits that you were not entitled to. You may request a waiver of this overpayment. (See the Overpayments section earlier in this chapter.) Or, you may have small amounts withheld from your SSI check until it is paid back. To avoid a possible overpayment, you may waive your right to continue being paid during your appeal, but it may take weeks before your appeal is decided.

Normally you cannot receive benefits after losing the first stage of the appeal, unless you are appealing a decision that your disability has ended.

If you have questions about the appeals procedure, ask at your local Social Security office. It is also very helpful to get a lawyer. If you are represented by a lawyer and you win, SSA must approve the lawyer's fee. Attorneys with legal services organizations, however, do not usually charge a fee for this assistance.

REPRESENTATIVE PAYEESHIP

If SSA decides that you cannot manage your SSI checks, it may appoint a representative payee to receive your checks for you. (See the Representative Payeeship section earlier in this chapter.)

CHANGED CIRCUMSTANCES

SSA should review your case every year to make sure that you are still eligible, unfortunately, they often don't.

Be sure to notify SSA within 10 days if there are changes in your circumstances that may affect your SSI eligibility or benefits. Otherwise, you could end up being overpaid. You may even be penalized for failure to report these changes. Report changes in writing and keep a copy for yourself. SSA is notorious for not keeping records of oral reports. If you do not use SSA forms, be sure to include in your report:

- Your name and address.
- Your Social Security claim number.
- An explanation of the change in circumstances.
- Date the change occurred.
- Your signature.

Examples of changes that must be reported to Social Security include:

- Change of address
- Entering/leaving a hospital, nursing home, or other institution
- Plans to leave the United States for at least 30 days
- Separation from your spouse or a change in marital status
- Someone joining or leaving your household
- Buying, selling, giving or receiving an item of property
- Income changes, other than general increases in Social Security benefits
- Major changes in physical condition if you are receiving SSI benefits because you are blind or disabled
- Death

OTHER HELP

If you are eligible for SSI, you might also be eligible for help with medical bills under Indiana's Medicaid program. (See the Medicaid section in Chapter 3.) You might also be eligible for such social services as help with chores at home and rehabilitation. For more information, contact your county's Division of Family Resources office, <http://www.in.gov/fssa/dfr/2999.htm>, and Area Agency on Aging.

FOR MORE INFORMATION

If you have questions about the SSI program, ask at your local Social Security office. Look in the telephone book under offices of the U.S. government, Social Security Administration. You can also go to the SSI home page at <http://www.ssa.gov/ssi/index.htm>.

SUPPLEMENTAL NUTRITION ASSISTANCE PROGRAM (SNAP)/FOOD STAMPS

The Supplemental Nutrition Assistance Program (SNAP), formerly known as food stamps, is a federally funded program which helps low-income households buy the food they need for good health. There are no age requirements to receive food stamps. Eligibility is determined for a given length of time called a certification period, typically one year.

USE

SNAP benefits are like a credit card that you spend like money to buy food and plants and seeds to grow food. They are accessed with a plastic Hoosier Works Card, like an ATM card. You cannot use them to buy alcoholic beverages, tobacco or cigarettes, household supplies, soaps and paper products, medicine, hot foods that are ready to eat, pet foods or other non-food items.

You can use SNAP benefits at any grocery or other store that has been approved to accept them. You can also use them to pay for meals on wheels, group meals for the elderly, and restaurant meals if the organization giving the meals has been approved.

ELIGIBILITY AND BENEFITS

Eligibility is determined by household. Each separate household must be certified separately for food stamps. A household is:

1. A person, or group of persons, living alone.
2. A person or, group of persons, living with others but usually purchasing and preparing meals separately
3. A group of individuals who live together and customarily purchase food and prepare meals together.

If parents live with their children, the parents and children are not considered separate house-

holds unless at least one parent is age 60 or older, or defined as disabled for food stamp purposes, and each household usually buys and prepares food separately. A spouse of a household member cannot be a separate household. A boarder, someone who lives with a household and pays a reasonable compensation to the household for room and meals, is only eligible for SNAP benefits if the household is eligible and wants the boarder to be considered part of the household.

If you live in an institution that provides most of your meals, you may not be eligible for SNAP benefits. Residents of subsidized housing for the elderly, however, can be eligible.

If your household meets the eligibility requirements, you will receive benefits. You do not have to pay for the benefits. The amount that each household gets each month depends on the household's size, income, housing expenses, and medical expenses. Medical expenses are only counted for disabled persons and persons age 60 or older.

The financial eligibility requirements include an income test and a resources test. There are also non-financial eligibility requirements, such as registering for work if not exempted and providing a Social Security number.

INCOME TEST

The amount of income that you can have and still be eligible for SNAP benefits depends on the size of your household. These amounts are adjusted annually on October 1. You need to check with FSSA to determine the current allowable income for your household. Information about Indiana's SNAP program can be accessed online at <http://www.in.gov/fssa/dfr/2691.htm>.

Eligibility of most households is now based on gross income. If, however, the household contains a member who is age 60 or older, or who fits the given definition of disabled, that household's eligibility is based only on net income. Net income is first figured by adding all of the countable income of all household members together. This includes most types of income including most government benefits. After adding together all countable income, \$152 is automatically subtracted. If the household is more than four persons, the standard deduction is more. More may also be deducted for care of a dependent and for shelter expenses including utility expenses. Persons

who are over age 60, receive SSI benefits, or who fit the program's definition of disabled also receive an extra deduction for medical expenses that exceed \$35 per month. The amount of benefits is then based on the net income and the size of the household.

RESOURCES TEST

Resources include cash, bank accounts, stocks, bonds, vehicles, and property that you own. Usually, a household is not eligible for SNAP benefits if it has accessible resources worth more than \$2,000. If at least one person in your household is age 60 or over or is disabled, your household can have up to \$3,000 in resources. Some resources are counted and others are not. Your house, surrounding lot, household goods, personal belongings, and life insurance policies are not counted. All vehicles used for household transportation are exempt as well. Only recreational vehicles and those not used for household transportation will have their equity value counted as a resource.

WORK REQUIREMENT

The program may require members of your household to register for work and/or accept a job. Persons do not have to work, however, if they are age 60 or older, younger than 16, physically or mentally unfit to work, taking care of a child under age six or an incapacitated person, receiving unemployment compensation, or already employed.

APPLYING FOR BENEFITS

You can apply on-line for benefits at www.in.gov/fssa/dfrr/2999.htm. You can also print an application at that website. You can go to your county office of the Division of Family Resources for assistance to complete an application. Finally, you can telephone 1-800-403-0864 to have an application mailed to you. The application is not considered filed until filed on-line or received at the DFR office or Document Center.

If all members of your household receive SSI benefits, you may apply for SNAP benefits at the Social Security office.

It is important to apply as soon as possible. Food stamps are paid only for days beginning with the day you apply.

After you have signed and turned in your application form, a worker will conduct a confidential interview with you or another member of your household.

If you applied for SNAP benefits at the Social Security office, you do not have to go to the DFR office for an additional interview. If no one in your household can go to the DFR office for an interview, you may send an adult friend or relative to be interviewed for you. This person must know your household's circumstances and finances. If you cannot get to the DFR office and cannot send someone, especially if you are age 65 or older or handicapped, you should ask the DFR office to interview you over the telephone.

Do not hold back information. Tell the worker all relevant information and let the worker decide whether you are eligible.

The DFR office must tell you whether you need to do anything more, such as submit documents. The office will then notify you whether you are eligible, how long your certification period is, and the monthly amount of stamps that you will receive.

You may be able to get SNAP benefits within five days if you let the worker know of your immediate need. Emergency food stamps are available only to persons who have very low income and few resources. There are special rules for migrant farm workers. Otherwise, if you are eligible, you will receive an identification card and a notice of eligibility, and may participate in the program within 30 days from the date you first applied.

Once approved, you will be given a Hoosier Works Card, which you will use with the grocer or other provider. Once a month your allotment will be electronically added to your account, and you will then be able to access your benefits.

If you receive notice that you are not eligible, the notice should explain why your application has been denied. If you think that your application has been wrongly denied or that you have not received the right amount of benefits, you should discuss the matter with someone at the DFR office or by calling 1-800-403-0864. If you still disagree, you can ask for a fair hearing, at which your disagreement will be considered.

RIGHTS

For SNAP, you have the right to:

- Receive and submit a written application the same day you ask for it.
- Have an adult friend or relative apply for you if you cannot get to the food stamp office yourself.

- Have an interview at your home or by phone if you are age 65 or older or handicapped and cannot get to the DFR office or send someone in your place.
- Get your benefits within 30 days after you apply, if you are eligible and have done all that is required of you.
- Receive advance notice if your benefits are going to be reduced or stopped within the certification period.
- See your own records and a copy of the rules for SNAP. You should make advance arrangements to do this.
- Have a fair hearing if you disagree with any action or decision on your case.

Whenever you disagree with a decision, you can ask in writing, in person, or over the phone for a fair hearing. You should make this request within 90 days of the action you are complaining about or anytime during that certification period. If you are already receiving benefits and your benefits are going to be reduced or stopped, and if you request the hearing within 10 days from the date the notice was mailed, your benefits should continue during the time you are waiting for a hearing decision, but only until your certification period ends. At a fair hearing you can explain your disagreement. You can have a friend, relative, or lawyer help you prepare for and speak at the hearing.

RESPONSIBILITIES

Under SNAP you have the following responsibilities:

- Answer all questions honestly.
- Provide the necessary proof of your living arrangements and finances.
- Report promptly to DFR if your gross income increases the gross monthly income limit for your household size. This is the only change that must be reported.
- Do not let other persons use your food stamp cards or documents.
- Use your benefits only to buy eligible items. If you fail to meet your responsibilities, you may be asked to repay the value of benefits incorrectly used and may be disqualified from the program, fined or imprisoned.

Note: The SNAP program may change. You can get current information about the program from your local DFR office.

TOWNSHIP TRUSTEE BENEFITS

If you need help paying for basic needs, you can apply to the trustee in your township. The trustee must help people in need, regardless of their age. If you are eligible for trustee benefits, the trustee will not give you cash, but will instead pay whoever provides you with what you need. For example, the grocer, the doctor, the landlord, the mortgage company, the utility company, etc.

The law says that the trustee must help pay for the following expenses when necessary: medical care, including doctor's fees, hospital bills, prescriptions, special diets, nurses, etc.; funeral expenses; school textbooks, supplies, shoes and clothing.

The law requires the trustee to help needy persons to pay for other basic needs, including:

- Food, clothing, shelter, electricity, water
- Fuel for heating and cooking
- Necessary household supplies, including first aid and medical supplies for minor injuries and illnesses
- Necessary household furnishings, including basic furniture, utensils, and heating and cooking stoves
- Necessary household appliances
- Transportation required to find a job

You are eligible for help from your township trustee if you are in need. The law requires the trustee to have written standards to tell you who is eligible, what benefits are provided if you are eligible, and how to apply. If the standards are so strict that you are denied help that you really need for basic needs of life, you should challenge the trustee's standards by appealing. (See later in this section for how to appeal.)

The trustee may investigate your financial circumstances and approach your relatives who live in the township and ask them to assist you. The trustee can also require you to try to find ways to meet your needs, for example, by applying for SNAP benefits, Medicaid, Social Security, or SSI.

The trustee cannot ask you to promise to repay any aid that you receive unless you receive “lump sum” retroactive Supplemental Security Income (SSI) benefits, although the trustee can file a claim against your estate when you die. The trustee may ask you or a member of your family to work in a local government office or non-profit agency in order to work off your benefits at the federal minimum wage. You cannot be required to work if:

1. You are 65 years old or older
2. You are a minor
3. You already have a full-time job
4. You are not physically able to do the work
5. You are needed to care for someone else
6. There is no work available

You do not need to have lived in the township for any given length of time in order to be eligible for benefits. If your home is in the township, it is illegal for the trustee to deny you assistance based on how long you have lived there.

The law does not limit this assistance to emergencies. If you continue to need assistance and continue to be eligible, the trustee should not refuse to continue giving you assistance. The trustee may, however, ask you to re-apply periodically.

To apply for trustee benefits, you should go to your township trustee's office and apply in writing. Your township trustee should be listed under the name of your township. You can find a directory online at www.indianatownshipassoc.org/index.php/indiana-townships. If you do not know which township you live in, you may contact your county auditor's office to find out. You have a right to fill out a written application. The trustee must give you a prompt decision within three working days. The decision must be in writing and provide the reasons if you are denied any of the assistance you have requested. If you are already receiving benefits and the trustee decides to stop or reduce your benefits, the trustee must send you written notice at least 10 days before benefits are stopped or reduced. The notice must give the reasons for the change.

If you disagree with the trustee's decision, you can appeal to your County Commissioner's office. The trustee's notice should tell you how to appeal. Generally, you will have 15 days to request an appeal. However, if you have been receiving benefits which the

trustee wishes to reduce or stop, you must request an appeal hearing within 10 days in order to continue those benefits until the appeal has been decided. The Commissioners must decide your appeal within 10 working days and must give you notice of their decision within five working days of the decision. If you want to appeal the decision of the County Commissioners, you can go to court. You should see a lawyer before appealing to a court.

PRIVATE RETIREMENT PLANS

Many people employed in the private sector will receive payments from an employer sponsored retirement plan when they stop working. Such plans may be funded during an employee's working years by contributions from the employee, the company, or, if the employee is a member of a union, under a collective bargaining agreement. Workers then are entitled to draw benefits when they retire, or, in some cases, when they become disabled. Most retirement plans will also pay benefits to the dependents or beneficiaries of the worker if the worker dies before retirement.

Some retirement plans are called “qualified” retirement plans because they qualify for special tax treatment under the rules of the Internal Revenue Code. For example, a business is allowed a current income tax deduction for its contributions to a qualified retirement plan. Also, any contributions workers make, and any growth in the plan, are not taxed until the benefits are paid to the workers.

This chapter explains some of the important things you should know about private retirement plans. However, this explanation does not try to cover everything and so it may be smart to consult a tax advisor such as an accountant or an attorney about your particular situation. The advisor can explain the alternatives available so that you can get the most from your retirement benefits.

TYPES OF PENSION PLANS

There are two major categories of pension or retirement plans.

Defined Benefit Plan. The defined benefit plan is the traditional pension plan. The employer promises you a specific benefit at retirement and for your remaining life based on a formula. The employer

makes contributions to the plan in an amount that is determined to provide that promised benefit to you. Because the benefits are defined in the plan, most defined benefit plans do not permit you to make contributions. Here is an example of how the benefit might be determined:

Example: A plan provides that the employee will receive a pension equal to 1% of his compensation for each year of service. If the employee works for 25 years by retirement age and his compensation was \$50,000, the pension provided by the plan would be \$12,500 per year (\$50,000 x 25 years x 1%).

Under a defined benefit plan, the employer retains an actuary to compute the amount of annual contributions needed to fund the benefits that will be paid to you under the plan. You are guaranteed to receive the stated pension and a federal agency insures the pension amount up to a government established maximum monthly benefit. (See the section The Law later in this chapter). Any investment risk falls on the employer.

Defined Contribution Plan. Defined contribution plans have become the more popular type of retirement plan in recent years. Under a defined contribution plan an individual account is established for you, and money is contributed to that account each year. The plan has a stated, or defined, contribution limit each year. Once the employer makes the contribution to your account, the employer has fulfilled its promise, and there is no continuing obligation to contribute additional funds. Often the employer contributes a set percentage each year, and you are able to contribute additional funds to the account. Upon retirement, death or disability, the benefits paid out will be based on the amount in your account. These defined contribution plans are not insured, and any risk of loss in the investment is on you.

The most popular defined contribution plans include profit sharing plans, money purchase plans and employee stock ownership plans.

Profit Sharing Plans. Due to a change in the law, a profit sharing plan now permits an employer contribution each year that is no longer based on the employer's profits. The employer retains the right to increase or decrease the contribution amount each year, or to decide to make no contribution in a particular year. A 401(k)

plan often is tied to the typical profit sharing plan and permits employees to contribute to the plan from their own compensation on a pre-tax basis. Many 401(k) plans also allow the employer to match all or a portion of the pre-tax contributions made by the employees.

Money Purchase Plan. A money purchase plan is a defined contribution plan under which the employer must contribute a fixed percentage of the employee's compensation to the plan each year. The money purchase plan is becoming less common due to the greater flexibility provided by the 401(k) plan.

Employee Stock Ownership Plan. An employee stock ownership plan (ESOP) is a tax qualified retirement plan that is designed to invest primarily in the stock of the employer.

OTHER EMPLOYEE BENEFIT PLANS

Keogh plan. Keogh Plans (also called H.R. 10 Plans) cover self-employed persons and their employees. Deductible contributions made the plan will reduce self-employment income, and the earnings on those contributions are not taxed until the money is withdrawn from the fund at retirement. Keogh Plans are usually established as defined contribution plans.

Simplified Employee Pension plan (SEP). Businesses of any type and size are eligible to set up a Simplified Employee Pension plan (SEP). SEPs are much less expensive to administer than a full-fledged retirement plan, yet still offer tax-favored advantages. The employee sets up an individual retirement account (IRA), and the employer can make tax deductible contributions to the employee's IRA each year up to the lesser of \$53,000 (as of 2015) or 25% of the employee's compensation.

SIMPLE Plan. The SIMPLE plan is available to employers of 100 or fewer employees. Contributions of up to \$12,500 (as of 2015), plus \$3,000 more for those age 50 or older are made to a special IRA account for each employee based on salary deferral elections by the employee. The employee's contribution generally is matched by an employer contribution of up to three percent of the employee's compensation.

Individual Retirement Arrangement (IRA). IRAs have become increasingly popular. Traditional IRAs,

like qualified plans, let you postpone income tax on your earnings. You can set aside money in your working years and may be able to postpone tax on that money until you withdraw money for retirement. At that time, you probably will be in a lower income tax bracket, so your tax on the money will be less than if it had been taxed in the years earned.

The Roth IRA became available in 1998 and contributions you make to a Roth are not deductible for income tax purposes, but the Roth grows tax-free and you pay no income tax on withdrawals. The annual contribution limits for traditional and Roth IRAs are the same. However, unlike a traditional IRA, you may continue to contribute to a Roth after age 70 ½, and you are not required to take any distributions from the Roth before death. Contributions to Roth IRAs are subject to income limitations. Depending upon how much income you have and your filing status (for example, married and filing jointly), your ability to contribute may be reduced or eliminated.

If you also have a qualified retirement plan, any worker, full-time or part-time, can set up an IRA, subject to income limitations similar to those which apply to a Roth IRA. Also, a married worker can contribute to an IRA for a non-working spouse. The main advantages are postponement of income tax, on a traditional IRA, and a savings source for retirement. The disadvantage is that money you put in an IRA will be tied up until you reach age 59 ½.

The limits for annual contributions to IRAs (both traditional and Roth) are adjusted for changes in the cost of living. Working individuals over age 50 can make even greater contributions each year. The limits are as follows:

Annual IRA Contribution Limits

<i>Year</i>	<i>Individuals under 50</i>	<i>Individuals 50 – 70</i>
2013	\$5,500	\$6,500
2014	\$5,500	\$6,500
2015+	Adjusted for inflation Index, plus \$1,000 in \$500 increments	

You may start withdrawing from your IRA without penalty at age 59 ½. If you withdraw money before age 59 ½, you pay not only the income tax due on the

withdrawal if the IRA is a non-Roth, but also a 10% premature withdrawal penalty.

For more information about Keoghs, SEP, SIMPLE plans, or IRAs, consult your tax advisor, a lawyer, or the Internal Revenue Service. Many financial institutions offer IRAs and can also give you information. Do shop around. Most banks offer basic IRAs, for example, but they differ as to interest rates, minimum deposits, and investment risks. An expert who knows your specific financial history is in the best position to advise you on these specific matters.

THE LAW

Complex federal laws, including many sections of the Internal Revenue Code, regulate employer retirement plans and IRAs.

ERISA. The Employment Retirement Income Security Act of 1974 (ERISA) sets minimum standards for qualified plans relating to reporting and disclosure, funding and the maximum contribution and benefit limits. ERISA covers most company sponsored plans, including most defined benefit plans and defined contribution plans. ERISA does not cover plans sponsored by the government, churches or the military. ERISA is an extremely complex law, and it has exceptions for almost every rule. It applies only to people who have retired or become disabled after January 1, 1976.

PBGC. Defined benefit plans also are covered by the Pension Benefit Guaranty Corporation (PBGC) Termination Insurance under Title IV of ERISA. Most Defined Contribution Plans are not covered.

TRA 97. The Tax Relief Act of 1997 added the Roth IRA and also permits a spouse of an individual participating in a qualified plan to make contributions to a traditional or Roth IRA, if certain income levels apply.

IRC 401(a). Section 401(a) of the Internal Revenue Code sets out the minimum distribution rules relating to distributions of benefits at retirement and following death from all qualified plans, qualified annuities and the several forms of IRAs.

Employers and IRA providers are permitted to offer fewer than all of the distribution choices contained in the 401(a) rules. So, it is important for you to obtain a copy of your plan or IRA agreement in order to find out specifically the rules that apply to your situation.

YOUR RIGHTS UNDER FEDERAL LAW

ERISA gives you important rights to information concerning your pension or other qualified retirement plan. However, it is important to remember that not every employee is covered by a plan. The law does not require an employer to have a plan for its employees or to continue a plan once it is begun. If the employer does have a plan, however, that plan must meet the following requirements of federal law.

Your employer must furnish to you automatically and for free:

- A summary plan description written in plain language which explains the plan rules and your benefits.
- A summary of the retirement plan's annual report to the federal government.
- Upon termination of your employment, or upon a break in service, a statement explaining the amount of your vested benefits.
- Upon written request, an individual benefit statement that sets out the total benefits you have accrued to date and whether they are vested. You have the right to demand this benefit statement once every 12 months, and it must be furnished to you within 30 days of your written request.

CONDITIONS FOR QUALIFICATION

In exchange for offering the tax benefits attributable to pensions and qualified retirement plans, the Internal Revenue Code requires that every plan satisfy a series of complex conditions and restrictions. The employer must assure that these requirements are satisfied or the plan will lose its tax qualification, which could have adverse tax consequences for you, as well as for the employer. The most important of these requirements are discussed in the following sections.

ELIGIBILITY AND PARTICIPATION

Eligibility and participation requirements include the following:

1. Generally, if the employer has a plan, those employees who work more than 1,000 hours during a year must be eligible to participate in the plan. The plan may also require an employee to be age 21 to be eligible to participate. However, employees who are

represented by a labor union which bargains for their benefits may be excluded from the plan.

2. An employee who satisfies the eligibility requirements must become a participant no later than six months after reaching age 21 or after completion of one year of service. A year of service is defined by ERISA to mean a 12 month period in which the worker has worked at least 1,000 hours.
3. A plan may require two years of service as a condition for participation if the plan also provides full and immediate vesting.

VESTING

Generally, a plan must meet the following vesting requirements:

1. You must be 100% vested in the plan benefits after three years of service with the employer.
2. Alternatively, a plan may provide for six-year graded vesting, that is, a vesting schedule that provides at least 20% vesting after two years, increasing by 20% per year thereafter.
3. You must always be 100% vested in your own contributions to the plan.

NONDISCRIMINATORY COVERAGE

Because a retirement plan may be designed to exclude a portion of an employer's work force, the Internal Revenue Code provides a series of tests to insure that the effect of a plan's coverage provisions do not result in prohibited discrimination in favor of highly compensated employees such as owners. The tests are mainly mathematical and involve an analysis of the percentage of highly compensated employees who are covered by the plan as compared to the percentage of non-highly compensated employees who are covered. Additionally, the Internal Revenue Code requires that a defined benefit plan cover the lesser of 50 employees or 40% or more of all employees of the employer if such a plan is offered.

CLAIMS AND APPEALS

ERISA requires all employer retirement plans to have procedures for submitting claims and for appealing decisions. When you claim benefits, you have a right to:

- A decision within a reasonable time.
- Written notice if your claim is denied, including

specific reasons.

- A reasonable opportunity for a full and fair review of the decision.

You have at least 60 days to appeal the decision in writing. To prepare for the appeal, you have the right to submit written material to support your claim and to see the relevant documents that the plan administrators have. You do not necessarily have the right to argue in person at a formal hearing. You are entitled to a written decision on your appeal within 60 days of your request for appeal.

If you still are not satisfied with the decision, you can appeal to a court. A lawyer can help you with these procedures. Be aware, however, that the plan may have set limits on the amount of time you have to act. The United States Supreme Court has said that, if the time limits are reasonable, they will stop any further appeals to courts filed after the time limits have expired.

OTHER PROTECTIONS

ERISA also protects a worker from loss of benefits due to the employer's going out of business, acquisition of the worker's company by a new employer, or amendment or termination of the retirement plan. In addition, ERISA imposes new duties on administrators of retirement plans to make sure that funds in the plan are properly managed.

A retirement plan should not discriminate against older workers or prevent them from participation. (See the Age Discrimination in Employment section in Chapter 12.) There is one exception. If a worker begins work within five years of the normal retirement age, and if the retirement plan is a defined benefit plan, then the employer can limit the new worker's participation in the plan.

If you have questions about your employer's plan, ask the plan administrator. If you need help planning your retirement finances or enforcing your rights to benefits, consult a lawyer.

RECEIVING BENEFITS DURING LIFE FROM DEFINED BENEFIT PLANS (PENSIONS)

If you meet all the requirements discussed above, you can begin to receive your pension benefits from defined benefit plans when you reach your plan's retirement age. Some plans provide for early retire-

ment but require the early retiree to take a lower benefit. Some plans also start paying benefits when you become disabled. A very few plans pay the employee a lump sum when the employee leaves the job at any age, but only if a small amount of money is involved.

Benefits are usually paid monthly, and some plans provide for increases in benefits to reflect the cost of living.

Even though your pension plan states a normal retirement age, most employers cannot force you to retire. (See the Age Discrimination in Employment section in Chapter 12.) Most pension plans let you work full-time or part-time and still receive pension benefits. Some, however, suspend payment if you return to work for your former employer or in the same industry, trade, or geographic area. You also can receive both Social Security and pension benefits. In some cases, your pension benefit will be affected by the amount of Social Security you receive.

Also, when there is a divorce, a spouse can share in retirement benefits if those benefits are vested. The spouse must obtain a court order at the time of the divorce to protect his or her interest in the worker's retirement benefits. For more information, consult a lawyer.

RECEIVING BENEFITS FROM OTHER QUALIFIED PLANS AND IRAS

The Internal Revenue Service issued regulations that tell when and how you and your beneficiary must withdraw retirement money from retirement plans, such as 401(k) plans, 403(b) plans, and IRAs. The rules allow several options, but you must check your own plan or IRA agreement to determine whether it permits all the distribution choices the Internal Revenue Service says are allowed. Plans do not have to offer all of the choices which are legally allowed.

DISTRIBUTIONS BEFORE AGE 59 1/2

A distribution to you from your qualified plan or traditional IRA before the age of 59 1/2 is a premature distribution subject to a penalty of 10%. The penalty is designed to discourage the use of a retirement vehicle as a short-term deferral device rather than as a long-term retirement savings.

There are exceptions to the penalty. Some exceptions apply only to IRAs, and others are available only for employer-sponsored retirement plans. Most of the exceptions are triggered only by particular hard-

ships, such as death, disability or unemployment, or depend on a particular use of the funds distributed, such as college tuition, health insurance premiums, or a first-time home purchase. See your attorney if you require a premature distribution.

DISTRIBUTIONS BETWEEN 59 1/2 AND 70 1/2

There are no penalties for distributions to you from your IRA or qualified plan after you reach age 59 1/2. You may take a small or a large distribution, or no distribution at all, without penalty, if you meet the conditions for a distribution. A primary consideration when evaluating whether or not to take distributions before age 70 1/2 is the resulting income tax impact. The increased income may throw you into a higher tax bracket, or may contribute to a phase-out of personal exemptions or a reduction of itemized deductions.

MINIMUM REQUIRED DISTRIBUTIONS AT AROUND AGE 70 1/2

To encourage the use of IRAs and qualified plans as retirement devices, federal regulations impose a substantial penalty if an individual fails to begin taking retirement plan distributions at the required beginning date (RBD). For most people in most plans and all traditional IRAs, the RBD is April 1 following the year in which you reach age 70 1/2.

At your RBD, distributions from an IRA and, in most cases, from a qualified plan, must begin. Failure to take the required distributions and to subject the required amount of deferred income to income tax invokes a hefty 50% penalty on the amount that should have been taken but was not.

You determine your distribution for each year after your RBD by dividing your retirement account balance, as of December 31 of the prior year, by a life expectancy factor that is set forth in the table.

To use the Uniform Table, you simply divide the factor from the table into the prior year-end account balance of your retirement plan, or IRA, to determine the minimum required distribution for the year.

Example: Your IRA has \$100,000 as of last December 31. You will be 79 this year. Your minimum required distribution for this year is \$100,000 divided by 19.5 or \$5,128.

Uniform Table

Age	Factor	Age	Factor
70	27.4	93	9.6
71	26.5	94	9.1
72	25.6	95	8.6
73	24.7	96	8.1
74	23.8	97	7.6
75	22.9	98	7.1
76	22.0	99	6.7
77	21.2	100	6.3
78	20.3	101	5.9
79	19.5	102	5.5
80	18.7	103	5.2
81	17.9	104	4.9
82	17.1	105	4.5
83	16.3	106	4.2
84	15.5	107	3.9
85	14.8	108	3.7
86	14.1	109	3.4
87	13.4	110	3.1
88	12.7	111	2.9
89	12.0	112	2.7
90	11.4	113	2.4
91	10.8	114	2.1
92	10.2	115+	1.9

The Uniform Table and simple calculation method apply in nearly every situation for life-time distributions. The only exception is if you are married to someone more than 10 years younger. If so, you must use a different table to calculate your yearly required distribution. You may contact the IRS or your attorney to obtain a copy of that table.

DEATH DISTRIBUTIONS WHEN THE WORKER DIES (PENSIONS)

Most monthly benefit pension plans must provide at least half of the benefits the worker would have received upon retirement to the spouse of a deceased worker. This arrangement is sometimes called a joint and survivor annuity. Under the joint and survivor annuity rule, the worker's monthly benefit is

reduced to leave something for the spouse. For pensions beginning on or after January 1, 1985, survivor benefits are payable unless the spouse gave written consent to waive those benefits. The worker cannot waive survivor benefits for the spouse. If survivor benefits are waived, the worker will receive a higher pension, but then the spouse is not protected if the worker dies before the spouse.

If the worker dies before retirement, the rules are more complicated, but in many cases, the surviving spouse can receive benefits. For more information about the protection that your retirement plan gives to a spouse after a worker's death, read the summary plan description and consult with the plan administrator.

WHEN THE WORKER DIES (QUALIFIED PLANS AND IRAS)

Required distributions of your qualified retirement plans and IRAs to your beneficiaries after your death are based on the life expectancies of those beneficiaries. The actual beneficiary of a plan is not determined until September 30 of the calendar year following the year of your death. So, opportunity exists for some post-death planning.

For example, a spouse who would inherit an IRA may disclaim, allowing a younger generation to inherit. The payments then would be stretched out over the longer lives of those children, permitting more deferred income tax growth. This post-death planning usually only works, though, if you have designated a primary and a contingent beneficiary of your retirement account.

COMPUTING DISTRIBUTIONS IN THE EVENT OF DEATH BEFORE RBD

If you die before your RBD, April 1 of the year following the year you turned age 70 ½, the beneficiaries you designate receive distributions, as follows:

Surviving Spouse. If the beneficiary is your spouse, he or she can choose one of the following options, if the qualified plan or IRA agreement so permits:

- Rollover the benefits into your spouse's own IRA.
- Take distributions over 5 years.
- Receive distributions over your spouse's life expectancy, recalculated annually. If your spouse chooses this option, he or she must begin receiving

the distributions no later than December 31 of the year you would have reached 70 ½.

Individual Beneficiary. If the beneficiary is a non-spouse individual such as a child, the child can:

- Take distributions over 5 years.
- Receive distributions over the child's fixed life expectancy, beginning no later than December 31 of the year following the year of your death. If you name multiple beneficiaries, the distributions are made over the life expectancy of the oldest of the group unless separate accounts are created.

Non-Individual Beneficiary. If a beneficiary is a non-individual, such as a charity, estate, or corporation, all death distributions are made under the five-year rule.

COMPUTING DISTRIBUTIONS (DEATH AFTER RBD)

If you die on or after your RBD, the IRS rules require that in the year of death, the minimum required distribution must be paid from your retirement account, still using the Uniform Table. After the year of death, distributions are paid to beneficiaries, as follows:

Surviving Spouse. If the beneficiary is the participant's surviving spouse, the spouse can:

- Rollover the benefits into his/her own IRA.
- Receive distributions over his/her life expectancy, recalculated annually. If the spouse dies before the benefits are all paid, any benefits remaining will be paid out over the remaining, fixed, life expectancy of the surviving spouse, computed as of the age of his/her birthday in the year of his/her death.

Individual Beneficiaries. If the beneficiary is a non-spouse individual, the beneficiary can take the benefits over the beneficiary's fixed life expectancy. If there are multiple beneficiaries and they are all individuals, they take the required distributions over the oldest beneficiary's fixed life expectancy, unless separate accounts are created.

Non-Individual Beneficiaries. If a beneficiary is a non-individual, such as an estate, charity, or corporation, the participant is treated as having no designated beneficiary. In this case, the applicable distribution period is the remaining years of the worker's life expectancy, determined using the IRS' single, fixed, life expectancy table.

A WORD ABOUT ROTH IRAS

A Roth IRA owner is not required to receive any distributions, minimum or otherwise, from the Roth IRA during life. However, the owner can withdraw his own contributions to the Roth IRA at any time tax-free. All distributions, even from earnings on the contributions, are tax-free after the owner reaches age 59 ½ and once the Roth has been open for five years.

After the death of the Roth IRA owner, distributions are made over the life expectancy of the named beneficiary.

PUBLIC PENSIONS

STATE EMPLOYMENT BENEFITS

If you worked for the state government, in Indiana, you may be eligible for retirement or disability benefits under the state's program called the Indiana Public Retirement System (INPRS). INPRS is among the largest 100 pension funds in the United States. It serves approximately 450,000 members and retirees representing more than 1,187 employers. The employers include public universities, school corporations, municipalities, and state agencies.

INPRS includes the two largest public retirement plans in the state: The Indiana State Teachers' Retirement Fund (TRF) and the Indiana Public Employees' Retirement Fund (PERF). (In 2011, the Indiana General Assembly combined the two plans under INPRS. INPRS includes seven separate retirement funds: TRF; PERF; 1977 Police Officers' and Firefighters' Pension and Disability Fund; State Excise Police, Gaming agent, Gaming Control Officers and Conservation Enforcement Officers' Retirement Plan; Judges' Retirement System; Prosecuting Attorneys' Retirement Fund; and Legislators' Retirement System – Defined Benefit Plan.)

In addition to the seven plans mentioned above, INPRS manages the Pension Relief Fund. The Indiana General Assembly created this fund in May 1977 to address the unfunded pension obligations of police officers' and firefighters' pension systems of Indiana cities and towns. This fund is supported from a portion of the cigarette and alcohol taxes and the investment income earned on them. A fixed distribution formula provides relief payments bian-

nually, and is based on the number of retirees and the benefits paid in the past year. INPRS does not administer the local pension funds. In fact, the local funds have been closed to new membership since the creation of the 1977 Police Officers' and Firefighters' Pension and Disability Fund, which INPRS does administer.

The contact information for INPRS is as follows:

For information about INPRS plans except TRF:
telephone number (888) 526-1687

For information about TRF:
telephone number: (888)286-3544
TDD for Hearing Impaired: (317) 233-4160

INPRS mailing address:
One North Capital, Suite 001
Indianapolis, Indiana 46204

INPRS fax numbers:
Local: 317-232-3882/ Toll-Free: (866) 591-9441

Website: www.in.gov/inprs/contactus/htm.
Members can login from the website to find out various information about benefits, etc.

RAILROAD RETIREMENT BENEFITS

The Railroad Retirement program offers benefits to former railroad employees and their dependents. These benefits and eligibility criteria are very similar to Social Security benefits. (See the discussion of Social Security benefits.) If you are eligible to receive both railroad retirement and Social Security, your total benefits will be determined by a formula calculation and paid by the Railroad Retirement Fund.

Eligibility for benefits is based on years of service. Your years of service need not have been consecutive, and in some cases, your military service may be counted as railroad service. If you have at least 10 years of covered railroad work or five years performed after 1995, you can get full retirement benefits starting at age 65. As with Social Security, you can start getting benefits between ages 62 and 65, but your benefits will be permanently fixed less than the full amount. If you have 30 or more years of covered railroad employment, you may retire at age 60 or 62 and receive a reduced benefit or may wait until age 62 and retire on full, unreduced benefit.

Some retirees are eligible for an extra sum of money under the Supplemental Annuity System. You are eligible at age 60 if you have at least 30 years of railroad service, or at age 65 if you have 25 to 29 years of service.

Two kinds of railroad benefits exist for disabled railroad workers. Eligibility for these benefits depends on whether the disability is total or merely occupational. In addition, some relatives of railroad workers are also eligible for benefits when the worker becomes disabled or dies.

The above information is general and does not cover exceptions or special cases. For specific information about Railroad Retirement benefits, contact:

U.S. Railroad Retirement Fund
50 South Meridian Street, Suite 303
Indianapolis, Indiana 46204
(317) 226-6111 or (800) 808-0772
<http://www.rrb.gov>

FEDERAL EMPLOYMENT BENEFITS

Employees of the federal government have their own public pension program. If you worked for the federal government prior to 1987, you may be eligible for Civil Service Retirement (CSR) benefits. These benefits replace Social Security and have multiple benefit levels depending upon the timing and circumstances of your retirement, including benefits for disability.

The test for disability for federal employees covered under this program is different from Social Security's test. You are disabled for purposes of this program if your federal employer cannot place you in another job that you can perform and if the Office of Personnel Management approves your disability claim.

Almost all new employees hired after December 31, 1983 are automatically covered by the Federal Employees Retirement System (FERS). Certain other employees not covered by FERS have the option to transfer into the plan. FERS has three components: Social Security, Basic Benefit Plan, and Thrift Savings Plan. Employees covered by FERS and pay into and are covered by the Social Security System under normal Social Security benefits. Employees also have accounts through the Thrift Savings Plan (TSP), which includes employer and voluntary employee contributions and is tax-deferred. Also, FERS provides addi-

tional retirement annuity payments based upon the length of service and salary of the employee.

When a former federal employee dies, his or her surviving spouse and dependent children might be eligible for survivors' benefits. Civil Service Retirement benefits and procedures are very similar to Social Security. To find out more information about Civil Service Retirement benefits, the contact information is:

U.S. Office of Personnel Management
Attn: Retirement Operations Center
P.O. Box 45
Boyers, PA 16017
(888) 767-6738/TTY: 855-887-4957
Business Hours: 7:40 a.m. – 5:00 p.m. (EST),
Monday –Friday
email: retire@opm.gov
<http://www.opm.gov/retirement-services/>

Veterans' Benefits

OVERVIEW OF VETERANS BENEFITS

This chapter reviews federal veterans benefits related to Compensation and the Non-Service Related Improved Pension (herein referred to as “Pension”) available to veterans, surviving spouses, and in certain cases, dependents, as well as some of the more relevant state veterans benefits. Although this chapter is not an exhaustive list of VA benefits available, contact information for federal and state VA offices are listed at the end.

FEDERAL PROGRAMS

The two federal programs that this chapter discusses are the Compensation and Pension programs. This chapter provides a brief overview of each program, discusses eligibility criteria that the programs share, and then discusses the specific eligibility criteria associated with each program.

COMPENSATION—BRIEF OVERVIEW

VA Compensation is a program where a benefit is paid to veterans who have disabilities incurred or aggravated during active duty. The disability does not need to be related to combat or a job held during active duty. Rather, the disability must have occurred during the time of service and in the line of duty. Compensation eligibility is not based upon the amount of income or assets. Instead, it is awarded based upon a disability determination. While somewhat similar to workers compensation eligibility in the private sector, VA compensation does not require a total disability rating for benefits to be paid. Instead, the VA gives disability ratings in 10% increments. The amount paid is directly related to the percentage of disability. The higher the percentage of disability, the higher amount paid.

Surviving spouses or dependent children of military personnel who die in active duty and surviving spouses of dependent children of veterans who die as

a result of a service connected disability are eligible for dependency and indemnity compensation (DIC).

NON-SERVICE RELATED PENSION (“PENSION”)—BRIEF OVERVIEW

Veterans who served during a period of war (as defined by Congress) and who are permanently and totally disabled from a cause not solely related to their military service may be eligible for Pension benefits. In addition, under certain circumstances the surviving spouse and dependent children may also be eligible for Pension benefits. While both Compensation and Pension require some finding of a disability (although the test for disability for each program differs somewhat), Pension also requires that the claimant satisfy net worth and net income test. (The claimant is the person applying for the benefit. If the veteran is alive, the veteran is always the claimant. If the veteran is deceased, the claimant may be the surviving spouse and/or dependent child.)

BASIC ELIGIBILITY REQUIREMENTS THAT BOTH PROGRAMS SHARE

Although Compensation and Pension programs each have their own distinct eligibility rules, they share some of the basic eligibility requirements. Common eligibility principles center around what it means to be a veteran; what constitutes active duty; and the type of discharge from service that is required to be eligible for the benefit(s).

Active Duty. Compensation and Pension programs both require active duty service by the veteran. The VA defines a veteran as “a person who served in the active military, naval, or air service, and who was discharged or released therefrom under conditions other than dishonorable.” The VA’s definition of a veteran requires not only that a person served in the military, but also that that service was active. In some cases, this may encompass members of the Armed Forces Reserves or National Guard who have served on active duty.

For example, a Reservist who is activated to serve in Afghanistan for 12 months is considered to have served on active duty during that time.

Type of Discharge. The type of discharge is another factor that determines whether the VA will consider a person a veteran for either benefit program. A person desiring veteran status must have been discharged or released under conditions other than dishonorable. (Note that the language that the VA uses to describe the character of a veterans service does not correspond precisely with the language used by the military. The military has its own language that it uses to describe the circumstances under which a person was discharged.)

The military issues five types of discharges: 1.) Honorable discharge (HD); 2.) Discharge under honorable conditions (UHC), or general discharge (GD); 3.) Discharge under other than honorable conditions (OTH), or undesirable discharge (UD); 4.) Bad conduct discharge (BCD) (which can be issued by sentence or a special court-martial); and 5.) Dishonorable Discharge (DD) or a dismissal (both by general court-martial).

Individuals with dishonorable discharges generally cannot get benefits. Individuals with discharges under other than honorable conditions, undesirable discharges and bad conduct discharges may, but are not necessarily eligible for VA benefits. Individuals with honorable discharges, discharges under honorable conditions, and general discharges usually qualify for benefits.

For those discharges that are questionable, the VA will first adjudicate the issue of the character of service to decide whether the veteran was separated from service under dishonorable conditions or other than dishonorable conditions. In a character of service determination, the VA reviews the entire period of service to evaluate the quality of service and judges if it was good enough to merit receipt of benefits. Initial decisions are rendered at the VA regional office having jurisdiction over the claim. Adverse decisions can be appealed to the Board of Veterans Appeals and subsequently to the United States Court of Appeals for Veterans Claims.

There may be situations when a discharge may be changed by administrative action. The statutory bar to benefits described above may be overcome if the discharge is upgraded by the service departments Board for Correction of Military Records (BCMR). All discharges upgraded by a service department BCMR to at least a general discharge (GD) are final and conclusive on the

Department of Veterans Affairs and may be enough to allow a veteran to meet the discharge requirements that apply to eligibility for veterans benefits.

SPECIFICS ABOUT THE VA PENSION.

If the active duty and discharge requirements are satisfactorily met, the VA considers whether other pension-specific requirements relating to Basic Eligibility, Net Worth, and Net Income are met.

The additional Basic Eligibility criteria for the Pension require that the veteran have had active duty wartime service. The veteran must have had 90 days of continuous active duty before 1980 or 24 months of continuous active duty after 1980. Also, at least one day of the continuous active duty must have occurred during a declared period of wartime, although the veteran need not have been in a combat zone or even overseas. The official declared wartime dates as determined by Congress are listed below:

<i>Official Declared Wartime Dates</i>
<i>Mexican Border War:</i> May 9, 1916 - April 5, 1917
<i>World War I:</i> April 6, 1917 - November 11, 1918 (April 1, 1920 if served in Russia)
<i>World War II:</i> December 7, 1941 - December 31, 1946
<i>Korean War:</i> June 27, 1950 - January 31, 1955
<i>Vietnam War:</i> August 5, 1964 - May 7, 1975 (February 28, 1961 if served in Vietnam)
<i>Persian Gulf War:</i> August 2, 1990 - (date not yet determined)

If the claimant (the person applying for benefits) successfully meets the service-related eligibility requirements, the next basic eligibility requirement is that the claimant has a qualifying disability. There are two (2) different levels of benefits available depending on the claimant's level of disability: Service Pension and Special Monthly Pension. The Special Monthly Pension consists of two (2) types of benefits: Housebound and Aid & Attendance.

The Service Pension and both types of Special

Monthly Pension are available to the veteran as well as to the veteran's surviving spouse and dependents of the veteran. There is also a Death Pension potentially available to surviving spouses and dependent children. In addition to having to satisfy all of the Basic Eligibility, Net Worth and Net Income tests that would be required of the veteran, if alive, surviving spouses and dependent children seeking the Death Pension must also satisfy requirements related to marriage (for surviving spouses) or dependency (for dependent children). These additional requirements are discussed briefly below.

The Service Pension is the base level of pension. The VA states that individuals eligible for this level of benefit are permanently and totally disabled. Permanently and totally disabled means that the claimant is 65 or over, is in a nursing home or has been determined to be disabled by the Social Security Administration. In the event that the claimant cannot show that he or she falls within one of the above categories, he or she may establish permanent and total disability by showing that he or she is unemployable and reasonably certain to continue throughout life or that he or she suffers from a disability that makes it impossible for the average person to follow a substantially gainful employment, if the disability is reasonably certain to continue throughout life.

Being Housebound for purposes of the improved pension means "substantially confined to the home or immediate premises due to a disability which is reasonably certain will remain throughout their lifetime". A claimant can show Housebound eligibility one of two ways. The claimant can show that he or she is permanently and totally disabled and is substantially confined to the home. In the alternative, the claimant can show that he or she has a disability rating of 100% or more and a second rating of 60% or more. The 100% disability rating must be a permanent disability. Being Housebound does not mean that the claimant never leaves home. Instead, it means that the claimant is more or less confined to the home unless assistance is received.

A claimant meets the Aid and Attendance requirements if in a nursing home, blind, or nearly so. If the claimant is not in the nursing home or blind, a showing of a substantial daily need for assistance from another to perform the functions required by everyday living. These resemble the activities of daily living that

are discussed in the Medicaid context. Specifically, the claimant is unable to dress or undress; unable to keep himself or herself clean and presentable; frequently needs adjustments to any special prosthetic or orthopedic appliances; is unable to attend to the wants of nature; or has a physical or mental incapacity that requires assistance on a regular basis to protect the claimant from the hazards of his or her daily environment. For Aid and Attendance, the need must be a regular need, not a constant need.

While the veteran is living, pension benefits are only payable to the veteran. Hence, the spouse of a living veteran cannot apply for pension benefits, regardless of the level of benefit being sought:

Specific Death Pension Requirements. The VA also provides a pension benefit for surviving spouses of veterans who met the basic eligibility requirements for pension or were receiving or were entitled to receive compensation or retirement pay for a service-connected disability at the time of their death. This pension for surviving spouses is called a Death Pension. In order to be eligible, the surviving spouse of a veteran who met the basic eligibility requirements must have been validly married to the veteran at the time of their death. The marriage can be a common-law marriage and count for VA purposes. The surviving spouse and the veteran must have been married at least one year prior to the veteran's death. This particular requirement will also be met, however, if the couple was married for any period of time if a child was born to them before or during the marriage, if the marriage occurred before or during the veteran's service, or if the marriage occurred prior to the following dates

<i>Marriage Must Occur Prior to These Dates</i>	
<i>World War II Veteran</i>	January 1, 1957
<i>Korean War Veteran</i>	February 1, 1965
<i>Vietnam War Veteran</i>	May 8, 1985
<i>Persian Gulf Veteran</i>	January 1, 2001

Also, the surviving spouse must not have remarried or lived with someone and held themselves out as married, unless the remarriage ended prior to November 1, 1990 by death, or unless legal proceedings to end the remarriage were started by November 1, 1990.

Furthermore, the surviving spouse must have been living with the veteran at the time of their death. If the couple was living apart, it must have been for medical, business or other reasons besides marital discord, unless the marital discord was not the fault of the surviving spouse.

If the surviving spouse applies for Death Pension benefits within one (1) year of the veteran's death, benefits will be paid dating back to the first day of the month the veteran's death, otherwise the effective date is the date of the claim.

Death pensions are also available for surviving children. A surviving child is eligible if:

1. The veteran met the basic eligibility criteria for the Service Pension;
2. The veteran was receiving or was entitled to receive compensation or retirement pay for a service-connected disability at the time of death;
3. The child is not in the custody of an eligible surviving spouse;
4. The child is the biological, adopted or stepchild of the veteran;
5. The child is unmarried; and
6. The child is less than 18 years of age (23 if still in school or is disabled and incapable of self-support prior to age 18).

While the Pension is a way for a veteran, the surviving spouse or dependent child to receive tax-free income to assist in paying for in-home care, assisted living care or nursing home care, everyone is not necessarily eligible. Pension eligibility requires that the VA claims examiner consider the claimant's net worth and income in deciding whether benefits should be granted. If the claimant can pay his or her living expenses for a reasonable amount of time, then the VA will most likely bar pension eligibility.

The VA looks at the veteran's net worth to determine whether the Pension should be paid. The VA denies a claim for pension benefits when the "corpus of the estate", or net worth of the veteran, as well as the estate of the veteran's spouse and dependent children are such that it is reasonable that some part of it can be used for the veteran. The VA defines "corpus of the estate" as the market value, less mortgages and other encumbrances, of all real and personal property owned by the claimant except the claimant's dwelling (single-family unit), including a reasonable lot area,

and personal effects suitable and consistent with the claimant's reasonable mode of life. If the VA believes that the countable estate and the income (see discussion on income below) make it reasonable for the claimant to use some part of his or her net worth to provide for care, the VA will deny the claim or terminate current benefits. The VA reviews each case based on its facts to determine whether the claimant is eligible to receive benefits. The VA must be convinced that the claimant has a need for the pension monies before they will be awarded.

Some individuals believe that net worth meets the means test if it is \$50,000.00 or less for a single person and \$80,000.00 for a married couple. This is actually a misstatement. Instead, factors considered include the following: the amount of income in the household; whether property can be readily converted to cash without substantial sacrifice; the claimant's life expectancy; the number of dependents; and the potential rate of depletion of the assets, including unusual medical expenses.

With regards to income, unless excluded by the VA, generally payments of any kind from any source will be counted as income during the twelve month period in which they were received. Gross income, not net income, must be used. It is also a "household" calculation in that the income of the veteran, a dependent spouse, and any dependent children.

The VA broadly defines what is income and offers few exceptions. Essentially, once income is received, it is countable for VA purposes, unless it is specifically a gift from a charitable organization, welfare or public or private relief, such as supplemental Social Security Income. Exclusions from income are extremely important as they reduce the amount of income the claimant has for purposes of pension eligibility. Some of the more common exclusions are as follows:

1. ***Unreimbursed recurring medical expenses.*** The claimant must have paid a medical expense that was incurred by the veteran or a relative of the veteran who is a member of the veteran's household. The expense must not be reimbursed from any source. Unreimbursed recurring medical expenses are by far the most common deduction to reduce income for pension eligibility purposes.
2. ***Profit from the sale of property.*** Profits from the sale of real or personal property, except from the

sale of a business, are not considered income. Note that as a practical matter, the claimant is not required to sell his home to receive the pension. However, if the claimant sells the home after applying for the pension or after he begins to receive the pension, the proceeds from the sale of real estate, while not considered income, are considered part of the corpus. The likely result is that the reporting of these additional assets will be a termination of benefits until the claimant can show that excess resources no longer exist as a bar to pension eligibility.

3. **Welfare.** Private or public donations or relief from welfare organizations are not income. Maintenance provided by a friend, relative or charitable organization is not income. Money paid to an institution for maintenance of an individual confined to an institution because of impaired health is not considered income. Hence, money paid by a non-dependent child to assist a parent with his day to day bills is arguably not considered income. This is an important point to keep in mind as planning for VA benefit eligibility is considered.
4. **Fire insurance or casualty loss insurance payments.** Any fire or casualty loss insurance

proceeds received for loss sustained by claimant or within claimant's household are excluded.

5. **VA Pension payments.** Non-service connected pension payments, including accrued benefits, are not income. This means that if a claimant receives pension benefits from the VA retroactively such proceeds are not considered income by the VA.

How much income is too much? The answer to this question depends on the level of benefit being sought (Basic Service, Housebound or Aid and Attendance); whether the veteran is applying; whether the veteran has a spouse or dependents; whether there is just a surviving spouse or dependents; the gross income of the household; and the allowable exclusions that can be deducted from the gross income to offset the household income amount. For 2015, the benefit charts for the veteran and the surviving spouse are as follows (see Table 1 below, and Table 2 on page 34):

To calculate whether a claimant is eligible, the total exclusions are deducted from the gross countable income. While there are some specific adjustments that are made to that number in certain circumstances, the general rule is that the amount of the claimant's allowable deductions is deducted from his or her

Benefits Chart (2015)

Table 1: 2015 Pension Benefit figures – Wartime Veteran

<i>Type of Benefit</i>	<i>Maximum Annual Pension Rate (Income Limit)</i>	<i>Monthly Maximum Annual Pension Rate (Income Limit)</i>
Service Pension	\$12,868 (Medical expenses to be deducted must exceed \$643)	\$1,072 (Medical expenses to be deducted must exceed \$53)
With one dependent	\$16,851 (Medical expenses to be deducted must exceed \$842)	\$1,404 (Medical expenses to be deducted must exceed \$70)
Housebound	\$15,725	\$1,288
With one dependent	\$19,710	\$1,642
Aid & Attendance	\$21,466	\$1,788
With one dependent	\$25,448	\$2,120
For each additional dependent child	\$ 2,198	+\$183
2 Veterans married to each other	\$16,851	\$1,404

household countable gross income. That amount is then deducted from the maximum annual pension amount. For example, Fred, a veteran, meets the basic service requirements, having served more than 90 days of active duty with one day during the Korean War and having been honorably discharged. Fred is substantially confined to his home, as he cannot leave without assistance. Fred and his wife, Ginger, have a gross countable household income of \$13,000.00. They have \$5,000.00 of deductible expenses. \$13,000.00 (gross countable income) minus \$5,000.00 (deductible expenses) equals \$8,000.00. This \$8,000.00 amount is deducted from the maximum annual pension amount, which for Fred, who is claiming Housebound status is \$19,710.00. \$19,710.00 minus \$8,000.00 equals \$11,710.00 This is the approximate amount that Fred will receive over the next year if he meets the other pension requirements. Please note that this example is a general example as to how the program works. While the VA website, www.benefits.va.gov contains helpful information and tips, help is also available if desired.

Seeking help with applying for the non-service related pension. The VA maintains a list of accredited VA claims representatives. The list of these individuals may be found at www.va.gov/ogc/apps/accreditation/index.asp. An accredited VA representative is not supposed to charge for the filling out of the claim paperwork. While they can charge for review of documents and planning

to apply for the benefit and can charge for reconsideration or appeal work if the benefit is denied, they cannot charge for the filling out of the application. In addition, you can find your County Veterans Service Officer (CVSO) at www.in.gov/dva/2343.htm or by contacting your county government office and inquiring.

Caution about the VA benefit. The VA Pension is a potentially wonderful benefit that can help pay for care in the home, assisted living care or nursing home care. However, VA rules for eligibility are not the same as Medicaid eligibility rules. Over the past couple of years the VA has been discussing legislation to make it harder to plan for VA non-service pension eligibility. While this legislation is not in force as of the writing of this chapter, the attention to the legislation leads one to believe it may be passed at some point in the future. Also, please remember that you want to always consider how any planning done to qualify for VA benefits may later affect any need for Medicaid benefits to assist in paying for home-based community services (waivered services) or nursing home care.

COMPENSATION—SPECIFIC ELIGIBILITY

In general, veterans are entitled to Compensation benefits if (1) they were discharged or released under conditions other than dishonorable, (2) their disease or injury was incurred or aggravated in the line of duty, and (3) the disability is not a result of their own willful

Benefits Chart (2015)

Table 2: 2015 Pension Benefit figures – Surviving Spouse

<i>Type of Benefit</i>	<i>Maximum Annual Pension Rate (Income Limit)</i>	<i>Monthly Maximum Annual Pension Rate (Income Limit)</i>
Death Pension	\$8,630 (Medical expenses to be deducted must exceed \$431)	\$719 (Medical expenses to be deducted must exceed \$36)
With one dependent	\$11,296	\$941
Housebound	\$10,548	\$879
With one dependent	\$13,209	\$1,100
Aid & Attendance	\$13,794	\$1,371
With one dependent	\$16,456	\$1,371
For each additional dependent child	\$ 2,198	\$183

misconduct or abuse of alcohol or drugs.

Veterans eligible for Compensation receive monthly payments. As of December 1, 2013, for a single veteran without dependents, these payments ranged from \$130.94 for a disability rated as 10 percent disabling, to \$2,858.24 for a disability rated as 100 percent disabling. The rates of compensation payments are not automatically adjusted for inflation, and they can be increased only if Congress passes specific enabling legislation.

Before any type of disability rating is assigned and any money paid, the VA must first determine whether the veteran's disability is service connected. The definition of "service connected" involves the term "in the line of duty."

For the VA to find a disability or death to be service connected, it must determine that the disability occurred or was aggravated or that death occurred during active duty and in the line of duty. "In the line of duty" means that an injury or disease was incurred or aggravated during a period of active service, unless caused by the veteran's own willful misconduct or abuse of alcohol or drugs.

Once service connection is established (often the most challenging part of a compensation claim), a disability rating is assigned. This disability rating determines how much the claimant will receive in monthly compensation payments. The disability ratings are based, as far as practicable, upon the average impairments of earning capacity resulting from such injuries in civil occupations. The rating schedule provides 10 grades of disability: 0%, 10%, 20%, 30%, 40%, 50%, 60%, 70%, 80%, 90%, and 100%. A 100% disability rating is also called a total rating because it means that a veteran is totally disabled. The higher the disability percentage assigned, the higher the monthly compensation payment the veteran will receive.

If a service-connected condition increases in severity, the veteran may apply for an increase in the evaluation of the service-connected condition.

All is not lost for a veteran whose injury is service connected but who receives a 0% rating. First of all, the toughest part of the application process has been achieved—establishing service connection. If the veteran's injury worsens, the veteran can submit additional medical evidence without having to start the claims process over. Also, the veteran may be entitled to certain benefits within the VA health care arena.

Willful misconduct as a bar. A determination by the VA that an injury or disease was the result of willful misconduct creates a bar to any benefits that may be based on that disability. Similarly, if a veteran's death is the result of his or her willful misconduct, the death will not be considered service connected and that persons survivors will not be entitled to dependency and indemnity compensation (DIC).

There is a presumption that an injury or death suffered while an individual is on active military service is incurred in the line of duty and is not the result of willful misconduct. To overcome this presumption, the VA must establish by a preponderance of the evidence that the service member engaged in willful misconduct and that misconduct proximately caused the service member's injuries or death. Willful misconduct is an act involving conscious wrongdoing or known prohibited action with knowledge of or a wanton and reckless disregard of its probable consequences.

There are circumstances where a veteran can receive more than the rate provided for a disability rated 100%. If a veteran has suffered certain severe disabilities, the veteran may be entitled to special monthly compensation (SMC), which can provide compensation payments at a rate much greater than the 100% rate. Severely disabled veterans in need of regular aid and attendance (interpreted as help with certain activities of daily living on a regular basis) or daily health-care services may be eligible for additional compensation.

As noted above, the VA pays a form of compensation to surviving spouses, children, and parents of deceased veterans whose deaths were caused by service-connected conditions dependency and indemnity compensation (DIC). DIC for surviving spouses is not based on the disability or income of the surviving spouse; however, income is a factor when the parents of a deceased veteran have basic eligibility for DIC.

Entitlement to VA compensation benefits is not affected by earned or unearned income. The value of the veteran's estate is never a factor as to entitlement to VA compensation benefits. On occasion, a veteran may be entitled to both compensation and pension. The VA cannot pay both benefits concurrently. The veteran can either elect which benefit to receive but in most cases the VA will notify the veteran of the dual entitlement and select the benefit paying the highest amount.

STATE VETERANS' BENEFITS

There are several benefits available to veterans through the State of Indiana. These benefits include:

Indiana Veterans Memorial Cemetery. Indiana Veterans Memorial Cemetery opened for internments on December 1, 1999. The Cemetery is located adjacent to the Madison State Hospital and Clifty Falls State Park in Madison, Indiana. Any Hoosier veteran eligible to be buried in a national cemetery may be eligible to be buried in the Indiana Veterans Memorial Cemetery. Spouses of eligible veterans may also be buried in the Cemetery. To obtain an application for burial, contact the Indiana Department of Veterans Affairs (see below for contact information). To schedule an internment, contact the Cemetery Superintendent at 1415 North Gate Road, Madison, Indiana 47250, (telephone: 812-273-9220 and fax: 812-273-9221).

Each county auditor is authorized to pay up to \$100.00 for the burial of a veteran or a veteran's spouse, and pay up to \$100.00 for the setting of a federal headstone. Veterans must have received an honorable discharge and an application must be filed with the county auditor in the county of residence.

License Plates. Any Indiana resident who was honorably discharged from the active armed forces can purchase a Hoosier Veterans license plate. The veteran must take his or her DD-214 or Discharge Certificate to the local Bureau of Motor Vehicles and pay \$15.00 for the plate. For those that qualify, the following additional plates are available from the BMV: Disabled Veteran; Ex-Prisoner of War, Purple Heart, Support Our Troops, Gold Star, and POA/MIA (for current POA/MIAs). Each plate has certain requirements to be able to purchase it. Contact your local BMV, the Indiana Department of Veteran Affairs or inquire at www.in.gov/dva/2343.htm

Indiana Soldiers and Sailors Children's Home. This facility, located in Knightstown, provided for the care, training and education of children of indigent veterans. The home closed with the graduating class of 2009. However, former residents and students may be able to participate in the Indiana Remission of Fees program and receive help with book fees from a special fund that the Home established. For book fees, the student must submit the ROF application. The limit for book fees is \$600 per semester. To qualify for extra help through the ROF program, see below.

Indiana Veterans' Home. The Indiana Veterans' Home is located in West Lafayette. It was originally created to care for veterans during the Civil War, welcoming its first resident in 1896. It provides short-term rehabilitation services, nursing care and domiciliary care for Hoosier veterans that have been honorably discharged and their spouses. The Indiana Veterans' Home also has a dedicated memory care unit for those with Alzheimer's disease or other dementias. No wartime service is required. The veteran must have resided in Indiana for at least 12 months before admission (a waiver of this requirement may be possible).

The Indiana Veterans' Home accepts private payment, insurance, Medicare (Medicare A once the resident has had a qualifying hospital stay and needs short-term rehabilitation therapy services), and Medicaid.

Contact information for the Indiana Veterans' Home is as follows:

Indiana Veterans' Home
3851 N. River Road
West Lafayette, Indiana 47906-3762
(765)463-1502

Personal Property and Property Tax Deductions. A disabled veteran may be entitled to a Disabled Veteran Tax Deduction. To apply, the veteran needs his or her DD214 and a pension certificate or an award of compensation issued by the United States Department of Veterans Affairs. If the veteran does not have the necessary paperwork to apply, State Form 51186 can be completed and forwarded to the Indiana Department of Veterans Affairs so eligibility can be determined.

The disabled Hoosier veteran that owns or is buying under contract taxable personal property, real property, a mobile home or a manufactured home may be entitled to a \$12,480 tax deduction under the following conditions:

1. Served at least 90 days of honorable service; and
2. Are totally disabled (not necessarily service-connected but the disability must be evidenced by the U.S. Department of Veterans Affairs pension certificate); or
3. Are at least 62 years old and have a 10% service-connected disability.

Surviving spouses may also obtain this property tax deduction under certain circumstances. However, neither the veteran nor the surviving spouse is enti-

tled to the deduction if the value of the real property is greater than \$143,160.00.

The disabled Hoosier veteran that owns or is buying under contract taxable personal property, real property, a mobile home or a manufactured home may be entitled to a \$24,960 tax deduction under the following conditions:

1. Served honorably in the Armed Forces during any period of wartime; and
2. Are at least 10% service-connected disabled.

The surviving spouse of the veteran may also be able to receive this deduction.

Disabled Hoosier veterans may be entitled to receive a \$37,440 tax deduction (both of the above deductions) under the following conditions:

1. Served honorably during any period of wartime; and
2. Is 100% service-connected disabled; or
3. Is at least 62 years old with at least a 10% service-connected disability,

For registration years starting after December 31, 2013, an individual that is not eligible for a property tax deduction may be able to claim a credit against vehicle excise tax. The maximum currently allowed is the lesser of the amount of excise tax owed for the vehicle or \$70.00. This credit may be used for up to 2 vehicles per year. To qualify, there are several requirements that are set forth at IC 6-6-5-5.2 or can be found at www.in.gov/dva/2383.htm

Remission of Fees (Free Tuition) for the Child(ren) of a Disabled Veteran. The rules for this program depend on whether the veteran initially entered military service on or before June 30, 2011 or after that date.

On or Before June 30, 2011. Natural or legally adopted children of a disabled veteran may be eligible for free tuition at any state-supported post secondary school or university in the State of Indiana. All students must provide a copy of their birth certificate or adoption papers when they apply for admission. This can be used at any age as long as the child was adopted by the age of 24 and the child is a resident of Indiana.

To qualify, the veteran must have served in active duty in the U.S. Armed Forces during a period of wartime or performed duty equally hazardous that

was recognized by the award of service, campaign or expeditionary medal of the United States (the military discharge must reflect that medal). In addition, the veteran must have been a resident of Indiana for at least three consecutive years. Also, the veteran must have declared a service-connected disability or suffered a service-connected death as determined by the U.S. Department of Veterans Affairs or the Department of Defense; or received the Purple Heart Medal; or the veteran was a resident of Indiana at the time of entry into the service and was declared a POW or MIA after January 1, 1960; or the student was a veteran-related pupil of the Indiana Soldiers' and Sailors' Home.

Generally, the Remission of Fees is good for 124 undergraduate or graduate semester hours. The amount remitted is 100% of tuition and all mandatory fees. If the program is used for graduate work, reimbursement occurs at the undergraduate rate and the applicant has to plan how to make up any difference.

On or After July 1, 2011. Natural or adopted children of eligible disabled veterans may be eligible for remission of fees. The change from the above rule is that for adopted children, the child must have been adopted before age 18.

<i>Eligible Wartime Dates</i>
<i>World War I:</i> April 6, 1917 - November 11, 1918
<i>World War II:</i> December 7, 1941 - December 31, 1946
<i>Korean War:</i> June 27, 1950 - January 31, 1955
<i>Vietnam War:</i> August 5, 1964 - May 7, 1975
<i>Persian Gulf War:</i> August 2, 1990 - present
For the long list of expeditionary medals that qualify, please go to www.in.gov/dva/2378.htm

The veteran must have served in active duty for the U.S. Armed Forces during a period of wartime (recognized wartime periods after June 30, 2011 and including any wartime period that started before June 30,

2011 but continued past June 30, 2011) or performed an equally hazardous duty that was recognized by the award or service, campaign or expeditionary medal of the United States. The veteran must have entered military service from Indiana or must have been a resident of Indiana for at least 5 consecutive years during his or her lifetime.

The veteran must be declared to have a service-connected disability or suffered a service-connected death as determined by the U.S. Department of Veterans Affairs or the Department of Defense; or the veteran received the Purple Heart Medal.

Similarly to children of veterans who entered the military on or before June 30, 2011, the remission of fees is good for 124 hours of education. However, it can only be used for undergraduate work. The amount that will be remitted depends on the percentage of the veteran's disability. Children of veterans rated with an 80% or greater service-connected disability or whose parent received the Purple Heart Medal will receive 100% remission of tuition and mandatory fees. Children of veterans rated to have less than an 80% service-connected disability will receive 20% remission plus the disability rating of the veteran. For example, if the veteran has a 30% service-connected disability rating, the child will receive a 50% remission on tuition and mandatory fees. If the veteran's disability rating changes after the start of the academic semester, quarter or other period, the change in disability rating shall be applied with the beginning of the following aca-

demic semester, quarter or period.

In addition, the program has grade point average (G.P.A.) requirements. Also, students are limited to 8 years in the program and must initially apply for the program before their 32nd birthday.

For more information or an application for the Remission of Fees program, see <http://www.in.gov/dva/2357.htm>.

The above is by no means an exhaustive list of the state benefits potentially available to veterans and in certain cases their families. For more information please see www.in.gov/dva/2343.htm. The link to obtain the contact information for your County Veterans Service Officer (CVSO) can be found at this page too. Also, for more information about state veterans benefits, the Indiana Department of Veterans Affairs contact information is as follows:

Indiana Department of Veterans Affairs
302 West Washington Street, Room E-120
Indianapolis, Indiana 46204-2738
(317) 232-3910

For information more information about federal veterans benefits, the Veterans Affairs Regional Office contact information is as follows:

Veterans Affairs Regional Office
575 N. Pennsylvania Street
Indianapolis, Indiana 46204-1581
(800) 827-1000

Healthcare

PLANNING FOR LONG TERM HEALTHCARE NEEDS

The catastrophic cost of long term care is the greatest threat to the financial security of most older adults. Medicare does not cover long term care in a nursing home, and Medicare's coverage of home care is limited. The vast majority of Medicare supplement (Medigap) insurance policies offer little or no long term coverage. In fact, less than 3% of the costs of nursing home care in this country are paid by either Medicare or private insurance. The result is that most families pay this cost out of their savings until they reach poverty level and then turn to the Medicaid program for assistance. Planning ahead can help alleviate these harsh results.

The first step in planning ahead is to assess what coverage you have. If you have health or long term insurance, find out what it will cover. It is also useful to consider what steps you would need to take to qualify for Medicaid to cover nursing home costs. Now that Medicaid has rules to help protect a community spouse, Medicaid may be a viable option where one spouse enters a nursing home and one spouse remains at home.

It is also important to assess what you wish to accomplish. If it is important to you to preserve assets to pass along to your heirs, then you will want to make certain that you are protected against the cost of long term care. You may wish to purchase long term care insurance or seek legal advice concerning how you may be able to protect assets. If it is unimportant to you whether there are assets left to pass to heirs, then you may be content with simply relying on Medicaid once your assets are reduced sufficiently so that you are eligible for Medicaid.

MEDICARE

Medicare is a federal health insurance program that helps persons 65 or older and some disabled persons pay for medical care. Your eligibility for Medicare does

not depend on your financial situation. Medicare has four parts. Part A, called Hospital Insurance, can help you pay for in-patient care in a hospital and for limited care in a nursing home, hospice, or at home.

Part B, called Medical Insurance, can help you pay for doctors' services, out-patient hospital services, and some other medical services and supplies. Not all medical expenses are covered by Medicare, and Medicare does not always pay the full cost even of covered services. You should read the following explanation carefully to understand what Medicare does not cover. Because of the gaps in Medicare, you may want to supplement your Medicare program with other health insurance. (See Supplemental & Long Term Health Care Insurance)

Part C, called Medicare Advantage, includes health plan options, such as HMOs or PPOs, approved by Medicare and run by private companies. For a person choosing this type of plan, the plan takes the place of the traditional Medicare Parts A and B.

PART D IS PRESCRIPTION DRUG COVERAGE COVERED LATER IN THIS CHAPTER.

If you have very low income, you may want to apply for Medicaid, another federal program that helps pay medical expenses for elderly or disabled persons with low income. (See Medicaid)

Medicare is a federal program run by the Center for Medicare and Medicaid Services. You apply for Medicare at your local Social Security office. The government has also entered into contracts with private insurance companies who administer the Medicare payments. In Indiana, Medicare payments are handled by National Government Services. National Government Services is called an "intermediary" when it handles claims from hospitals, nursing homes and home health agencies under Part A. National Government Services is called a "carrier" when it handles claims from doctors and other providers of medical services under Part B. The involvement of these different organizations is sometimes confusing to Medi-

care recipients. On matters of application or eligibility, you will usually deal with a Social Security office. On matters of claims, coverage, and payment, you will often deal with National Government Services. For general information about the Medicare program, contact your local Social Security office.

WHO IS ELIGIBLE AND HOW DO YOU APPLY

Part “A” benefits. You should apply when you become eligible. Do not wait for illness or injury. Four categories of persons are eligible for Part A benefits:

1. You are automatically eligible for Part A benefits if you are 65 or older and are eligible for either Social Security retirement, survivor’s benefits or Railroad Retirement benefits. (See Social Security) You should apply for these benefits about three months before your 65th birthday. If you started receiving Social Security or Railroad Retirement benefits before age 65, you should receive your Medicare card automatically when you reach age 65.
2. You are also eligible for Part A if you are younger than 65, are disabled and have been eligible for, though not necessarily receiving, Social Security or Railroad Retirement disability benefits for at least two years. If you are getting disability benefits, you should receive your Medicare card automatically after two years. (See Social Security’s definition of disability)
3. If you have chronic kidney disease at any age and are eligible for Social Security or Railroad Retirement disability benefits, you are eligible for Part A without waiting for two years.
4. If you are 65 or older but not otherwise eligible, you may choose to enroll in Part A. Persons who have retired from work in the federal government are usually not eligible. If you choose to enroll, you must pay a monthly premium (\$407 in 2015, but only \$224 if you have 30 quarters of coverage) and must also enroll in Medicare Part B. The premium for Part B is higher for every year you wait to apply beyond age 65, unless you delay enrolling for Medicare because you are working and have insurance through your employer. If you are in this fourth category, you must file an application at a Social Security office sometime between January 1 and March 31.

NOTE: If you are signed up for Part A, you will be automatically enrolled in Part B, too, unless you tell the Social Security Administration that you do not want Part B coverage.

Part “B” benefits. Part B benefits are for persons who are 65 or older or disabled. Everyone who receives Part B benefits must pay a premium of \$104.90 a month in 2015. This amount changes annually. The premium is higher for every year you wait to apply beyond age 65. If you are eligible for Medicaid, Medicaid may pay your premium for Part B.

You are eligible for Part B if you are eligible for Part A benefits. If you are enrolled for Part A benefits, you will also be automatically signed up for Part B. You can opt to decline Part B coverage, but you should keep Part B coverage unless you are absolutely certain that you have other insurance coverage for those items covered under Part B. Although you can later sign up for Part B, in many cases you will then be required to pay a higher Part B premium for the rest of your life.

YOUR MEDICARE CARD

If you are covered by Medicare, you will be given a Medicare card. If you and your spouse are both covered, you should have separate cards with separate claim numbers. You should show your card whenever you receive services that Medicare will pay for. Put your full claim number, **including the letter**, on all claims and other correspondence about Medicare. Carry your official card with you when you are away from home. If you lose your card, call Social Security to get a replacement.

COVERAGE

Generally, Medicare will not pay for:

1. Services by healthcare organizations and professionals who are not licensed under state or local health laws.
2. Care by a hospital, nursing home or home health agency that is not approved to participate in the Medicare program. Be sure to ask these organizations whether they are approved for Medicare.
3. Custodial care, which is help that does not require professional skills or training; for example, help in eating, walking, dressing, bathing and taking medicine.

4. Care that is not reasonable and necessary.

If you have received care reasonably believing that Medicare would cover the expense, you will not be held responsible for paying for that care even if it turns out that the care is not covered because it is custodial or not reasonable or necessary. This rule, called ‘waiver of liability,’ applies to Part A benefits, but only applies to Part B benefits if the doctor or supplier agreed to accept an assignment. (See Part A coverage) Even if your doctor did not accept assignment, you will not be responsible to pay your doctor for services Medicare found not to be reasonable and necessary. This does not apply if either your doctor could not reasonably have been expected to know that Medicare would not pay for the services, or if the doctor informed you in advance in writing that he or she believed Medicare was likely to deny payment for that service. If you disagree with Medicare’s decision about such services, you can appeal that decision. A nursing home should notify you within three days of admittance if your care there is not covered by Medicare.

PART A COVERAGE

Part A benefits can help pay for four types of expenses: in-patient hospital care, in-patient care in a nursing home, hospice care and home health care.

Medicare can help pay for only a limited number of days in a hospital or nursing home in each benefit period. A benefit period starts when you first enter the hospital and ends when you have been out of the hospital or skilled nursing home for 60 days in a row. There is no limit to the number of benefit periods you can have, but there are limits to Medicare payments within each benefit period. Also, Medicare will not pay for every expense in a hospital or nursing home.

When you are in the hospital. Medicare will pay for in-patient hospital expenses only if a doctor prescribes hospital care, the care can only be provided in the hospital, the hospital participates in Medicare, and a hospital committee agrees that you need the care.

Part A Hospital Insurance does not cover:

1. Doctor’s services while you are in the hospital. Part B might cover this.
2. Personal convenience items you request such as TV, radio, telephone, etc.
3. Private duty nurses.
4. Extra charge for a private room, unless it is

medically necessary.

5. Fees for the first three pints of blood per year that you do not replace.

Other expenses, such as a semi-private room, regular nursing services, meals, therapy, medical supplies, drugs, wheelchairs and walkers are usually covered.

In special circumstances, Part A might help pay for hospital care in a foreign hospital, in a Christian Science Sanatorium or in a hospital that does not participate in Medicare. Part A can also help pay for a lifetime total of up to 190 days in a psychiatric hospital. For information about these special cases, call your Social Security office.

Medicare limits the amount of covered expenses it will pay in each benefit period. From day number 1 through day number 60 in each benefit period, Part A pays for all covered expenses except the first \$1,260 in 2015. The first \$1,260 is your deductible and you must pay it. From day number 61 through day number 90, Part A pays for all covered expenses except \$315 a day in 2015, which you must pay yourself. If you need more than 90 days of care in a hospital, you can use up to 60 additional days. During these reserve days, Part A pays all but \$630 a day in 2015, which you must pay yourself. These amounts change annually.

NOTE: You only get 60 reserve days in your lifetime. Once you have used them, they are gone. They will not be available again in the next benefit period. You can decide yourself whether and when to use these reserve days. You may choose to use private insurance or other funds to pay hospital expenses after day number 90 and save your reserve days. If so, you should notify the hospital in writing ahead of time.

The following examples might help explain Part A hospital coverage.

Example #1: Mrs. A enters the hospital on June 1. On June 12, she goes home. Mrs. A must pay the \$1,260 deductible, and Medicare Part A will pay the rest of her covered hospital expenses.

Example #2: Mrs. B enters the hospital on June 1 and does not go home until August 15. For the first 60 days, Mrs. B must pay the \$1,260 deductible, and Part A will pay the rest of her covered hospital expenses. After day number 60, Mrs. B must pay \$315 a day, and Part A will pay the rest.

Example #3: Mr. C is in the hospital for 55 days. He must pay the \$1,260 deductible, and Medicare Part A will pay the rest of his covered expenses. After he

has been home for 20 days, he is readmitted to the hospital for the same condition. Because he has been home less than 60 days, the second hospital stay is in the same benefit period. So the day he is admitted is considered day number 56, and he does not have to pay the deductible again. After 5 days, however, he will have to start paying \$315 a day.

Example #4: Mr. D is in the hospital for 7 days. He pays the \$1,260 deductible, and Medicare Part A pays the rest of his covered hospital expenses. After he has been home for 90 days, he returns to the hospital. Because he has been home longer than 60 days, a new benefit period will begin when he re-enters the hospital. His first day after readmission will be day number 1, and he must pay the \$1,260 deductible again.

NOTE: The amounts that you pay change each year, so check with your Social Security office.

When you are in a nursing home. Part A can help pay for care in a skilled nursing home facility after you have been in a hospital. Not all nursing homes provide the level of care necessary to make that home a *skilled nursing facility*, so be sure to check before you assume that Medicare will help pay for that facility's care. To be covered, the nursing home must be certified for Medicare, and also you must meet all the following requirements:

1. You have been in a hospital at least three days in a row, not counting the day you were discharged.
2. You need follow-up care in a skilled nursing facility for the same condition that was treated in the hospital.
3. You enter the facility soon, usually within 30 days, after you leave the hospital.
4. A doctor certifies that you need daily skilled nursing or rehabilitation care, not just custodial care or periodic nursing care.
5. The facility's review board agrees that you need this type care.
6. The facility, including the wing or part where you stay, provides skilled nursing care.

If your stay in the nursing home is covered, Part A will help pay for up to 100 days of care in each benefit period so long as you continue to need skilled nursing care. If you leave the facility before you have used your 100 days and you are readmitted within 30 days, you may be able to use the rest of your 100 days even though you do not have a new three day stay in the hospital.

In each benefit period, Part A will pay the following amounts:

1. From day number 1 through day number 20, Part A will pay for all covered expenses.
2. From day number 21 through day number 100, you must pay \$157.50 a day in 2015 (this amount changes each year), and Part A will pay the rest of covered expenses.
3. After day number 100, you must pay all expenses.

Notice that if you are in a nursing home very long, Medicare will run out. As a practical matter, you may not get Medicare payments even for the full 100 days as Medicare may decide you no longer need daily skilled services. The average number of nursing home days for which Medicare actually pays is much less than 100. This means that you should not count on Medicare for substantial payment of nursing home expenses. (See Supplemental & Long Term Health Care Insurance)

Covered services in a skilled nursing facility include:

1. A semi-private room
2. Meals, including special diets
3. Regular nursing services
4. Drugs furnished by the facility
5. Medical supplies
6. Use of wheelchairs
7. Rehabilitation services

Part A cannot pay for:

1. Your doctor's services while you are in the facility, although Part B may help pay for these services. (See Part B coverage)
2. Private nurses.
3. Extra charges for a private room, unless the room is medically necessary.
4. Personal convenience items such as TV, radio, or telephone in your room.
5. Fees for the first three pints of blood per year that you receive and do not replace.

PART B COVERAGE

Medicare Part B can help pay for doctor's services, outpatient therapy, out-patient hospital care, home health care and other services and supplies not covered by Part A.

Part B covers a doctor's services you receive in the doctor's office, in a hospital, in a skilled nursing

facility, in your home or anywhere else in the United States. Sometimes, especially if your doctor recommends surgery, you may want a second opinion. Part B helps pay for a second opinion.

Part B also typically helps pay for:

1. Medical and surgical services
2. Out-patient hospital care, including emergency room services
3. Diagnostic tests and procedures
4. X-rays
5. Drugs that cannot be self-administered
6. Medical supplies
7. Out-patient rehabilitation
8. Reasonable charges for radiology and pathology services while you are in a hospital
9. Outpatient treatment for mental illness
10. Services of a licensed podiatrist, but not for routine foot care
11. Independent laboratory services, if the laboratory is certified by Medicare
12. Necessary ambulance transportation by an ambulance service approved by Medicare. Not used merely to get to the doctor's office
13. Prosthetic devices, such as heart pacemaker, corrective lenses after a cataract operation, breast prosthesis after a mastectomy, colostomy bags, etc.
14. Artificial limbs and braces
15. Oxygen equipment
16. Wheelchairs
17. Home dialysis equipment
18. Various screening tests, including mammograms, pap smears, bone mass measurement, diabetes screening, cardiovascular screening, prostate cancer screenings, glaucoma tests, and colorectal exams
19. Medical nutritional therapy for persons with diabetes or renal disease
20. Flu and pneumonia shots
21. Smoking cessation

Under Part B, payments are based on the calendar year rather than the benefit period used for Part A. You must pay the first \$147 of all Part B expenses in 2015. This is your deductible, which changes each year. After you have paid the first \$147 of expenses,

Part B will pay 80% of the remaining reasonable charges for the year. You must pay the other 20%.

NOTE: Medicare Part B only counts reasonable charges for medical bills. Medicare uses a formula to determine what a reasonable charge for each service is and will pay only 80% of this reasonable charge. What Medicare calls a reasonable charge for a service is often less than what the doctor or other provider actually charges. As a result, you may have to pay the difference between what Medicare considers a reasonable charge and what the doctor or other supplier actually charges you. So it is important to ask whether your doctor or other supplier will accept an assignment. A doctor who accepts assignment cannot bill you for this difference. Even if the doctor does not accept assignment, there are limits on what the doctor can charge you, as discussed below.

HOME HEALTHCARE UNDER BOTH PART A AND PART B

Medicare pays for some part-time skilled health services if you are confined to your home because of illness or injury. The agency that provides the care must be certified by Medicare.

Medicare cannot pay for:

1. Full-time nursing care at home
2. Drugs or medicines, with some exceptions
3. Meals delivered to your home
4. Help with dressing, bathing, or meeting personal needs such as shopping services
5. Homemaker services

There are no longer limits on the number of home health visits you can have, although you must only need part-time or intermittent services. Full-time services, up to eight hours per day, can be covered for a temporary period not over 21 days.

To find out what home health services are available in your area, contact your Area Agency on Aging as listed in Chapter 16.

HOSPICE CARE

Medicare Part A can pay for hospice care for persons with a terminal illness where death is expected within six months. The hospice must be certified by Medicare. Medicare pays for two 90 day periods and an unlimited number of 60 day periods. At the start of each period, the hospice medical director

or other hospice doctor must recertify that you are terminally ill. Medicare will pay the full cost of medical and support services, including physician and nursing services, medical appliances and supplies, short-term inpatient care, therapy counseling, and home health and homemaker services. You will pay no more than \$5 for each prescription drug and other similar products for pain relief and symptom control and 5% of the Medicare-approved amount for inpatient respite care. By agreeing to hospice care, you agree to receive care related to your terminal illness only from the hospice program, and you give up the right to receive Medicare services from other providers.

PRESCRIPTION DRUG COVERAGE

Persons with Medicare A and B can sign up for a Part D Prescription Drug Plan for a monthly premium that varies depending on the plan selected. There are also opportunities to sign up for Medicare managed care plans that may include prescription drug coverage. Medicare contracts with several private companies to provide this benefit, so the plans have various options, with different covered prescriptions at different costs.

For prescriptions available under a standard plan, in 2015 a beneficiary will be responsible for a part of the annual cost of the prescriptions, as follows:

1. Must pay the first \$320, the deductible;
2. Must pay 25% of the costs between \$320 and \$2,960;
3. In the “coverage gap” between \$2,960 and \$6,153.75, you pay the remaining costs after a 55% discount on brand-name drugs and a 35% discount on generic drugs;
4. Once your share of the costs for the year reaches \$4,700, you are no longer in the “coverage gap.” (The total cost of brand name drugs, not just the discounted price you pay, counts toward your total costs.) You then will pay \$2.65 for generics, \$6.60 for brand drugs, or a 5% co-payment, whichever is highest.

The “coverage gap” is gradually being reduced each year. It will be gone by 2020.

There are specific provisions designed to assist low income persons. Persons eligible for both Medicare and full Medicaid coverage, “dual eligibles”, do not receive prescription drug coverage under Medicaid,

but instead receive their drug coverage under Medicare Part D. There are no premiums or deductibles, and co-payments range from \$1.20 to \$6.60 per prescription. Part D plans may not cover as many prescriptions as are covered under Medicaid, so some Medicaid recipients may be disadvantaged.

There is assistance available for low income persons who do not qualify for full Medicaid benefits. Persons with incomes below 135% of poverty level and assets under \$7,280 for a single person or \$10,930 for a couple in 2015 receive a premium subsidy, are not responsible for a deductible and pay co-payments ranging from \$2.65 to \$6.60 per prescription in 2015. Persons with incomes below 150% of poverty level and with assets under \$12,140 for a single person or \$24,250 for a married couple in 2015 receive premium subsidies on a sliding scale, have a deductible reduced to \$66, pay 15% co-payments for prescriptions and after that, pay co-payments of \$2.65 to \$6.60 per prescription.

HOW PAYMENTS ARE MADE

Part A. You do not have to send in any claims or bills for care received from a hospital, skilled nursing facility or home health agency under Part A. These agencies file your claim for you, and Medicare then pays them directly. You will get a notice that explains what Medicare covers. The hospital, nursing home or home health agency cannot bill you for any additional amount for covered services other than the deductible amounts discussed above.

If you have questions about what Medicare has paid, you should contact your local Social Security office.

Part B. Part B payments may be made in either of two ways:

(1) The doctor or other supplier may *accept an assignment*.

By choosing to accept an assignment, the doctor or supplier agrees not to charge you more than what Part B considers a reasonable charge. The doctor will file the claim with Medicare and collect payment directly from Medicare. You can then be billed only for the part of the yearly \$147 deductible that you have not yet met and 20% of the remaining reasonable charge. You can, of course, also be charged for any services that Medicare does not cover. You cannot be charged for the difference between the doctor or

supplier's fee and what Medicare determines to be a reasonable charge.

So, a doctor who accepts an assignment is agreeing to charge no more than the amount Medicare approves. You should ask your doctor or other supplier to accept an assignment of your claim against Medicare. You are probably better off if the doctor or supplier agrees to this method of claiming medical payments. Some doctors and suppliers accept assignments on all Medicare claims. Directories listing these doctors and suppliers can be obtained from a Social Security office or purchased from Medicare.

(2) If the doctor or supplier *does not accept an assignment*, Medicare will then pay 80% of the approved charge, minus any part of the \$147 deductible you have not yet met for the year.

Under this method of payment, the doctor or supplier can bill you for the amount that he charges over and above what Medicare considers a reasonable charge. So you may have to pay more under this method of payment. But there are still limits on how much a doctor can charge you. A doctor cannot charge more than 115% of the Medicare approved amount.

Also when a doctor performs elective surgery on an unassigned basis and charges \$500 or more, the doctor cannot charge more than Medicare's reasonable charge unless the doctor disclosed in advance in writing his or her fee, the estimated Medicare payment and what the patient will need to pay.

Even if your doctor or supplier does not accept assignment, he or she must still submit a Medicare claim for you. No fee can be charged for submitting a claim. Medicare will send you a check for the amount it covers, and you are responsible for paying the entire bill of the doctor or supplier, subject to the limits discussed above.

Medicare may take up to six months to process a claim. They will not begin any payments until you have submitted bills that add up to your \$147 deductible for the year.

IF YOU DISAGREE WITH A DECISION BY MEDICARE

Part A. An initial coverage determination is made by Medicare based upon a claim submitted by the health care provider. The provider initially decides whether the care is covered by Medicare. If you are notified by a provider that care is not covered under Medicare, you can

request that the claim be submitted to Medicare.

A claim cannot be submitted unless services are actually provided. For example, a skilled nursing home may notify you that your care is not covered by Medicare. If you go home, you cannot file a claim and pursue an appeal for skilled nursing home services. Unless you request that the provider submit the claim to Medicare, there will not be an official determination which you can appeal.

If you only have a denial from the provider but you believe the care ought to be covered by Medicare, the first step is to request the provider to submit the claim to Medicare. Nursing homes must notify you of the right to request that a claim be submitted. If you request the nursing home to submit the bill to Medicare, the nursing home cannot bill you until Medicare decides whether the bill is covered. Likewise, you can request that a home health agency submit a claim for home health care. However, a claim cannot be submitted unless the services are provided, and the agency can require you to pay for the care in the meantime.

If Medicare denies the claim, it will mail a notice which should explain the reason for its decision. If you disagree with the decision, you have 120 days to request that Medicare redetermine its decision. The form to request redetermination is available at your local Social Security Office.

If you disagree with the redetermination, you have 180 days to ask Medicare for reconsideration. Maximus, a contractor, will issue a new decision within 60 days after reviewing the file.

If, after a review, you still disagree with the decision and more than \$120 is at issue, you have 60 days to request a hearing before a Medicare Administrative Law Judge. You can then eventually appeal to federal court if at least \$1,180 is at issue.

There is a special expedited review process if you think you are being asked to leave a hospital too soon or if your skilled nursing facility services or home health services are terminated. If the provider determines that you no longer need care, it will issue a Notice of Non-Coverage. If you do not request a review, the provider can bill you for all the costs of your stay beginning with the third day after you receive the Notice of Non-Coverage.

The provider cannot charge you unless it gives you a Notice of Non-Coverage. You can request an expedited (fast) review as explained in the Notice. You must make your request by noon of the day after you receive the

Notice of Non-Coverage. The QIO for Indiana is KePRO, which you can contact at 1-855-408-8557. You must make your request for review by noon of the first work day after you receive the Notice of Non-Coverage. The QIO will ask for your views before making its decision. You will not be responsible for the cost of care before you receive the QIO'S decision.

If the QIO agrees with the provider, then you can be billed for all costs beginning at noon of the day after you received the QIO's decision. The QIO's decision will explain your next appeal rights.

Review by an Administrative Law Judge of the decision is available if at least \$200 is in controversy, and review in federal court is eventually available if at least \$2,000 is at issue.

Part B. After a claim has been submitted under either Part A or Part B, Medicare should send you a notice that explains what Medicare decided on your claim and what services Medicare will pay for. Examine the notice carefully. If you do not understand it or if you disagree with the decision, contact Medicare.

If you disagree with Medicare's decision, you have the right to ask for a review of the decision. Someone at the Social Security office can help you make the request for review. You must request the review within 120 days after you receive the notice of decision on your claim. The notice you receive from Medicare should tell you exactly what steps you can take to appeal.

If you disagree with the redetermination, you have 180 days to request reconsideration of the decision. The reconsideration should be complete within 60 days.

If, after reconsideration, you still disagree with Medicare's decision, and if the disputed amount is at least \$140, you have 60 days to ask for a hearing by a Medicare Administrative Law Judge. To reach the \$140 amount under Part B, you can combine several claims if they are all within the appeal time allowed.

If after a hearing decision by Medicare, you are still dissatisfied and if at least \$140 remains in controversy, then you have 60 days to request the Medicare Appeals Council to review the decision. You can then eventually appeal to federal court if at least \$1,400 is at issue.

Where to get more information. If you want to know more about Medicare, ask your local Social Security office for a free copy of The Medicare Handbook.

If you have questions about Medicare or if you want

to apply, you should ask at your local Social Security office. You can telephone Social Security toll-free at 1-800-772-1213. You can telephone Medicare toll-free at 1-800-633-4227.

Because the Medicare law is subject to change, you should call your local Social Security office before you rely solely on the information in this book.

MEDICAID

Medicaid is a government program that pays necessary medical expenses for many needy persons, including the needy elderly, blind and disabled. Medicaid pays directly to the provider, that is, to the doctor, hospital, nursing home, pharmacist or other provider of medical services. Both the federal and the state government pay for Medicaid and set rules for the program.

MEDICAID AND MEDICARE

Medicaid and Medicare both help pay medical bills, but the programs are very different. Medicare is available without regard to your financial situation. You can receive Medicaid in most cases only if you have a low income and few assets. Medicare is a federal program run locally by Social Security offices. Medicaid is a cooperative federal-state program, and the Family and Social Services Administration (FSSA) is the agency which is ultimately responsible for the program in Indiana.

Medicare is basically the same throughout the United States. Medicaid programs vary from state to state and pay for more kinds of services than Medicare. In fact, Medicaid can pay for some of the gaps in Medicare coverage. You can participate in both Medicare and Medicaid if you are eligible for both programs. A participant in both programs is referred to as a *dual eligible*. (See Medicare)

THE APPLICATION PROCESS

All ninety-two counties in Indiana now use the "hybrid" version of the modernization plan that was initiated by the State in 2006. According to the State, the hybrid system combines the best features of the previous county caseworker model and the privatized modernization system.

Although there is a local Division of Family

Resources (DFR) office in each county, all Medicaid application/eligibility materials are processed by the FSSA Document Center in Marion, Indiana. An “Eligibility Specialist” (ES) can be reached between the hours of 8:00 a.m. and 4:30 p.m., Monday through Friday at 1-800-403-0864, but there is no longer one specific caseworker assigned to an individual’s case; instead, the case is processed by multiple staff. An ES has access to an electronic file only. The Document Center is responsible for scanning all submitted materials and storing the information electronically. No hard files are kept in the system for the ES to review. An individual should never send an original document to the Document Center. The applicant/recipient can call the Document Center or go online (see below) to confirm that his or her documentation has been received and/or processed.

If an individual is not physically or mentally able to complete the application, the application may be completed by that person’s spouse, guardian, agent under power of attorney, or other interested person.

Each applicant/recipient has an individual bar code to ensure that each document that is submitted to the Document Center is correctly linked to his or her electronic file. Application forms are now bar coded for each particular person’s case. In addition, once a case number has been assigned, the applicant/recipient can access bar-coded cover sheets online which should be used to submit any further documentation in the case.

An applicant can obtain an application form online at www.in.gov/fssa, by telephoning the FSSA Document Center at 1-800-403-0864, or by going to a local DFR office and using the computer at the local office.

An online application can be signed electronically and filed online by starting with the DFR Benefits Information page at <http://www.in.gov/fssa/df/2999.htm> and clicking on “*Apply for Benefits Online*.” This page is used not only for the application process but also to check on the status of a case.

The “*Apply for Benefits Online*” link will then direct the user to the “*Welcome to the Benefits Portal*” page which allows individuals to employ a screening tool to determine for which program(s) the applicant may be eligible. This is useful only for those persons who are uncertain for which benefits they may qualify or even if they can qualify.

To start the application for Medicaid, the user

should choose “*Apply for Health Coverage, SNAP, and/or Cash Assistance online*.” At the next prompt, the user should choose “*Health coverage application*” to begin the application process. The FSSA benefits page estimates that it will take the user about forty-five minutes to complete the process.

During the application process, the applicant has the ability to print out bar-coded authorized representative forms. In order to assist an applicant in the Medicaid process or to receive notices on behalf of the applicant, an individual must be an *Authorized Representative*. Therefore, the applicant or his or her legal representative (such as a guardian or person serving under power of attorney) should fill out and sign these forms and submit them to the Document Center once the application is assigned a case number.

If this form is not printed during the application process, the applicant can print out generic authorized representative forms from the FSSA—DFR home page or can go to “*Check status, report a change, or receive proof of eligibility*” to obtain a case-specific bar-coded form once a case number is assigned to the case (typically, with the notice of interview appointment).

Alternatively, an application can be completed online, saved, printed and signed by the applicant. The signature pages must then be mailed or faxed to the Document Center in order to make the application official and fix the application date.

If an applicant calls the Document Center to start the application process, the Center will obtain information and then mail a bar coded application form to the caller. The caller will then sign the form and mail or fax it to the Document Center. The date of application is not the date of the initial call but the date that the Document Center receives the signed signature page, either by mail or by fax.

Once the application is completed, the applicant may receive a call from the Document Center to schedule an interview. This typically happens within two or three days of the submission of the application, although FSSA does not always schedule interviews by phone. Regardless of whether the applicant receives a call, a written notice of interview is sent. Interviews are conducted by Eligibility Specialists by telephone or in person. It is the applicant’s choice. The interview should be scheduled within two weeks of when the application was filed. Often, only very short notice of the scheduled appointment is provided.

The law requires Medicaid to act on a Medicaid application within forty-five days, or, if the applicant is under age sixty-five, within ninety days of the date the application is received by FSSA.

If Medicaid denies an application, it must state the reason. If the applicant disagrees, he/she has the right to appeal. If the applicant is eligible, a blue, credit card-sized Medicaid ("Hoosier Health") card will be mailed to the recipient within about two weeks of the approval notice. This card should be given to all medical care providers, including doctors, hospitals, pharmacists, etc., every time the recipient needs services. Medicaid can pay for necessary medical care as far back as three months before the month of application *if the applicant was eligible* during those three months.

The Medicaid office will check at least once a year to make sure that the recipient continues to be eligible by doing a "redetermination" of eligibility. Typically, Medicaid will send out a "Medicaid/Hoosier Healthwise Eligibility Review Form" (sometimes called the "Medicaid mailer"), which is the recipient or the recipient's representative must complete. In addition, Medicaid may check on a recipient's eligibility if it learns that circumstances have changed. A recipient has a duty to tell Medicaid within ten days when there is a change in circumstances that may affect eligibility for Medicaid.

NEW ELIGIBILITY RULES FOR INDIANA AS OF JUNE 1, 2014

On June 1, 2014, Indiana changed the way applicants obtain Medicaid coverage in the aged, blind or disabled categories. To be eligible for Medicaid, the applicant must be age sixty-five or older, or blind, or disabled. Some of the most dramatic changes are in the disability category.

From June 1, 2014 forward, Indiana will automatically enroll individuals who are eligible for Supplemental Security Income (SSI) under the Social Security Administration (SSA). Furthermore, Medicaid will accept all SSA determinations of disability. In the past, even if an individual was receiving Social Security disability income (SSDI), the FSSA Medical Review Team would still have to make its own determination of disability. With a few exceptions, if the Social Security Administration has made a determination that an individual is not disabled, then that person will not be eligible for Medicaid.

For those disabled persons currently receiving

Medicaid who do not receive SSDI or SSI, Medicaid will require those recipients to apply for disability through SSA when it is time for the recipient's Medical Review Team progress report. Current recipients may want to initiate a disability application with SSA prior to their next scheduled progress report.

Certain working individuals with disabilities are eligible to buy Medicaid coverage. This coverage was authorized by the federal Ticket to Work and Work Incentives Improvement Act of 1999. This program is referred to as MED Works.

To be eligible, an individual must:

1. Have a severe medically determinable impairment;
2. Be at least 16 years of age but no more than 64 years of age;
3. Be engaged in a substantial and reasonable work effort;
4. Not have countable resources above \$2,000 for a single individual or \$3,000 for a married couple;
5. Have countable income at or below 350% of the federal income poverty level for an individual but excluding a spouse's income.

There is also a special category of benefits to assist women with breast or cervical cancer. This category provides that a woman under age sixty-five who does not qualify for Medicaid under any other category, who does not have other credible health insurance coverage and who needs treatment for breast or cervical cancer will qualify for Medicaid if the family income is less than 200% of poverty level. Eligibility lasts as long as treatment is needed. The Indiana Breast and Cervical Cancer Program can be contacted at (317) 233-7633 or (800) 433-0746.

You must be a U.S. citizen or a lawfully admitted alien. You do not have to have lived in Indiana for any certain length of time to be eligible for Medicaid. If you have moved to Indiana with the intention of making this your home, the Division of Family Resources should not deny you Medicaid benefits just because you have not lived here for a particular length of time; however, there are a few exceptions. If Medicaid denies your application because you have not lived here long enough, you can request a fair hearing to challenge that decision. (See Appeals) You also must meet an income test and a resources test to be eligible for Medicaid.

INCOME RULES FOR APPLICANTS AND RECIPIENTS EXCEPT FOR THOSE WHO ARE INSTITUTIONALIZED OR RECEIVE SERVICES UNDER A MEDICAID WAIVER

In 2015, if a non-married applicant lives at home, he/she is income eligible for Medicaid if the individual's countable income is \$981 (the 2015 federal poverty level) or less. If the applicant is married, the combined income of the couple cannot be greater than \$1,328 regardless of whether one or both are applying for Medicaid. The applicant's SSI payments are not counted toward these maximum amounts and \$20.00 of the applicant's income is not counted. A person who does not have Medicare and who has income greater than 100% poverty will be directed to the marketplace. (See Chapter 6 for more information on the Affordable Care Act.) There are exceptions to these rules for persons receiving certain services under a "Medicaid waiver" or for those persons who are institutionalized. (See below for the rules for waiver and institutional recipients.)

If an individual has Medicare, there are also exceptions to these rules. If the applicant's income is greater than these standards but less than 185% of the federal poverty level, the individual may still be eligible for Medicaid to provide some coverage under Medicare Savings Programs. A person with Medicare who has income below 150% poverty will qualify for QMB, which will function like a Medicare supplement policy, while a Medicare recipient with income greater than 150% poverty should consider purchasing a Medicare supplement policy. Although Medicare recipients who have income between 150% and 185% of poverty level can get help to pay their Medicare Part B premiums, they cannot get any help with paying their actual medical expenses. See below for more information on the Medicare Savings Programs

Examples

- Rosemarie is single, lives at home, and has monthly income in 2015 of \$846. She is income eligible for the Medicaid program as her income is less than \$981.
- Max is single, age 72, has Medicare coverage, lives at home, and has monthly income in 2014 of \$1,022. Max does not meet the income eligibility test for Medicaid, but he does qualify for a Medicare Savings Program under Medicaid.
- Herman is age 49, single and disabled and is a Medicare recipient. He lives at home and has

monthly income in 2015 of \$1,900. He is not eligible for Medicaid or for a Medicare Health Savings Program. He cannot apply for health coverage through the Marketplace as he is a Medicare recipient. He should try to obtain a Medicare supplement policy through the private market.

- Martha is age 49 and disabled, but she is not a Medicare recipient. She lives at home and has monthly income in 2015 of \$1,400. She is not eligible for Medicaid due to her income and she is not eligible for a Medicare savings program as she does not have Medicare. Martha will be directed to the marketplace.

Medicaid may take into consideration the income of your spouse, but not the incomes of your children or other persons, unless those incomes are actually available to you.

INCOME RULES FOR APPLICANTS AND RECIPIENTS WHO ARE INSTITUTIONALIZED OR RECEIVE SERVICES UNDER A MEDICAID WAIVER

If the applicant/recipient resides in a nursing home or qualifies for a Medicaid waiver, he/she is income eligible if the individual has \$2,199 or less in monthly income. The \$2,199 (2015) standard is called the "Special Income Level" ("SIL") and it is three times the annual federal poverty level. The SIL typically changes on January 1st of each year. If the individual's income is greater than the SIL, he or she will not qualify for Medicaid. However, there is one exception to this rule. An applicant/recipient can create a "qualified income trust" to hold the income in excess of the SIL. This qualified income trust is commonly known as a "Miller trust," and an applicant or current recipient whose income is above the Special Income Level must use this device in order to be eligible for Medicaid.

Most applicants or recipients who need a Miller trust can download a form from the state's website at www.fssa.gov. FSSA has created a template and instructions for persons with access to the internet. For those persons who are unable to access the form online, area agencies on aging, Indiana Legal Services, Inc., and the local DFR office will be able to assist. Individuals can also contact an elder law attorney for assistance with creating and managing the Miller trust.

For those applicants/recipients who pass the income eligibility test, Medicaid applies a “post eligibility budget” which allows certain deductions to be applied against the individual’s income for budgeting purposes. For a recipient who is in a nursing home, for example, the post eligibility budget allows deductions of \$52 for the individual’s personal needs each month, the cost of the recipient’s health care insurance premium, and a court-approved fee of \$35 monthly for the individual’s guardian. There may be other expenses considered in the post eligibility budget.

If the recipient receives services under a Medicaid waiver or is in a nursing home and has a spouse at home (the “community spouse”) whose income is less than \$1,967 (effective through June 30, 2015 and \$1,991 projected as of July 1, 2015), then the recipient can give the spouse enough money each month to raise his or her income to this standard. **This figure changes every year in July.** The community spouse may also be entitled to an “excess shelter allowance” if he or she has high shelter expenses such as mortgage, rent, utilities, taxes, insurance, etc. Dependent family members may also be able to keep some of the income of the Medicaid spouse. The spouse at home can always keep all of his or her own income.

RESOURCES TEST

Resources are the money, property and possessions a person owns. Some resources are countable, or “non-exempt,” while some resources are “exempt” and do not count toward the resource limits set by Medicaid. Some resources may be considered “non-liquid,” meaning that they cannot be converted to cash within twenty working days of a request to do so. These resources may be exempt so long as the applicant agrees to dispose of the property.

A single person can have resources worth up to \$2,000 and still be eligible for Medicaid. A couple can have resources worth up to \$3,000. Special rules apply to couples in situations in which one spouse lives at home and the other lives in a nursing home.

There is no limit to the amount of real estate a Medicaid applicant or recipient can own. If the real estate does not fall into one of the exempt categories of property, then the applicant/recipient must offer it for sale or rent in order for it to be exempt.

The home is not counted as a resource as long as the applicant/recipient lives in it or intends to live in it.

If the Medicaid applicant/recipient is single and lives in a nursing home, and there is an apparent contradiction between the individual’s intent and ability to return home, Medicaid will ask you for a doctor’s statement indicating that it may be possible for the institutionalized person to return home. The home also is exempt if the individual’s spouse, disabled child or dependent minor child lives or intends to live there.

Income-producing real estate and property owned jointly with rights of survivorship with another person or persons are not counted toward the resource limit.

Funds held in an Individual Retirement Account or work-related pension plan, including Keogh Plans, by a non-recipient spouse are not counted as resources.

Irrevocable funeral trusts and life insurance policies which are irrevocably assigned for payment of funeral and burial expenses are exempt resources. Certain life insurance policies may be exempt, but, generally, the cash surrender value of life insurance policies will count toward resource limit. However, in order for an insurance policy or irrevocable funeral trust to be exempt, it must designate the Medicaid recipient’s estate or Medicaid itself to receive any excess amounts after payment of funeral and burial expenses for reimbursement of Medicaid benefits provided to the recipient after age 55 for services received after October 1, 1993 and after age 65 for services received before October 1, 1993. If your resources except for the cash value of your non-exempt life insurance are below the resource limit, then you will pass the resource test if you agree to dispose of or spend down the cash value of your insurance within 90 days after being approved for Medicaid. A recipient can have any amount of private health insurance, though, and still be eligible for Medicaid.

One vehicle of any value is exempt as a resource for the applicant/recipient or a member of the household. If there is more than one vehicle, the one with the highest equity should always be the one that is exempt.

There are several other types of exempt or non-countable resources. An individual can check with an elder law attorney knowledgeable in this area of the law for more specific information on the Medicaid resource rules.

Certain transfers of property can make an applicant or recipient ineligible for Medicaid if he or she did not receive something of equivalent value in return for the transfer. If an individual has made,

or plans to make, a gift or disclaim an interest in an estate to which he or she is entitled, you should consult with an elder law attorney on the effect of the gift or disclaimer on Medicaid eligibility. Medicaid can “look back” five years to determine if transfers in violation of these rules have occurred.

The Medicaid office can file a lien against a recipient’s real estate, but only if the recipient is institutionalized, in a nursing home, intermediate care facility for the mentally retarded or a hospital, and Medicaid determines that the recipient cannot reasonably be expected to be discharged and return home.

If Medicaid determines that the recipient will be unable to return home to live, then it may file a lien against the individual’s interest in any real estate. It cannot obtain a lien against the home, however, if any one of the following persons is living there:

- The recipient’s spouse
- The recipient’s child under age 21
- The recipient’s child who is disabled as defined by SSI
- The recipient’s parent
- The recipient’s sibling who has an ownership interest in the home and who has lived in the home continuously beginning at least one year before The recipient was admitted to the medical institution.

The lien law is complex and contains many exceptions to Medicaid’s ability not only to file a lien, but also to enforce it. An elder law attorney who is expert in Medicaid law can assist with this difficult issue.

Medicaid has a “preferred claim” against a deceased recipient’s estate for the amount of benefits it has paid out for the recipient after age 55 for services received after October 1, 1993 and after age 65 for services received before October 1, 1993. The estate includes assets that pass by will and also some assets that do not, such as assets transferred into a revocable living trust after April 30, 2002. The estate also includes the recipient’s interest in property held jointly with rights of survivorship with another person but only if the joint ownership was created after June 30, 2002. Whether the home will be part of an estate at death and subject to this claim depends on the how the property is titled. In any event, if the recipient’s spouse, dependent or disabled child continues to live in the home after the recipient’s death, Medicaid cannot make a claim against the home.

Special rules for nursing home residents with spouses at home:

If an individual entered an institution, a nursing home or hospital, on or after September 30, 1989 and has a spouse at home, the spouse (known as the “community spouse”) is allowed to keep a “spousal resource allowance” of one half of the resources up to \$119,220 that the institutionalized individual and the community spouse owned at the time of institutionalization. If the combined resources are \$23,844 or less, the community spouse can keep all of the resources. The \$119,220 and \$23,844 standards are 2015 figures. **These numbers increase in January of each year.** The chart below illustrates how these rules work in 2015:

<i>If the resources are:</i>	<i>The spousal share is:</i>
\$238,440 or greater	\$119,220
\$100,000	\$ 50,000
\$ 50,000	\$ 25,000
From \$23,844 to \$47,688	\$ 23,844
\$23,844 or less	All of the resources

In addition, the institutionalized spouse is allowed to keep up to \$2,000 in resources. Any countable resources in excess of the \$2,000 resource allowance plus the community spouse’s resource allowance must be spent or invested in non-countable or “exempt” resources. The planning process for couples in these situations can be quite complex. An elder law attorney who is an expert in Medicaid law can assist.

Different rules apply if the institutionalized spouse entered the nursing home before September 30, 1989 and has a spouse at home, although it is unlikely that there are many individuals who fit this criteria in 2015.

COVERAGE

Medicaid coverage is broad. In Indiana, Medicaid will usually pay for the medical services listed below and for some services not mentioned on this list. Some items require prior approval by the Division of Family Resources. The provider will take care of asking for the prior approval. Medical services included:

- Physician services

- In-patient and outpatient hospital care
- Laboratory and x-ray services
- Nursing home services
- Intermediate care facilities for persons with mental retardation
- Assisted living facilities, with a waiver
- Home health services and other non-medical personal care (See Medicaid Waiver Services)
- Prescription drugs
- Medical supplies and equipment
- Outpatient mental health services
- In-patient psychiatric care for persons under age 21 or over age 65
- Dental services with a \$600 limit per year on most services
- Optometric services, including eyeglasses
- Physical and occupational therapies
- Speech pathology, audiology, and related supplies
- Respirators, therapy, and related supplies
- Private duty nursing
- Chiropractic services
- Podiatric services
- Transportation for Medicaid-covered services
- Burial assistance

Some of these services are optional services, meaning that the federal government does not require Indiana to provide the service. As a result, a service listed above may be “on the chopping block” as Indiana strives to contain Medicaid costs in the coming years.

You may choose the doctor, pharmacist, hospital, nursing home or other provider who will care for you as long as that provider is certified by Medicaid. You do not have to go to the least expensive doctor. To make sure that the provider is certified by Medicaid, show your Medicaid card to the provider before you receive services. You can also ask Medicaid for a list of providers in your area who are certified. If you receive services from a provider who does not participate in Medicaid, you will have to pay the cost yourself.

MEDICARE SAVINGS PROGRAMS: QUALIFIED MEDICARE BENEFICIARY (QMB), SPECIAL LOW INCOME MEDICARE BENEFICIARY (SLMB), QUALIFIED INDIVIDUAL (QI), AND QUALIFIED DISABLED WORKER (QDW)

Some people who are ineligible for regular Medicaid may qualify for special Medicaid benefits called Qualified Medicare Beneficiary (QMB), Special Low Income Medicare Beneficiary (SLMB), Qualified Individual (QI), and Qualified Disabled Worker (QDW).

For a person eligible for QMB, Medicaid will pay the Medicare Part B, and Part A, where applicable, premiums and any Medicare deductibles or co-payments. Only those medical services that are covered by Medicare are covered by QMB. If an individual has SLMB or QI coverage, Medicaid will pay for the Medicare Part B premiums. Unlike the QMB, SLMB, and QDW categories, the QI category is not an open-ended entitlement. Once the state exhausts the funds allotted for this program, no other individuals can receive the benefit. Indiana keeps separate track of the QIs it serves.

Under QDW, Medicaid will pay the cost of the Medicare Part A premium rather than the Part B premium. Since the cost of the Part A premium is substantially higher than that of the Part B premium, this is an important benefit for those who qualify under this category.

QMB, SLMB, QI, and QDW have their own financial eligibility rules. The income limits are higher than those for regular Medicaid as noted in the section “**Income Rules for Applicants and Recipients Except for Those Who Are Institutionalized or Receive Services under a Medicaid Waiver**” above. Contact Medicaid for information on the current limits as these figures change frequently.

HOW BILLS ARE PAID

The provider sends the claim to Medicaid, and Medicaid pays the provider directly. Even though Medicaid does not always pay the provider’s usual fee, it is illegal for the provider to bill for amounts that Medicaid does not pay. There are exceptions, however. In the following situations, the recipient may have to pay part or all of the bill.

1. If the service is not covered by Medicaid, the recipient must pay for it yourself.
2. If the provider does not participate in Medicaid, the recipient must pay the bill.

APPEALS

If Medicaid denies an application, it must notify the applicant in writing. Also, if a recipient is already

receiving benefits and Medicaid plans to reduce or limit benefits, it must usually give the recipient at least a ten day notice. The notice must contain the reasons for the change.

If an applicant/recipient disagrees with a decision or action by Medicaid, he or she has the right to appeal. The following are examples of appealable issues:

- The denial of eligibility
- The termination of eligibility
- The violation of your civil rights
- lack of timeliness of the Medicaid decision (e.g., award of eligibility, limit on payments for particular services, or issues concerning the amount of income Medicaid says a recipient must contribute toward medical care).

To appeal, the individual must notify the county or state office in writing within thirty days of the effective date of the disputed action. If a timely appeal is filed, the law gives the applicant/recipient (the “appellant”) the right to a fair hearing. If a recipient requests a hearing before the effective date of Medicaid’s proposed action, benefits must continue until a decision is reached after the hearing.

Before the hearing, the appellant has the right to see any information pertaining to the case. A lawyer can be very helpful at this stage. If the appellant cannot afford a lawyer, a legal services program office may be able to help. (See the Legal Services Chapter of this book for additional information on these programs.)

The hearing should be held at a location that is convenient to the appellant. If the appellant is homebound or in a nursing home and cannot get to a hearing, the hearing can be held at the appellant’s location.

At the hearing, the appellant may be represented or assisted by a friend, lawyer, or other person. The hearing will be like an informal trial. An administrative law judge hears the case. The appellant has the right to testify, to have others testify, and to cross-examine Medicaid’s witnesses. The appellant should bring to the hearing all papers that relate to the case and be ready to explain the reason for appealing.

Medicaid must notify the appellant in writing of its decision within ninety days of the day the hearing was requested. The notice should tell the appellant how to appeal further if unsatisfied with the decision. The appellant must appeal within ten days of receiving the decision from the hearing. If the decision is still nega-

tive at that level, the appellant may be able to appeal to a court. At that stage, the appellant will need a lawyer.

SUPPLEMENTAL AND LONG TERM HEALTHCARE INSURANCE

MEDICARE SUPPLEMENTAL INSURANCE

Many older persons purchase private health insurance as protection against illness or injury. Even if you have Medicare, you may want to supplement your Medicare coverage with private health insurance. If you read carefully the section on Medicare, you will see that there are many medical expenses not covered by that program. Medicare was not designed to meet all the medical needs of older persons.

If you buy health insurance to supplement Medicare, you should read the policy carefully. You want coverage that fills the gaps in Medicare that are important to you but does not duplicate Medicare’s coverage. Many insurance companies sell insurance, called Medicare Supplements, specifically designed to fill in the gaps in Medicare. These gaps include:

- Prescription drugs not taken in a hospital
- Long term care in a nursing home
- Services that are considered “extras” in a hospital or nursing home
- Full-time nursing care at home
- The deductibles and copayments that you must pay under Medicare

Many older persons purchase private health insurance as protection against illness or injury. Even if you have Medicare, you may want to supplement your Medicare coverage with private health insurance. If you read carefully the section on Medicare, you will see that there are many medical expenses not covered by that program. Medicare was not designed to meet all the medical needs of older persons.

If you buy health insurance to supplement Medicare, you should read the policy carefully. You want coverage that fills the gaps in Medicare that are important to you but does not duplicate Medicare’s coverage. Many insurance companies sell insurance, called Medicare Supplements, specifi-

cally designed to fill in the gaps in Medicare. *These gaps include:*

- Days 61-90, you pay \$315 a day.
- Days 91-150, you pay \$630 (reserve days).
- After Day 150, you pay the entire cost.
- You also pay for the first three pints of blood.

For a stay in a nursing home in 2015, Medicare has these gaps:

- Any care that is less than skilled nursing care, e.g., custodial in nature.
- Days 21-100, you pay \$157.50 a day.
- After Day 100, you pay the entire cost.
- You also pay for the first three pints of blood.

Some Medicare Supplement policies cover nursing home expenses only after Medicare benefits are exhausted. Yet Medicare law makes it difficult to “use up” all your Medicare coverage. As a result, you may be left with a useless insurance policy that never takes effect.

For bills from a doctor or other supplier in 2015:

- You pay the first \$147 a year. This amount increases periodically.
- You pay 20% of the rest of covered expenses.
- You pay the difference between what the doctor or supplier charges and what Medicare allows.

For more details concerning gaps in Medicare, see the Medicare section. All these dollar amounts are subject to change. For current information, ask at your local Social Security office.

FEDERAL LAW PROTECTS CONSUMERS

Federal law helps to protect consumers. Companies are required to issue standardized policies so that it is easier to compare policies issued by different companies. There will be only 10 different types of policies which can be issued. Insurance companies are required to use the same format to describe their plans, again making it easier to compare policies.

Insurance companies must warn consumers that persons normally do not need more than one supplemental policy. Consumers should normally not purchase more than one policy because in most situations only one policy will provide benefits anyway.

An insurance company cannot discriminate or

refuse to sell a supplemental policy during the first six months after a person age 65 or older first enrolls for benefits under Medicare Part B. The policy can provide a waiting period of up to six months for pre-existing conditions for which the person received treatment or was otherwise diagnosed during the six months before the policy became effective. But, if you replace one supplemental policy with another, you cannot be forced to go through a new six month period for pre-existing conditions.

All Medicare supplemental policies will be guaranteed renewable, and an insurance company cannot cancel your policy due to your health. A policy can be cancelled only for nonpayment of premiums or material misrepresentation. If a policy is terminated for all policyholders by the group policyholder and not replaced, the insurer must offer the policyholders an individual policy that provides for the continuation of benefits.

LONG TERM HEALTHCARE INSURANCE

Many insurance companies are now offering long term care or nursing home policies. Be careful in buying this type of policy. Many such policies do not provide the protection you are most likely to need. For example, many persons are in nursing homes because they need help with daily living, yet many policies are limited to care that is medically necessary. Pay special attention to the definition of medically necessary in the insurance contract. Also, many policies limit coverage to skilled care and would not cover custodial care.

In shopping for long term care policies, find out whether a given policy guarantees renewability; a policy that can be cancelled by the insurance company after a need arises may be worthless. Indiana law now provides that a long term health care insurance policy cannot be cancelled or terminated on the grounds of age or a decline in health. Find out also whether the company limits rate increases, some companies attract you with low rates but then raise rates dramatically later. Find out about the company policy on pre-existing conditions. Be aware of the maximum number of days covered. A policy that pays for 365 days of continuous stay will not be renewable after one year of stay in a nursing home.

The state Medicaid office offers a program that allows you to keep more assets and still receive Med-

icaid if your long term care insurance policy pays toward the costs of your long term care. For every dollar of benefits paid out under an individual's long term care policy for Medicaid-eligible long term services, that person's asset limit increases by the same amount. So, for example, for a policy that pays out \$50,000 in benefits, \$50,000 will be added to the Medicaid resource limit for that individual.

A person who purchases a qualified policy meeting the maximum benefit criteria will have no asset limit once the policy has paid out the maximum benefit amount. This means, for example, that when the policy has paid the maximum benefit, an individual with \$500,000 in the bank could immediately qualify for Medicaid. Furthermore, Medicaid will have no claim on the assets when that individual is deceased. The maximum benefit amounts required to obtain total asset disregard through 2020 are:

2015.....	\$320,883
2016.....	\$336,927
2017.....	\$353,773
2018.....	\$371,462
2019.....	\$390,035
2020.....	\$409,537

Further information is available from the Indiana Long Term Care Program office at 317-233-1470 or on its web site at www.in.gov/fssa/iltcp. The website lists the insurance companies which offer qualified policies and the insurance agents who have completed the required training course and who are marketing qualified policies.

For more information on general insurance issues, contact the Indiana Department of Insurance at 1-800-452-4800.

GENERAL TIPS ON SHOPPING FOR HEALTH INSURANCE

Whatever type of health insurance you want, you should shop carefully and compare the policies of different companies. Consider, for example, how quickly the insurance company pays a claim. Also consider whether the company gives you individual attention and helps you answer questions about your policy. Here are some general tips for buying health insurance:

1. It is not usually advantageous for an older person to drop the insurance he already has in force in order to buy a new policy. Consider the matter carefully.
2. Do you really need additional health insurance? Consider the alternatives and do not buy insurance that duplicates protection you already have. For example, if you have a low income and are eligible for Medicaid, that program will pay most of your medical bills. Even if you do not qualify for full Medicaid benefits, you may qualify for Medicaid as a Qualified Medicare Beneficiary which functions like a Medicare supplemental insurance policy. (See Medicaid) If you belong to a Health Maintenance Organization (HMO), you probably already have substantial coverage for health expenses. An HMO provides insurance in a sense. You pay a premium or membership fee to join an HMO. You then receive health services directly from the doctors and other providers who participate in the HMO.
3. Check the waiting period to see how soon the policy will cover an illness that began before the effective date of the policy. At the time you get the insurance you may already have a condition that will later require medical attention, and you probably want to be covered for related expenses as soon as possible.
4. Watch out for policies that pay fixed amounts for certain expenses. These policies may sound attractively cheap, but this type of policy rapidly becomes inadequate as medical expenses increase.
5. Be suspicious of policies that let the insurance company refuse to renew your policy on an individual basis.
6. Neither the state nor the federal government sells a policy to supplement Medicare. If a salesperson tells you that his policy is sponsored by the government, or that he represents any government agency, do not buy from him and report him to the state insurance department.
7. Purchase of more than one Medicare Supplement policy is usually a poor buy.
8. Do not let a salesperson frighten you into buying any insurance policy. Think calmly about whether you need the coverage that is offered.
9. Indiana law protects you against pushy

insurance salespeople. Even if you have already signed an application, you may cancel a health insurance policy within 10 days of receiving the policy. You simply mail the policy back to the insurance company's home office and ask for a refund of any premium you paid.

10. You should pay premiums by check, payable to the insurance company. Do not pay with cash and do not make the check payable to the agent.
11. You should keep a copy of your completed application so that you will know what you have bought. You should also get a receipt for anything including money, an insurance policy, etc. you gave to the insurance agent. The receipt should contain the agent's name, company address and company telephone number.

If you have questions about health insurance or if you have complaints about your insurance company or agent, you can get help from:

Consumer Services Division
Indiana Department of Insurance
311 W. Washington St., Suite 300
Indianapolis, IN 46204
(317) 232-2395 (Indianapolis)
(800) 622-4461 (toll-free number)

You can also obtain from this office booklets of advice concerning various aspects of health insurance.

TREATMENT DECISIONS

RIGHT TO TREATMENT

In this country, you generally do not have a right to receive medical treatment. There are limited exceptions. For example, if you have been committed to a psychiatric facility against your will, you have the right to receive appropriate treatment there. If you are eligible for certain medical programs of the government, for example, hospital care for certain veterans, then in some sense you have a "right" to some kinds of medical care. But, as a general rule, you do not have a legally enforceable right to receive medical treatment.

RIGHT TO PARTICIPATE IN TREATMENT DECISIONS

If you are being treated, however, you have the right to participate in decisions about your medical treatment. You must give informed consent to that treatment. Your consent is informed if the doctor tells you the important facts about your condition, the options for treatment and the significant advantages and risks of each option. If the doctor proceeds to treat you before you have given informed consent, his actions might be an illegal battery.

This requirement of informed consent does not apply in an emergency. In an emergency, treatment will usually be given on the basis of implied consent, which means an assumption that the person, if able, would have agreed to the treatment.

If the person needing treatment is incapable of making a decision about health care, certain other persons may give informed consent on behalf of the incapable person. The Indiana Health Care Consent Act allows certain people to consent to your health care without your written authority and without court approval.

Unless you have previously appointed a health care representative or a court has appointed a guardian to make personal care decisions for you, the following people may consent to your health care: your spouse, your parent, your adult children, your adult siblings, or your religious superior, if you are a member of a religious order. None of these individuals has priority over another, so if there are disagreements regarding the course of your health care, the interested individuals are often faced with going to court to resolve their differences. The Health Care Consent Act also allows you to appoint in writing your health care representative.

RIGHT TO REFUSE TREATMENT

This right to give your consent includes the right to refuse consent to any medical treatment that you do not want.

A patient in a psychiatric facility has the right to ask that treatment stop. If a voluntary patient makes the request, the treatment must stop. An involuntary patient may ask a court to order the end of treatment. The treatment must then stop until the court makes a decision.

If you are capable, you have the right to refuse medical care, including artificially delivered nutrition and hydration that is necessary to save your life.

Sue Ann Lawrence was a young woman left in a persistent vegetative state as the result of an accident. Because she had suffered brain damage as a child, she was never able to express her wishes regarding life prolonging medical care. The Indiana Supreme Court was asked to decide whether Sue Ann's parents had authority to request withdrawal of the feeding tube which kept her alive.

In 1991, the Court decided that the Indiana Health Care Consent Act applies when the family of a never-competent person in a persistent vegetative state seeks to withdraw medical treatment. The Court specifically determined that the term medical treatment includes artificially delivered nutrition and hydration.

The Court went on to say that a family is not required to go to court for permission to withhold or withdraw health care. According to the Court, courts should become involved only when no one is available to make decisions or when there are disagreements concerning the care.

Since the Indiana Health Care Consent Act allows several different categories of people to consent to your health care and does not give priority to any of the persons who can consent, problems often occur when there are several family members in disagreement over how decisions should be made. Despite the court decision in the Lawrence case, advance written instructions or "directives" are still necessary to ensure that your wishes will be respected.

RIGHT TO GOOD TREATMENT

A doctor who treats you has the legal duty to apply reasonable knowledge and skill and to use reasonable care in treating you. If you are dissatisfied with your doctor's treatment, you can simply change doctors. If your complaint is serious, you should notify the Attorney General's Office, 302 W. Washington St., 5th Floor, Indianapolis, IN 46204, 317-232-6330. If injury results, you can sue the doctor for malpractice.

Similarly, a hospital, nursing home or other health facility has the duty to use reasonable care in treating and caring for you. (See Health Care Facilities) Complaints about your treatment in these facilities should first be discussed with the facility's administrator. You can also make complaints regarding long term care facilities to the Division of Long Term Care, Indiana State Department of Health, 2 North Meridian Street, Section 4B, Indianapolis, Indiana 46204, 1-800-246-8909.

If you have a complaint about a nursing home, you also can contact your local ombudsman program, listed in Chapter 16. In extreme cases, you can sue the facility.

MENTAL HEALTH SERVICES

Mental health is important at all ages, but some people find that growing old brings additional losses, pressure and loneliness. Sometimes you can find help for these problems by talking with a friend, relative, doctor or clergy person. Other times you should consult a psychiatrist or go to a counseling or mental health center. You should get professional help when:

1. Mental or emotional problems become too big to handle by yourself.
2. You are overwhelmed by depression, anxiety, anger or loneliness.
3. You are dependent on alcohol or drugs.

To find a psychiatrist or other trained mental health professional, call your county medical society or mental health association. Your Area Agency on Aging can also refer you to a counseling center.

You can also get help at your local mental health center. Indiana has 30 community mental health centers. To locate one in your area, look in the phone book under mental health, social services or counseling. At each center a professional staff provides a variety of services for all ages and special programs for older adults. It is illegal for a mental health center to discriminate against you because of your age, color, race, national origin, religion, sex or handicap. Fees are based on ability to pay. You will not be turned away because you cannot pay. For further information, contact the Indiana Division of Mental Health and Addiction at 1-800-901-1133.

Some medical insurance pays for care by a psychiatrist or mental health center. Medicare and Medicaid can pay for some in-patient care in a community mental health center or a mental hospital. For information about Medicare, call a Social Security office. For information about Medicaid, call the Division of Family and Children in your county.

Do not let pride or negative attitudes about mental health care prevent you from seeking the help you need. Mental health is as important as physical

health, and like physical health, sometimes needs professional help to maintain.

CIVIL COMMITMENT

Psychological problems and mental illness may appear at any age. Many persons with these problems can find help from a clergyperson, doctor, counselor, psychiatrist, social worker, relative or close friend. An accurate diagnosis of the problem is extremely important for older persons. Many treatable disorders, such as anemia, drug reaction, depression or even a virus, can cause symptoms that resemble mental illness or “senility.” Signs of mental impairment should be checked with a doctor who specializes in treating older persons if possible. In addition, community mental health centers can help with many mental problems. (See Mental Health Services) But when a person develops a psychiatric disorder that seriously affects his thinking, feeling or behavior and impairs his ability to function, civil commitment to a psychiatric facility may be necessary. (See Adult Protective Services)

Civil commitment results in significant loss of liberty, so Indiana requires that all commitments be supervised by the courts. Indiana laws are very specific to protect the constitutional rights of the person whose commitment is being considered. This discussion is merely a summary of those laws. If you are considering committing yourself or someone else for treatment, you should consult a lawyer for specific advice.

VOLUNTARY COMMITMENT

In Indiana, you can voluntarily commit yourself if you believe that you are mentally ill and need psychiatric help. You do this by applying for admission to a psychiatric hospital, community health center or other approved institution. A family doctor or someone at a mental health facility can explain the procedure for voluntary commitment.

Even if you sign yourself in, you may not be free to leave when you want. You must first submit to the superintendent or attending doctor a written request to leave. The institution then has 24 hours, not counting weekends and holidays, to decide whether to let you go. If your request is denied, you have the right to a court hearing and you then have all rights of a person who has been **involuntarily** committed. You may be kept in the

institution until the court decides your case.

A voluntarily committed patient has the absolute right to refuse unwanted treatment.

INVOLUNTARY COMMITMENT

Involuntary commitment is commitment to which you either do not or cannot consent. You can be committed against your will only if a court decides that *both* these requirements are met:

1. You are mentally ill. That is, you have a psychiatric disorder that substantially disturbs your thinking, feeling, or behavior and impairs your ability to function.
2. You are gravely disabled or dangerous. You are gravely disabled if you are in danger of coming to harm, either because you cannot provide for your food, clothing, shelter or other essential human needs or because a serious impairment or obvious deterioration of your judgment, reasoning or behavior results in your inability to function independently. You are dangerous if your mental illness presents a substantial risk that you will harm yourself or others.

Old age alone is not a reason to commit anyone. It is against the law for you to be committed if you are not dangerous and are capable of surviving safely in freedom by yourself or with the help of willing and responsible family members or friends.

If you have been declared incompetent and the court has appointed a guardian of your person (See Guardianship), then your guardian may apply for your admission to a psychiatric hospital. You cannot be committed simply because you have a guardian. Also, even if your guardian petitions for your commitment, you cannot be committed against your will unless a court finds that the requirements listed above are met. Furthermore, if you are committed, you are not necessarily legally incompetent, and you are not necessarily required to have a guardian appointed for you.

COMMITMENT PROCEDURES

Indiana has several procedures for involuntary commitment:

1. **Immediate Detention**, which can last no more than 24 hours. A law enforcement officer may take a person to a psychiatric facility if the officer has reasonable grounds to believe that the person

is mentally ill, dangerous to self or others and in immediate need of hospitalization and treatment.

2. **Emergency Detention**, which can last no more than three working days. To order emergency detention, a court must find that the person is mentally ill *and* dangerous *and* in need of immediate restraint. The petition for emergency detention must include a doctor's statement that the person is mentally ill and dangerous.
3. **Temporary Commitment**, which can last no more than 90 days unless it is renewed for one additional 90 day period.
4. **Regular Commitment**, which is appropriate when the person appears to be suffering from a chronic mental illness which is expected to require custody, care or treatment in a mental health facility for more than 90 days or indefinitely.

Each of these procedures is different, so you should get legal advice on your particular situation. If you face temporary or regular commitment as outlined, the following procedure should protect your constitutional rights.

1. Any person, such as a relative, friend, guardian, health or police officer, can file a written petition with the court. The petition must include a doctor's written statement that says that the doctor has examined you within the past 30 days and believes that you are mentally ill and either dangerous or gravely disabled, and that you need care or treatment.
2. The court sets a date for the hearing.
3. You must get a copy of the petition and adequate notice of the hearing so that you and your lawyer can prepare for the hearing.
4. You have a right to be present at the hearing unless you are disruptive or your presence would harm yourself. Do not sign any papers to waive this right unless you are sure you should not be present.
5. You have a right to have a lawyer represent you at the hearing. If you cannot afford a lawyer, ask the court to appoint one for you.
6. You have the right to testify at the hearing, to present your own witnesses and to cross-examine other witnesses.
7. The court may commit you to a psychiatric hospital, a nursing home, a local mental health

center or the care of another mental health program. You have the right to be committed to the least restrictive alternative suitable for your treatment. This means that the court must assign you to the place and the program that least interferes with your liberty and personal life while providing the treatment you need. In some circumstances, you may be placed on outpatient status, which means that you could live outside the psychiatric facility and receive treatment as an outpatient.

8. You have the right to appeal the court's decision.

AFTER COMMITMENT

Once you are committed, you lose many important rights. Because civil commitment leads to such a drastic loss of liberty, consult a lawyer if someone is trying to commit you against your will. (See Legal Services)

After you are committed, you still have some basic rights. You have the right to receive professional services appropriate to your needs. You have the right to ask a court for a hearing to determine whether you should be released. You have the right to humane care and protection from harm. You have the right to practice your religion. You have the right to consult your attorney.

You also have certain "conditional rights" that are subject to reasonable restrictions. These include the right to keep and wear your own clothes, to keep personal possessions, to have access to individual storage space for your own private use and to keep and spend a reasonable amount of your own money. You have the right to reasonable means of communication with persons outside the facility, including visits at reasonable times. You have the right to send and receive mail unopened and to place and receive telephone calls.

You have the right to be told the nature of the treatment program, including medication, proposed for you, the known effects of this treatment and of non-treatment and the alternatives, if any. You have the right to refuse to submit to the proposed treatment and to petition a court for consideration of that treatment. The court should decide to respect your refusal, unless the state makes a strong showing that:

1. The treating psychiatrist believes that the proposed treatment will be of substantial benefit in treating your condition, not just in controlling your behavior.

2. The probable benefits from the proposed treatment outweigh your concerns and the risk of harm to you.
3. After an evaluation of every alternative form of treatment, it is plain that the proposed treatment is reasonable and is the least restrictive of your liberty. Anti-psychotic drugs should not be continued for a long time against your will if you do not substantially benefit from them.

PAYING FOR HOSPITALIZATION

In Indiana, you or your spouse, guardian or, in some cases, the township trustee must pay the cost of psychiatric hospitalization. The Indiana Division of Mental Health may, however, waive those costs upon request.

FOR FURTHER INFORMATION

For information about state mental health institutions, call the Indiana Division of Mental Health and Addiction at 1-800-901-1133.

Long Term Care Alternatives

There are many kinds of home and community services that promote independent living for older adults aimed specifically at keeping older adults in their own homes. Some of these programs are privately funded; others are sponsored by the government. If your needs can be met by one or more of these programs, you might be able to get along better in your own home and avoid the need for a nursing facility. The services available vary from one part of Indiana to another so you will need to investigate what services are available in your area. To receive an assessment of what services you need and to find out which are available in your area, ask your Area Agency on Aging. Inquire carefully into the quality of service provided. You might also consider whether your needs could be met by sharing a home with someone else. (See Home Sharing)

HOME HEALTHCARE

Home health agencies provide nursing care, physical therapy and other health care in your home. Make sure that the agency is licensed by the state and inquire about the quality of care offered. In addition, some communities have nursing homes or other centers that provide day care and treatment for older adults. Besides helping other persons receive care and attention without institutionalization, these centers can also provide respite for family members who need a break from fulltime care of an older relative.

Home health care can be covered under Medicare Part A or Part B. It will be considered to be covered under Part A unless the patient is only covered under Part B. Even then, the home health care coverage under Part B is identical to coverage under Part A. There is no deductible or co-payment required for the patient for home health services. If the service is covered by Medicare, Medicare is responsible for the full cost. You can only be charged for services that Medicare does not cover.

Home health services are covered if the following are true:

1. You are homebound. You may leave the home if absences are brief, infrequent or for medical purposes.
2. You are under the care of a doctor who certifies the need for home care and sets up a plan.
3. You need intermittent or part-time skilled nursing services or physical, speech, or occupational therapy. Full time services (eight hours a day) can be covered for a temporary period not exceeding 21 days.
4. The services are provided by a home health agency certified by Medicare.
5. The services are reasonable and necessary to the treatment of an illness or injury.

If these requirements are met, Medicare can also pay for part time or intermittent services of home health aides, medical social services, medical supplies, and 80% of the approved cost of durable medical equipment. Thus, if you need skilled home health services, Medicare can also pay for the services of a home health aide. But if you need a home health aide, and do not need any skilled services, Medicare will not provide any coverage.

The home health agency makes the initial Medicare coverage decision. If it decides that the services are not covered by Medicare, you can request that a claim be submitted to the intermediary for an official decision which can then be appealed. However, you must be receiving the services for a claim to be submitted. Thus, unless the agency is willing to wait for payment until the Medicare claim is acted upon, you will likely need to arrange to privately pay for the services and then later get a refund if the claim is approved. (See Medicare for more information on the appeal process).

If the home health agency decides that Medicare covered services will be terminated or reduced, the agency must give you a Notice of Medicare Non-Coverage. The Notice must be provided no later than two

days before the proposed end of the services. You can request an expedited (fast) review by Health Care Excel, the Quality Improvement Organization for Indiana, by telephone or in writing. The telephone and fax number will be in the notice. A request for expedited review must be made by noon of the calendar day after you receive the Notice of Non-Coverage. Health Care Excel will obtain health care records from the agency, interview you, and review any additional records you provide. Health Care Excel will issue a decision within 72 hours. Its decision will include information about further appeal procedures, including the right to expedited reconsideration of its decision.

Medicaid also covers home health agency services for those persons receiving Medicaid. Coverage is available for services provided by an RN, LPN, home health aide, renal dialysis aide, physical therapist, occupational therapist or respiratory therapist. Prior approval must be obtained from Medicaid before services are provided, except that prior approval is not required for services provided for the first 15 days after release from a hospital where your doctor ordered the services before your release. The coverage criteria are similar to Medicare. You must be medically confined to your home, the services must be prescribed by your doctor and the services must be intermittent or part time and medically reasonable and necessary. One requirement not contained in Medicare is that the services must be less expensive than any alternate types of care.

IN-HOME SUPPORT SERVICES

MEALS

Every county in Indiana offers a meal program for people over 60. Monday thru Friday, older adults gather together for a well balanced meal. There is no specific charge for the meal, but you are encouraged to donate whatever you can afford. You can use food stamps for your donation. No one will ask you questions about your income.

Also, Area Agencies on Aging and Meals on Wheels deliver meals to persons who are unable to fix their own meals. Volunteers deliver nutritional meals each day from Monday through Friday. Often special diets can be accommodated. You can pay for these meals

but, if you cannot afford to pay the full cost, arrangements can sometimes be made to receive the meals on a donation basis.

For more information about meal programs, contact your Area Agency on Aging.

TELEPHONE

Telephone service is vital to many older persons. If you have difficulty using a telephone, ask your telephone company about ways to adapt the telephone for your disability. Telephone companies offer a variety of special devices to permit persons with hearing, sight or motion impairments to use the telephone. Many companies also do not charge you for Directory Assistance if you cannot use a telephone directory because of a vision or motion impairment; call the telephone company to get an application form for this exemption.

Some organizations offer telephone reassurance programs, which arrange for someone to call you every day to make sure that you are all right. Ask your Area Agency on Aging if such a service is available in your area.

Your telephone company may offer assistance to reduce the price of service for low income customers who receive subsidized housing, food stamps, SSI, Medicaid or energy assistance. Contact your telephone company for information and to apply.

TRANSPORTATION

Many bus and taxi companies offer discounts for senior citizens and special transportation arrangements for the disabled. If you are eligible for Medicaid, that program pays for transportation to and from a doctor or medical facility and, if necessary, the cost of someone going with you. Ask your Area Agency on Aging whether there are any other transportation or escort services in your area.

MEDICAID WAIVER SERVICES

Persons eligible for Medicaid can also potentially receive not only medical services, but also some non-medical services known as “waiver services.” They are referred to as waiver services because Indiana had to obtain a waiver from the federal government to provide them. Waiver services include:

1. Home delivered meals
2. Home modification—Up to \$15,000 of

modifications to clients who own their homes. Includes ramps, railings, bathroom adjustments, etc. General repairs are not included.

3. Adaptive aids or devices—Examples include emergency response systems, electronic speech devices, meal preparation devices, etc.
4. Adult day care
5. Personal/attendant care
6. Homemaker
7. Respite care
8. Case management services
9. Assisted living
10. Adult foster care
11. Community transition funds—Up to \$1,000 to pay one-time expenses to move from an institution into the community.

To qualify for these services a person must qualify for nursing home placement. Your Area Agency on Aging can assess your eligibility for this program and tell you about the current availability of these services in your area. Waiting lists for this program have been eliminated.

CHOICE—COMMUNITY AND HOME OPTIONS TO INSTITUTIONAL CARE FOR THE ELDERLY AND DISABLED

The CHOICE program provides a variety of in-home services to persons age 60 or over and to the disabled who are at risk of institutionalization. Services include attendant care, homemaker services, respite care and other services for primary or family caregivers, adult day care, home health services and supplies, home delivered meals, transportation and other services necessary to prevent institutionalization.

Your local Area Agency on Aging assesses you and determines what services you need to stay at home. The program is designed to fill gaps not covered by your family, insurance, Medicare or Medicaid. The Agency also assesses what share, if any, of the cost of services for which you should be responsible. Waiting lists may be lengthy. You should contact your local Area Agency on Aging to see if you qualify.

OTHER SERVICES

A wide variety of other services are available in different communities, including:

1. Homemaker services — help with light housecleaning, preparing meals, laundry,
- washing dishes and seasonal cleaning
2. Handyman services — help taking care of your yard, minor repairs
3. Counseling — legal, financial, tax, employment, pre-retirement
4. Friendly visitor services — someone to visit you regularly, read and write letters, etc.
5. Services for the blind — to help you adjust to loss of sight
6. Recreation and social activities
7. Day care for older adults
8. Continuing education
9. Information, referral and case management
10. Respite care for Alzheimer patients

Many of these services are free to older persons with low income. Ask your local Area Agency on Aging about these and other services that might meet your needs and help you remain living at home.

HEALTHCARE FACILITIES

Some older persons need the special care that a nursing home provides. This discussion gives some information about:

- Types of nursing home care available
- Sources of help for paying nursing home costs
- Legal standards that nursing homes should meet —rights of residents
- How to enforce residents rights
- Choosing a good nursing home

The term nursing home or nursing facility can refer to different types of facilities. Indiana law calls nursing homes health care facilities and classifies them into these categories, according to level of care:

Residential Care Facility. A residential care facility provides room, meals, laundry and occasional help with dressing, personal care, medications and diets. Nursing care is provided only in emergencies.

Comprehensive Nursing Care Facility. This type of facility provides more than room, meals and laundry. It also provides, under doctor's orders, nursing care, special diets, administration of medications, general medical supervision and, in some cases, rehabilitation and restorative therapy. Legislative

changes did away with the skilled nursing facility (SNF) and intermediate care facility (ICF) distinction for Medicaid certified facilities. Nursing Facilities (NF) are now held to the same standard of care. Medicare certified facilities will continue to have skilled Medicare beds.

RESIDENTIAL CARE

Residential care facilities that house three or fewer residents or related residents are not licensed or registered anywhere in the State. Residential facilities that have four or more unrelated residents and that provide residential nursing care must have a license from the Indiana State Department of Health (ISDH). Licensed residential facilities must meet the standards outlined in the Indiana Administrative Code. The ISDH conducts an annual survey of licensed residential facilities and maintains public information files on every licensed residential facility.

Before entering a residential facility, you should review the information at the ISDH website at www.in.gov/isdh/reports/QAMIS/ltccr/index.htm#category for every licensed facility you are considering. The ISDH is charged with investigating complaints against residential facilities. (See Enforcing Your Rights) Results of any complaint investigation are also included in the public files.

Residential Care Assistance Program (RCAP). Residential Care Assistance may be available to help pay for care in a licensed boarding or residential home. You must be over age 65 or disabled or blind, and you must have low income. Your disability does not have to be permanent. Eligibility for this program is currently frozen; new applicants are not being accepted.

COMPREHENSIVE CARE FACILITIES (NURSING HOMES)

Nursing facilities are held to a high standard of care that focuses on the residents' "highest practicable physical, mental and psychosocial well-being." Nursing facilities are directed to recognize "individual needs and preferences" to the enhancement of the quality of life of each resident. This standard is dictated by the Nursing Home Reform Amendments to the Omnibus Budget Reconciliation Act (OBRA) of 1987 and subsequent technical amendments. Indiana Health Facility Rules have been revised in order to comply with the Reform Law.

QUALITY OF LIFE

Residents must be allowed to choose activities, schedules and health care consistent with interests, assessments and plans of care and make choices about aspects of his/her life in the home that are significant to the resident.

The rules have eliminated minimum standards of care. Facilities are to assist resident to attain the "highest practicable physical, mental and psychosocial well-being." Facilities must ensure that the resident's abilities "do not diminish unless circumstances of the individual's clinical condition demonstrate that diminution was unavoidable" in the 12 care areas listed below:

- Activities of daily living
- Vision and hearing
- Pressure sores
- Urinary incontinence
- Range of motion
- Psychosocial functioning
- Naso-gastric tubes
- Accidents
- Nutrition
- Hydration
- Special needs
- Drug therapy

PRE-ADMISSION SCREENING PROGRAM

Every person entering a nursing home in Indiana is subject to a "pre-admission screening program." The program applies to all applicants for nursing homes, not just persons eligible for Medicaid. Unless you have a mental illness or a developmental disability diagnosis, you may choose not to participate, but then you will be ineligible for Medicaid coverage of the nursing home's daily rate for one year after the date you enter the nursing home.

Under the program, a team of persons (including your doctor) will assess your medical, social and psychological needs to decide whether those needs can be met by services available in the community. If such services can meet your needs without a nursing home and at less than the cost of nursing home care, then your placement in a nursing home will be "dis-

approved.” Disapproval does not mean that you may not enter the nursing home, but it does mean that you will be ineligible for Medicaid coverage of the nursing home’s daily rate for one year. If community services are not available to meet your needs, or if they cost more than the cost of care in a nursing home, then your admission to a nursing home will be approved.

PRE-ADMISSION SCREENING AND RESIDENT REVIEWS (PASARR)

Federal law requires States to conduct pre-admission screening and resident reviews (PASARR) of all nursing home residents or prospective residents suspected of having serious mental illness (excluding dementia) or mental retardation of a related disorder. The purpose of the PASARR program is to prevent the inappropriate placement of persons whose primary care need is for special services or active treatment and not medical care.

Any PASARR decision can be appealed. Nursing home residents who have resided in the facility for 30 months and who are found not to have a primary medical need for nursing home placement will be given the option of appropriate placement or remaining in the nursing facility.

PAYING FOR NURSING HOME CARE

Medicare. Medicare can pay some nursing facility expenses if you are eligible and several requirements are met. You must go to the nursing home soon after a hospital stay of at least 3 days. The home (including the wing or part where you live) must be certified as a Medicare skilled nursing facility, and you must need that level of care. Medicare can pay basic expenses for the first 20 days in the nursing home. From day #21 through day #100, Medicare can pay for expenses after you pay the first \$157.50 a day in 2015. This amount is adjusted each year on January 1. Medicare seldom pays any expenses after 100 days in the nursing home. For more information about Medicare, contact a Social Security office.

Medicaid. Medicaid can help pay for nursing facility services if you meet the categorical and financial eligibility requirements. If you are not within the income limits, you might be eligible for Medicaid anyway if your medical expenses are high. The Medicaid laws help protect the income and resources of the “at home” spouse of the nursing home resident. (See Medicaid) Even if you are not eligible for Med-

icaid when you enter the home, you may find that before long your Medicare benefits and personal resources have run out, and you need Medicaid. This happens to many people; so you may want to consider choosing a home that is certified for Medicaid, in case you later need that program’s help. You can get information about Medicaid from a County Division of Family Resources. (See Medicaid)

Veterans’ Benefits. Some veterans can get help with nursing home expenses from the Veterans Administration. Some children and surviving spouses of veterans can also get this help. To receive these benefits you must choose a nursing home that is under contract with the Veterans Administration. For further information, ask your VA office.

Private Health Insurance. Private insurance might pay some nursing home expenses. Because Medicare pays so little, you should consider buying private insurance that covers long term nursing care. Shop carefully. Some Medicare Supplement policies cover nursing home expenses only after Medicare benefits are exhausted. Yet Medicare law makes it difficult to “use up” your Medicare coverage. As a result, you may be left with a useless insurance policy that never takes effect. (See Supplemental and Long Term Health Care Insurance)

REGULATION

Both state and federal law regulate nursing homes. State law has different rules for each type of home. Federal law applies only to facilities that choose to participate in Medicare or Medicaid. State inspection teams from the Indiana State Department of Health inspect each facility at least every 9 to 15 months to make sure that the facility meets all legal requirements. (See Residential Care)

RIGHTS OF RESIDENTS

You do not give up basic civil rights when you enter a nursing facility. You must comply with reasonable rules and procedures, and you must respect the rights of staff and other residents. As long as you have not been declared incapable by a court, (See Guardianship, and Rights of Incompetent Residents) you maintain the right to:

- Speak freely
- Practice your religion

- Enter into contracts
- Manage your own property and finances
- Associate with and visit whomever you want
- Communicate with persons outside the home
- Be free of physical, mental and sexual abuse
- Make your own decisions about medical treatment.

Federal and state law provide the following rights to residents:

1. ***The right to information.*** Nursing facilities must inform residents of their rights at admission and upon request. Facilities must provide:
 - A copy of the latest survey (inspection) results and any plan of correction in a public area.
 - Advance notice of changes in their room or roommate.
 - A written copy of the legal rights, including personal funds, the right to file a complaint and how to contact the ombudsman and the state survey agency.
 - Written information about services covered under the basic rate and extra charges.
 - Written and oral information concerning Medicaid.
 - Notification of nurse staffing waivers.
2. ***Self determination.*** Nursing facilities must respond to residents' needs and concerns, as expressed by residents, or their legal representative. Residents have the right to:
 - Choose their personal physician.
 - Receive full information, in advance, and participate in their care plan and treatment.
 - Receive reasonable accommodation for individual needs and preferences.
 - Voice grievances without reprisal and receive a prompt response.
 - Organize and participate in resident groups.
3. ***Personal and privacy rights.*** Residents have the right to:
 - Participate in social, religious and community activities as they choose.
 - Be provided privacy during medical treatment, personal visits, written and telephone communications.
 - Have confidentiality of all records protected.

4. ***Involuntary transfer and discharge rights.***

Residents may only be transferred under the following conditions:

- Facility is unable to meet the medical needs of the resident.
- Resident's health has improved so that nursing care is no longer needed.
- Health or safety of other residents is endangered.
- Resident has failed, after reasonable notice, to pay for his/her care.
- The facility closes. Notice of Relocation must be given on the form specified by the ISDH. Residents and their representatives have the following notice rights:
 - At least 30 days advance notice, or as soon as possible if immediate transfer is needed for immediate health need.
 - Notice must include the reason for the transfer, the proposed transfer location information concerning the resident's right to appeal the transfer, the name, address and phone number of the local and state ombudsman program (See Ombudsman Program), appeal request form.
 - Preparation and orientation by facility to ensure safe and orderly transfer from the facility.

5. ***Visitation rights.*** Residents have the right to receive visitors:

- Immediate access by personal physician and representatives from state and federal agencies, including the ombudsman program.
- Immediate access by relatives, if resident consents.
- Immediate access by others with "reasonable" restrictions.
- Reasonable visits by groups, subject to resident's consent.
- Access by ombudsman to records with consent of the resident.

6. ***Protection against Medicaid discrimination.***

Discrimination in treatment of residents is prohibited and applicants for admission are protected from fraudulent activities.

Facilities must:

- Have identical policies regardless of source of payment.
- Provide information on how to apply for Medicaid.
- Not request, require or encourage residents to waive rights concerning Medicaid.
- Not transfer or discharge solely because payment source has changed from private pay to Medicaid.
- Not require guarantor of payment.
- Not “charge, solicit, accept or receive gifts, money, donations or other considerations” as a precondition for admission or continued stay for persons eligible for Medicaid.

7. *Protection of personal funds.* If a resident requests the facility to manage his/her funds, the facility must:

- Keep funds over \$50 in an interest bearing account.
- Keep resident and facility funds separate.
- Keep and provide to the resident complete and accurate accountings, with a written record.
- Not charge for service or items covered by Medicaid.
- Upon a resident’s death, turn funds over to the administrator of the estate.
- Purchase a surety bond or provide other assurance of security.

8. *Rights against restraint and abuse.* Residents are protected from physical, mental and sexual abuse and the inappropriate use of physical and chemical restraints, including freedom from:

- Physical or mental abuse, corporal punishment or involuntary seclusion.
- Restraints used for discipline or convenience of staff.
- Restraints used without a physician’s written orders to treat medical symptoms.
- Drugs used to control mood, mental status or behavior without a written physician’s order in the plan of care for a specific medical symptom and an annual review for appropriateness by an independent, external expert.

9. *Rights of incompetent residents.* The law states specifically that when a resident has been found by a court to be incompetent under the

laws of the state, the rights of the resident “shall devolve upon, and, to the extent judged necessary by the court of competent jurisdiction, be exercised by the person appointed under state law to act on the resident’s behalf.”

LEAVING THE NURSING FACILITY

You can leave a nursing facility for the day, overnight or permanently (unless you have a guardian), and the staff may not prevent you from leaving. Remember, however, that the facility is responsible for your care and safety and may have set up procedures for pre-arranging a leave or discharge. If you sign a release of responsibility, the nursing home is no longer responsible for you when you are gone.

If you are gone overnight, you may have to pay a fee to hold your bed while you are gone. Check your home’s policy on leaves. Medicare and Medicaid will not pay to hold your place if you are gone overnight.

CARE PLAN DEVELOPMENT

OBRA and the state rules mandate the assessment and care planning process be the basis for care that helps residents “attain or maintain the highest practicable physical, mental or psychosocial wellbeing.”

Assessment. Each resident entering a facility must be assessed within 14 days of admission. The assessment shall be the basis for the plan of care. The assessment must be reviewed quarterly and redone annually or earlier when there is a significant change in the resident’s mental or physical condition. The assessment is to be coordinated by an RN, with participation by appropriate health professionals.

Care plan meetings. The information gathered from the assessment will be used as the basis for the plan of care the facility has for the resident. Care plan meetings will be held periodically to update information and reevaluate goals and approaches. Residents, families and representatives are allowed to participate and should be encouraged to do so.

WHEN ARE RESTRAINTS ALLOWED?

In the Resident Rights section, OBRA states that residents have “the right to be free from physical or mental abuse, corporal punishment, involuntary seclusion and any physical or chemical restraints imposed for purpose of discipline or convenience and not required to treat the resident’s medical symp-

toms.” Restraints may only be imposed (1) to ensure the physical safety of the resident or other residents, and (2) only upon the written order of a physician that specifies the duration and circumstances under which the restraints are to be used (allows for emergency exceptions until such an order could reasonably be obtained).

The Federal Interpretive Guidelines tell ISDH surveyors to determine if restrained residents have experienced a decline and if facilities periodically reevaluate the need for the restraint and make efforts to eliminate their use. A physical restraint is defined as “any manual method or physical or mechanical device, material or equipment attached or adjacent to the resident’s body that the individual cannot move easily which restricts freedom of movement or normal access to one’s body.”

The guidelines further direct surveyors to determine if: less restrictive alternatives have been attempted; occupational and physical therapists have been consulted; the resident and family have received a full explanation; and the device is an “enabler.” Surveyors are also to determine if the resident suffers from any adverse mental, physical or psychosocial effects from the restraint. Residents are to be free from unnecessary drugs and are not to be given antipsychotic drugs except to treat a specific condition.

If you have questions concerning restraints ask your doctor. You can also call your local ombudsman. (See Ombudsman Program)

NURSE STAFFING

OBRA requires facilities to provide 24-hour licensed nursing services to meet resident nursing needs, with registered nurse coverage at least eight consecutive hours a day, seven days a week. Facilities may request a waiver of the RN requirements from the ISDH Health Facilities Division and the regional office of the Health Care Financing Administration in Chicago.

Indiana facilities granted nurse staffing waivers will be subject to ISDH surveyor walk-throughs. The ISDH can rescind waivers if the quality of care has declined, or if the facility has not continued diligent efforts to recruit staff.

ENFORCING YOUR RIGHTS

If your rights are being violated, or you have a complaint, you should talk with the facility’s admin-

istrator. Follow the facility’s grievance procedure and if the facility does not respond, you can get outside help from other sources.

1. *Indiana State Department of Health (ISDH).*

The ISDH conducts an annual standard survey in each facility. Extended surveys are conducted if the standard survey indicates sub-standard care. ISDH is also responsible for investigating complaints filed with the office.

The survey focuses on resident outcome but this does not mean surveyors must wait until the resident suffers a negative outcome before citing a deficiency.

Local Ombudsmen participate in the survey process. The surveyors contact the ombudsman during the survey to inform the ombudsman of the survey and invite the ombudsman to the Resident Council Meeting (with resident approval) and the Exit Conference. The ombudsman can share complaints with the survey team. Complaints can be filed with:

Health Facilities Division

Indiana State Department of Health
2 N. Meridian Street
Indianapolis, IN 46204
(317) 233-7442, (800) 246-8909
(Written complaints are best, but telephone complaints are accepted.)

2. *Nursing Home Ombudsman Program.*

Ombudsman is a Swedish word that means citizen representative. A nursing home ombudsman is a representative for residents and can do the following:

- Investigate and seek to resolve complaints about nursing home care that affects the health, welfare or quality of life of a nursing home resident.
- Protect the rights of residents.
- Assist residents to assert their rights.
- Work to insure quality care and treatment of residents.
- Answer questions and provide information about nursing home care and related services.
- Educate residents, families, staff and community about nursing home resident rights.

Anyone can contact the ombudsman program for assistance; however, the resident will be

consulted and direct the actions of the ombudsman. You can contact the State Ombudsman program:

State Ombudsman Program

Indiana Family & Social Services Administration
Division of Aging & Rehabilitative Services
P.O. Box 7083
Indianapolis, IN 46207-7083
(317) 232-7134, (800) 622-4484

3. **A lawyer** can help you enforce your rights. A lawyer can give you advice and, if necessary, help you in a lawsuit. (See Legal Services)
4. **The Medicaid Fraud Control Unit** in the Attorney General's office investigates complaints in Medicaid certified facilities. The complaint does not have to involve a Medicaid resident.

Medicaid Fraud Control Unit

Indiana Attorney General's Office
302 W. Washington Street, 5th Floor
Indianapolis, IN 46204
(317) 915-5300, or (800) 382-1039

5. **If the Veterans Administration placed you** in the home, or if you receive Veteran Benefits, contact Social Services at the nearest VA hospital.
6. **To report criminal conduct** (cruelty, fraud, etc.), notify the County Prosecutor's Office. Look in the telephone book under County Government Offices.

When you consult these sources for help for yourself or someone you know, you may want to ask them about confidentiality and how your problem will be handled. The Department of Health, the Ombudsman, and lawyers all are required to treat your inquiry or complaint with confidentiality if you wish. If you fear retaliation for making a complaint, you should discuss this with them and they can advise you about ways your problem can be handled while protecting you from any retaliation.

MAKING THE DECISION

If you are considering nursing home care for yourself or someone else, you should first ask: is a nursing home the best alternative? What home services are available in the community? Which services are paid for in part or in full by Medicare, Medicaid or another program? If your community offers good home services and/or day care for older persons, you might

prefer to maintain independent living. Your Area Agency on Aging can tell you what services are available. (See In-Home Support Services) The Pre-admission Screening program helps determine who needs nursing home care and who does not.

You should consult past years' surveys for the nursing homes you are considering. These reports are public records. All nursing homes are required to have available in a public area copies of the ISDH survey and plan of correction. If the home's administrator is reluctant to discuss these reports with you, be suspicious. Comparative information can be found at Medicare's Nursing Home Compare at www.medicare.gov/nursinghomecompare/search.html and on the health department's website, www.in.gov/isdh/reports/QAMIS/ltccr/index.htm#category.

When considering a particular facility, ask to see a current Indiana license for both the home and its administrator. Make sure they are current. If you need Medicare and Medicaid, find out if the home is certified for these programs. Ask to see any contract or other document you will have to sign. Be sure that you understand all the terms. A lawyer can explain parts you do not understand. If someone from the home makes a promise or representation, get it in writing and have it made a part of the written contract. Be sure you understand exactly what services the home provides and what all your costs will be. The home cannot require Medicaid patients to pay a deposit before entering the home.

Be especially careful about Life Care Contracts. These contracts typically require you to turn over your home or possessions to the nursing home in return for the facility's promise to care for you for the rest of your life. You should definitely consult a lawyer before signing this type of contract.

Make full inquiry before you decide. After all, the facility you choose will be your home, at least for a while. Ask questions of the staff, residents and family and friends of residents. Visit the facility in person. A tour with a staff member can be helpful. It can also be informative to visit the home unannounced. You may want to visit during the evening or on a weekend. Here are some questions to help you decide. (These questions do not all raise legal points, but they suggest information that might be helpful.)

- Is the home certified for Medicare and/or Medicaid (if you need these programs' help)?

- What do past years survey reports indicate about the home's compliance with the law?
- What does the plan of correction say the facility is doing to address the problem? Look around, is this being done?
- Are all financial agreements in writing?
- What services are included in the price? Not included?
- Will you receive a refund of advance payments if you leave the facility?
- Ask to see a copy of the residents' rights. Do staff members know about these rights?
- Is regular medical attention assured?
- Are doctors and nurses available other than in emergencies? What arrangements are there for hospitalization if it becomes necessary?
- Can each resident choose his own doctor? Pharmacist?
- Are drugs carefully labeled?
- Who dispenses drugs?
- Where is the isolation room required for residents with contagious diseases?
- What arrangements are there for therapy?
- What arrangements are there for mental health services?
- Does the staff seem cheerful and helpful?
- Is there a call light for each bed? For the bathrooms?
- During your visit, how long does it take staff to respond to call lights?
- What is the turnover rate for employees?
- Do aides knock or speak before entering rooms?
- Does staff know and use residents names?
- What do the grounds look like?
- Is there a good place to go for fresh air?
- Is the home attractive?
- Does the home look clean? Smell clean? Check the bathrooms, closets, and linens. Look into the kitchen.
- Is the home well-lighted?
- Is there room for wheelchairs to maneuver?
- Are there ramps where needed?
- Are there non-slip surfaces in the bathroom?
- Are there handrails and grab-bars where necessary in the hallways and bathrooms?
- Is the place free of hazards underfoot and generally designed to minimize accidents?
- Are the chairs comfortable? Not easily tipped? Designed to meet each resident's individual needs?
- Are exits clearly marked and unobstructed?
- When was the last fire drill?
- Are doors locked from the inside?
- Are you allowed to look in every section of the home?
- Can you talk freely with residents? Or is there a staff person at your elbow?
- Is there a dietitian associated with the facility?
- Are special diets available?
- Are meals served at regular times?
- Are there 14 hours or less between the evening meal and the next day's breakfast? Is a bedtime snack offered?
- Do those who need help eating get it? While the food is still warm?
- Does the food look appetizing? Are substitutes offered?
- Do lots of trays return with uneaten food?
- Ask for a tray. How does the food look? Smell? Taste?
- Do the menus correspond with the meals actually served?
- Is the food preparation area separate from the garbage?
- Is there fresh water by each bed?
- May residents keep their own possessions and furnishings?
- May residents decorate their own rooms?
- What arrangements are there for grooming?
- Are there screens, curtains, etc., to guard privacy for personal care? Are they in good repair and functioning? Does staff use them?

- How much attention is given to matching roommates?
- Does the daily schedule seem to be set up for the convenience of residents?
- Are there convenient visiting hours?
- Are there regularly scheduled activities? This is an important question for facilities where the residents are capable of such activities. Are there evening and weekend activities?
- Are the facilities adequate for social and recreational activities? Are activities offered for every level of resident ability?
- Are arrangements made for religious services?
- What is the home's policy on leaves of absence? When can a resident leave and for how long?
- Talk to residents and friends of residents. Are they pleased with the home? What services does the social services department offer?
- What are the qualifications of the staff in the social services department?
- How many residents are physically restrained?
- What type of security system does the facility have?
- Is there a safe area for residents who wander?

SPECIAL CARE UNITS

Special care units are sometimes used to meet the needs of specific groups of residents, such as Alzheimer's patients. If you are looking at a special care unit it is important to compare services offered to meet the special needs of the target population. Examples would be specialized activities and therapies along with environmental adaptations. You should also ask for staff qualifications. Has the staff received special ongoing training to better work with the population?

All facilities that have special care units must file a disclosure form with the State Ombudsman. This form identifies services provided, admission requirements and other information that help you compare facilities. These forms can be reviewed by contacting the nursing home ombudsman in your area.

PERSONAL HYGIENE ITEMS

Nursing home residents whose care is paid for by Medicaid or residents who are in a Medicare skilled bed with Medicare paying for their care, should not be charged for the following personal hygiene items:

- Shampoo, comb, brush
- Bath or disinfecting soaps
- Razors, shaving cream
- Toothbrush, toothpaste, floss
- Denture adhesive, cleaner
- Moisturizing lotion
- Tissues, cotton balls, swabs
- Deodorant
- Incontinence supplies and care
- Sanitary napkins, related supplies
- Towels, washcloths
- Hospital gowns
- Over the counter drugs
- Hair and nail hygiene services
- Bathing assistance or supplies
- Basic personal laundry

If a resident would like a specific brand item other than that which is provided by the facility, the resident pays the difference between the cost of the facility provided brand and the brand that the resident is requesting.

The Patient Protection and Affordable Care Act

The purpose of the Patient Protection and Affordable Care Act (“ACA” also known as Obamacare) is to expand options for affordable health care insurance. It is one of the most significant changes in health insurance delivery since the implementation of Medicare and Medicaid. The ACA seeks to expand health insurance through 4 mechanisms: the Individual Mandate, Employer’s Duty to Offer, Medicaid expansion and creation of the Health Insurance Exchange or Marketplace. Because of the law’s scope, details about how the law will be implemented are still being worked out. This article is intended to give you a general overview of the major components of the law and how it may affect you.

SCOPE OF HEALTH INSURANCE COVERAGE

Prior to the ACA, health insurance policies varied widely. One plan may have provided hospitalization only coverage, another might have excluded maternity care or mental health services. Except for certain employer-sponsored plans, health insurers could also examine an individual applicant’s health history (pre-existing conditions) to determine whether or not to offer health insurance coverage and at what cost to the insured. The ACA addresses both these issues, by requiring policies to meet certain minimum essential coverage and prohibiting insurers from denying coverage or charging different premiums because of pre-existing conditions. Insurers can now vary premiums only by age (to a limited extent), tobacco status, geographic region, and family size.

The areas of minimum essential coverage under the ACA are listed below. The precise details of what is covered within these categories may vary from plan to plan and state to state, however.

- Ambulatory patient services
- Emergency services

- Hospitalization
- Maternity and newborn care
- Mental health and substance use disorder services, including behavioral health treatment
- Prescription drugs
- Rehabilitative and habilitative services and devices
- Laboratory services
- Preventive and wellness services and chronic disease management
- Pediatric services, including oral and vision care

The ACA also brought benefits to younger and older Americans. It allows children to stay on a parent’s health insurance plan until age 26. The ACA required traditional Medicare to cover preventative services such as an annual wellness visit, mammograms and colonoscopies.

INDIVIDUAL MANDATE

Starting in 2014, citizens and legal residents must have health insurance with minimum essential coverage or pay a tax penalty. Exemptions from the requirement include: Individuals who would have to pay more than 8% of their income for health insurance, individuals with incomes below the threshold required for filing taxes, financial hardship, those who qualify for religious exemptions, undocumented immigrants, people who are incarcerated, and members of Indian tribes.

Medicare, Medicaid (traditional Medicaid, Hoosier Healthwise, and Healthy Indiana Plan) and Tricare (military health coverage) all satisfy the requirements for minimum essential coverage. Many employer sponsored insurance programs also satisfy the requirements. Your employer (or your spouse’s employer) is required to provide a Summary of Benefits and Coverage notice no later than October 1 of

every year. This notice indicates whether or not the employer sponsored insurance program complies with the ACA's requirements. If you are on Medicare, Medicaid, or other insurance which meets the requirements of the ACA, you will not incur a tax penalty.

The tax penalty is a specified percentage of income or a specified dollar amount, whichever is greater.

- 1% of taxable income in 2014 – 2.5% in 2016 or
- Dollar amount is \$95 in 2014 to \$695 in 2016.

After 2016 the penalty is to increase annually by the cost-of-living adjustment. Example: The tax penalty for a family of four, none of whom had adequate insurance would be \$2,780 in 2016. In most circumstances the tax penalty will be less than the costs to acquire health insurance coverage.

EMPLOYER'S DUTY TO OFFER COVERAGE

The ACA also requires employers with 50 or more employees are required to offer "qualified" health insurance to full-time employees and their dependents. A qualified plan under the ACA means it must provide minimum coverage (discussed above) and also be affordable. The ACA does not require employers to offer insurance to spouses of employees, although many employers do.

In order to be considered affordable, the employer must pay at least 60% of the total of all health care costs when averaged across all enrollees. This does not mean that the employer pays 60% of each and every charge. You may still have a deductible and co-pays. The employee's portion must also cost less than 9.5% of employee's household income.

The deadline for enforcing the requirement for employers to provide coverage has been extended, but is currently anticipated to begin in 2015.

If an employer has a duty to offer health insurance coverage under the ACA and does not offer such coverage, it is subject to a tax penalty.

HEALTH INSURANCE MARKETPLACE/EXCHANGE

Health Insurance Marketplaces also called "Exchanges" have been created to give individuals additional options for purchasing health insurance policies.

Each state has its own marketplace or uses the federal marketplace to offer approved policies from insurance company providers to citizens and legal immigrants. The Health Insurance Marketplace for each state can be accessed at www.healthcare.gov. You can also apply over the phone or submit a paper application.

The health insurance plans on the Marketplace must provide minimum essential coverage, but some provide greater levels of care. For easier comparison, plans are grouped into metallic levels depending on the level of cost sharing.

- Bronze = plan covers 60% of health care costs when averaged across all enrollees, participants pay 40%
- Silver = plan covers 70%, participants pay 30%
- Gold = plan covers 80%, participants pay 20%
- Platinum = plan covers 90%, participants pay 10%

"Catastrophic" plans are available for young adults up to the age of 30 or other individuals, regardless of age, if no other Marketplace plan would cost less than 8% of their income.

In order to make health insurance more affordable, the ACA provides tax credits and subsidies for individuals with household incomes between 100% and 400% of the federal poverty level. In order to be eligible for the credits, the individual must also not have access to affordable coverage through their employer or be eligible for Medicaid or Medicare. Marketplace plans are the only place where these tax credits and subsidies can be applied. The premium tax credits immediately buy-down the cost of the insurance premium for qualifying individuals and families with incomes between 100% and 400% federal poverty level ("FPL") (about \$24,250 to \$97,000 for a family of 4 in 2015). In addition to lowering the premium cost, the out of pocket costs are limited for individuals with household incomes between 100% and 250% of the FPL (about \$24,250 to \$60,625 for a family of 4 in 2015).

Eligibility for tax credits and premiums is based on financial information you submit at the time of applying for coverage. If your income subsequently changes, the tax credit you receive may be reconciled (higher or lower) on your federal tax return.

When selecting a health insurance plan, it is important to compare both cost as well as coverage. While a bronze level plan may be available at little to no cost, individuals with serious or chronic

health conditions may generally not be well served by a bronze plan because it is designed to only cover 60% of participant's health care costs. Plans can have different prescription drug coverage, so it may be important to you to find out if your prescriptions are included in the plan. Many marketplace health insurance plans have narrow networks, meaning only certain doctors or hospital networks are covered as "in-network" providers.

You may find plan coverage details available at the state's marketplace website. Many hospital networks and advocacy organizations have navigators or assisters who can help applicants access information in order to decide between plans. You can ask your health care provider to refer you to an individual within their organization that can help you. A list of contacts for qualified individuals in your area is available at <http://localhelp.healthcare.gov>.

Enrollment in health insurance plans through the Marketplace is generally only available during an open enrollment period. This open enrollment period will be specified in advance of each calendar year, but generally it will be during November and early December for coverage starting January 1 the following year. If you miss this open enrollment period, you will not be able to enroll in Marketplace plans until the following year, unless you qualify for a special open enrollment period. Special enrollment

periods occur if you lose other health insurance coverage, or need to amend coverage because of marriage or a birth in your family.

MEDICAID EXPANSION

When originally passed by Congress, the ACA anticipated that eligibility for Medicaid would be expanded to ensure that all low income individuals would have access to affordable health insurance coverage. Medicaid is a program with both federal and state participation, however, and the Supreme Court found that the States could not be required to expand Medicaid as originally envisioned by the ACA.

Accordingly, states have an option to expand Medicaid or not. States that choose to expand Medicaid receive additional federal funding to help off-set the costs of the additional insured individuals. States that do not expand Medicaid have a hole in providing health insurance coverage to individuals under 100% of the federal poverty line (a large percentage of the uninsured), as those individuals do not qualify for tax credits and subsidies in the Health Insurance Marketplace. Indiana has adopted the Healthy Indiana Plan, popularly known as HIP 2.0, as its hybrid form of Medicaid expansion. The plan will apply to all non-disabled persons ages 19 to 64 who earn between 23 and 138 percent of the federal poverty level.

Housing

Safe, affordable housing is something we all want. Whether you rent or own, it's helpful to know about different types of housing and laws that may affect you.

RENTAL HOUSING

SUBSIDIZED HOUSING

If you can't find a decent, affordable place to live, you might apply for subsidized housing. These units are not emergency housing and may have waiting lists.

Subsidized housing has special protections for tenants, such as requiring good cause to evict, limits on rent, etc. However, all tenants are required to abide by the terms of their leases. Indiana landlord-tenant laws also apply to subsidized housing.

There are many different types of subsidized housing. Rent is generally lower than the private market. Rent can change if your income changes.

Because there are so many different kinds of subsidized housing, it can be a challenge to find all of it. Good resources include the following:

- U.S. Department of Housing and Urban Development (HUD) – You can call customer service at (800) 955-2232 or go to www.hud.gov. Click on “find rental housing.” There you can look up low rent apartments (by location, number of bedrooms, and special needs such as senior housing).
- Other Indiana resources are at www.indianahousingnow.org and www.in.gov/ihcda.

Often, the best resource is a local resource. Your local community action agency, area agency on aging or other agencies often have more complete local lists.

- Call the Indiana Community Action Association at (800) 382-9895 or go to www.incap.org.
- Call the Indiana Association of Area Agencies on Aging at (317) 205-9201 or go to www.iaaaa.org.

Public housing. Public housing is owned and operated by local public housing authorities (PHAs).

Their purpose is to provide decent, safe and sanitary housing for people with low incomes. Programs in Indiana vary in different parts of the state and often give priority to the elderly and the disabled.

Applications usually require a personal or phone interview. You will pay about 30% of your adjusted income for rent. Even if you have no income, housing authorities may set minimum rents (from \$0 to \$50 per month).

Tenants in public housing have special rights, but they also have responsibilities that are stated in the lease. Tenants cannot be evicted without good cause or without going to court. A housing authority must provide a grievance procedure that tenants can use to appeal or make complaints.

Housing authorities have low-rent units which they own and operate. They may also have Section 8 vouchers for you to find a private landlord who might accept a voucher for rent.

To find out if public housing is available in your area and how you qualify, contact your local housing authority. See <http://www.hud.gov/offices/pih/pha/contacts/states/in.cfm>.

Section 8. The federal government provides Section 8 rent subsidies, which is for low or moderate income people who live in privately owned housing. There are two primary types of Section 8. One is project-based Section 8. The other is tenant-based Section 8 (or the Section 8 voucher program).

In project-based Section 8, rent is subsidized in an apartment complex. When you move, the subsidy stays with the apartment. A landlord must have good cause to evict you.

In tenant-based Section 8, you get a voucher for rent. You then find a house or apartment where the landlord will accept a Section 8 voucher. Sign up for vouchers through housing authorities that offer them. IHCA (Indiana Housing and Community Development Authority) also offers Section 8 vouchers through local community action agencies. Find your local CAA by calling (800) 382-9895 or go to www.incap.org.

Once you find a place to rent, the unit must pass an inspection. A tenant can generally only be evicted for good cause during the lease term. However, Section 8 voucher landlords no longer have to renew the lease after the first year. If the landlord chooses not to renew, he or she does not have to have good cause to evict you.

There are specialized vouchers for certain populations, such as supportive housing for veterans (VASH). If you are interested in Section 8 vouchers, contact your local housing authority. If there is no housing authority in your area, call 1-800-382-9895.

Elderly and disabled housing. Inexpensive housing may also be available to low-income elderly people through subsidized apartments specifically designed for older residents. Some places may be limited to older residents only. Others may be for seniors and people with disabilities.

To get a list of subsidized apartments for the elderly or disabled in Indiana, contact:

Department of Housing and Urban Development
151 North Delaware, Suite 1200
Indianapolis, Indiana 46204-2526
317-226-7739

Rural housing. For a list of U.S. Dept. of Agriculture Rural Development Multi-family Housing, go to http://rdmfhrentals.sc.egov.usda.gov/RDMFHRentals/select_county.jsp?st=in&state_name=Indiana&st_cd=18. There you can search for unit by town and zip code.

Low Income Housing Tax Credit (LIHTC). Another source of affordable housing is the U.S. Treasury Low Income Housing Tax Credit (LIHTC) program. Investors/developers get tax credits which help lower the rent.

LANDLORD-TENANT LAW

This section covers some basic landlord-tenant issues. While Indiana has several landlord-tenant laws, your rights as a tenant also depend on what your lease says and the specific facts in each case. A lawyer can help you with a landlord-tenant question or problem.

Leases may be written or oral, but a written lease helps ensure the terms are clear to all parties. Read your lease carefully and be sure you understand every part. If you rely on a promise by the other party, be sure to get it in writing so it's clearly part of the lease.

It's also wise to keep copies of any notices you send to the landlord, as well as detailed notes about your contacts with the landlord.

Make sure you have a complete copy of your lease. Once you sign, you are bound by its terms (although some lease clauses may not be enforceable under the law, such as a clause that says the landlord can immediately remove you from the property in any manner without going to court).

Keep good records of your payments. Never give cash without getting a receipt. If you don't get a receipt when you pay, write one yourself and have the landlord sign it.

Condition of the premises. Indiana law requires landlords to deliver property to tenants in a safe, clean and habitable condition. They must also comply with health and housing codes. Contact your local building or health departments for information on what the codes require.

Landlords must keep electric, plumbing and heating systems in working order and maintain appliances they have provided. Tenants must use these systems and use appliances in a reasonable manner and keep the premises reasonably clean.

Units must have a working smoke detector (which must be fixed within 7 working days after written notice of a problem). Tenants may not disable smoke detectors and must replace batteries as needed. If a smoke detector is hard-wired and not working, give the landlord notice in writing.

If repairs are needed, notify the landlord in writing. You must give the landlord a reasonable amount of time to make repairs and not interfere with access to the property.

If the landlord will not make needed repairs, a court can order the repairs and award damages and attorney fees. Because Indiana law does not generally allow tenants to withhold rent, it is strongly recommended that you get legal advice before trying it. There may be a few cases where a tenant could make a minor repair and deduct the cost from rent, but it depends on your lease language and only after advance notice to the landlord.

Landlords must enter units at reasonable times after giving reasonable notice of intent to enter. A landlord can enter without notice if there's an emergency, but must not use the right of entry to harass a tenant. Tenants must not unreasonably withhold

consent for landlords to enter for repairs, inspections or to show the property.

Ending the lease. It's important to read your lease carefully about how the lease ends or how it's renewed. There may be penalties for ending the lease early. If you don't give the notice required by the lease, it may be automatically renewed, and you could end up owing rent or penalties you did not intend to owe. Watch out for lease language that allows a landlord to collect rent for the rest of the lease term if you leave early.

The type of notice a landlord is required to give will depend on what the lease says and the type of lease (for example, a month-to-month lease may be terminated with a 30-day notice). If the tenant is behind on rent, the landlord may have to give a 10-day notice to quit and a chance for the tenant to catch up. However, in many cases, the law does not require any notice (for example, if there is an express agreement to pay rent in advance).

In some cases, an early termination may be justified if the property is not habitable (and you have given the landlord notice and a chance to repair) or there has been domestic violence. (See protections against domestic violence, below).

Eviction. If a tenant violates the lease (such as by not paying rent or damaging the property), the landlord can terminate the lease. If the tenant has not moved out in time, the landlord should file in court for eviction.

It's unlawful for a landlord to keep tenants' possessions in order to force you to pay rent (but a mobile home park can prevent removal of a mobile home if the tenant is behind on rent). The landlord cannot interfere with the tenant's possession of property (such as shut off utilities, change the locks or remove the door), except as authorized by a court order.

If the landlord unlawfully tries to force you out, you can file in small claims court for an emergency possessory order to regain possession of the property until the landlord follows the proper procedure for eviction.

When a landlord sues for eviction, the court generally has two hearings. At the first hearing, the court decides who has the right to possession of the property. Unless you have a good defense, the landlord will likely win. Defenses might include the landlord not giving the right notice of termination, continuing to accept rent from you, or not giving you a warning that late payments will no longer be accepted if

there's a long history of late payments.

If the landlord wins, the tenants will be ordered out by a certain date. If they are not out by that date, the sheriff's office may be able to help enforce the order.

The court sets a second hearing to decide the amount of damages (damages can include past due rent). A tenant may also claim damages.

A landlord can ask for a court order to put a tenant's property in storage. If ordered, the landlord must give you the address of the storage unit and a copy of the court order. The tenant has a right to demand release of exempt property that's in storage without having to pay. Exempt property is any personal property that is medically necessary, used in your trade or business, a week's worth of clothing, blankets, and items needed for the care and schooling of minor children. The rest of the property must be released on payment of the storage facility expenses.

If a landlord improperly keeps the tenant's property, the tenant can sue and ask the small claims court to order the landlord to return his or her possessions. A tenant can bring this lawsuit with or without a lawyer.

Security deposits. Indiana law requires a landlord to return the tenant's security deposit (or give an itemized list of any deductions from the deposit) within 45 days of termination. Some leases have a shorter time (30 days). The tenant must give the landlord written notice of a forwarding address before the 45 day period begins. The address does not have to be where you are living, but where the landlord can return the deposit or send notice of deductions. It's a good idea to send your address by certified mail, so you have proof you did it.

If the landlord does not send the required notice, the law presumes no damages have occurred, and the landlord cannot collect for physical damages or cleaning fees. The landlord may still, however, collect for unpaid rent.

If the landlord does not return any part of the deposit that was not applied to damages within 45 days, the tenant can recover all of the deposit plus attorney fees.

It's best to have a joint inspection of the property with the landlord immediately after you have moved everything out and cleaned up. You should take good pictures and have a third party present during the inspection. Hopefully, you took detailed pictures of

the condition of the property at the time you moved in. This can protect you if the landlord claims you damaged the property, but the damage was present when you moved in.

PROTECTIONS AGAINST DOMESTIC VIOLENCE

Both Indiana and the federal government have legal protections in housing for survivors and victims of domestic violence.

Indiana law. Indiana law provides certain lease protections for individuals who have had acts of domestic or family violence against them, as well as certain sex offenses and stalking. These protections include the right to terminate a lease early without extra charges, the right to have locks changed, and the right not to have a landlord terminate a lease or deny you housing only because you are a victim of these crimes.

If you have a protective order or no contact order, a tenant can request that a landlord change the locks to a dwelling unit. The request must be in writing and include a copy of the order. If the perpetrator of the act does not live in the same unit as the tenant, the landlord must change the locks within 48 hours of the written request and give the tenant a key. If the perpetrator does live in the same unit as the tenant, the landlord must change the locks within 24 hours of the written request. The landlord then must not give the perpetrator any access to the unit, unless a court order allows the perpetrator access to retrieve personal belongings.

If the landlord changes the locks in the time required, the tenant must reimburse the landlord for the cost of the locks. If the landlord does not change the locks in the time required, the tenant may change the locks, and the landlord must reimburse the tenant for the cost of the locks. The tenant must give the landlord a key.

In order for a tenant who is a victim of domestic violence or sexual assault to terminate a lease early under Indiana law, the tenant must give a 30 day written notice to the landlord, along with a copy of a protective order or no contact order, including a recent safety plan from an accredited organization that recommends relocation for the tenant. For help, contact local agencies through the Indiana Coalition Against Domestic Violence (ICADV) at (800) 332-7385 or www.icadvinc.org.

Federal law. The federal Violence Against Women Act (VAWA) gives valuable protections to people who rent under most subsidized housing programs. Applicants or tenants should not be denied admission to, denied assistance or evicted if the reason is that the person is or has been a victim of domestic violence or other acts. A major drawback, however, is that it does not apply to private housing.

VAWA protects people who are victims of actual or threatened domestic violence, dating violence, sexual assault or stalking. It also protects people who live in the same household as the victim.

The 2013 reauthorization of the law expands protections to lesbian, gay, bisexual and transgender people, as well as immigrant survivors of sexual assault and domestic violence. The law also provides emergency transfer rights and the right of survivors to remain eligible for housing subsidies.

Under the law, owners and managers are allowed (but not required) to make a written request for certification that someone is a victim. Certification can be provided through law enforcement or court records, a statement signed by the victim and a service provider, attorney or health professional, or, at the landlord's discretion, a statement from the survivor only. Once the landlord has requested in writing that the victim provide certification, the tenant (or prospective tenant) has 14 business days to respond.

FAIR HOUSING LAW

Fair housing laws help assure equal housing opportunity by prohibiting discrimination against certain categories of people. Fair housing laws apply to the sale, rental or financing of housing.

It is against fair housing laws to discriminate against people on the basis of their disability, race, color, national origin, religion, sex or family status (families with children under the age of 18). While age is not a protected category (except under fair housing ordinances in Indianapolis and Marion County), many Hoosier seniors fall under others protections, such as disability, sex or race.

About 40% of fair housing complaints are based on disability discrimination. Disability means you have physical or mental impairments that substantially limit one or more activities of daily living. You are protected, even if you don't have a disability, if a

provider perceives you as having a disability or you have a record of having a disability.

People with disabilities have extra protections under fair housing laws in 3 other areas: reasonable accommodations, physical modifications, and accessibility.

If you are disabled and need some help to have an equal chance to enjoy your dwelling, you may be able to request a reasonable accommodation from your housing provider. For example, if, due to your disability, you need a special parking place to get to your unit or you need a service or therapy animal in “no pets” housing, you can ask for an exception to rules or policies that might otherwise apply to you. Your request must be reasonable. Providers may not be required to make accommodations if it causes them an undue financial or administrative burden.

A request for reasonable accommodation may be appropriate in cases where you are at risk of losing your housing due to lease violations that could be corrected with additional help. For example, you may need a live-in aide or housekeeping help to properly maintain your apartment. If you have a disability, you may need medication or therapy to help control certain behaviors that otherwise might result in lease violations.

If you need to make a physical modification to your unit or a common area, you can request that a modification be made (such as adding grab bars, a ramp, widening doorways, etc.). If you live in private housing, you may have to pay for the cost of modifying your individual unit and may have to restore the unit after you move.

If you believe you have been discriminated against in violation of fair housing laws, you can file a complaint through an administrative agency or in court. The Indiana Civil Rights Commission can be contacted at (800) 628-2909 or www.in.gov/icrc. Several localities have human rights commissions. There are also fair housing organizations, such as the Fair Housing Center of Central Indiana, which can be contacted at (855) 270-7280 or www.fhcci.org. The Indianapolis Office of Fair Housing and Equal Opportunity (FHEO) investigates fair housing complaints, including those involving HUD funded programs in Indiana. You can contact them at (317) 226-6303, extension 5014.

HOMEOWNERSHIP

Retirement is a time to look at whether you can afford to remain in your home. Medical expenses may significantly increase as you age. Home maintenance costs increase as your house ages. At a time when income is decreasing, it can be difficult to meet rising expenses. A practical solution may be to change your living situation to reduce expenses.

Refinancing a home mortgage. Your house is a substantial asset. Be cautious about refinancing your home mortgage or taking out a new mortgage in retirement.

When circumstances result in missed mortgage payments, you risk losing your home, not just your investment. It is important to avoid creating a lien on your home unless absolutely necessary. Is it really necessary to refinance your home?

- People often refinance to pay for large repairs to their homes, such as a roof or furnace. These are normal, reoccurring homeowner expenses. Ideally, you should set aside savings specifically for such repairs. If you cannot afford home repairs, think about downsizing your home.
- Some people refinance to pay for unexpected funeral costs of a family member. Buying life insurance is a better way to cover this type of expense.
- People refinance to pay off credit card debts, medical bills or judgments. This may seem attractive because mortgage interest rates are lower than credit card rates and there is a federal tax deduction for interest paid on a home mortgage. However, these “advantages” should be weighed against the risk of losing the house due to foreclosure. Failing to pay a credit card debt could result in a judgment against you, but failing to pay your mortgage could cause the loss of your home. Financial counseling can help you decide if this or some other option is the best way to deal with debts.

Before refinancing your home, consider if you can re-pay the loan if you become unable to work or if your spouse dies. Consider also whether you will be able to pay off the mortgage if you sell your house.

If you decide to refinance, look at your other expenses to decide how much you can afford for a monthly mortgage payment. A mortgage payment that is more than one-third of your income may result

in a financial crisis. You should be able to meet your regular monthly living expenses and have enough money left to save for emergencies.

WATCH OUT FOR PREDATORY LENDING

Predatory lending practices tend to target elderly and minority homeowners who want to refinance an existing mortgage. To avoid predatory lenders, shop for the best rates and terms and talk to your bank or current mortgage lender. Look at the estimated costs of the loan to see if you are truly receiving a benefit from the loan.

Predatory loans are characterized by high interest rates, prepayment penalties, high closing costs, balloon payments (a very large payment due at the end of the loan) and unscrupulous practices, such as over-valuing your home, lying about your financial circumstances on the loan application and disregarding your ability to repay the loan.

The goal of the lender in predatory lending is to take as much of your home equity from you as possible, usually through high closing costs. The result is that you may be trapped by a loan that exceeds the actual value of your home and is more expensive than you can afford. Such loans can be impossible to refinance or even pay off by selling the house.

Always consider having a trusted advisor review loan documents BEFORE you sign them. Small print coupled with pages and pages of legal wording can make it difficult to be sure you understand the terms and conditions of the loan.

WHEN LOANS GO BAD: THE INDIANA HOME LOAN PROTECTION ACT

In response to some of the unfair and abusive acts, Indiana passed a law to protect consumers from some harmful lending practices. The Indiana Home Loan Protection Act (HPLA) prohibits many loan practices used by some loan brokers and lenders.

Warning: many of the protections of the HPLA do not apply to regular banks or credit unions or to loans connected to various entities, such as Fannie Mae, Freddie Mac, HUD, the VA, Rural Housing, or loans funded by IHCD (Indiana Housing and Community Development Authority). However, NONE of these entities may commit deceptive acts, such as misrepresenting or hiding material information about your

loan. There are also federal laws that continue to provide protections in these loans.

HPLA not only prohibits brokers and lenders from misrepresenting or hiding important facts about your loan, it also prohibits other practices, such as financing insurance or advising you to not pay your current loan while you wait to close on another loan.

A creditor must post payments to your account the same day the payments are received. A creditor must also deliver you a payoff statement within 7 days of your request and may not charge you for a payoff statement or release of mortgage.

The HPLA limits the amount of fees and costs that may be charged before a loan is considered a high cost loan. High cost loans are subject to additional requirements. Consumers must receive a written notice that the loan is a high cost loan.

Violations of the HPLA are subject to a variety of legal remedies including damages, statutory damages of twice the finance charge, costs and attorney fees.

Consumers who think they may have been a victim of an unfair loan practice, should consult their attorney or file a written complaint with the Indiana Attorney General's Office. See www.in.gov/attorneygeneral.

WHEN YOU ARE BEHIND IN MORTGAGE PAYMENTS

Due to the foreclosure and economic crises of recent years, many people got behind on their mortgages. For some time, Indiana had the highest foreclosure rate in the country. There is significantly more help available now if you get behind on your mortgage.

If you fall behind in your mortgage payments, get advice as soon as possible. Do not let fear or embarrassment cause you to fall deeper into debt. Talk to your mortgage company's loss mitigation department. Talk to a housing counselor or credit counseling agency. Consider getting legal advice. Help is available.

The Indiana Foreclosure Prevention Network (IFPN) can help you avoid foreclosure.

Contact them at 877-438-4673 (877-get-hope) or at www.877gethope.org. They can provide you a free counselor. IFPN also has programs, such as Indiana's Hardest Hit Fund (HHF). This can help you catch up on your payments if you or someone in your home has been unemployed.

Another important resource is www.making-homeaffordable.gov. Many lenders participate in

the federal Home Affordable Modification Program (HAMP). Participating lenders are required to evaluate your circumstances for a loan modification or other loss mitigation.

Your mortgage company has programs for helping people who are behind on their mortgages. Among the options available, the mortgage company can:

- Suspend or lower your payments temporarily.
- Set up a repayment plan to allow time to bring your account current.
- Modify your loan to change the interest, to extend the length of the loan or to allow missed payments to be added to the end of the loan.
- Make a claim against mortgage insurance, if there is mortgage insurance, to bring the account current.
- Agree to accept a reduced payoff amount if you are selling your house to avoid foreclosure (a short sale).
- Allow a qualified buyer to assume the mortgage.
- Agree to accept a deed in lieu of foreclosure, where you deed the house back to the mortgage company in exchange for cancellation of your debt (note: there are tax consequences for cancellation of debt).

Each option has conditions you must meet. The mortgage company may be willing to consider other options. Waiting to discuss them may make it hard to avoid foreclosure.

A housing counselor or credit counseling agency can you look at your bills and analyze whether a workable budget can help. They may be able to negotiate with some of your creditors to accept lower payments while you catch up on your bills. A lawyer can advise you about bankruptcy and other legal strategies that may help you save your home.

Watch out for mortgage rescue offers. There are many scams out there, which charge you in advance for getting help with your mortgage. There is valuable information at <http://www.loanscamaalert.org/>.

Indiana has a law to protect you from mortgage rescue fraud. It requires foreclosure consultants to give you a written contract with notice of your rights, including notice of a right to cancel within 3 business days after you sign. The law also has an additional right to cancel within 7 business days after you sign.

A foreclosure consultant may not ask for money until all the promised services are performed (unless

they have a \$25,000 surety bond on file with the attorney general).

FORECLOSURE

When you get behind on your mortgage, the lender will send you several notices. It's important to pay attention to them, so you know your rights.

A notice of default will give you a date by which you must bring the mortgage current. If you don't pay or work something out by that date, the lender can accelerate your loan. This means the entire balance of the loan is due (all past due amounts plus the balance of the full amount owed on your original loan).

Indiana law says a lender must send you a certified letter of its intent to foreclose on your home at least 30 days before the lender files a foreclosure lawsuit.

Once a foreclosure is filed, you will be served a summons and complaint. You then have 20 days (23 days if you are served by certified mail) to file an answer with the court. If you do not file an answer, the lender may get a default judgment against you. This will make it harder to negotiate and may result in the sale of your home sooner.

The lender must also include a notice with the complaint that tells you about your right to have a settlement conference with the lender. You must request the settlement conference within 30 days of receiving the complaint. The notice will refer you to the Indiana Foreclosure Prevention Network, www.877gethope.org. Asking for a settlement conference is not the same as filing an answer to the lawsuit. You must do both. Some court give instructions that allow you to file an answer after the settlement conference.

In Indiana, there must be at least 3 months after the date of filing a foreclosure lawsuit to the date a sheriff's sale can be authorized following a judgment of foreclosure. Once there's a judgment, the sheriff has to advertise the sale for 3 weeks in a row before your house can be sold (the first ad must be at least 30 days before the sale).

Unless you can make an arrangement with the purchaser or lender, you must be out of the property at the time of the sheriff's sale. If you are not, the lender may get a writ from the court for the sheriff to remove you. Sometimes they will change the locks.

Once a house is sold at a foreclosure sale, the money will go to pay the expenses of the sale and the amount of any judgment owed. If there is money left

owing, you will have a judgment against you to pay the balance due, including other expenses, such as attorney fees. If the sale generates more money than is owed (which rarely happens), the excess money would have to be turned over to you after all deductions were made.

REVERSE MORTGAGES

A reverse mortgage is a type of “home equity conversion mortgage” (HECM). Strict regulations apply to this type of loan.

A reverse mortgage is a loan secured by a home that does not require repayment until the homeowner dies, moves out of the house permanently, or sells the house. Specifically, no monthly mortgage payment is required.

The homeowner must continue to maintain the property, pay your property taxes and homeowner’s insurance, pay any other property charges (such as homeowner association fees), and reside in the property. Failure to do so can result in a foreclosure.

Equity is the value of the home after subtracting any liens, including mortgages. If there are other liens, there must be enough equity in the house to pay off the existing liens.

Eligibility. To be eligible for a reverse mortgage, all owners of the house must be age 62 or older. The amount that is available from a reverse mortgage is based on the age of the youngest homeowner, the value of the house, and the location of the house. The amount available for the reverse mortgage will be a percentage of the actual value of the house. To estimate how much you could borrow on a reverse mortgage, see a reverse mortgage calculator at www.reversemortgage.org/About/ReverseMortgageCalculator.aspx, <http://rmc.ibisreverse.com> or <http://hudreversemortgages.org>.

Features. Common features of reverse mortgages are:

- Interest is added to principal each month so that the total debt owed increases over time.
- Fixed or adjustable interest rates may be available. If you choose a fixed interest rate, you will be limited to taking the proceeds as a lump sum.
- Interest is not income tax deductible until all or part of the debt is paid.
- The costs of obtaining a reverse mortgage are higher than for a regular mortgage, including a

mandatory insurance charge.

- Payments you receive are not taxable.
- You may be required to use some of the proceeds from the reverse mortgage to make repairs on your house to preserve its value.
- Since the reverse mortgage is a mortgage, you will be eligible for the mortgage exemption on your property taxes.

Proceeds from a reverse mortgage can be paid in one of three ways or in a combination: 1) A lump sum may be paid; 2) A monthly payment can be made to the borrower; 3) A home equity line of credit can be used. However, it is important to note that the amount available on a line of credit may decline over time, even if there are no payments made from the line of credit due to interest and other monthly fees.

Effect on government benefits. For homeowners who receive public benefits based on their income, funds from a reverse mortgage are not counted as “income” in the month received. The payments from a reverse mortgage are loan payments. However, in the month following receipt, the reverse mortgage payment will be treated as an asset (or resource) for purposes of Medicaid, Supplemental Security Income (SSI), and the SNAP/food stamp program if the payment is unspent and exceeds the program asset limits.

Is a reverse mortgage right for you? Further considerations... Consider if you really need a reverse mortgage. Although ads may make them seem very appealing, be cautious about taking out a loan on your property. Watch out for scams and fraud. Information about reverse mortgages is free from HUD. Be sure you have a good reason to use up your home equity through a reverse mortgage.

The Federal Truth in Lending Act requires lenders to inform you about the reverse mortgage’s terms and costs. **Be sure you understand them before signing the loan agreement.** Lenders must disclose the annual percentage rate and payment terms. On plans with adjustable rates, lenders must provide specific information about the variable rate feature. On plans with credit lines, lenders must also inform you of any charges to open and use the account such as an appraisal, a credit report or attorney’s fees.

Homeowners who cannot afford an existing mortgage may be able to refinance into a reverse mortgage. While a reverse mortgage should be viewed as a

last resort, it can provide financial relief for someone in danger of losing a home to foreclosure.

For homeowners who are income poor but house rich, a reverse mortgage can provide a monthly payment to help make ends meet. However, taking the proceeds as a lump sum might create a problem if the person lacks sufficient money to maintain the home.

Even though a reverse mortgage does not require a monthly payment, failure to pay your property taxes, homeowner's insurance, and make repairs to your home can result in a foreclosure and the loss of your home. You must consider if you will have enough income to pay these other expenses even if you no longer have a mortgage payment.

Once you have a reverse mortgage, it may be impossible to borrow other money using your house as security. Consider how you will pay for future expenses, such as a roof or a furnace, after your reverse mortgage has captured all of your home equity.

Many families pass on accumulated wealth through a family home. If you use the home equity in your house with a reverse mortgage, it will not be available to leave to your heirs. Depending on the balance, your heirs may receive some money after you die and your home is sold, but in some situations, there will be nothing left.

There are alternatives to a reverse mortgage, including a standard mortgage or refinancing an existing mortgage. Selling the house might be a good alternative since it will provide more proceeds than a reverse mortgage. Discuss your financial needs with family members who may also offer options, depending on your needs.

You can get more information online at:

AARP at www.aarp.org/money/credit-loan-debt/reverse_mortgages

U. S. Housing and Urban Development at www.hud.gov/buying/rvrsmort.cfm

NeighborWorks America at www.hecmcounselors.org/consumer-resources

HOME SHARING

Home sharing refers to a housing arrangement where two or more people decide to live together. They may do so for companionship, for mutual help, or to save money.

Shared housing can allow people to pool their resources in order to live in a secure, affordable home

in the community of their choice. If you are considering home sharing arrangement, you should carefully balance the advantages against disadvantages.

Effect on government benefits. If an older person in the shared home is needy and receiving government benefits, that person's benefits may be reduced as a direct result of the housing arrangement. Social Security benefits and Medicare are not affected by home sharing, but SSI, Medicaid and food stamp benefits might be reduced.

Supplemental Security Income (SSI). Two types of home sharing arrangements will reduce benefits of SSI recipients:

1. When an SSI recipient lives in the household of another and receives both food and shelter from that other person, the SSI recipient's benefits are reduced automatically by one-third. There is a way to avoid this "one-third reduction rule." If the recipient pays a pro rata or equal share of all monthly household expenses, the rule will not apply.
2. When an SSI recipient receives free food or shelter from another home sharer, the Social Security Administration will place a value on what is received. This amount will be treated as income to the SSI recipient and will then be subtracted from the recipient's benefits. However, as long as the recipient is paying fair value of the items received, or one-third of the maximum monthly SSI benefit, whichever is lower, then the recipient's SSI benefits will not be reduced.

Medicaid. A Medicaid recipient's benefits are not affected by the recipient's home sharing arrangement unless the recipient is receiving rent payments from another home sharer. In that case, rent may be treated as income to the Medicaid recipient. Even if the Medicaid recipient is living rent-free in someone else's home, the value of that housing is not counted as income under Medicaid as it is under SSI. (See Medicaid)

Food stamps. Food stamps are given to "households." A disabled person or a person age 60 and over can maintain a separate household for food stamp purposes. A "household" can consist of an individual or a group. An individual (or a couple) in a shared home may maintain the status of a separate household in order to maximize your food stamp benefits.

Home sharers can avoid reduced or lost food stamps by following simple rules. To be considered a separate food stamp “household,” an individual (or group of individuals) must buy and prepare food separately from other “households” sharing the home. The “household” does not necessarily have to store food separately or use a different stove or refrigerator, but home sharers, to be on the safe side, may wish to carefully label their food and store it on separate shelves of the refrigerator and cabinets.

Tax laws. Federal and state income tax laws provide both incentives and disincentives to home sharing. Due to the complexity of the law and each individual’s situation, you may want to consult with a tax professional to help you assess the effects of home sharing on your personal tax situation.

Personal exemptions. Personal exemptions provide an incentive in some situations for a taxpayer to share a home with an elderly person. For example, in tax year 2013, a federal taxpayer is allowed an exemption of \$3,900 for each dependent whose gross income for 2013 was less than \$3,900. (The exemption may be adjusted annually.) A dependent can be (1) a relative that lives in your home over half the year with you providing over half of their support, or (2) an unrelated individual who lives in your home the entire year with you providing over half of their support.

Since Social Security income is excluded from an older person’s gross income, many elderly persons can qualify as dependents unless they have other income exceeding the gross income limit. While Social Security benefits are not taken into account for the dependent’s gross income test, those benefits are considered in determining whether a taxpayer has contributed more than half of the support for the elderly dependent.

Rental Income. If the taxpayer is a homeowner who shares his home with others who pay the taxpayer rent, that rent counts as gross income to the taxpayer. This might discourage some home owners from sharing their houses with others. On the other hand, if the homeowner is over 65, he may be in a low-income tax bracket (because of loss of earnings due to retirement, for example), and may not suffer dramatically because of the rental inclusion. So the taxing of rental income may not be a major drawback to this home sharing arrangement.

UTILITIES AND WEATHERIZATION

Utilities are a major housing expense. This section covers utility rules you should know about and ways to get help to reduce your utility expenses.

The Indiana Utility Regulatory Commission (IURC) has rules about your treatment by gas, electric and water utility companies. These utilities must provide customers with free information about your rights and responsibilities. IURC does not oversee or have rules about every type of utility. (See list under Complaints, below.)

DEPOSITS

A utility company can require you to pay a deposit, depending on the circumstances. Deposit rules also vary a bit, depending on whether the utility is gas, water or electric or the size of the utility. What follows are examples.

If you are a current customer, a utility may ask for a deposit if you have been mailed a disconnect notice two months in a row or three times within a year or if your service was disconnected for nonpayment in the last 4 years.

If you are a new customer, you may not have to pay a deposit if you are creditworthy. For example, if you’ve been a customer of another utility for 2 years, you may not have to pay a deposit if you don’t owe money to a utility and didn’t get shut off for nonpayment or weren’t late more than twice in the last year. If you haven’t been a customer of a utility in the last 2 years, you may still avoid a deposit if you show you’re creditworthy through such things as work, buying or renting a home, or your charge accounts.

A deposit should not be greater than one-sixth of your estimated annual billing (one-third in some cases). If a deposit is more than \$70, a customer may be allowed to pay it in installments, depending on the size of the utility and whether you are a new or a current customer. Installment periods range from 60 days to 12 weeks.

Utilities must refund deposits with interest after you have paid your bills on time for a year or so (again, depending on the type of utility).

DISCONNECTIONS

If you get behind on a utility bill, you may be disconnected for nonpayment. The utility should mail

you a disconnect notice at least two weeks before the utility shuts off service (one week for water). The notice should be mailed to you or delivered to a responsible person in your family. It can be part of your regular bill. The notice must give the date that service will be shut off, the reason why, and provide a phone number to call to get information or dispute the shutoff.

Extension for medical hardship. The utility must delay the shutoff for 10 days if you provide a written statement from a doctor or public health official saying that a shutoff would be an immediate threat to the health or safety of anyone in the household. If you send a second letter, you can get a second 10-day extension (possibly longer for natural gas).

Extension for financial hardship. If you do not have money to pay your bill, or if you have another good reason for not paying, you can avoid a shutoff by explaining your hardship and paying the lesser of one-tenth of your bill or \$10.00 (\$25 for a gas utility). You must promise to pay the rest of that bill within 3 months, pay other undisputed bills as they are due, and must not have broken a similar payment agreement in the last year. The utility can charge a late fee.

If you get an unusually big bill because the meter broke or it was wrongly read or it has not been read for more than two months, then you can avoid a shutoff by paying a part of the bill (equal to the average bill for the preceding 12 months) and promising to pay the rest in installments. No late fee should be charged.

Shutoffs must occur between 8 a.m. and 3 p.m. on a day that the utility company's office is open. No shutoff can occur after noon if the utility office will not be open the next day. When someone comes to shut off service, you can still avoid the shutoff by giving reliable evidence that you have already paid the bill or are already disputing it. You cannot, however, avoid a shutoff by paying the person who comes to shut off the service.

If you rent your home and the utility bills are in the landlord's name, and the landlord fails to pay the bill, the utility may shut off service without notifying you. You must then work out the problem with your landlord. However, the landlord should not shut off utility service to force you to move (see Landlord-Tenant Law).

Some utility companies have a budget plan or

make special arrangements for older adults. In any case, if you cannot pay a bill, you should explain to someone at the utility company before the bill is due. Utility companies might be willing to grant you an extension for good cause. If you have applied for the Energy Assistance Program (EAP, see below) and are eligible, an electric or natural gas utility cannot shut off service between December 1 and March 15.

More information is at <http://www.in.gov/oucc/2382.htm>. If you can't reach an agreement with the utility, you can contact the IURC Consumer Affairs Division for assistance at (800) 851-4268.

COMPLAINTS

The IURC does not regulate all utilities. Municipal utilities and non-profit and small investor-owned water and sewer utilities can opt out of IURC jurisdiction. IURC also does not regulate propane gas or heating oil providers. See the bottom of this section for information on how to complain about utilities that are not within the IURC jurisdiction.

Complaints about a utility company's actions should first be made to the utility company. Complaints can be made by phone, in writing, through the utility's website, or at its business office. The utility must promptly investigate and advise the customer of its proposed resolution by phone, in writing or by e-mail.

The utility must advise the customer that if he or she is not satisfied with its proposed resolution, the customer may file an informal complaint with the IURC Consumer Affairs Division within 7 days.

If you decide to request a review, be sure to also send a copy of your complaint to the utility company and keep a copy yourself. You must appeal within 7 days from the time the utility notifies you of its decision. The IURC has 30 days to investigate your complaint. If you are not satisfied with the IURC resolution, you can request a review by the director of consumer affairs within 7 days. If you are still not satisfied, you can request a full commission review within 20 days. If you are still not satisfied with the commission's decision, see a lawyer.

While a case is under review, the utility should not shut off your service as long as you continue to pay undisputed charges. If you can't agree on what part of the bill you dispute, then you can

avoid disconnection by paying 1/12 of the estimated annual bill.

Send complaints to:

Consumer Affairs Division

Indiana Utility Regulatory Commission

101 W. Washington St., Suite 1500E

Indianapolis, Indiana 46204

Toll free (800) 851-4268

Fax (317) 233-2410

Consumers may contact the office via mail, telephone or fax. For more information, see <http://www.in.gov/iurc/2331.htm>. You can also file a complaint online at www.in.gov/iurc/consumer/complaint_form.html.

The Office of Utility Consumer Counselor (OUCC) also has public information available at <http://www.in.gov/oucc>.

For utilities that are outside IURC jurisdiction, you can determine if your service provider is under the jurisdiction of the IURC, by calling the Consumer Affairs Division at (800) 851-4628. If your utility is not within IURC jurisdiction, you can contact the Indiana Office of Utility Consumer Counselor (OUCC) at (888) 441-2494 or <http://www.in.gov/oucc>. You may also contact your locally elected utility board or council members who oversee utility matters within your city or county.

Complaints against propane gas or heating oil providers should be directed to the Consumer Protection Division of the Office of the Indiana Attorney General at (800)382-5516 or <http://www.in.gov/attorneygeneral>.

HELP FOR PAYING UTILITY BILLS

If you can't afford your utility bills, there are valuable programs that may help you offset your energy bills. Two important ones are Energy Assistance and Weatherization. You can contact your utility company to see if they have any programs. Township trustees may also provide help with utility bills if you are needy. (See Township Trustee Benefits)

Energy assistance program. If you are low income, the Energy Assistance Program (EAP) can help you pay winter heating or summer cooling bills. Local Community Action Agencies (CAAs) are responsible for running EAP and have outreach offices in every county.

If you are eligible, no money comes to you directly. Instead, the money is paid directly to your utility pro-

vider. This lowers your bills, but does not pay your whole bill. You do not have to pay back benefits received under this program, and no one gets a lien on your house. You are eligible even if you pay rent, and the rent covers your heat.

If you have applied for EAP and are eligible, your utility cannot disconnect your heat source during the time from December 1 through March 15. However, if you do not pay your utility bills during this period, it's likely your utility service will be disconnected after March 15th.

To apply for energy assistance, contact your local Community Action Agency (CAA) at www.incap.org/cap_agencies.html or call the Indiana Community Action Association at (800) 382-9895.

WEATHERIZATION PROGRAM

Indiana's Weatherization Assistance Program can lower energy costs by making your home more energy efficient. Weatherization programs are generally run through local Community Action Agencies and Area Agencies on Aging. To qualify, your income should be less than 200% of the federal poverty guidelines. Many agencies have priorities for seniors or people with disabilities.

If you qualify for weatherization (whether you're a homeowner or renter), your home will be assessed, and you may qualify for a variety of improvements, such as insulation, caulking, weather stripping, replacement of light bulbs, windows, furnaces, hot water heaters, etc. Different agencies may offer more assistance than others. For example, some agencies may also have rehab programs that can do additional repairs to your home.

Residential energy assessments and improvements may also be available through Energizing Indiana. This is a project of the Indiana Office of Utility Consumer Counselor (OUCC), the consumer group Citizens Action Coalition, and several utility companies. For more information go to <http://energizingindiana.com> or call (888) 446-7750.

Contact your local utility to see if other types of assistance may be available. For example, Duke Energy has a refrigerator replacement program for people who participate in the weatherization program. This can replace an old, low-efficiency refrigerator with a new, energy-efficient model.

Managing Your Affairs and Planning for Your Future

As you grow older, you may want or need help managing your affairs or taking care of yourself. On the other hand, you probably do not want anyone intruding more than is necessary into your life.

Many lawyers now engage in a practice of law that has come to be called “Lifetime Planning.” Lifetime Planning means maintaining control, and having your wishes carried out despite incapacity, terminal illness, or costly long term health care. A comprehensive “Lifetime Plan” addresses four major areas of concern:

1. It designates the person of your choice to exercise your legal authority and provides your instructions for handling life’s business if you are incapacitated. Legal devices for achieving these goals include the Power of Attorney and the Living Trust. (See below)
2. It states your desires about the use of life-prolonging medical technology and names your choice of representative to give consent to medical care when you are unable. The legal devices for achieving these goals include power of attorney for health care, appointment of health care representative and living will.
3. It addresses the financial security of your spouse and other family members if you have a long term care need. Useful planning tools are Long Term Care Insurance and Trusts. (See below)
4. It provides for an orderly and efficient transition for your survivors at your death. This goal is achieved using the Will, the Trust and Estate Planning that coordinates all of the methods of passing property at death into a single, organized and efficient plan. (See Planning for Death)

Even those persons who do not choose to see an attorney for their future planning needs are often confronted with the subject of lifetime planning. Certain Medicaid and Medicare certified health care providers, including hospitals, nursing homes and home

health agencies, must give you information about your rights under state law to use “advance directives,” (such as the power of attorney and living will) to instruct others on your care in the event of your incapacity.

While the Patient Self-Determination Act, which took effect in 1991, requires providers to give you the information, it also says that providers cannot force you to have advance directives before they will provide you with care. While many providers will now be giving out advance directive forms (such as the living will) for interested patients to sign, the planning process should be a thoughtful one, one in which you consider your individual needs and desires.

You should read this section of the book in conjunction with the sections on health care and planning for death. This chapter focuses on a number of different means by which you can plan for a possible incapacity while you are still capable of doing so. It also discusses Physicians Orders on Scope of Treatment (POST) which was enacted into law by the 2013 Indiana General Assembly. This law allows the use of a POST form by doctors to document and honor patients’ wishes in end of life situations. By carefully and thoughtfully planning for your future, you can decide not only who will manage your affairs for you if you are incapacitated but also in many instances how the decisions about your affairs and your care will be made. Each planning tool is helpful for certain needs, but you should be sure you understand the consequences of your choices.

POWER OF ATTORNEY

A power of attorney is a document which you (“the principal”) sign giving another person (“the attorney in fact”) the authority to handle your affairs. Its use is often essential to lifetime planning as you can not only give the authority for a person of your choice to

act on your behalf but also provide instructions to your “attorney in fact” on how you want things managed. Used as a planning tool, the power of attorney may avoid the need for guardianship in the future.

Although the term is power of attorney and the person acting for you is an “attorney in fact,” you do not have to give this power to a lawyer. You can give the power to a relative or anyone you trust who will agree to carry out your wishes under the power of attorney. You should try to name at least one successor “attorney in fact” in case the first attorney in fact is unable to serve.

You must be capable in order to give a power of attorney. One does not get a power of attorney over someone who has become incapacitated. If an individual is unable to create a power of attorney because of incapacity, a guardianship may be necessary to manage the affairs of the incapacitated person. (See Guardianship)

Your power of attorney must be in writing, signed by you and notarized. It can be prepared and notarized without witnesses. You should consult a lawyer for drafting the document so that it is worded precisely to achieve your goals. For example, if one of your goals is to plan for the possibility of long term care, you may wish to have special wording in the document giving your “attorney in fact” the authority to engage in Medicaid planning or to apply for public benefits if appropriate. If you are giving the authority to engage in real estate transactions, the document should be filed in the county recorder’s office. You should keep a copy and the person to whom you give the power of attorney should also get a copy.

Under a law passed by the Indiana General Assembly in 1991, all powers of attorney are “durable.” This means that your power of attorney remains in effect even if you later become incapacitated, unless the document states otherwise.

If you want the power of attorney to take effect only if you later become incapacitated, then the document should state that it takes effect only if you become incapacitated. However, most persons should make their powers of attorney effective upon signing. If you set up your document to become effective only upon incapacity, your attorney in fact will have to produce proof of your incapacity to “activate” the power of attorney. Typically, your attending physician will have to provide this proof of incapac-

ity. If you have not signed a proper release with your doctor, allowing your attorney in fact to access your medical information, your attorney in fact may not be able to prove your incapacity. Making a power of attorney effective upon signing does not mean that you will give up control of your affairs. On the contrary, you remain in charge of your affairs, and you retain the ability to revoke the power of attorney at any time you so choose as noted below.

You can state exactly what powers you want to give to your “attorney in fact.” For example, you can state that you are giving only the power to sell a specific piece of property.

You can also delegate very broad authority to your “attorney in fact,” including the authority to make decisions involving the withholding or withdrawal of health care. Health care, by definition in the power of attorney law, includes the withholding or withdrawal of artificially delivered nutrition and hydration.

However, if you want your “attorney in fact” to have this type of authority, you must also execute a separate health care representative appointment and attach the appointment document to the power of attorney.

The Power of Attorney Act specifically states that certain language be contained in the separate appointment of health care representative document in order to give the attorney in fact/health care representative the authority to withhold or withdraw health care. (See appointment of health care representative below)

Using the power of attorney, you can choose to nominate a guardian to serve in the event a court determines you need a guardianship at some later time. The person you nominate must be given first priority by the court in the selection of the guardian. (See Guardianship)

A guardian has no power to revoke or amend your valid power of attorney without a specific court order to do so. A court cannot make this kind of order without first holding a hearing.

You can revoke or change your power of attorney any time you choose. You must give notice of the revocation to your “attorney in fact.” If you do not appear to have the capacity to change or revoke the power of attorney, any interested person may petition a court for instruction. A hearing must be held and notice of the hearing given as the court directs.

The power of attorney may also end if you have stated any time limit on the powers and the time

expires; or, if you created the power of attorney to accomplish a specific task, and the task is completed. Unless the document states otherwise, your attorney in fact is entitled to reasonable fees for services as well as reimbursement of all reasonable expenses incurred on your behalf.

There are important differences between a power of attorney and a guardianship. (See Guardianship)

1. Giving a power of attorney is voluntary; you choose to give the power, you choose the exact powers to give and you choose the person to whom you give these powers. Guardianship may be voluntary, but a court might appoint a guardian even if you do not want one, and the court might appoint someone you would not choose to represent you.
2. You cannot create a power of attorney unless you are capable at the time you give the power, although your power of attorney continues to take effect after you become incapacitated or unless you otherwise direct. On the other hand, a guardian is appointed for you only if you are incapacitated.
3. You can revoke a power of attorney at any time by giving notice to your “attorney in fact;” it is very difficult to terminate a guardianship as there must be a court determination of your capacity.

Because a power of attorney allows you more freedom and flexibility than a guardianship, you might want to create a power of attorney now to avoid guardianship later.

APPOINTMENT OF HEALTHCARE REPRESENTATIVE

The Indiana Health Care Consent Act allows you to appoint a person to make your health care decisions if you are incapable of doing so. The appointment must be in writing and witnessed by an adult other than the person you are naming as representative.

Your representative cannot overrule your own previous instructions (such as those you have made in a living will) to your health care provider.

If you want your health care representative to have the authority to withhold or withdraw health care, including artificially delivered nutrition and hydration, the Indiana Power of Attorney Act

requires you to use language in “substantially the same form” as that provided in the Act. It is important that you see an attorney to prepare a form which includes the required language. In addition, the appointment of health care representative with the required language must be attached to a power of attorney which gives the attorney in fact health care powers. Elder Law attorneys will often create one comprehensive health care directive which combines the Health Care Power of Attorney, the Appointment of Health Care Representative, and Living Will (discussed below).

PSYCHIATRIC ADVANCE DIRECTIVES

A psychiatric advance directive can be executed by you, providing you are mentally capable, to express your preference and consent to treatment measures for a diagnosis of mental illness during subsequent periods of incapacity. You may express your wishes regarding medication administration, physical restraints, seclusion, counseling, admission to in-patient facilities and so on. The document must comply with certain provisions of the Indiana Health Care Consent Act regarding the execution of a health care directive. You must have your treating psychiatrist sign the document attesting to the appropriateness of your choices as stated in your directive as well as your capacity to execute the document.

LIVING WILL AND LIFE PROLONGING PROCEDURES DECLARATION

Both the living will and the life prolonging procedures declaration (see below) operate to continue an adult’s right to control medical treatment decisions even if the person is incapable at the time a decision must be made to provide, withhold or withdraw treatment.

A living will is not really a will at all - at least not in the sense that most of us understand the term. Whereas a will has to do with what happens to your property after death, the living will has more to do with the manner of your death. It is a document in which you state your desires to not have extraordinary life-prolonging measures used on you when recovery is not possible. Use of artificial respirators, surgeries, radiation and other treatments which may delay but would not prevent imminent death can be avoided by use of a living will.

A living will declaration is authorized under Indiana's Living Will and Life Prolonging Procedures Act. One of the most important benefits of using this document is that you relieve your loved ones of the burden of making these difficult decisions by stating your intentions in advance.

In order to execute a living will declaration, you must be competent and you must sign the document in the presence of at least two witnesses, who also must sign. Witnesses cannot be your parents, spouse, children or anyone who can benefit from your estate. The living will declaration must be delivered to your attending physician who should make it a part of your medical record.

It is important that you understand the current limitations of the living will in Indiana. Your living will takes effect only when you have a terminal illness. The Act defines terminal illness as one which will result in death within a short period of time if life prolonging procedures are not used. For example, the person who is in a "persistent vegetative state" is not necessarily terminally ill as the patient can remain in this state for an indefinite period of time.

The Act also provides for the withholding or withdrawal of medical procedures, treatments or interventions. These terms can include the withholding or withdrawal of artificially delivered nutrition and hydration, if you choose that option in writing.

Sue Ann Lawrance was a young Indiana woman who was left in a "persistent vegetative state" as the result of an accident. She was kept alive by feeding tubes at the time her case became public. Even if Sue Ann had been able to execute a living will prior to her incapacity, it may not have helped her because of the limitations of the Indiana law.

Although it is not absolutely binding on your doctor or health care institution, your living will is generally honored, especially if you have discussed your desires with your doctor, as well as your family, before a crisis arises.

LIFE PROLONGING PROCEDURES DECLARATION

The life prolonging procedures declaration is just the opposite of the living will. It states your wishes to use life prolonging procedures, no matter how extraordinary the care or cost.

A life prolonging procedures declaration is authorized under Indiana's Living Will and Life Prolonging

Procedures Act. Like the living will declaration, one of the most important benefits of using this document is that you relieve your loved ones of the burden of making these difficult decisions by stating your intentions in advance.

In order to execute a life prolonging procedures declaration, you must be competent and you must sign the document in the presence of at least two witnesses, who also must sign. Witnesses cannot be your parents, spouse, children or anyone who can benefit from your estate. The life prolonging procedures declaration must be delivered to your attending physician who should make it a part of your medical record.

CPR AND "DO NOT RESUSCITATE" ORDERS

When you enter a hospital or nursing home, it is normally as the result of a medical crisis or the need for continuous care. It is a time in your life when acute medical circumstances may arise which require rapid decisions at odd hours, decisions in which you and your appointed health care representative have a right to participate. The health care provider will often want you to make a decision or sign a form concerning your wishes on resuscitation.

If you do not want to receive cardio pulmonary resuscitation (CPR), your doctor can write an order in your medical record which tells the staff in the hospital or nursing home that you do not wish to have the procedure applied. This order is commonly referred to as a *Do Not Resuscitate* (DNR) order. Many persons choose to have a DNR order placed in their medical record.

It is also possible for persons who are not in a hospital or other health care facility to obtain an Out of Hospital "Do Not Resuscitate" Order. Without such an order, emergency personnel are obligated to take all possible steps, including CPR, even if the effort is excessively burdensome or futile. To obtain an Out of Hospital Do Not Resuscitate Order, your attending physician must certify that you either: 1) have a terminal condition that will result in death within a short period; or 2) you have a medical condition that would result in resuscitation being unsuccessful, or you shortly would experience repeated cardiac or pulmonary failure resulting in death.

Once you have obtained an Out of Hospital DNR Order, you should obtain an identification bracelet to wear that will alert emergency personnel of the Order. Such bracelets can be ordered from MedAlert by calling 1-800-825-3785.

INDIANA'S PHYSICIAN ORDERS FOR SCOPE OF TREATMENT ("POST") LAW

How you die and the treatment you receive or decline during those final stages has been a popular topic in recent news stories. Communicating your goals about your end of life care and treatment is a very important and personal topic for each person.

Indiana has a new law that dramatically impacts an individual's ability to declare the scope and nature of medical treatment desired at the end of life. Indiana's new law establishes the use of a Physician Orders for Scope of Treatment ("POST") form.

The POST form is intended to document your end of life treatment and health care preferences into medical orders that health care providers can follow. The Indiana State Department of Health has a POST form available on their website.

In general, you must be within twelve months of your death to qualify to sign the POST form. You must first be a "qualifying person" to be eligible to complete a POST form with your physician. You are a qualifying person if you have:

1. an advanced chronic progressive illness;
2. an advanced chronic progressive frailty;
3. a condition caused by injury, disease or illness from which there could be no recovery and death will occur within a short period of time; or
4. a medical condition that, if the person were to suffer cardiac or pulmonary failure, resuscitation would be unsuccessful.

Generally, this means that a physician would not be surprised if the patient pass away in the next twelve months. Once you have been identified as a qualified person, your physician must discuss your goals and treatment options available to you based upon your health. Your physician then completes the POST form. The form should be signed by your physician and by you or by your appointed health care representative. You may revoke a POST form at any time.

The POST form includes the following medical orders:

1. an order specifying whether cardio pulmonary resuscitation (CPR) should be performed if you are in cardiac arrest (no pulse and no breathing);
2. an order concerning the level of medical intervention (have a pulse and is breathing or have a pulse and is not breathing) to be provided

to you including for comfort measures;

3. an order that specifies whether antibiotics should be provided you; and
4. an order that specifies whether artificially administered nutrition should be provided to you.

Once signed, the POST is a medical order that can be followed by health care providers. A living will declaration is not a medical order, it is a statement of your future goals if you are in a condition where your death will occur in a short period of time. Even when you have a living will declaration and have appointed a health care representative, there can still be difficulty in ascertaining your wishes, particularly given the many and varied situations that may arise and bring with them significant health care decisions.

Since it is a new document and end of life treatment tool, it will take some time for individuals, health care providers and physicians to work with POST and implement it in the various health care facilities in Indiana.

Many individuals will not qualify to sign the POST because they will not be considered to be within twelve months of their death, but they are still interested in documenting their health care treatment goals and desires so they can be honored in the future.

LIVING TRUSTS FLEXIBILITY AND CONTROL

What is a trust? A trust involves the transfer of your assets into the name of a trustee (person or financial institution) to be handled as you direct in the trust document. You are called the "grantor," and the person who gets title to the assets is called the "trustee."

You may be your own trustee or co-trustee in order to remain in full control as long as it is possible or as long as you are comfortable with the responsibility of managing the assets in the trust. The trustee manages and distributes the assets for one or more "beneficiaries," according to your directions in the trust agreement.

A trust can be created during your lifetime for your own benefit or for the benefit of someone else, or it can take effect at your death, through your will. Depending on the goals you wish to accomplish, a trust can be written to be revocable or irrevocable. A revocable, living trust can be changed or ended altogether if you choose, and the assets will be put back into your own name. An irrevocable trust, as its name indicates, cannot be changed or ended except under very special circumstances, and you cannot later get

the assets back into your own name.

Irrevocable trusts allow management for lifetime gifts. In fact, you can set up an irrevocable trust yet retain a lifetime income from the assets. Estate planners and lawyers may prefer a trust arrangement since a trust arrangement is a flexible planning device.

Traditionally, trusts have been a mainstay of financial planning, particularly for older persons. They can be used to serve a number of functions, for example:

1. provide a caretaker of funds for a child or an incapacitated adult to be used as the grantor direct
2. provide financial management for the grantor's own assets and a means to pay bills, etc., even if he or she becomes incapacitated (A power of attorney can serve this purpose as well.)
3. provide a gift management device for your lifetime gift recipients, especially children
4. in some cases shift income to a person in a lower tax bracket as a tax planning device
5. pass property at death without probate proceedings.

A trust can be simple or quite complex. A lawyer writes a trust to meet the legal requirements and to help you accomplish your particular goals. You, as grantor, decide whom to select as trustee to carry out your desires, what assets are to go into the trust and how those assets will be managed and distributed.

A properly drafted document signed by the grantor and accepted by the trustee makes a valid trust. Generally there is no court oversight of the trustee unless a lawsuit is brought by someone with an interest in a transaction. Trusts often continue for many years, sometimes through two or more generations. Thus they require careful planning and wording.

The creation of a trust does not necessarily mean that you give up control over your assets. In fact, a living trust can be written to make you your own trustee. Another useful device is to create a trust agreement with a bank or individual but postpone placing assets into the trust until a later time of need. This can be done through a power of attorney where your agent transfers the assets to the previously created trust at your direction or in the event of your incapacity.

A trust does not mean that your current investments must change. Bank accounts, certificates of deposit, stocks, bonds, real estate and other assets can be transferred to your trustee to be held or you

can leave all investment decisions to your trustee's judgment. It depends on the directions you give when you create the trust.

Keep in mind that your living trust can be a transfer device like a will for the assets in the trust. Other estate planning tools, such as a power of attorney and a will, are used along with the living trust.

The cost of preparing a trust varies greatly, depending on the complexity of your goals. Trusts that are designed to solve many different problems can take longer to prepare and will involve large attorney's fees. The trustee is entitled to a fee for managing the trust. Banks, acting as trustee, usually charge a fee based on a small percentage of the trust's assets each year.

A lawyer or bank trust officer can tell you more about whether a trust may be right for you.

TAXES

Federal income tax. Most federal income tax laws apply to taxpayers of all ages. There are, however, some special tax benefits for the elderly. For more information about federal income tax and who must file, contact the Internal Revenue Service (IRS), listed in the telephone book with offices of the U.S. Government. Or call IRS toll-free at 1-800-829-3676. Ask for the free booklet *Tax Benefits for Older Americans*, Publication #554.

The IRS has a special program of volunteers who can help you fill out your tax return. The service is free. The program is called VITA (Volunteer Income Tax Assistance), and is available between January 1 and April 15 each year. To find out the nearest site for getting this help, call IRS toll-free at 1-800-829-1040. The IRS also coordinates a program called TCE (Tax Counseling for the Elderly), which includes a limited program for homebound seniors.

Some other organizations also provide free help with tax forms. To find out who provides this service in your area, contact your Area Agency on Aging. A lawyer or other tax advisor can also give current tax advice.

Tax laws change frequently and have recently changed significantly, so be sure you have up-to-date information.

Indiana income tax. As with federal tax laws, Indiana income tax laws also apply to taxpayers of all ages. Indiana tax law is subject to frequent change. You can get up-to-date information on Indiana income tax filing requirements by contacting:

Indiana Department of Revenue

Indiana Government Center North, Room N105

100 N. Senate Avenue

Indianapolis, IN 46204

317-232-2240 1-800-382-4646 (toll-free)

1-800-382-4539 or

(317) 232-4952 (for deaf communications only)

Property tax. Older persons who pay property taxes may be eligible for special exemptions. The laws governing property tax are also subject to frequent change. The County Auditor or County Assessor listed in the telephone book under County offices can give you the information you need.

CONCLUSION

No two persons' circumstances are exactly alike. The process of making a Lifetime Plan is a very individualized and personal process. It is essential to get the facts about your options from a knowledgeable person. By making a comprehensive Lifetime Plan with expert advice, you can help assure that both you and your loved ones will be protected and able to handle life's business according to your own values and lifestyles even if the unexpected happens.

The Indiana State Bar Association (phone 317-639-5465) has pamphlets dealing with various aspects of life planning. The Senior Law Project of Indiana Legal Services, Inc. (phone 317-631-9424) also has detailed information about "advance directives" and planning for incapacity.

Guardianship

When a person can no longer manage property or provide self-care, a guardianship may be appropriate. Guardianships can provide important protection to someone who is incapacitated. On the other hand, sometimes guardianships are unnecessarily imposed on persons who are capable of making their own decisions. Because the appointment of a guardian is more complex and serious than giving someone a power of attorney, you should definitely talk to a lawyer if you think that you or someone you know might need a guardian. Planning ahead can often avoid the need for guardianship. (See *Managing Your Affairs and Planning for Your Future*)

DEFINITIONS

1. **Guardian.** Someone appointed by a court to make decisions for an incapacitated person. In Indiana, conservator and guardian mean the same thing.
Almost any capable adult can serve as guardian. A county Division of Family and Children or a private charity can be a guardian. A non-resident person or corporation can serve as guardian if it is in the best interests of the person under guardianship.
2. **Incapacitated person.** Description of someone who is incapable of either managing property or providing self care or both. Incapacity may stem from infirmity, insanity, mental illness, alcoholism, excessive use of drugs or other incapacity. Although these conditions may contribute to incapacity, a person who has one or more of these problems is not necessarily incapable. Old age is never a basis upon which guardianship can be granted. **A person does not need a guardian just because he or she is old or infirm.** A guardian should not be appointed for a person unless the individual cannot manage property or provide self-care.
3. **Protected person.** A person for whom a guardian has been appointed.
4. **Stand-by Guardian.** The guardian of a protected person may designate an individual to serve as standby guardian if the guardian dies or becomes incapacitated. The stand-by guardian assumes all the authority of the guardian for a period of 90 days.
5. **Foreign guardian.** The guardian appointed by a court of the state in which the incapacitated person lives. A foreign guardian may file the guardian's letters of guardianship and the order of appointment in Indiana courts so as to retrieve assets of the incapacitated person located within the state of Indiana or otherwise tend to the affairs of the incapacitated person within the state of Indiana.

RIGHTS OF THE PROTECTED PERSON

The court should always look to the least restrictive alternative available to protect the interests of the incapacitated person. Courts should create "limited guardianships" whenever it is appropriate in order to encourage the self-improvement, self-reliance and independence of the protected person. In other words, if an individual is capable of making her own health care decisions, but cannot balance her checkbook, the court should create a guardianship limited to management of the checkbook.

Even though a guardianship may help a person who is no longer capable of property management or self care, it may also mean a loss of rights for the protected person. The law is not entirely clear on what personal rights the protected person has in an unlimited guardianship. The protected person may lose the right to make a gift, marry, drive a car and make decisions about health care and housing arrangements.

The protected person does not necessarily lose the right to make a will. The protected person can make a will if she is capable of understanding what property she has and knows the "objects of her bounty," the people who would receive the property when she dies.

"Letters of Guardianship," a document issued by

the court, should explain exactly what powers the guardian has and whether there are any limitations on the guardianship.

As guardianship can be a right-stripping process, the law provides a formal procedure with built in protections that must be followed before a guardian can be appointed.

PROCEDURES FOR ESTABLISHMENT OF GUARDIANSHIP

Any interested person may file a petition for the appointment of a guardian of an incapacitated person. The person filing the petition is not necessarily the person who will be appointed guardian.

The individual for whom the guardianship is sought has the right to both notice, which includes both a notice of rights and the petition for guardianship itself, and a hearing. The notice also must be given to the spouse, adult children, the attorney in fact under a power of attorney for the individual and any person serving as guardian for or who has the care and custody of the alleged incapacitated person.

If there are no adult children, notice must also go to the parents of the individual. If there are no parents, spouse or adult children, then at least one person most closely related by blood or marriage to the alleged incapacitated person must receive notice. The court may also direct any other person to receive notice.

The notice must be in substantially the same form that the guardianship law provides and must advise the individual that the proceeding may substantially affect the rights of the individual. The notice should also explain the rights of the individual to attend the hearing and be represented by an attorney, or if there is no attorney, a court-appointed *guardian ad litem*. (See below)

The hearing provides an opportunity for the alleged incapacitated person to present evidence and cross-examine witnesses, or in other words, to show the court why a guardianship should not be established.

The alleged incapacitated person must be present at the hearing unless the court determines by evidence that it is a risk to the individual's health or safety or that the individual has either knowingly and voluntarily consented to the appointment of a guardian or has knowingly or voluntarily waived notice of the hearing. However, if a consent

or waiver is signed, the judge must make sure that the person for whom the guardianship is sought was not incapacitated as a result of a mental condition that would prevent a knowing and voluntary consent or waiver.

RIGHT TO REPRESENTATION

The person for whom the guardianship is sought has the right to hire an attorney. In some cases, a court might be willing to appoint an attorney, although the court is not required to do so. The prospective guardian's attorney cannot also represent the alleged incapacitated person.

A *guardian ad litem* is a person appointed by the judge to help a person during a specific case. That assistance is only for that one case. The law requires the court to appoint a guardian ad litem if the alleged incapacitated person is not represented or is not adequately represented by counsel.

The guardian ad litem represents the interests of the alleged incapacitated person. However, that does not mean that the guardian ad litem will advocate for what the alleged incapacitated person wants. So, for example, if the individual does not want a guardianship, the guardian ad litem may still determine that it is in the best interests of the individual to have one.

IF YOU DO NOT WANT A GUARDIAN

If you do not want a guardian and someone is trying to have one appointed for you, you should see a lawyer right away. (See Legal Services Programs and Providers) If the court decides that you are incapacitated, ask the court to appoint only a limited guardian. You may also object to a particular person as guardian even if you agree that you should have a guardian. You may also nominate the person you wish to serve as guardian, although the court will have the final judgment on what is in your best interests.

If you lose at the hearing, you have the right to appeal to a higher court. Be sure to consult a lawyer for the appeal.

WHO SHOULD BE GUARDIAN

Once a judge or jury determines that a person is incapacitated and in need of a guardian, the court must then determine who is best qualified to serve as guardian.

The court must give consideration for appointment to the following persons in the order in which they are listed:

1. A person designated in the power of attorney of the incapacitated person.
2. The spouse of the incapacitated person.
3. An adult child of the incapacitated person.
4. A parent of the incapacitated person or a person nominated by will of a deceased parent of the incapacitated person.
5. Any person related by blood or marriage with whom the incapacitated person has resided for more than six months prior to the filing of the petition.
6. A person nominated by the incapacitated person who is caring for, or paying for the care of, the incapacitated person.

The court may pass over a person having priority in order to serve the best interests of the incapacitated person.

GUARDIAN'S DUTIES

The powers and duties of an appointed guardian may be unstated or may be very specific, depending on the final order of the court.

Generally, in an unlimited guardianship, the guardian is responsible for the care and custody of the incapacitated person and for the preservation of the "estate."

However, a guardian has no power with respect to property or personal health care decisions which are subject to a valid power of attorney.

The guardian *must* encourage the self-reliability and independence of the incapacitated person.

The guardian *must* file an accounting at *least* once every two years with the court which details the guardian's administration of the incapacitated person's estate *and* which describes the current condition and circumstances (including residence) of the incapacitated person.

The guardian can pay all the expenses of the guardianship proceeding out of the incapacitated person's estate. These expenses include reasonable medical, professional and attorney's fees.

The guardian is allowed to sell, mortgage, lease or exchange the property of the incapacitated person *with court approval* when it is in the best interests of

the incapacitated person.

The guardian may petition the court to do estate planning on behalf of the protected person. Types of estate planning contemplated here include gifting, the exercise of power over transfer on death or payable on death property, the release or disclaimer of interests held by the protected person in jointly owned property, the creation of trusts for the benefit of the protected person or the amendment or revocation of revocable trusts created prior to the guardianship, changing beneficiaries on insurance policies and other similar powers. These powers can only be exercised after approval by the court following notice and hearing on the matter.

The guardian may appoint a stand-by guardian to provide care for the protected person if the guardian dies or is otherwise unable to attend to the needs of the protected person. A stand-by guardian's appointment is only valid for a period of 90 days. During that time, the stand-by guardian or another suitable person should petition the court for appointment as the successor permanent guardian.

Anyone who believes that a guardian is not doing his duty or is abusing his position should **report the matter** to the court. The court may then order an investigation. The court may remove a guardian if the guardian has not performed properly or is unable to continue to perform his duties.

ENDING A GUARDIANSHIP

There are several ways that a guardianship might end:

1. Any person, including the protected person may ask the court to end the guardianship. That person must convince the court that the protected person has regained capacity.
2. A guardianship ends automatically when the protected person dies, but, the guardian may have limited authority to pay the protected person's debts (relating to funeral, burial, last illness, taxes, and so on), if the court approves.
3. A guardianship limited to management of the estate may be terminated by the court if the guardianship property is reduced to \$10,000 or less.
4. A guardianship also ends when the protected person moves to another state and has a new

guardian appointed there. When a guardianship ends, the guardian must make a final report to the court.

TEMPORARY GUARDIANSHIP

In an emergency, a court can appoint a temporary guardian for a period of no more than 90 days. Temporary guardianship is used, for example, in cases in which a person cannot or will not authorize medical treatment needed to save his life. The person seeking to establish the guardianship must show not only that an emergency exists but also that the welfare of the incapacitated person requires immediate action and no other person appears to have authority to act.

Notice must be given and a hearing must be held unless the court finds that immediate and irreparable injury to the person or injury, loss, or damage to the person's property will occur before the alleged incapacitated person can respond to the petition in a hearing.

If no notice is given and the incapacitated person petitions the court for modification or termination of the guardianship, the court must hear the petition at the earliest possible time.

Just as in a regular guardianship, Letters of Guardianship will be issued, limiting the guardian to only that which is necessary to resolve the emergency. The Senior Law Project of Indiana Legal Services, Inc. has more detailed information available on guardianship.

Planning for Death

When you try to order your affairs so that your property is distributed the way you want after your death, you are doing estate planning. The law provides several devices for the orderly transfer of property after death including wills. The living trust described above may be an attractive alternative to a will. In fact, a living trust may be the centerpiece of your estate plan. Though estate planning focuses on transfers at death, adults with family responsibilities should exercise their rights and responsibilities by estate planning throughout life. This may suggest life insurance, establishing trusts for minor children or perhaps a pre-nuptial agreement to limit rights of your spouse if you should die or divorce. For more information about these devices and about estate planning generally, you should consult a lawyer. (See Legal Services)

ESTATE PLANNING

If you make a will, you have made an estate plan because you have planned for the distribution of your property after your death. The term estate planning, however, also refers to a coordinated effort by you and your professional advisors (lawyer, accountant, insurance agent, financial planner and others) to minimize the federal death taxes and the expenses of death. Most financial transactions, whether they occur before or after death affect your estate plan. Estate planning includes the process of arranging your financial affairs so that transactions both before and after death reduce administrative expenses and tax burdens upon your heirs and loved ones and transfer your assets to your loved ones and/or charities the way that you desire.

You may make gifts to avoid having all of your assets spent for your own extended care. Direct gifts to family members or irrevocable trusts can be used for this purpose where only an income interest is retained on the gift into the trust. However, you

should consult with an attorney knowledgeable in both estate planning and Medicaid law, in case you may need assistance from Medicaid to pay for the cost of your long term care. A transfer (gift) of property can affect your eligibility for Medicaid.

Estate planning is not a one-time exercise. Your financial status and needs, and those of your family, are constantly changing, as are the tax and probate laws themselves. Complicated estate planning takes a high degree of skill and experience and can best be accomplished with professional guidance.

Lawyers, accountants and other professionals can assist you with estate planning. Numerous books and articles on the internet are available on overall estate planning and on specific topics such as insurance and living trusts to help you understand the alternatives.

WILLS

IF YOU HAVE NO WILL

If you die without a will, you are said to have died intestate, and an administrator (or administratrix, female) will be appointed to collect your assets, pay debts collectible against you, pay your funeral and burial expenses, and then distribute the remainder of your possessions to persons specified under fixed rules of Indiana law. The State of Indiana, in a sense, has written a Will for you as the Indiana General Assembly has decided how to distribute your property based upon what they think most people would want.

For example, if you die without a will and leave a spouse but no children and no parents, your property goes to your spouse. If you leave a spouse and one child, your spouse gets one-half and your child gets one-half. If a child dies before you, that child's children divide their parent's share. A later spouse who you have not had children with, receives one-half of your personal property. Plus, he or she gets 25% of your real estate. The children of your prior

marriage(s) receive the other one-half of the personal property as well as 75% of your real estate.

Because these rules are meant to cover general situations, based upon an assumption as to what a person would want, they may result in distributions to people, or in amounts, that you personally would not want, such as part of your estate going to your children when you want all of your estate going to your spouse as you may only want property passing to your children only if both you and your spouse have died. For this reason, most people prefer to have a say in the distribution of their property after their death, and this is done by a will.

MAKING A WILL

A will should say where or to whom your probate property should go after your death. It may recite funeral plans and indicate your desires to donate your body to science or to donate organs for transplants. However, funeral plans and organ donations should also be specified in other documents and be arranged separately from the will. Despite your desires and intentions, the will may not be available when such decisions must be made as your loved ones may not review your will until after your funeral.

A will may contain provisions for one or more trusts. The will often provides for the transfer (pour-over) of assets to your living trusts. The trust includes rules for distribution of your property to your beneficiaries in the same way that a will does. A living trust that is a management device during your final years can continue to exist after your death. Thus, the living trust may offer more flexibility than your will. (See Living Trust)

A will need not be a long or complicated document, but it must be made in strict compliance with state law. A person who makes a will is called a testator (or testatrix, female). A testator must be competent at the time the will is made.

The will must be in writing (typed or handwritten) and dated. The testator must acknowledge the will and sign in the presence of at least two witnesses. If the testator cannot sign (but is still competent), he can direct someone else to sign for him in his presence. The testator then watches the witnesses sign the will. Each witness must then watch each other sign. These witnesses must be at least 18 years old and should be persons who do not benefit from your will.

One key provision in your will is to name a **personal representative** to collect your probate assets, pay debts, expenses and taxes and carry out the terms of the will. The personal representative, commonly called the executor (or executrix, female), is usually a relative but may be a friend or bank trust department. You may want to choose an Indiana resident for convenience. However, a non-resident personal representative may serve, but there are some additional requirements that an executor who does not reside in Indiana must satisfy. Your personal representative will most likely hire an attorney for guidance.

In your will, you will name the beneficiaries who will be entitled to take property under your will. You will also state what you want each beneficiary to take and under what circumstances. One advantage of a will is its flexibility. You can provide who will receive your property, how much of your property they will receive and under what circumstance they will receive your property.

A surviving spouse can choose to take against the will, or in other words, to ignore what he or she has been given in the will and take instead one-half of the net estate. However, if the surviving spouse is a later spouse who you did not have children with and you did leave children surviving you; your spouse is only entitled to one-third of the personal estate and 25% of any real estate. To choose this option, the surviving spouse must state his or her choice in writing within ten days after the end of the time that other claims can be filed against the estate. The time to file claims against an estate ends three months after the first newspaper publication of the notice of appointment of the executor.

Although the law does not require you to have a lawyer draft your will, you should consult a lawyer—especially if your estate is large or your wishes are complicated. A lawyer can help insure that the document is valid, your intentions are clearly set forth in the document, and proper procedures are followed. If you write your own will, your use of the wrong language or use of the wrong procedures to sign the will can invalidate part or all of your will. A lawyer's fees for drafting a will are usually quite reasonable. It is proper to ask a lawyer before you hire him or her how much he or she charges for drafting a will. Counseling and drafting fees for trusts, powers of attorney and other estate planning arrangements can raise costs beyond the traditional will drafting fees. Extra legal

service during lifetime can pay handsome dividends when compared to traditional attorney fees for estate probate. In some cases, there is the possibility for tax savings with proper estate planning.

If your will was made in another state and was valid there, it is still valid when you move to Indiana. You may want to name a new personal representative for convenience, though a nonresident could serve.

Only the original will should be signed, but you, your lawyer, and your executor should keep a copy of your will. Keep the original will in a safe place. It is questionable whether you should keep your original will in your bank safe deposit box. After death, some procedure is usually necessary before a bank safe deposit box can be opened. However, in Indiana, the personal representative can present the bank with a special type of affidavit that permits the opening of the safety deposit box. This can be done without employing a lawyer, but it may be a good idea to have a lawyer prepare the affidavit.

As long as you are competent, you may change or revoke your will at any time. You should consider revising your will whenever there is a major change in your life circumstances. Changes to a will should be made with the same legal formalities required for the will itself. It is not sufficient just to write changes in the margins or to cross portions out. A formal amendment to a will is called a Codicil. A lawyer should draft a codicil to make sure it is valid. You can revoke a will by intentionally destroying it and all copies or by creating a valid new will. A later will replaces and revokes all earlier wills. Revocation of one will, however, does not necessarily mean that an earlier will is revived.

Do not procrastinate in regard to needed will changes. This is especially important when the change might offend an heir or beneficiary under your will or trust. Capacity to change a will is directly related to mental competence. If there is some doubt about your capacity to make independent decisions at the time of a will revision, an offended person may bring a challenge to your will.

PROBATE AND ESTATE ADMINISTRATION

Probate is the process by which the property of a deceased person is distributed to that person's heirs (if

no will) or to the persons listed in his or her will. Probate is necessary to pass title to assets in the name of heirs or beneficiaries that does not pass by other means.

Probate and estate administration is a series of steps. The probate court appoints a personal representative (executor), and the estate is "opened" usually with the aid of legal counsel. Notice is published of the opening of a decedent's estate. A three month period begins during which creditors of the deceased person may submit their claims.

Known creditors and beneficiaries of the will are entitled to notice of death by the personal representative. The personal representative must identify the assets and determine their fair market value. Identification and valuation also may apply to assets that will not require probate. Many assets transfer by alternative legal arrangements such as right of survivorship for joint property, transfer on death designations, individual beneficiaries on life insurance, living trusts, life estates and other contractual or legal arrangements like retirement benefits and social security entitlement for survivors. These alternative arrangements may avoid the need for probate.

The Federal Estate Tax presents a separate set of concerns. Some of the assets that avoid the probate process can be subject to the federal estate tax. Whether the assets were held in a joint tenancy, tenancy in common, solely owned, in trust or in a legal life estate or pass under your will, they are subject to the Federal Estate Tax. However, assets going outright to or in a properly structured trust for a surviving spouse (who is a U.S. citizen) and/or to a charity or charities are 100% deductible for federal estate tax purposes.

Indiana has abolished its Inheritance Tax for those dying after January 1, 2013. The Federal Estate Tax Exemption for 2015 is \$5,430,000. This amount is indexed for inflation and it will go up somewhat in future years. The top tax rate for those taxable estates above the exemption amount is presently 40%.

The Federal Estate Tax Exemption amount can be used by gifts you make during your life, taxable transfers at death or a combination of both. In addition, you can give \$14,000 per person per year and it does not use your Federal Estate Tax Exemption. This amount is indexed for inflation and may go up in future years. The annual exemption amount only has to do with the Federal Gift Tax and has nothing

to do with rules regarding gifting and later qualifying for Medicaid.

Most decedents have far less than the amount that will be subject to the federal estate tax. Remember that the surviving spouse could receive large sums from a deceased spouse with no estate tax since what he or she receives is 100% deductible! Very few estates are going to be above the exemption amount due to their size and after the amount going to the surviving spouse and/or charities is subtracted.

Estate administration in Indiana is **supervised** (the standard procedure), **unsupervised** or accomplished by a “no administration” procedure. Supervised administration requires probate court approval for asset distribution and sometimes for the sale of assets such as real estate. Unsupervised means court approval is not needed for each step of the probate process. Unsupervised administration is elected by the personal representative and allowed by the court if the deceased person’s will allows unsupervised administration or all beneficiaries of the estate consent to unsupervised administration. An unsupervised administration is permitted only when the estate is solvent, and as a practical matter, only when the personal representative employs experienced legal counsel.

No administration (small estates) is a third alternative for completing the probate process. It may be elected when the value of the gross probate estate, wherever located, less liens and encumbrances on those assets does not exceed \$50,000. In addition, 45 days must have elapsed since the decedent’s death; no petition for appointment of a personal representative is pending, and the claimant(s) is entitled to payment of the probate property.

No administration procedure requires the estate beneficiaries to sign an affidavit that lists the probate property and declares the above conditions to be true. If there is a will, the law requires that it be brought forward and officially placed on record with the court, even if the estate will not go through a formal probate process. Beneficiaries under the will are protected by this procedure of “spreading the will of record.”

There is a special procedure for automobile transfer where no probate administration is anticipated. If the person wanting title to a car either owned jointly or entitled to it under the will or the law for intestate succession, the Bureau of Motor Vehicles has a form to be filled out which is similar to the small estate affi-

davit. A copy of the death certificate should be taken to the BMV five days or more after death. There is only a five day waiting period from date of death to transfer a vehicle.

“No administration” may even be available to the estate of a decedent who had significant wealth. Assets held jointly with rights of survivorship, living trust assets and many other asset arrangements avoid the probate procedure.

In addition, a **summary administration** procedure is available when an estate is less than allowances, costs, expenses of administration and funeral expenses. In this situation, the personal representative may be allowed to make distribution of assets to those who are entitled to them by law. The law provides a priority for who gets paid first when assets do not equal debts and allowances. This procedure is “summary” in the sense that it is not necessary to wait the three months for all additional (non-priority) claims to be presented. A surviving spouse gets the first \$25,000 (family allowance). If there is no surviving spouse, children under age eighteen who were dependent on the decedent have the same priority claim on \$25,000.

JOINT OWNERSHIP OF PROPERTY

Not all of a person’s property will necessarily pass under his will. Property may go automatically to another person if it is owned jointly with the person who has died. Who receives joint property on your death may depend entirely on the terms of a joint bank account, deed, or other contract. It is important to understand the consequences of joint ownership of property.

JOINT REAL ESTATE

If you hold title to property in your name alone, and then when you die your property will pass under your will or, if there is no will, according to the rules for intestacy, the rules which apply when you don’t have a will.

It is common for a husband and wife to hold title to their home or other real estate in joint name with right of survivorship. This is called ownership as *tenants by the entirety*. Under this arrangement, upon the death of either spouse, the property

passes automatically to the other, no matter what the will says about the property. A survivorship affidavit should be filed at the county auditor's office and possibly the county recorder's office to update ownership records when the joint owner dies.

It is also possible for a person to hold property jointly with someone not his spouse. Joint ownership with someone else can be either with survivorship rights or without. If there is a right of survivorship, the death of one of the joint owners passes his ownership rights automatically to the other owner. If there are no survivorship rights, then the owners are called tenants in common. A tenant in common's interest does not pass to the other co-owner; instead, it passes under the deceased person's Will, if no Will, his or her intestate beneficiaries.

A husband and wife may be co-owners as tenants in common. They may switch from joint ownership to tenants in common in the process of estate planning. Once they are tenants in common their respective shares avoid rights of survivorship. This allows each spouse to do some restrictive planning with respect to their portion of the real estate.

Again, if you want to evaluate alternatives for ownership of real estate, you should consult an estate planning lawyer. There may be important tax consequences in any transfer or change of ownership of real estate. Be sure you understand the tax implications of your current situation and of the alternatives.

JOINT BANK ACCOUNT

Spouses often have a joint bank account. However, it is also quite common for a person, especially an older person, to place funds in a joint account with a child or other trusted relative. This is often done for convenience when the elderly person has difficulty getting to the bank or anticipates an illness or incapacity. Typically, the elderly person has no intention of *giving* the child or relative any rights to take and keep the money now. Sometimes the joint account is created to make a gift of what is left in the account *at the older person's death*.

Since the older person's reasons for setting up the joint account are not always clear, Indiana law makes certain presumptions. The two most important are: (1) Even though Indiana Law states that during the lifetime of the joint owners, ownership of a joint account is according to the amount each has contributed to the

account. Any party to a joint account may withdraw all or part of the funds without the consent of the other. (2) When one of the joint account owners dies, there is a presumption that any money remaining in the account belongs to the survivor named in the account, even if the will says otherwise. This means that you should not assume that money left in a joint account will be divided according to the provisions in your will. Also, keep in mind that the other party to a joint account may withdraw money from the account during your lifetime. For these reasons, you should open a joint account only if you trust the other person you name as joint owner and only after considering other options such as creating a power of attorney so that someone can access your account if you are unable. Also, if after your death, your bills and expenses cannot be satisfied by other assets in your estate, your joint bank accounts are available to cover allowable expenses and taxes if certain procedures are followed.

When you need assistance with financial affairs and property management, a living trust and power of attorney may be better alternatives than joint bank accounts. The operation of the power of attorney also ceases at death, but a living trust continues to function in the hands of the designated trustee. A lawyer can give you advice on these matters.

TRANSFER ON DEATH AND PAY ON DEATH DESIGNATIONS

"Transfer on death" (TOD) and "pay on death" (POD) accounts are your property and completely in your control during your lifetime, but are paid or transferred on your death to the persons you name as the recipients. No one other than you has any right to this property during your life, but the property passes outside of probate to the named recipient, rather than the person listed in your will or your heirs, when you die. You can change the beneficiaries on the accounts at any time. Real Estate and personal property such as furnishings and automobiles can be transferred on death by a proper deed, bill of sale or other proper written instrument.

LIFE INSURANCE

Many people have life insurance and have named the person to receive the death benefit upon their death. Death benefits are paid directly to the ben-

eficiary by the insurance company and do not go through probate.

Benefits payable directly to beneficiaries may be an important source of funds during estate administration (probate). Some estate plans may provide large sums of insurance to help meet your family goals and obligations. If you want the proceeds from your life insurance used to pay your debts and funeral expenses it might be better to have your life insurance proceeds paid to your trust and specify that your successor trustee pay those debts. If you have your life insurance payable to a child they would have no legal obligation to pay those debts although they could voluntarily pay such debts.

ANATOMICAL GIFTS

The medical need for human organ transplant such as the heart, kidneys, pancreas, lungs, liver and intestines has prompted many older persons to make anatomical gifts following death. In addition to organs, there is a need for tissues such as the cornea, skin, bone marrow, heart valves and connective tissue to treat otherwise catastrophic illness. A number of persons have chosen to donate their entire body after death for use in the education of future doctors and dentists. Donation of one's body can, if appropriately planned, reduce or eliminate funeral and interment costs.

In Indiana, if you are of sound mind and at least 18 years of age, you can choose to give all or part of your body for a transplant or for use in medical education or science. Persons under 18 years of age must have a parent's or guardian's consent. The law also allows a family member or guardian to authorize a gift of all or part of your body, unless you have indicated that such a gift is not to be made. The law does not permit family members to prevent donation if you have chosen to do so.

There are several ways in which you can direct that the gift be made. You can make the gift in your will, by completion of a donor card, by indicating your wish on your driver's license or by another written document. Each of the documents, except for your driver's license, requires your signature and the signature of two witnesses who witness your signature and then sign in your presence. If

you are unable to sign, you can direct someone else to sign for you in the presence of the witnesses. The easiest and most effective methods of donating are the use of either a donor card or your driver's license.

Regardless of how you indicate the gift, it is essential that you discuss your wishes with your family and other care givers. Discussion of your wishes with one of the organizations listed below is also highly recommended as they can provide detailed information and guide you through the process.

You can change or revoke a gift at any time by formally changing your will or destroying the donor card or document and preparing a new one. Any change in your wishes should be discussed with your family members and care givers.

Details of organ, tissue or whole body gifts and donor cards may be obtained from any of the following organizations:

Organ, Tissue and Eye Donations

Indiana Organ Procurement Organization
429 N. Pennsylvania St., Suite 201
Indianapolis, IN 46204-1816
(317) 685-0389
1-888-275-4676 (24 Hours)
www.iopo.org

Eye Tissue

Indiana Lions Eye & Tissue Transplant Bank
Indiana University Medical Center
702 Rotary Circle
Indianapolis, IN 46202
(317) 274-8527
1-800-232- 4384 (24 Hours)
www.tbionline.org

Whole Body Donation

I.U. School of Medicine
Anatomical Education Program
Medical Science Building, Rm 5035
635 Barnhill Drive
Indianapolis, IN 46202-5120
(317) 274-7450
www.anatomy.iupui.edu/anatomical

General Organ Donation Information (National)
www.organdonor.gov

FUNERAL AND BURIAL PLANNING

PREPAYMENT METHODS

There are advantages in arranging in advance for your funeral and burial and in prepaying for these services. First, this allows you to make certain that your wishes will be followed. It also allows you to make thoughtful, unpressured decisions and insure that your family will not need to make quick decisions at a time of grief. Also, the law does not require embalming except in some cases (certain communicable diseases, body to be transported interstate, etc.) A viewing of the body may be beneficial but is not required. The body may be buried immediately; there is no required waiting period.

If the body is cremated, there is a 48-hour waiting period. Indiana law allows the ashes to be buried in a cemetery or scattered on waterways or on private property if the property owner consents.

When making arrangements with a cemetery for burial, you should get an itemized list of services that the cemetery provides. Some cemeteries are charitable organizations and have rate structures related to ability to pay. If the cemetery allows, you might save money by buying the grave marker from an independent dealer. Some cemeteries, however, charge extra to install markers that are not their own. Cemeteries often charge for installing and maintaining grave markers.

If you need help paying for a funeral, you might be eligible to receive death benefits from Social Security, the Veterans Administration or Medicaid.

It is a good idea to arrange for someone to house-sit at the decedent's house during visiting hours at the funeral home and during the funeral. Burglars sometimes read the obituaries in the newspaper to find out the homes that are likely to be empty during a funeral or visiting hours.

Prepaying also insures that your family will not need to concern itself with payment arrangements. Another advantage is that funds used for prepayment will not be considered in determining eligibility for Medicaid if the arrangements are irrevocable.

Indiana law provides that funeral and burial expenses can be prepaid with an **irrevocable funeral trust fund**. You enter a contract with a funeral home listing the services, equipment, facilities and mer-

chandise to be provided and listing the cost for all items. The amount you pay is deposited in a trust fund in an Indiana financial institution. The interest earned accrues to the trust fund, and after your death the principal and interest are distributed to the funeral home for performance of the contract. You have the right to change the funeral home selected at any time.

Some funeral homes use an **insurance policy** to fund prepaid funeral and burial expenses. Ownership of the policy must be irrevocably assigned to the funeral home as a trustee for you, and the funeral home cannot borrow against the policy.

Indiana law provides that you have 30 days after signing a contract for prepayment to **revoke the contract** by giving the funeral home written notice of your decision to revoke the contract. This requirement may be waived by you if you are applying for Medicaid. If you revoke the contract in a timely manner, the funeral home must refund all payments you have made.

FUNERAL ARRANGEMENTS

The funeral director should explain to you about the services offered and the price for each service. If the funeral is sold as a package, he or she should tell you exactly what services are included in the package. He or she may be willing to eliminate some unnecessary services from a package if you do not want to pay for them.

You may want to ask about less expensive alternatives. For example, you can ask if there are less expensive caskets than the ones that are shown to you; there is usually a great range in prices for caskets. The law does not require a casket, although there must be some container. The cemetery, however, may require a casket. A sealed casket is not required except in the case of certain communicable diseases.

Indiana does grant a person the right to sign a Funeral Declaration. This form allows you to describe what kind of services and burial arrangements you would want and who you would want to make your arrangements.

WHEN SOMEONE DIES

The death of someone close to you brings shock, grief and bewilderment. The purpose of this discussion is to answer some questions that you might ask right away or in the first few overwhelming days. You

will, of course, need more detailed answers, but this discussion can be a starting point.

Throughout this discussion, the person who has died is called the decedent.

WHOM TO CALL FIRST

If someone dies at a hospital or a nursing home, the staff will usually know whom to contact. If the death occurs somewhere else, you will need to call the coroner or a doctor to verify the death.

You should then call a funeral home. The decedent may have made arrangements with a particular home. If not, your clergyperson or doctor might recommend a good funeral home. Someone from the funeral home will come to get the body and will talk with you about arrangements for the funeral, visiting hours and burial. The funeral director will consult with your clergyperson and family concerning any funeral and burial services.

ANATOMICAL GIFTS

The person who has died may have intended to donate his body or some part of it, for transplanting or for medical science or education. (See Anatomical Gifts) If so, this gift needs to be made immediately after death. Check with the decedent's close relatives and check his will and the back of his driver's license to see if he expressed an intention to make such a gift. If he did not, close relatives can make the decision.

If eyes or kidneys are to be donated, they will be removed without unnecessary harm to the body, and the body will then be returned to the family.

If the whole body is to be donated, you should call a funeral director. If the decedent has not already made arrangements with a particular funeral director, the family may choose any director located in Indiana. The funeral director must sign the proper papers with the Department of Health and get the necessary information from the decedent's doctor and family. The director will also make sure that the body is delivered in time.

The Indiana State Anatomical Board will directly pay the funeral home director for the embalming. The funeral home may, however, charge more for these arrangements than the Board will pay. You should ask the funeral director what expenses you will have to pay. There may be a funeral service, after which the body will be delivered to the Anatomical Board. After the scientific study of the body, the remains will be

cremated and the ashes either returned to the family or buried in Crown Hill Cemetery in Indianapolis.

JOINT BANK ACCOUNTS

Any money held by the decedent and someone else in a joint account is presumed to belong to the surviving owner. You should call the bank and find out how to take the deceased name off the account. Most likely all you will need to present is a death certificate.

SAFE DEPOSIT BOXES

The decedent's safety deposit box is not automatically available to survivors, unless it is held jointly. If a personal representative or administrator is appointed, they will have access to the safety deposit box by showing the bank the document showing their appointment. If no estate is opened, the personal representative or administrator can sign a special kind of affidavit to gain access to the box.

MEDICARE

If the decedent participated in Medicare, Medicare will pay directly to the hospital, nursing home or home health agency for covered services provided to that person prior to death. (See Medicare, Part A) For bills of doctors and other medical suppliers covered under Medicare, Part B payment will depend on whether the bills have already been paid. If a bill was already paid by the patient before he died, or has been paid with funds from the decedent's estate, Medicare will pay the representative of the estate. If there is no legal representative of the estate, Medicare can send payments to a surviving member of the patient's immediate family.

If someone other than the patient has paid the bill, Medicare can pay that person; that person should get the required claim form from a Social Security office. If the bill has not been paid, Medicare will pay the doctor or other supplier directly if that doctor or supplier has accepted an assignment of the claim. Otherwise, the person legally responsible for paying the medical bills can submit to the Social Security office an itemized bill and Medicare can then pay that person for the bill.

For more information about Medicare payments for someone who has died, call a Social Security office. Look in the telephone book under offices of the U.S. government.

SOCIAL SECURITY

If a person who received Social Security dies, you may keep the check or payment (direct deposit) for the month of death but not the following month. This is true even if the recipient dies at the end of the month. Be sure to notify the Social Security Administration of the death. Otherwise, if you keep a check or payment after the month of his or her death, you may be required to pay them back later. (See Overpayment)

If the decedent had the required number of quarters of work, a surviving spouse or child may receive a one-time death benefit of \$255.00. The death benefit can no longer be paid directly to a funeral home. For information about this Social Security death benefit, call a Social Security office.

VETERANS' BENEFITS

The Veterans Administration (VA) can pay all or a portion of the expenses of burying a veteran and up to \$150 for a cemetery space headstone. The amount may vary based on date of death, dates of service and if the death was service related or if the deceased died while in active service. The VA will also give the next of kin an American flag for use at the funeral and to keep. For information, contact a VA office.

County governments can pay up to \$100 for setting a government headstone in the county of burial. Apply for these benefits at the County Auditor's office or County Veterans Service Office.

WHOM TO NOTIFY

You should notify any agency from which the decedent was receiving assistance checks. For example, if the decedent was receiving Social Security or SSI benefits, notify the Social Security Administration. Generally, the funeral home notifies Social Security of the death. If the decedent was receiving Medicaid or other welfare assistance, notify the Family and Social Services Administration.

Survivors should check to see if they are eligible for death benefits or survivor's benefits under the decedent's public retirement system (Social Security, Railroad Retirement, Civil Service Retirement, and Veterans' Pensions). (See Public Pensions)

If the decedent received a private pension, notify the administrators of the pension plan; ask whether the surviving spouse is eligible to start receiving payments. (See Private Pensions)

Notify any insurance company with whom the decedent had an insurance policy or annuity. Notify life insurance companies right away; there may be a deadline for giving them notice.

You should notify any financial institution, brokerage firm or other company which the decedent had money on deposit or other holdings. They should be able to advise you on how to transfer the funds or property.

You might also check with the decedent's employer or former employer to see if survivors are eligible for any employee death benefits.

WILLS AND PROPERTY

If the decedent's probate estate is worth more than \$50,000, then the estate must be probated in court. If there is no will, the court will appoint an administrator to administer the estate. If there is a will, the will must be probated which means that it must be proven in court. The court will appoint a personal representative (usually the person named in the will) to administer the estate. The personal representative may be asked to post a bond. The personal representative should get legal advice about his duties.

A lawyer can explain to you the procedures involved in administering an estate or if the small estates procedure could be used.

INCOME TAX RETURNS

If the decedent would have had to file a tax return if he had been living, then both federal and state income tax returns must be filed for him for the year of death. A copy of the death certificate must be attached to the state return. A surviving spouse can still file a joint return for the year of death. For the next two years after the year of death, the surviving spouse can file as a widow/widower and take advantage of joint return rates if that spouse has not remarried, has a dependent child and provides more than half the cost of keeping the home for himself and the child.

CONSUMER FRAUD

Some dishonest salespersons aim their frauds at grieving relatives. Especially be aware of the salesperson that delivers goods and tells you that the decedent had ordered the goods (perhaps as a surprise for you) and asks you to pay for them. Insist on proof that the decedent did order the goods.

WHAT TO DO FIRST

When a loved one passes away surviving family members feel many different emotions. Trying to get a good grasp on the decedent's affairs can be overwhelming and may add to the stress and discomfort as the person who is charged with handling the person's final affairs is usually the person who is closest to the deceased. The first thing to keep in mind is that you will get through the ordeal but you have to take it one day at a time.

As a starting point you should make two lists. The first list should set out who you need to contact about the loved one's death. The second list is a list of assets that the person owned, how they are titled or if they have a beneficiary and a listing of the Financial Institution or other company that is holding the funds, the account number and the amount in the account or the death benefit if the item has a death benefit. Complete the first list before you start on the sec-

ond list as you may gather information for the second list in completing the first list. When you contact the Bank who holds the decedent's funds ask how the account is titled and the amount on deposit. When you call the life insurance company, ask who is the beneficiary and the amount of the death benefit. Try to get as much information as you can to put on the second list. There may be some information they may not give you without further action. Once you have completed the first list and have the second list prepared that is when you may want to consult with an attorney. The more information you have and the better you are organized, will greatly assist the attorney in helping you and may cut down on some attorney fees as it less work the attorney will have to perform. Again, you will get through this difficult time but you need to have a plan for how to wind up the person's affairs and then stick with the plan one item or one day at a time.

Elder Abuse, Neglect, and Exploitation

CRIMES AND ADULT PROTECTIVE SERVICES

Under Indiana law, it is a crime to physically abuse, neglect or exploit an endangered adult or a dependent. Failure to report suspected battery, neglect or exploitation of an endangered adult or dependent is a crime.

In civil matters, penalties may be increased when the victim of an unfair or deceptive act is an elderly person. See Chapter 13 for further information about consumer fraud.

Endangered Adult. An *endangered adult* is legal term for a person at least 18 years old who:

1. Cannot manage her property or take care of herself;
2. Because of some incapacity resulting from mental illness, mental retardation, dementia, habitual drunkenness, excessive use of drugs or other physical or mental capacity, and
3. Is harmed or threatened with harm from neglect or battery, or exploitation of her personal services or property.

A *dependent* includes an adult who is mentally or physically disabled.

BATTERY AGAINST OLDER ADULTS

A *battery* is the deliberate touching of a person in a rude, insolent, or angry manner. Although a battery against anyone is a crime, a battery against an endangered adult results in a greater criminal punishment. Also, a battery against a dependent results in a greater punishment if the person who committed the battery was a caretaker of the victim.

NEGLECT OF OLDER ADULTS

The crime of *neglect* includes the deliberate abandonment or cruel confinement of a dependent, depriving that person of necessary support, or placing that person in a situation that may endanger that person's life or health.

EXPLOITATION OF OLDER ADULTS

Exploitation of a person refers to the deliberate and unauthorized use of that person's personal services or property for the advantage or profit of another. In Indiana, exploitation of a dependent or endangered adult is a crime.

REPORTING OF ADULT ABUSE

Anyone who suspects that an endangered adult is being neglected, battered or exploited has the duty to report the facts. Failure to report is a crime. The report should be made to the police (dial 911) or to Adult Protective Services (APS), which is administered by the Indiana Division of Aging. A report can be made by calling 1-800-992-6978, the statewide number.

Persons who in good faith make an abuse report are protected from retaliation and from liability for making the report, even if the report turns out to be wrong. An investigation by APS will be made. If the investigation shows the person is an endangered adult, then APS may intervene to provide protective services.

If the APS investigation fails to support the report, identifying records about the report should be destroyed.

A victim of abuse may refuse to help in the prosecution of an abuser. It is important to realize that the victim may be embarrassed or afraid of retaliation. The victim may be afraid of going to a nursing home if the caretaker is removed. The victim may choose to live with a bad situation rather than have a family member arrested. APS can arrange for supportive services to help a victim through the process of prosecuting the abuser.

PROTECTIVE SERVICES

Protective services may include medical, psychiatric, residential and social services. The endangered adult should, if possible, participate in the plan for

services to help that person. A court order may issued to stop others from interfering with the provision of needed services.

If the victim is not competent to make decisions, a friend or family member can seek guardianship, and the guardian can seek prosecution on the victim's behalf. If it is the guardian who is abusing the dependent or misusing funds, it is important that the probate court be contacted in addition to law enforcement.

These laws about protective services are designed to help persons who need help. If a competent person does not want these services, that person has the right to refuse such services. If there is doubt about the person's competency, a court may consider if such services should be ordered. In this situation, the endangered person has the right to be represented by an attorney and the right to have the court appoint an attorney if the person cannot afford one.

The court can order protective services over the victim's objection only if it finds the person to be an endangered adult who needs the services and who cannot make an informed decision about the need for those services. Any services that the court orders must be those that interfere as little as possible with the victim's liberty while providing the protection needed.

The court order must then be reviewed at least every six months and can be continued only if the reviewing court finds that (1) the services will probably lead to achievement of their goal, or (2) ending the order

would endanger the adult's physical or mental health. Also, a request to change or end the court order for services may come from the endangered adult, the guardian or custodian, or anyone providing services, as well as from the government.

In an emergency, protective services can be ordered after a less formal hearing. Emergency orders, however, can last only 10 days or, in extraordinary cases, 30 days. After that, the government must ask for a more formal hearing in order to continue the services.

THEFT OF SOCIAL SECURITY FUNDS

Social Security benefits are required to electronically deposited into a bank account or paid to a special debit card. This should limit the ability of others to steal Social Security benefits. Do not give your personal access codes to others to withdraw money from your account.

The Social Security Administration allows a person to choose a representative payee to receive that person's Social Security funds if it has found that the person is unable to manage the funds. The person may change representative payees by contacting the Social Security Administration. If a representative payee misuses the Social Security funds, a report should be made to the Social Security Administration which investigates complaints.

The Social Security Administration can be reached at (800) 772-1213 or at a local office.

Age Discrimination

AGE DISCRIMINATION IN EMPLOYMENT

Both federal and state law protect older workers against age discrimination in certain employment practices. Federal generally provides more protection.

FEDERAL LAW

Federal law protects older workers against age discrimination in the following employment practices: hiring, firing, retirement, compensation, fringe benefits, including group health plans, work conditions and privileges promotion, referral to jobs, membership in labor organizations, and classified job advertising. It is also unlawful to harass a person because of his or her age or to retaliate against an employee or applicant because they have opposed unlawful age discrimination or participated in an investigation, proceeding or litigation involving age discrimination.

The federal law prohibits discrimination by most private employers with at least 20 employees, government employers, labor unions with at least 25 members or a hiring hall, and employment agencies.

It is illegal for these employers and agencies to discriminate against workers and applicants for work who are over age 40.

1. Elected state and local officials and their personal staff and policy-making advisors are not protected at all.
2. Executives and other persons in high policy-making positions who are eligible for annual non-forfeitable pensions of \$44,000 or more are not protected above age 65.
3. Firefighters and law enforcement officers are subject to certain limitations based on age if state law permits or requires this.

It is illegal for an employer covered by the federal act to discriminate against you because of your age. To prove a case of age discrimination you must show that age was the determining or “but for” factor in the employment action.

An employer covered by federal law cannot force you to retire. There is an exception for high-paid executives; these employees can be retired at age 65. The federal government cannot force its own employees to retire, although there are some exceptions for hazardous jobs.

In the following circumstances, however, an employer is not acting illegally:

1. The employer is not acting illegally if his action is really based on a reasonable factor other than age. He cannot, however, give a reason that is only a pretext or cover-up for age discrimination. If your age is what made the difference, the employer has probably acted illegally.
2. Also, an employer’s action is not illegal, even if it is based on your age, (1) if his age requirement relates to some activity that is reasonably necessary to the normal operation of his business, (2) there is a factual basis for believing that all or most persons in the excluded age category could not perform the activity safely and efficiently, and (3) it is not practical for the employer to consider each worker or applicant individually to determine whether he could perform the activity. For example, an employer can refuse to hire an older actor to portray a young character in a play.

STATE LAW

Indiana’s law protects workers age 40 through 74. Indiana’s law protects only against an employer’s dismissal of an employee or failure to hire or rehire. This law forbids age discrimination by most private employers in for-profit businesses who have fewer than 20 employees, as well as labor organizations and state and local governments and agencies.

ENFORCEMENT

The Indiana Civil Rights Commission (ICRC) administers the state age discrimination law. The Equal

Employment Opportunity Commission (EEOC) administers the federal law. If you believe that you have been discriminated against because of your age and you are covered by federal or state age discrimination laws, you may immediately take one of these two steps:

1. If the employer has fewer than 20 employees, file a complaint with the ICRC:

Indiana Civil Rights Commission
100 North Senate Street, Room N103
Indianapolis, IN 46204
(317) 232-2600, or (800) 628-2909
www.state.in.us/icrc/

You must file a charge with the ICRC within 180 days of the discriminatory act. The ICRC can investigate your complaint and try to persuade the employer not to discriminate against you. If this attempt fails, the ICRC can issue a complaint and hold a formal hearing. The ICRC can order the employer to stop discriminating. This order must be issued within three months of the discriminatory act, so do not delay in filing your complaint.

2. If the employer has 20 or more employees, file a written charge with EEOC:

Equal Employment Opportunity Commission
101 West Ohio Street, Suite 1900
Indianapolis, IN 46204
(317) 226-7212, or (800) 669-4000

Someone at the EEOC office can help you write the charge. Be sure to specify age discrimination. To protect your right to sue the employer, you must file with the EEOC within 180 days of the discriminatory act.

The EEOC will seek to settle the matter informally. If the matter does not settle, the EEOC will investigate the charge. If the EEOC determines that unlawful discrimination did occur and the employer does not agree to resolve the charge, the EEOC may litigate the case. If the EEOC does not sue the employer it will send you a Notice of Right to Sue Letter and you can sue the employer in federal court. You must sue within 90 days of the receipt of the Notice of Right to Sue Letter otherwise your claim is forever barred. Consult a lawyer promptly if you plan to sue. If you win your case, the court can order the employer to stop discrimination, order the employer to hire, reinstate or promote you, and can award you lost wages. If the violation is found to be willful, the court might double the amount of lost wages.

If you have a valid claim of age discrimination and the employer agrees to settle the matter, you may waive your claim in exchange for something of value from your employer. What you receive in return must be something more than what you are already entitled to receive such as normal severance benefits.

An enforceable waiver must, however, be knowing and voluntary, which means, among other things, (1) that it must be written in understandable language and clearly waive your rights, (2) that you have a reasonable time to think about your decision, and (3) that your employer must encourage you to consult an attorney. You have 21 days to consult with an attorney and seven days to revoke the waiver after you sign it.

It is illegal for an employer to retaliate or discriminate against you because you have filed a charge or sued under the federal age discrimination laws.

PROVING DISCRIMINATION

Sometimes an employer says directly that your age is the reason he treated you differently. Usually, however, discrimination is more subtle and difficult to prove. You should carefully gather your evidence. Keep all written documents including e-mail you have received in connection with the unlawful employment action(s). Write down what was said to you, including dates and the names of persons with whom you have spoken. Find out as much as you can about your employer's usual practices.

For example, the following questions suggest information you might obtain if an employer has refused to hire you because of your age. (You do not need to answer them all before you file a charge.)

- Did the employer advertise the job opening?
- Did the ad mention age?
- What was the job description?
- What are the qualifications for the job?
- What are the qualifications of the person who got the job?
- Did the person who interviewed you mention your age? (It is not illegal for an employer to ask your age, so long as he does not use the information to discriminate against you illegally).
- Did the interviewer emphasize youth?

- Did he indicate that the job might be too much for you?
- Why did the employer say you were not hired?
- What did you lack?
- If you had to take a test, how was it scored?
- What was considered a passing score?
- How does your score compare with the scores of other applicants and with the score of the person who got the job?
- How old was the person who got the job?
- Was the person who got the job substantially younger (at least 10 years younger than you)?
- How many older persons work for this employer?

Present this information to the ICRC or EEOC when you file with these agencies, or to a lawyer.

For more information about age discrimination laws, contact EEOC or the ICRC at the addresses listed above.

AGE DISCRIMINATION IN HOUSING

When it comes to housing, older people are doubly disadvantaged. Many are unaware of their housing rights. Many more are unable to represent their own interest because of the very conditions associated with their age, disabilities and frailty.

Older persons are frequently subject to discrimination, which isolates them. Fear of reprisal also keeps some from seeking to enforce their rights.

Federal and state laws provide tools for addressing these issues. The Federal Fair Housing Act as well as the Indiana Fair Housing Act provides for reasonable accommodations which may allow older tenants to retain their housing, and their independence, as they age.

These Acts prohibit discrimination in housing on account of race, national origin, religion, sex, familial status or handicap. There is no separate category for age. The Acts prohibit discrimination on account of handicap and requires reasonable accommodation be made for the elderly.

The definition of “handicap” may apply to many people who do not think of themselves as handi-

capped. Elders are protected from housing discrimination if they:

- Have a physical or mental disability that substantially limits one or more major life activities, including hearing, mobility and visual impairments, chronic alcoholism and chronic mental illness
- Have a record of such disability, or are regarded as having such a disability.

What that means is that if a potential landlord discriminates against an elder thinking one is impaired in regard to mobility, the elder is in the protected class.

Additionally, the Acts cover most housing, both private and public. The only exemptions are for owner-occupied buildings with no more than four units, single-family housing sold or rented without a broker and housing operated by organizations, bonafide religious groups, private clubs that limit occupancy to members.

The Acts relate to the sale and rental of housing. No one can take any of the following actions based on race, national origin, religion, sex, familial status or handicap:

- Refuse to rent or sell housing
- Refuse to negotiate for housing
- Making housing unavailable
- Set different terms, conditions or privileges for sale or rental of a dwelling
- Provide different housing services or facilities
- Falsely deny that housing is available for inspection, sale or rent
- Deny access or membership related to sale or rental of housing.

Specific prohibitions related to handicap give the following additional protections:

- Landlord must allow you to make reasonable modifications necessary for you to use your dwelling (or common use area), at your expense.
- Landlord must make reasonable accommodations in any rules, policies or services if necessary for you to use the housing.

ELDER COMMUNITY EXEMPTION

Buildings and communities may not discriminate against people based on familial status. That means

they can not discriminate against families with one or more children under 18 living with:

- A parent
- A person who has legal custody of the child or children
- The designee of a parent or legal custodian, with written permission.

Housing for older persons is exempt from this prohibition if:

- The HUD Secretary determines that it is specifically designed for and occupied by elderly persons under a federal, state or local government program.
- It is occupied solely by persons who are 62 or older.
- It houses at least one person who is 55 or older in at least 80 percent of the occupied units; it has significant services and facilities for older persons; it adheres to a published policy statement that demonstrates an intent to house persons 55 or older.

“62 OR OVER” HOUSING

The second of the three categories of housing for older persons that is exempt from Title VIII’s prohibitions against familial status discrimination in housing “intended for, and solely occupied by, persons 62 years of age or older.” To qualify under this exemption, all residents of the housing development must be at least 62 years old.

This means, for example, that if a qualifying retirement community with all older residents receives an application from a husband aged 62 and a wife aged 59, it would have to reject this application because of the wife’s age in order to maintain its “62 or over” exemption. The exemption would also be lost if the community allowed one of its current residents to occupy a unit with a new spouse or other person who is under 62. The community could, however, accept a younger resident and still be exempt if it qualifies for the “55 or over” exemption. The HUD regulations recognize only one exception to the rigid rule that all occupants must be at least 62 years old. According to HUD, units in the development may be occupied by under-62 employees and their families without jeopardizing the exemption, so long as these employees “perform substantial duties directly related to the management or maintenance of the housing.”

The statute requires that “62 or over” housing not only be “solely occupied by” people of that age group, but also be “intended for” such persons. This means that housing could fail to qualify for this exemption even though all of its occupants are older persons if it is not “intended for” such persons. This would certainly be unusual, for in most cases, the very fact that all of the residents are at least 62 would be strong evidence that the housing was intended for this age group. In addition, the legislative history makes clear that this exemption is available “regardless of what other features the housing may or may not have.” Still, it is at least conceivable that a small apartment building could have all elderly tenants without the landlord having intended this result and would therefore not qualify for the “62 or over” exemption.

“55 OR OVER” HOUSING

The third of the three categories of housing for older persons that is exempt from the Acts’ prohibitions against familial status discrimination is housing intended and operated for occupancy by persons 55 years of age or older, and:

- At least 80 percent of the occupied units are occupied by at least one person who is 55 years of age or older.
- The housing facility or community publishes and adheres to policies and procedures that demonstrate the intent required under this subparagraph.
- The housing facility or community complies with rules issued by the Secretary (of Housing and Urban Development) for verification of occupancy.

MAKING A DISCRIMINATION COMPLAINT

If you have a complaint of housing discrimination, you should write HUD or call the Hotline at 1-800-669-9777. 1-800-927-9275 TTD In Washington D.C. 1-202-708-0836, Indiana Civil Rights Commission 1-800-629-2809, and/or your local civil rights commission.

Consumer Protection

INTRODUCTION

Common scams involve everything from miracle drugs to work at home programs to diet aids to ways to make money for retirement. In any situation, be suspicious of a price or deal that sounds too good to be true—it probably is.

Beware of:

- Deals that take place in unusual meeting places;
- Deals that require you to pay a large amount of money in advance;
- Salepeople who contact you uninvited;
- Salespeople who try to pressure you into making an immediate decision without the benefit of careful thought and the ability to discuss it with someone you trust;
- Requests for personal information, such as your bank account numbers; and
- Any deal that seems too good to be true.

If you do pay a large amount of money, do so by check or credit card instead of cash. This way, you will have a record of the payment in case you are not satisfied with the goods or services. For safety reasons, do not carry a large amount of cash with you. Put your Social Security and pension benefits directly into a deposit account each month.

Check out businesses on the Internet before you make a purchase. See if there are complaints. Avoid businesses that fail to list an address and contact information. The Better Business Bureau, a traditional consumer agency that provides reliable information about companies, has free information online. The Federal Trade Commission identifies many scams by publishing alerts. Internet search engines can help find other sources of information. The more information you have, the better armed you will be to make wise choices.

Always obtain a copy of any document that you sign. Always keep copies of letters that you send. When you receive written responses to your letters,

do not write on the responses. Keep a clean copy of such responses.

Indiana law extends special protections to elderly Hoosiers who are victims of unfair consumer acts. This includes treble damages. It is important to take immediate action if you have been a victim of an unfair consumer act. In some cases, your ability to recover stolen or lost funds will depend on how quickly you are able to take action against the other party.

BUSINESS OPPORTUNITY FRAUDS

Beware of “get rich quick” business opportunities, especially franchises and work-at-home schemes. Be especially suspicious of guaranteed profits, business ventures that require large investments of your money at the beginning and hastily arranged meetings in temporary offices.

Do not be hurried into a decision. Get everything in writing and review it with an attorney before you sign or promise anything and before you invest any of your money. You have substantial rights under Indiana law and may have important rights under federal law.

For example, an Indiana statute requires that potential investors receive extensive information at least 72 hours before signing an investment agreement. That same statute gives investors 30 days to change their minds after signing an agreement. For these reasons, if you fail to consult a lawyer before you make a significant business investment, it is still worthwhile to talk with an attorney even after you have signed on the dotted line.

CHARITY FRAUDS

Unfortunately swindlers in this group often use the same approaches as legitimate charities. If you are asked to donate to a charity, find out the name, address and phone number of the organization and contact the organization directly. Legitimate charities are happy to provide you with information on their causes. Never pay by cash, but instead write a

check directly to the charity to ensure your donation is going to the group you intend it to help.

A legitimate charity will wait for your contribution and will accept checks. Do not donate to a charity that insists on cash. Be suspicious of a telephone solicitation where the individual wants to pick up your monetary donation at your home. Be careful about charities with names similar to well-known charitable organizations. Again, take your time and investigate the situation. Resist high pressure tactics.

Indiana law now requires all professional fundraisers working for charities to register with the Consumer Protection Division of the Indiana Attorney General's Office. These fundraisers must disclose the name of the charity and the percentage of collections that will actually go to the charity. Information about current fundraising activities and the financial reports are available at: <http://www.in.gov/attorney-general/2382.htm>.

CONSUMER LOANS AND CREDIT

Most of us borrow money for various purposes, to buy a car or a house, to pay for school, to finance home repairs, etc. One way of comparing the cost of credit is by the interest rate charged on the loan. However, this is only one factor.

There are other costs, "finance charges," that you pay for credit. Credit sellers and lenders are required by the Federal Truth In Lending law to disclose credit terms before or at the time of sale. These disclosures are meant to help you compare terms so that you can get the best deal. Read the contract and each document that you are asked to sign. If you disagree with the terms, do not sign the document.

The disclosures should tell you, the annual rate of interest, the finance charge, the amount to be financed, the total of the payments, the number of payments, the amount of the payments and when payments are due. The disclosures should also tell you if the loan requires you to give a security interest (or lien) in the item being purchased, the amount of late charges and whether there will be a prepayment charge if you pay off the loan early.

Before you apply for a loan or if you are denied credit, it is useful to look at your credit report. You can obtain a free copy of your credit report each year from www.annualcreditreport.com, calling (877) 322-8228, or writing to Annual Credit Report Request Service, P. O. Box 105283, Atlanta, Georgia 30348-5283.

Reviewing your credit report can help spot errors and identity theft problems. Both good and bad credit information will appear on your report. If you disagree with any information reported, you have a right to challenge it. Contact the credit reporting agency to dispute the information. The credit reporting agency must investigate your concerns.

CREDIT CARDS

Credit cards are open-end loans. Understanding their terms may be more difficult since charges are incurred over a period of time and payment amounts vary based on the balance due. Credit cards may also charge an annual fee in addition to interest. Include that cost when comparing credit cards. Some credit cards include other services beyond the extension of credit that may be desirable discounts. As with any contract, it is important to read the small the print. Credit card companies may also change their terms from time to time. Read the notices that you receive. By continuing to use a credit card, you waive any objection to the new terms.

Throughout this Reference, emphasis has been placed on paying by credit cards. There are two reasons for this advice. First, you are entitled to dispute "billing errors" on your credit cards. One type of billing error is a charge for goods or services you did not order, accept or that were not delivered as agreed.

To dispute a charge, you need to **write** to the credit card company within 60 days of when that charge first appeared on your billing statement. Your letter should state your name and account number. Explain why you believe that a specific charge is wrong. The credit card company must then investigate the dispute. While the investigation is taking place, you are not required to pay the disputed amount, and the amount does not accumulate interest.

The second reason to pay by credit card is that for purchases of more than \$50 made in your home state within 100 miles of your residence, you can hold the credit card company liable as well as the seller for your claim. A prerequisite to making a claim against a credit card company is that you must notify the seller of the goods/ services of your complaint and give the seller an opportunity to correct the situation.

When you pay by credit card, the credit card company has a financial incentive in your satisfaction with your purchase and will go to bat for you with the seller.

DOOR-TO-DOOR SALES

Be wary of buying goods or services from a door-to-door salesperson, especially if the person comes to your door without your invitation. If you have doubts about a salesperson at your door, ask for the individual's name and the name, address and telephone number of the company. Contact the company, verify that the salesperson is a member of the company. Check on the company's reputation by calling the Better Business Bureau.

You are not obligated to open your door to someone you do not know. If you are fearful, or you do not want to talk to someone, you do not have to open your door to salespeople. Often, you can see when someone is going door-to-door talking to your neighbors.

Do not be taken in by a young salesperson who claims to be working his or her way through school. It may be true, but it is also a gimmick to win your sympathy. If you do buy a product or service, pay by check and make it out to the company and never to the individual salesperson.

If you agree to buy something, the law **in some cases** gives you three business days to change your mind. Sundays and legal holidays are not business days. The law provides this “cooling-off” period to protect you against high-pressure sales tactics. It applies whenever you have made a purchase of \$25 or more, **and the sale takes place in your home** or at any place other than the seller's place of business (sales made in a hotel room or at a product party at someone else's home, for example).

The salesperson is required to tell you about your right to cancel and must give you two copies of a cancellation form. The salesperson should also give you a dated receipt, and the name and address of the merchant so that you can write to cancel your order, if you decide to do so.

To cancel, sign and date one copy of the cancellation form and mail or hand deliver it to the given address no later than midnight of the third business day after the contract date. To ensure that the merchant receives your cancellation form, you can send it by certified mail. Keep a copy of the form for your records. You do not have to give a reason for the cancellation.

The cancellation must be in writing because a merchant is not required to honor a telephoned or verbal cancellation. If the salesperson does not provide you with a cancellation form, you can write a let-

ter. By cancelling in writing, you will have proof of the cancellation.

Within ten (10) days of cancellation, the merchant must return any papers you signed. The merchant must also refund any money that you paid and return any trade-in. If you have the product in your possession, the merchant should pick up the item within 20 days. If you agree to send the product back, you should be reimbursed for your mailing costs.

Home improvement or home repair salespeople such as asphalt pavers, roofers and tree trimmers often solicit door-to-door. Sometimes home contractors do the work before the cooling-off period is over. If this should happen, do not let this situation stop you from canceling. As long as the work was not an emergency, you can still cancel and you are not obligated to pay for any of it.

The cooling-off rule does **not** apply to:

- Sales made at the seller's place of business;
- Sales of less than \$25;
- Sales made entirely by mail;
- Sales of real estate, insurance or securities; or
- Emergency home repairs.

GENERAL INFORMATION ABOUT CONTRACTS

Do not sign any contract or document until you have read and understood it. This means reading the fine print, too. Take the contract home to study and discuss with a family member or trusted friend. Be suspicious if the other party will not let you take the contract with you to think about it. Never sign a contract that has blank spaces in it; cross them out first. If you have concerns about a contract, consult an attorney before you sign it.

Make sure that the entire understanding is in the contract. If a salesperson makes a promise, guarantee or statement that you are relying upon, **get it in writing** as part of the contract. Otherwise, you will not be able to prove that the promise or statement was made. If a merchant hesitates to put any of his promises in writing, go elsewhere. It is nearly impossible to enforce unwritten promises that were not included in the contract.

Once you sign a contract, keep a copy as a record. Do not sign a contract (or any legal document) without getting a copy for yourself.

To prevent misunderstandings and avoid prob-

lems, contracts should be in writing. However, a verbal contract can be enforced. This type of contract is usually as binding as a written contract. Realize that you could be responsible for promises you make, even if they are not in writing.

Contracts concerning land should always be in writing, including contracts to sell or lease land. Contracts involving large sums of money should be in writing to avoid disputes.

Once you have signed a contract, you are generally bound by it. If you change your mind, you may still be obligated to make payments on the contract. In some cases, there may be a clause in the contract that lets you out of the agreement under certain circumstances. Although there are limited situations where you can cancel a contract within three days, these situations are limited. (See Door-to-Door Sales above) Most contracts are valid once signed. So, when in doubt, do not sign a contract until you are satisfied with the deal.

Many people mistakenly believe that there is a right to cancel a contract for the purchase of a motor vehicle. Contracts made at a dealership are not subject to the three day right to cancel rule. For a large purchase, such as a car, take time to consider the deal.

HOME IMPROVEMENT/HOME REPAIR

A common scam on homeowners—particularly senior citizens—involves a salesperson who comes uninvited to your house to sell you repair services that you may or may not need. Legitimate businesses, particularly construction companies, do not usually offer their services by unsolicited door-to-door sales.

These frauds often involve blacktopping your driveway, putting siding on your house, roofing, furnaces, painting and energy-saving devices. Remember that you can always say “no.” Call the police if a salesperson refuses to leave your house.

You are never required to open your door to a salesperson. You are not required to invite that person into your home. Be wary of allowing a stranger to come into your home, especially anyone who just show up at your door.

When deciding to hire a business, take your time, shop around and get advice from someone you trust. Do not let a salesperson rush you into any decision! Be especially suspicious of a salesperson who:

- Just “happens” to have material left over from another job. (very common swindle);

- Says your job will be a “sample” or “model” for other customers;
- Will not put total costs in writing; or
- Wants an immediate decision.

Get the name, address and phone number of the company the salesperson represents. Then call the company and check out the legitimacy of both the firm and the salesperson. Ask questions! Find out what other jobs the contractor/salesperson has done, get references, **and then contact the references.**

If you agree to have work done and it will cost more than \$150, the company must prepare a written contract and give you a completed copy. Review the contract and be sure you agree with all the terms BEFORE signing it. Written terms in the contract trump any spoken promises. If the salesperson is not willing to put the promise in writing, do not rely upon the promise. The contract must contain:

- The price of the work/repairs;
- The approximate start and completion date for the work;
- A statement of any events that might delay completion; and
- A reasonably detailed description of the proposed work.

If specifications (drawings, list of materials, etc.) are not available when the contract is signed, they must be given to you for your review and approval before the work begins.

If you decide to have the work done, do not pay more than 1/3 of the cost as a deposit. Never leave a house key with a repairman while you are gone. Check on the work as it progresses.

Do not pay the remainder of the cost until you are satisfied with the project. Do not sign a completion certificate until the work is done to your satisfaction. When you pay the final bill, pay by credit card or check, so that you have a record of the payment transaction. Do not pay by cash.

Once you have paid all or most of the money due, it may be extremely difficult to get the job finished to your satisfaction. Do not give in to requests for payment until the work is done.

Even if you are dissatisfied with a home repair, you should get legal advice before you stop payment on a check to the company who did the work. Otherwise,

you risk foreclosure on your house if there is a lien on your house. Repairmen and construction companies may take a lien or mortgage your home to make sure you pay them for their work. If they do this, they must tell you clearly in the written contract that this could happen. If you suspect they have done this without your knowledge, contact a lawyer for advice. (See also Chapter 7 on Homeownership Issues)

MAIL ORDERS

Ordering goods via the mail is convenient, and there are many excellent mail order businesses. Unfortunately, some businesses prey on older consumers. Before you order from a company, check with the Better Business Bureau (1-317-488-2222 in Central Indiana) to make sure there are no complaints filed against the company. Read the description of the goods, and do not rely on pictures that can be misleading. Find out about the company's return policy and keep a copy of your order, marked with the date you mailed the order. Never pay with cash. If possible, pay by credit card so you have a written record of the transaction.

You should receive the ordered goods within a reasonable time—usually 30 days. There are some exceptions such as magazine orders that take longer. If you have trouble with your order, contact the company. You might also get help from the magazine or newspaper that carried the ad for the product or service.

If you received goods that you never ordered, you may choose to either send them back or keep them. If you decide to keep the goods, you do not have to pay for them. Some companies mail you goods that you never ordered in the hope that you will feel compelled to pay for them or that you will like the products and order more. If this same company tries this gimmick again, report it to the postal inspector.

MORTGAGE FORECLOSURE RESCUE SCAMS

The recent rise in mortgage foreclosures has brought with it a rise in scams to “help” homeowners avoid foreclosure. These scam companies often do nothing for the homeowner while charging a substantial, upfront fee. Tactics used by scam programs include counseling the homeowner to make payments to the scam company rather than the mortgage company, asking the homeowner to sign over the deed to the home, and asking for predated

checks. A legitimate company will not ask you to do these things.

Check with the Better Business Bureau before hiring a mortgage rescue company. Find out if the company is in good standing. Beware of new companies that have no history. Beware of a company that does not have an address or obvious place of business. Review written contracts carefully before hiring a rescue firm. Be clear on the service to be provided and the cost of the service.

Often the only service that the scam companies can supply is to contact your mortgage company to negotiate a loan modification. The company may emphasize its use of government programs, as if it has special knowledge or access that you do not.

However, you can contact your own mortgage company for a loan modification on your own without paying someone else to do it. While this can be a difficult process, there is no reason to think that the scam company can or will do a better job for you. The scam rescue company is only interested in making money from your financial desperation.

Beware of foreclosure rescue companies that operate from out of state. An out of state company cannot represent you in court if you have been sued by your mortgage company. Only a lawyer licensed in Indiana can represent you in court. Ask if the mortgage rescue company has a licensed attorney who will represent you in court.

You must not ignore a law suit. Failure to take timely action could result in the loss of your home. Do not depend on negotiations and assurances that you can ignore the law suit while a loan modification is pending. Once you are sued by your mortgage company, you need to contact a lawyer.

If you believe that you have been a victim of a mortgage foreclosure rescue scam, contact the Indiana Attorney General's office to file a complaint.

Free help for homeowners is available through the Get Hope program through the Indiana Foreclosure Prevention Network at (877) GET-HOPE or www.877GetHope.org. You can learn about the government programs available to homeowners through this free program.

REFINANCING YOUR HOME MORTGAGE

For most people, the most valuable asset they own is their home. It is important to use caution before taking out a new mortgage on your home or refi-

nancing the existing mortgage. Each time you do, you reduce the accumulated equity in your house.

“Equity” is the difference between the market value of your home less any liens/mortgages on the title. Equity represents your investment in the house. Retired people often rely on not having a mortgage payment to reduce their living expenses in retirement. Equity can be a source of funds for repairs, emergencies, downsizing to a smaller home or an asset to pass on to your heirs.

It is possible to refinance your mortgage to the extent that you have used up all of the equity in your house. When you do that, you have lost your investment in the house until you pay down the mortgage. Chances are the amount of the monthly payments in such cases will be more than a retired homeowner can afford. Affordable payments (including the principal, interest, homeowners insurance, and property taxes) should be less than one-third of the household income.

Predatory lenders take advantage of homeowners by making high interest loans with harsh terms and without concern for whether the homeowner can make the payments. Before agreeing to a mortgage, seek trustworthy advice about the deal. Know what interest rate to expect and know what payment amount you can afford.

TELEPHONE PRIVACY/TELEMARKETERS

Many companies solicit business over the telephone. While telephone solicitations can be legitimate ways to gain your business, they can also be unwanted intrusions, or even deceptive or fraudulent scams.

Indiana’s Telephone Privacy law helps protect you from unwanted telephone solicitations by allowing you to register your home telephone number on a telephone privacy list maintained by the Office of the Attorney General. You can register your number by logging on to the Attorney General’s website at: www.in.gov/attorneygeneral and clicking on the “Telephone Privacy” link on the left side of the screen. If you do not have Internet access, you can also register by calling 1-888-834-9969.

As long as your telephone number is on the telephone privacy list, the law prohibits most telemarketers from calling you. The exceptions are:

- Telephone calls that you request
- Telephone calls primarily relating to existing debts

or contracts you have with the telemarketer

- Charitable organizations who use employees or volunteers to make the calls
- Newspapers who use employees to make the calls
- Realtors
- Insurance agents

Hoosiers may register at any time because Indiana’s Telephone Privacy List is updated every quarter (January 1, April 1, July 1 and October 1). Registration is free and once your number is registered, you do not have to register again. If you have registered your home phone number on the list, be wary of any telephone solicitation you receive that you believe does not fall within one of the exemptions listed above.

If you receive a call from an organization that you do not believe is exempt from the calling restriction, there are steps you can take that will help the Attorney General’s Office enforce the law. Do not hang up! Find out as much information about the group calling you as possible so that the Attorney General’s Office can investigate the problem:

- Name of the company making the call
- Date and time of the call
- Product or service offered
- Telephone number of the company calling you.
(this is not always possible, but please make every effort to get their phone number).

Once you have gathered this information, log on to www.in.gov/attorneygeneral and go to the Telephone Privacy section and click on “download complaint form.” Complete the form, sign it and mail it to the address provided on the form. If you do not have access to the Internet, you can call 1-812-355-5915 to request a complaint form.

The Attorney General’s staff will review your complaint, contact the telephone solicitor, investigate the matter and notify you of the status. It is very important that you are willing to participate in an investigation. You should be prepared to testify in court and obtain phone records from your telecommunications carrier.

Indiana law provides additional protections for you in the event you are a victim of telemarketing abuse or fraud. For these reasons, you should contact an attorney and the Consumer Protection Division of

the Office of the Attorney General if you feel you have been abused or defrauded through an unwanted telemarketing call.

TIMESHARES

Timeshares at vacation properties (permanent ownership of a specific week of time at a resort) are often aggressively marketed with the lure of “free” prizes. You may be subjected to a long, high-pressure sales pitch as a condition of any prize.

Contrary to the sales pitch, if you consider purchasing a timeshare, it can be difficult to trade your timeshare unit for another one in a different part of the world. The ease or difficulty of doing a trade depends on the season (week of the year that you “own”) and the location of your unit and how desirable it is to others.

Beware of claims that your timeshare unit or membership is re-sellable. Usually it is not, and the seller will rarely buy it back from you. If the company or seller assures you that the seller will buy it back from you, get that promise in writing along with information about the re-purchase price.

Even after you have paid for a timeshare, ongoing maintenance fees apply, even if you do not use the timeshare. Consider carefully if you can afford the long-term commitment. Check the Internet to find out how easy it is to sell a timeshare interest.

SWEEPSTAKES

Another scam to be avoided is the check that arrives telling you that you have won a sweepstakes prize. The catch is that you have to pay certain fees or taxes to an out of country account to claim your

prize. You are instructed to cash the check and wire the money to the prize company so that the rest of the larger award can be sent to you, usually with a quick deadline to claim your prize. Often the check looks legitimate and appears to be written on a real bank. However, the check is fraudulent. By the time you discover the fake, it may be too late to avoid the loss of your own funds. Distrust any deal that seems to be too good to be true. Not only may it not be true, it could cost you money.

ADDITIONAL ASSISTANCE

The Consumer Protection Division of the Indiana Attorney General's Office provides free assistance to Hoosiers who may have been the victims of consumer fraud and have been taken advantage of in a consumer transaction.

In order for the staff to investigate a situation, a written consumer complaint form **MUST** be completed, signed and mailed back to the Attorney General's Office at:

Indiana Attorney General's Office
Consumer Protection Division
302 West Washington Street, 5th Floor
Indianapolis, IN 46204

Be sure to include copies of contracts and related documents with your complaint.

For a complaint form, log on to the Attorney General's website at: www.in.gov/attorneygeneral and click on “Consumer Services” and then click on “download complaint form.” If you do not have access to the Internet, you may call (317) 232-6330 or toll-free at 1-800-382-5516 and request that a complaint form be mailed to you.

Grandparents' Rights

GRANDPARENT VISITATION

Most grandparents may visit with their grandchildren without a court order. Families typically work out between themselves the amount and frequency of visitation that family members want with each other. Sometimes, however, agreement is impossible and the parties seek court intervention.

A child's relationship with his or her grandparent is important and may be entitled to protection under Indiana's Grandparent Visitation Act. However, grandparent visitation ordered by a court necessarily impinges, at least to some degree, on a parent's constitutionally protected rights. Therefore, a court must balance the parents' rights and the children's best interests, limiting grandparent visitation awards to amounts of time which do not substantially infringe on the parents' right to control the upbringing of their children.

CRITERIA FOR SEEKING VISITATION

The Grandparent Visitation Act is specific to grandparents and, at this time, does not apply to great-grandparents, step-grandparents, uncles, aunts or other relatives. In the past, legislation has been introduced to expand this law to great grand-parents but that is not the current law.

A grandparent may petition a court for visitation rights with a child in limited situations. Not every grandparent is entitled to ask for court-ordered visitation and/or not every state has grandparent visitation laws. In Indiana, a grandparent may petition the court for visitation if:

1. One or both of the child's parents is deceased;
2. The marriage of the parents of the child has been dissolved in Indiana; or
3. The child was born out of wedlock, except that the paternal grandparents can seek visitation only if paternity has been established.

If the parents divorced in a state other than Indiana (see 2 above), a grandparent may still seek visitation under certain circumstances. You should consult with a lawyer with expertise in this area for assistance.

BEST INTERESTS OF THE CHILD

The court can grant grandparent visitation rights if such visitation is found to be in the best interests of the child. The court will consider whether the grandparent has had or has attempted to have meaningful contact with the child when deciding if visitation is in the child's best interests.

The law allows for grandparent visitation where the child has been adopted by a stepparent or a biological grandparent, sibling, aunt, uncle, niece, or nephew.

The amount of visitation that could be ordered by the court is decided on a case-by-case basis. There is no set rule as to the amount or frequency of visitation that a court must order and there are no grandparent visitation guidelines. The court may consider who else is entitled to visitation and what the past history of visitation with the grandparent has been, as well as the age of the child and the geographic distance involved. The court may even interview the child to determine whether visitation is appropriate or what visitation schedule should be ordered.

RESOURCES ON GRANDPARENT VISITATION

The law in this area, as in others, is constantly changing. You should check sites such as www.aarp.org for information on the latest developments in grandparent visitation rights. In the absence of court-ordered visitation, grandparents should try to work out visitation arrangements with the parents or parent of the child. For instance, an offer to babysit may help everyone involved and help the parents appreciate the value of the grandparent/grandchild relationship.

GRANDPARENTS RAISING GRANDCHILDREN

Recent census data indicated that about 4.4 million grandchildren in this country live with their grandparents. Statistics also show that these numbers have been steadily increasing. In 1970, about 2.9 million children lived in a grandparent's home while 3.9 million children lived with a grandparent in 1997.

Grandparents can also play very important roles as a relative caregiver (foster parent or adoptive parent). In some situations, grandparents may become involved in the DCS Child and Family Team Meeting process, aiding their children who are the primary caretakers of their grandchildren.

TAX BREAKS FOR RAISING A GRANDCHILD

If you are raising a grandchild and are financially responsible for the child, you should be aware of certain tax breaks which may be available to help you. You may be eligible to claim the child as a dependent, qualify for tax credits and possibly receive the Earned Income Tax Credit.

The Internal Revenue Code defines a grandchild as a "dependent" if the child lives with you for more than one-half of the year, is below the age of 19 (unless the child is permanently and totally disabled or is a student below the age of 24), and did not provide for more than half of his/her own support.

You may claim an "exemption" on your tax return for any grandchild who qualifies as a dependent. This definition also qualifies your grandchild as a dependent if you are eligible to file your tax return as a "head of household." Generally speaking, you get the advantage of "head of household" status if you are unmarried but care for a dependent.

A different tax credit may be available for you if you are working, have a dependent grandchild, and your income is below a guideline amount set each year (for example, the maximum for 2013 was \$51,567 for filing jointly with three children). If the above criteria pertains to you, you may be eligible for the Earned Income Tax Credit. Usually this tax credit will give you the greatest amount in your tax refund.

Another federal tax credit, the Child Tax Credit gives you a refundable credit of \$1,000 per dependent

under the age of 17 (even if disabled).

The Dependent Care Credit helps offset some of the costs paid for child care. The Dependent Care Credit gives you a refundable credit for qualified child care expenses which allowed you to work and also care for a grandchild who is under the age of 13 or disabled. For tax year 2013, for example, up to \$3,000 could be claimed for one dependent under this credit and \$6,000 for two or more dependents.

If you are working, you may be able to include your dependent grandchild in your employee benefits. The new definition of "dependent" in the Internal Revenue Code also applies to all qualified employee benefit plans including health insurance plans.

Tax laws change almost every year, so please check with your accountant or tax preparer for the current tax breaks for which you may qualify. The AARP offers their Tax-Aide program in which volunteers help seniors with tax questions and returns. Call 1-888-227-7669 for a location near you.

The IRS also sponsors a free program to help you with tax questions. The Volunteer Income Tax Assistance (VITA) program offers free tax help to individuals whose incomes qualify for the Earned Income Tax Credit (in the tax year 2013, that amount is \$46,227 or \$51,567 married filing jointly) with three dependents. VITA Volunteers are trained by the IRS to help you prepare and file your tax return. Call 1-800-829-1040 for a location near you.

CHILD SUPPORT AND PUBLIC BENEFITS

Grandparents who are raising their grandchildren are entitled to child support and may petition a court for child support from the parents. A grandparent may also apply for Temporary Aid for Needy Families (TANF), which are cash benefits available from the county office of the Division of Family Resources (DFR). In Indiana, TANF applicants must meet both state and the federal guidelines for the program. The amount of TANF benefits is relatively low but may range from \$139 per month to \$697 per month depending on income and household size. Besides TANF, a child living with a grandparent may also be eligible for Medicaid benefits. Application for both benefit programs may be made at the same time at the local DFR office.

Programs and Services for Older Hoosiers

IDENTIFICATION CARD

If you do not drive a car but need an identification card, you can obtain an identification card from the Bureau of Motor Vehicles (“BMV”) at any license branch. The BMV offers identification cards for Indiana residents of any age who do not have a driver’s license. You cannot hold both an identification card and a driver’s license at the same time. You may need an identification card for a variety of reasons, including for voting purposes, leisure activities or travel. These identification cards are available for free if you need the card for voting purposes. The identification card will have the same shape as a driver’s license and will contain similar information to identify you. The cards are valid for six years and can be renewed.

When you go to apply for a card, you will need to bring certain documentation that identifies you. You should check the latest documentation requirements before you go to the license branch since the required documents change from time to time. You can confirm these visiting the Bureau of Motor Vehicles website at www.in.gov/bmv.

WORK PROGRAMS

AMERICORPS

Vista. Volunteers In Service to America is a national program of volunteers who serve low-income communities in the United States, Puerto Rico, Virgin Islands and Guam. Volunteers work particularly on the problems of troubled youth, low-income elderly and the disabled or handicapped. Volunteers live and work among the poor for one year, mostly on local development projects. About 15% of volunteers are 55 years of age and over. For more informa-

tion contact the VISTA program listed in your local telephone directory or locate them on www.national-service.gov/programs/ Americorps

SENIOR CORPS PROGRAMS

The federal government sponsors several programs that give older persons the chance to volunteer to help others. These programs are administered through the Senior Corps program and are described below. Some of these programs are available only in parts of Indiana, so if you are interested in volunteering for a program be sure to ask whether that program is available in your area. For information, write or call the ACTION office for Indiana:

Senior Corps

46 East Ohio Street

Room 226

Indianapolis, IN 46204

(317) 226-6724

www.national-service.gov/programs/senior-corps

Get Involved: Indiana connections: volunteer match.

You could also look in your telephone book under the name of the specific program.

Retired Senior Volunteer Program (RSVP). Volunteers in RSVP work part-time for a nonprofit organization in their community. They may choose their assignments from a list of possibilities compiled by the local RSVP office. For example, RSVP volunteers may serve in hospitals, nursing homes, offices of charities, or schools. Anyone who is at least 60 years old and retired can volunteer. There are no requirements of income, education, or experience. Volunteers receive no pay, but do receive training and may also receive assistance with transportation to and from their work.

Foster Grandparent Program. Foster grandparents are persons 60 years of age or older who volunteer to work with children who have special needs.

A foster grandparent must have a low income and be willing to devote four hours of attention, five days a week, to two children who need special attention. Many of these children are sick, neglected, handicapped, retarded, or disturbed. The program provides its volunteers with a small tax-free stipend, hot meals during work times, a transportation allowance, training, insurance, and an annual physical exam.

Senior Companion Program. The Senior Companion Program is open to low-income persons at least 60 years old who want to serve as companions to frail and infirm elderly persons in their communities. Each volunteer serves two clients, each for 10 hours a week. Companions perform such services as reading and writing letters, escorting clients on errands, shopping and generally visiting with the clients. Volunteers receive a small, tax-free stipend, hot meals during work times, a transportation allowance, training, insurance coverage and an annual physical exam. The only SCP program in Indiana is in Indianapolis.

SENIOR COMMUNITY SERVICES EMPLOYMENT PROGRAM

This program provides training and employment opportunities for low Income persons age 55 or older who are not working. Through this program, seniors benefit from training, counseling, and community service assignments at faith-based and community organizations in their communities, prior to transitioning into the workforce.

Participants are placed at eligible host agencies (primarily at faith-based and community organizations) for which they are paid the minimum wage for an average of 20 hours per week. A host agency is either a private nonprofit organization (other than a political party) that is tax exempt under section 501(c) (3) of the Internal Revenue code of 1954, or a public agency operated by a unit of government. Most areas of the State are covered. For information and to see if you are eligible, contact:

Experience Works

200 E. Association St., Suite 206B
Ellettsville, IN 47429
866-796-8550
812-522-7930

Senior Service SCSEP Grantees: Indiana

SCSEP participants must be:

- Fifty-five or older
- Legally eligible to work in the U.S.
- Living in a household with income no more than 125 percent of the federal poverty level

Special consideration is given to people who are any of the following:

- Sixty-five and older
- Have a disability
- Have limited English proficiency or low literacy skills
- Live in a rural area
- Are a veteran
- Have low employment prospects
- Are homeless or at risk of homelessness

Other Indiana Program are found in:

- Bridges Community Services, Inc (Muncie)
- Catholic Charities Fort Wayne—South Bend (Fort Wayne)
- Northern Indiana Workforce Board (St. Joseph)

DISCOUNTS

Banks, utility companies, stores and other businesses sometimes offer discounts or other special considerations to older adults.

If there is a disability component to the discount, you may be asked to show proof of any disability by getting a written document from your doctor.

For further information about parking privileges for the disabled, contact your local license bureau.

To save money on prescription drugs, ask your doctor about generic drugs. Generic drugs are drugs identified by their chemical names instead of brand names. They are often much less expensive than brand name drugs.

Members of United Senior Action (USA) who are 60 or older can participate in USA's Discount Plan and receive discounts at many places. Most of these places are in central Indiana, but the program is expanding statewide and older persons anywhere in Indiana can participate by joining USA. USA is a

coalition of groups interested in senior citizens. Individuals as well as organizations can join. To find out about USA's Discount Plan, call or write:

United Senior Action
324 W. Morris St., #114
Indianapolis, IN 46225
(317) 634-0872

PARKING FOR PERSONS WITH DISABILITIES

Many parking lots now reserve special parking spaces for physically disabled persons. Any car that parks in these spaces must have a special disability placard or license plate. Disability parking privileges may be granted either on a temporary or permanent basis by completing an application form from the Bureau of Motor Vehicles ("BMV"). A person of any age may be eligible for a placard if he or she (1) has a temporary or permanent physical disability that requires him to use a wheelchair, walker, braces or crutches, or (2) has temporarily or permanently lost the use of one or both legs, or (3) is certified by a doctor as being severely restricted in mobility, either temporarily or permanently, by a heart condition, arthritis or orthopedic or neurological impairment. A doctor licensed in Indiana must sign the application to apply for either temporary or permanent disability parking privileges. Placards for those who have a permanent disability are available at no cost. Temporary disability placards are available for a \$5.00 fee. Persons who

transport these eligible disabled persons may also obtain a placard.

A person may apply for a disability license plate if he or she (1) has a permanent disability requiring the use of a wheelchair, walker, braces or crutches, (2) has permanently lost the use of one or both legs, (3) experiences restricted mobility due to certain medical conditions, or (4) is permanently blind or visually impaired. Disability license plates are available for the cost of vehicle registration and taxes. Certain disabled veterans may be eligible to apply for a Disabled Hoosier Veteran license plate by submitting a separate form to the BMV, which must be certified by Indiana's Department of Veterans' Affairs. A disability parking placard must be displayed on the vehicle's dashboard or rear view mirror. A disabled person who is eligible may use the placard in any vehicle in which he or she is riding.

Placards or license plates for those who are permanently disabled do not expire until a physician certifies that the person is no longer under a disability. Temporary placards expire either six (6) months from the date of issuance, or on the date indicated by the person's physician, whichever occurs first. If you have a placard with an expiration date, you will need to re-apply to continue disability parking privileges.

It is against the law to misrepresent your eligibility for a placard or to use the placard when no one in the car at the time is eligible.

Forms to apply for disability parking placards or license plates are available at BMV branch locations and on the BMV website at www.in.gov/BMV.

Resource Guide

LAWYER REFERRAL SERVICES

For your local bar association president to make a referral in your county, contact:

Indiana State Bar Association
One Indiana Square, Suite 530
Indianapolis, IN 46204
(317) 639-5465
(800) 266-2581

<http://www.inbar.org/>

(The Indiana State Bar Association will only provide you with the contact information for the local bar president who will in turn make a referral)

Allen County Bar Association
924 South Calhoun Street
Fort Wayne, IN 46802
(260) 423-2358
www.allencountybar.com

Evansville Bar Association
123 N.W. 4th Street, Suite 18
Evansville, IN 47708
(812) 426-1712
www.evvbar.org/

Indianapolis Bar Association
107 N. Pennsylvania Street
Suite 200
Indianapolis, IN 46204
(317) 269-2000
www.indybar.org

Lake County Bar Association
291 W. 84th Drive, Suite B
Merrillville, IN 46410
(219) 738-1905
www.lakecountybar.com

Marion County Bar Association
617 Indiana Avenue, Suite 211
Indianapolis, IN 46202
(317) 634-3950

St. Joseph County Bar Association
101 S. Main Street
South Bend, IN 46601
(574) 235-9657
www.sjcba.org

Terre Haute Bar Association
506 Ohio Street, Suite 7
Terre Haute, IN 47808
(812) 234-8800

LEGAL SERVICE PROVIDERS

District A

Counties: Lake, Jasper, Newton, and Porter

These providers assist people who are low-income.



NWI Volunteer Attorneys, Inc.

Serving only residents of all counties in District A
Assistance possible for the following legal issues:
Adoption, Bankruptcy, Consumer, Paternity, Custody, Child Support, Parenting Time, Dissolution of Marriage, Domestic Violence, Landlord/Tenant, Foreclosure Defense, Public Benefits, Wills/POA/Guardianships, and Non-profit corps. NO criminal, traffic/drivers license, juvenile delinquency or cases for money damages.

651 E. Third Street

P.O. Box 427

Hobart, IN 46342

To apply: (219) 945-1799

To apply: (866) 945-1799

Attorneys only: (219) 942-3404

(219) 945-0995 (f)

probono@hobartlaw.net

Download an application and links to other legal resources:www.nwivolunteerlawyers.org

Indiana Legal Services Inc. - Merrillville

Serving only residents of all counties in District A
Assistance possible for the following legal issues:
Family Law, Consumer Law, Senior Law, Housing, and Public Benefits

7863 Broadway

Suite 205

Merrillville, IN 46410

(219) 738-6040

(888) 255-5104

(219) 738-6050 (f)

Spanish speaking assistance available

Intake hours:

Monday and Wednesday 9:00-11:00 a.m. (walk-ins)

Tuesday 9:00-11:00 a.m. (telephone calls)

lsnwi@mail.icongrp.com

<http://www.indianajustice.org/>

Indiana Legal Services, Inc. - Hammond

Serving residents of Lake and Porter Counties

Assistance possible for the following legal issues:

Family Law, Consumer Law, Senior Law, Housing, and Public Benefits

Greater Hammond Community Center

824 Hoffman

Hammond, IN 46320

(219) 853-2360

(219) 853-2397 (f)

Spanish speaking staff available

Intake hours: Tuesday 9:00 a.m.-11:00 a.m. (Housing);

Wednesday 1:00 p.m.-3:00 p.m. (General, no housing or family); Thursday 9:00 a.m.-11:00 a.m. (Family)

<http://www.indianajustice.org/>

Valparaiso School of Law Clinic

Serving residents of or legal issues in Porter County only

Assistance possible for the following legal issues:

Immigration, Criminal, General Civil, Juvenile, Domestic Violence, Mediation, Tax and Post-Conviction

Heritage Hall

510 Freeman Street

Valparaiso, IN 46383

(219) 465-7903

valpolaw@valpo.edu

<http://www.valpo.edu/law/clinic/>

Intake September through March

Lake County Family Court Assistance

Serving residents of Lake County who have a domestic relations matter in Lake County Courts

Volunteer attorneys can provide basic information

and assistance in completing the State of Indiana pre-printed forms regarding domestic relations matters.

Contact the Family Court Coordinator to determine eligibility and set up an appointment for services.

(219) 881-6157

Office Hours: Monday-Friday 8:30 a.m.-4:00 p.m.

Neighborhood Christian Legal Clinic

Serving residents of Lake County only

Assistance possible for the following legal issues:

Landlord/Tenant, Guardianship, Custody/Visitation, Immigration, Bankruptcy, Child Support, Housing/Foreclosure, Wills/Estate, Disability Benefits, Discrimination, Consumer/Debt, and Tax Controversies. No Criminal issues or Divorce cases.

Must attend an Intake to receive assistance.

Intake sessions in Lake County:

Second Wednesday of Every Month

Registration begins at 9:00 a.m. CST

Catholic Charities

940 Broadway

Gary, IN 46402

Second Wednesday of Every Month

Registration begins at 11:30 a.m. CST

Catholic Charities

3901 Fir Street

East Chicago, IN 46312

Visit the website for more information: <http://www.nclegalclinic.org/intakeschedule.aspx>

City of Hammond Legal Aid Clinic Department

Serving residents of the City of Hammond only

Assistance possible for the following legal issues:

Consumer, Public Benefits, Housing, Educational, Guardianships, Landlord/Tenant Disputes, Wills, Living Wills and Family Law

5231 Hohman Avenue

Suite 605

Hammond, Indiana 46320

(219) 853-6611

(219) 853-6313 (f)

Monday-Friday 8:30-4:30 p.m.

<http://www.gohammond.com/web/index.php?legalaidclinic>

American Civil Liberties Union of Indiana

Serving residents of Indiana

Assistance possible for the following legal issues:
Civil Liberties or Constitutional Rights Violations

1031 E. Washington St.

Indianapolis, IN 46202

(317) 635-4059 ext. 102

<http://aclu-in.org/>

Online form can be found at: <http://www.formstack.com/forms/?1157118-hfibE7kI4V>

Disability Legal Services of Indiana, Inc.

Serving residents of Indiana

Assistance possible for the following legal issues:

Adults and children with disabilities who have issues in educational matters, probate, and disability law compliance

5954 N. College Avenue

Indianapolis, IN 46220

(317) 426-7733

(317) 282-0608 (f)

Cannot offer legal advice or answer legal questions over the phone

Visit the website to complete an intake form: <http://www.disabilitylegalservicesindiana.org/>

Hoosier Environmental Council

Serving residents of Indiana

Assistance possible for the following legal issues:

Environmental and Land-Use Issues

3951 N. Meridian

Suite 100

Indianapolis, IN 46208

(317) 685-8800

(317) 686-4794 (f)

<http://www.hecweb.org/about/legal-defense-fund/>

District B

Counties: Elkhart, Kosciusko, LaPorte, Marshall, St. Joseph, and Starke

These providers assist people who are low-income.



The Volunteer Lawyer Network, Inc.

Serving only residents of all counties in District B.

Assistance possible for the following legal issues: Family Law, Adoptions, Guardianships, Foreclosure, Landlord/Tenant, Consumer/Collections, Estate Law, Wills, Power of Attorneys, Health Care Directives, Contracts, Real Estate, Bankruptcy, and Immigration

P.O. Box 1358
117 1/2 N. Main Street
South Bend, IN 46624
(574) 277-0075
(574) 277-2055 (f)

Office Hours: Monday-Friday 8:00 a.m.-4:00 p.m.
volunteerinc@att.net

www.volunteerlawyernetwork.org/

Indiana Legal Services South Bend Office

Serving only residents of all counties of District B

Assistance possible for the following legal issues: Family Law, Consumer Law, Senior Law, Housing Issues, and Public Benefits

401 E. Colfax
Suite 116
The Commerce Center
South Bend, IN 46617
(574) 234-8121

(800) 288-8121
Fax: (574) 239-2185

Intake hours: Monday-Friday 9:00 a.m.-3:00 p.m.

<http://www.indianajustice.org/>

Notre Dame Legal Aid Clinic

Assistance possible for the following legal issues: Mental Health Advocacy, Foreclosures, Collections, Landlord/Tenant, and Disability Benefits. No Criminal, Divorce, Visitation, Child Support, Custody, or Bankruptcy.

725 Howard Street
South Bend, IN 46617
(574) 631-7795
(574) 631-6725 (f)

<http://law.nd.edu/legal-aid-clinic/>

Will accept cases in the months of September, October, January, and February

Neighborhood Christian Legal Clinic

Serving residents of LaPorte County

Assistance possible for the following legal issues: Landlord/Tenant, Guardianship, Custody/Visitation, Immigration, Bankruptcy, Child Support, Housing/Foreclosure, Wills/Estate, Disability Benefits, Discrimination, Consumer/Debt, and Tax Controversies. No Criminal issues or Divorce cases.

Intake: Second Wednesday of Every Month
Registration begins at 2:00 p.m. CST
Catholic Charities
321 W. Eleventh Street
Michigan City, IN 46360

Visit the website for more information: <http://www.nclegalclinic.org/intakeschedule.aspx>

Just Help: Elkhart County Legal Advocacy Center, Inc.

Serving only residents of Elkhart County

Provides legal advice and assistance on general civil issues on a sliding scale (reduced) fee

400 W. Lincoln Avenue
Goshen, IN 46526
(574) 537-8592
(574) 533-7666 (f)
info@justhelplegal.org
<http://www.justhelplegal.org/>

Office Hours: Monday, Wednesday, and Friday 8:30 a.m.-12:00 p.m. and 1:00 p.m.-4:30 p.m.

Elkhart Legal Aid Services, Inc.

Serving only residents of Elkhart County

Assistance possible for the following legal issues:
Guardianships, Divorces and Disability Benefits

401 South Second Street
Elkhart, IN 46516
(574) 294-2658
(574) 294-2650 (f)
elkhartlegalaid@aol.com

American Civil Liberties Union of Indiana

Serving residents of Indiana

Assistance possible for the following legal issues: Civil Liberties or Constitutional Rights Violations

1031 E. Washington St.
Indianapolis, IN 46202
(317) 635-4059 ext. 102
<http://aclu-in.org/>

Online form can be found at: <http://www.formstack.com/forms/?1157118-hfibE7kI4V>

Disability Legal Services of Indiana, Inc.

Serving residents of Indiana

Assistance possible for the following legal issues:
Adults and children with disabilities who have issues in educational matters, probate, and disability law compliance

5954 N. College Avenue
Indianapolis, IN 46220
(317) 426-7733
(317) 282-0608 (f)

Cannot offer legal advice or answer legal questions over the phone

Visit the website to complete an intake form: <http://www.disabilitylegalservicesindiana.org/>

Hoosier Environmental Council

Serving residents of Indiana

Assistance possible for the following legal issues:
Environmental and Land-Use Issues

3951 N. Meridian, Suite 100
Indianapolis, IN 46208
(317) 685-8800
(317) 686-4794 (f)
<http://www.hecweb.org/about/legal-defense-fund/>

District C

Counties: Adams, Allen, Dekalb, Huntington, LaGrange, Nobel, Steuben, Wells, and Whitley

These providers assist people who are low-income.



Volunteer Lawyer Program of Northeast Indiana, Inc.

Serving only residents of all counties in District C

Assistance possible for the following legal issues:
Dissolution of Marriage, Adoption, Bankruptcy, Landlord/Tenant, Consumer, Immigration (Allen County only), Collections, Small Claims, Contracts, Real Estate, POA/Wills/Health Care Directives, Estate Law, Guardianships, Social Security Disability, and Tort Defense. No CHINS, Criminal, Driver's licenses issues, or Traffic tickets.

927 S. Harrison Street
Fort Wayne, IN 46802
(260) 407-0917
(877) 407-0917
(260) 407-7137 (f)
terry@vlpnei.org
<http://www.vlpnei.org/>

Office Hours: Monday-Friday 9:00 a.m.-4:30 p.m.

Allen County Bar Association Legal Line

Serving residents of Allen County

Free legal advice for local attorneys
Every Tuesday from 5:00-7:00 p.m.
(260) 423-2358

Neighborhood Christian Legal Clinic

Serving residents of Allen, Dekalb, Huntington, and Noble Counties

Assistance possible for the following legal issues: Landlord/Tenant, Guardianship, Custody/Visitation, Immigration, Bankruptcy, Child Support, Housing/Foreclosure, Wills/Estate, Disability Benefits, Discrimination, Consumer/Debt, and Tax Controversies. No Criminal issues or Divorce cases.

347 W. Berry Street, Suite 101
Fort Wayne, IN 46802
(260) 456-8972
(260) 456-8983 (f)
fwcontact@nclegalclinic.org

Must attend an Intake to receive assistance

Please visit the website to see the Intake schedule: <http://www.nclegalclinic.org/intakeschedule.aspx>

Indiana Legal Services-Fort Wayne

Serving residents of Adams, Allen, Dekalb, Huntington, Steuben, Wells and Whitley Counties

Assistance possible for the following legal issues: Family Law, Consumer Law, Senior Law, Housing Issues, Public Benefits

919 S. Harrison, Suite 200
Fort Wayne, IN 46802
(260) 424-9155
(888) 442-8600
(260) 424-9166 (f)

Intake Hours: Tuesday, Wednesday, and Thursday
9:00 a.m.-11:00 a.m.

<http://www.indianajustice.org/>

American Civil Liberties Union of Indiana

Serving residents of Indiana

Assistance possible for the following legal issues: Civil Liberties or Constitutional Rights Violations

1031 E. Washington St.
Indianapolis, IN 46202
(317) 635-4059 ext. 102
<http://aclu-in.org/>

Online form can be found at: <http://www.formstack.com/forms/?1157118-hfibE7kI4V>

Disability Legal Services of Indiana, Inc.

Serving residents of Indiana

Assistance possible for the following legal issues: Adults and children with disabilities who have issues in educational matters, probate, and disability law compliance

5954 N. College Avenue
Indianapolis, IN 46220
(317) 426-7733
(317) 282-0608 (f)

Cannot offer legal advice or answer legal questions over the phone

Visit the website to complete an intake form: <http://www.disabilitylegalservicesindiana.org/>

Hoosier Environmental Council

Serving residents of Indiana

Assistance possible for the following legal issues: Environmental and Land-Use Issues

3951 N. Meridian, Suite 100
Indianapolis, IN 46208
(317) 685-8800
(317) 686-4794 (f)

<http://www.hecweb.org/about/legal-defense-fund/>

District D

Counties: Benton, Boone, Carroll, Clinton, Fountain, Montgomery, Parke, Tippecanoe, Vermillion, White, and Warren

These providers assist people who are low-income.



District D Pro Bono

Serving only residents of all counties in District D

Same office as Indiana Legal Services-Lafayette

8 N. Third Street, Suite 102

Lafayette, IN 47901

(765) 423-5327

(800) 382-7581

(765) 423-2252 (f)

freeattorney@indianadistrict4.org

<http://www.indianadistrict4.org/>

Online form can be found at: <http://www.indianadistrict4.org/Online-Form.php>

Indiana Legal Services, Inc. - Lafayette

Serving residents of Benton, Carroll, Clinton, Fountain, Montgomery, Tippecanoe, Vermillion, Warren, and White Counties

Assistance possible for the following legal issues: Family Law, Consumer Law, Senior Law, Housing Issues, and Public Benefits

8 N. Third Street, Suite 102

Lafayette, IN 47901

(765) 423-5327

(800) 382-7581

(765) 423-2252 (f)

Office Hours: Monday-Friday 8:00 a.m.-12:00 p.m. & 1:00 p.m.-4:30 p.m.

<http://www.indianajustice.org/>

Indiana Legal Services, Inc.-Indianapolis

Serving residents of Boone County

Assistance possible for the following legal issues: Family Law, Consumer Law, Senior Law, Housing Issues, and Public Benefits

Market Square Center

151 North Delaware

Suite 1800

Indianapolis, IN 46204

(317) 631-9410

(800) 869-0212

(317) 631-9775 (f)

Spanish speaking staff available

Intake Hours by Telephone: Monday and Friday 9:00 a.m.-11:00 a.m. and Wednesday 1:00 p.m.-3:00 p.m.

Intake Hours by Walk-in: Wednesday 9:00-11:00 a.m. and Tuesday and Thursday 1:00 p.m.-3:00 p.m.

<http://www.indianajustice.org/>

Indiana Legal Services, Inc.-Bloomington

Serving residents of Parke County

Assistance possible for the following legal issues: Family Law, Consumer Law, Housing Issues, and Public Benefits

College Square

Second Floor

214 South College Avenue

Bloomington, IN 47404

(812) 339-7668

(800) 822-4774

(812) 339-2081 (f)

Office Hours: Monday-Friday 8:30 a.m.-5:00 p.m.

<http://www.indianajustice.org/>

Indiana Legal Services, Inc.-Columbus

Serving senior residents of Parke County (60+ years old)

Assistance possible for the following legal issues: Senior Law

Area XI Council on Aging

1531 13th Street, Suite G

Columbus, IN 47201-1302

(812) 372-6918

(866) 644-6407

(812) 372-7846 (f)

<http://www.indianajustice.org/>

Neighborhood Christian Legal Clinic

Serving residents of Boone County

Assistance possible for the following legal issues:

Landlord/Tenant, Guardianship, Custody/Visitation, Immigration, Bankruptcy, Child Support, Housing/Foreclosure, Wills/Estate, Disability Benefits, Discrimination, Consumer/Debt, and Tax Controversies. No Criminal issues or Divorce cases.

Must attend an Intake to receive assistance. Below are the Intake sessions in Boone County:

First, Third, and Fifth Saturday of Every Month

Registration begins at 9:00 a.m.

First Presbyterian Church of Lebanon

128 E. Main Street

Lebanon, IN 46052

Second and Fourth Saturday of Every Month

Registration begins at 9:00 a.m.

Zionsville Presbyterian Church

4775 W. 116th Street

Zionsville, IN 46077

Visit the website for more information: <http://www.nclegalclinic.org/intakeschedule.aspx>

Indianapolis Legal Aid Society

Serving residents of Boone County

Assistance possible for the following legal issues: Adoption, Paternity, Visitation, Guardianship, Support, Custody, Divorce, Housing, Bankruptcy, and Debt Collection. No assistance for fee-generating cases and criminal issues.

615 N. Alabama, Suite 122
Indianapolis, IN 46204
(317) 635-9538
(317) 631-4423 (f)

Office Hours: Monday-Friday 9:00 a.m.-5:00 p.m.

<http://www.indylas.org/index.php>

Legal Aid Corporation of Tippecanoe County, Inc.

Serving residents of Tippecanoe County with a legal issue in Tippecanoe County

Assistance possible for the following legal issues: Adoption, Guardianship, Child Support, Name Changes, Custody and Visitation Rights, Paternity, Divorce and Separation, Juveniles and CHINS, Landlord/Tenant, Mental Commitments, Debt Collection Defense, and Contract Defense

212 N. 5th St.
Lafayette, IN 47901-1404
(765) 742-1068
(765) 742-1069 (f)

Office Hours: Monday-Friday 8:00 a.m.-4:00 p.m.

<http://tclegalaid.org/>

American Civil Liberties Union of Indiana

Serving residents of Indiana

Assistance possible for the following legal issues: Civil Liberties or Constitutional Rights Violations

1031 E. Washington St.
Indianapolis, IN 46202
(317) 635-4059 ext. 102
<http://aclu-in.org/>

Online form can be found at: <http://www.formstack.com/forms/?1157118-hfibE7kI4V>

Disability Legal Services of Indiana, Inc.

Serving residents of Indiana

Assistance possible for the following legal issues: Adults and children with disabilities who have issues in educational matters, probate, and disability law compliance

5954 N. College Avenue
Indianapolis, IN 46220
(317) 426-7733
(317) 282-0608 (f)

Cannot offer legal advice or answer legal questions over the phone

Visit the website to complete and intake form: <http://www.disabilitylegalservicesindiana.org/>

Hoosier Environmental Council

Serving residents of Indiana

Assistance possible for the following legal issues: Environmental and Land-Use Issues

3951 N. Meridian
Suite 100
Indianapolis, IN 46208
(317) 685-8800
(317) 685-4794 (f)

<http://www.hecweb.org/about/legal-defense-fund/>

District E

Counties: Cass, Fulton, Grant, Howard, Miami, Pulaski, Tipton, and Wabash

These providers assist people who are low-income.



District E Pro Bono

Serving only residents of all counties in District E

Same office as Indiana Legal Services—Lafayette

8 N. Third Street

Suite 102

Lafayette, IN 47901

(765) 423-5327

(765) 423-2252 (f)

(800) 382-7581

Indiana Legal Services Inc.—Lafayette

Serving residents of Cass, Howard, Miami, Tipton,
and Wabash Counties

Assistance possible for the following legal issues:
Family Law, Consumer Law, Senior Law, Housing
Issues, Public Benefits

8 N. Third Street

Lafayette, IN 47901

(800) 382-7581

(765) 423-5327

(765) 423-2252 (f)

Office Hours: Monday-Friday 8:00 a.m.-12:00 p.m.
and 1:00 p.m.-4:30 p.m.

<http://www.indianajustice.org/>

Indiana Legal Services—South Bend

Serving residents of Fulton and Pulaski Counties

Assistance possible for the following legal issues:
Family Law, Consumer Law, Senior Law, Housing
Issues, Public Benefits

401 E. Colfax

Suite 116

The Commerce Center

South Bend, IN 46617

(574) 234-8121

(800) 288-8121

(574) 239-2185 (f)

Intake Hours: Monday-Friday 9:00 a.m.-3:00 p.m.

<http://www.indianajustice.org/>

Indiana Legal Services-Fort Wayne

Serving residents of Grant County

Assistance possible for the following legal issues:
Family Law, Consumer Law, Senior Law, Housing
Issues, Public Benefits

919 S. Harrison, Suite 200

Fort Wayne, IN 46802

(260) 424-9155

(888) 442-8600

(260) 424-9166 (f)

Intake Hours: Tuesday, Wednesday, Thursday 9:00
a.m.-11:00 a.m.

<http://www.indianajustice.org/>

Miami County Bar Association

Serving residents of Miami County

Judge Daniel Banina

Superior Court Courthouse

25 N. Broadway

Peru, IN 46970

(765) 472-3901

Howard County Legal Aid Program

Serving residents of Howard County

Howard County Bar Association

Brent Dechert

P.O. Box 667

Kokomo, IN 46903

(765) 459-0764

American Civil Liberties Union of Indiana

Serving residents of Indiana

Assistance possible for the following legal issues:
Civil Liberties or Constitutional Rights Violations

1031 E. Washington St.

Indianapolis, IN 46202

(317) 635-4059 ext. 102

<http://aclu-in.org/>

Online form can be found at: <http://www.formstack.com/forms/?1157118-hfibE7ki4V>

Disability Legal Services of Indiana, Inc.

Serving residents of Indiana

Assistance possible for the following legal issues:
Adults and children with disabilities who have issues
in educational matters, probate, and disability law
compliance

5954 N. College Avenue

Indianapolis, IN 46220

(317) 426-7733

(317) 282-0608 (f)

Cannot offer legal advice or answer legal questions
over the phone

Visit the website to complete an intake form: <http://www.disabilitylegalservicesindiana.org/>

Hoosier Environmental Council

Serving residents of Indiana

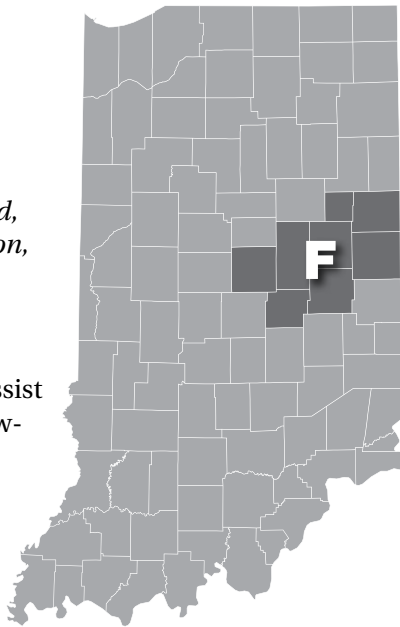
Assistance possible for the following legal issues:
Environmental and Land-Use Issues

3951 N. Meridian
Suite 100
Indianapolis, IN 46208
(317) 685-8800
(317) 685-4794 (f)
<http://www.hecweb.org/about/legal-defense-fund/>

District F

*Counties: Blackford,
Delaware, Hamilton,
Hancock, Henry,
Jay, Madison, and
Randolph*

These providers assist
people who are low-
income.



District 6 Access to Justice, Inc.

Serving only residents of all counties in District F
Assistance possible for the following legal issues:
Guardianship, Mortgage Foreclosures, Divorce, Small
Estates, Landlord/Tenant, and other civil matters.
No Criminal, Fee-Generating Cases, or Immediate
Assistance.

P.O. Box 324
New Castle, IN 47362
(800) 910-4407
(765) 521-0790 (f)
www.myjustice.org/
district6access@hotmail.com

You may type your responses directly into the
form and then print the form to turn in to Legal
Volunteers. This document is only valid for use with
Access to Justice, Inc. in District 6.

Indiana Legal Services - Fort Wayne

Serving residents of Blackford and Jay Counties
Assistance possible for the following legal issues:
Family Law, Consumer Law, Senior Law, Housing
Issues, and Public Benefits

919 S. Harrison, Suite 200
Fort Wayne, IN 46802
(888) 442-8600
(260) 424-9155
(260) 424-9166 (f)

Intake Hours: Tuesday, Wednesday and Thursday,
9:00 a.m.-11:00 a.m.

<http://www.indianajustice.org/>

Indiana Legal Services - Indianapolis

Serving residents of Delaware, Hamilton, Hancock,
Henry, Madison, and Randolph Counties

Assistance possible for the following legal issues:
Family Law, Consumer Law, Senior Law, Housing
Issues, and Public Benefits

Market Square Center
151 N. Delaware, Suite 1800
Indianapolis, IN 46204
(800) 869-0212
(317) 631-9410
(317) 631-9775 (f)

Telephone intake hours: Monday and Friday, 9:00
a.m.-11:00 a.m.; Wednesday, 1:00 p.m.-3:00 p.m.

Walk-in intake hours: Wednesday, 9:00 a.m.-11:00
a.m.; Tuesday and Thursday, 1:00 p.m.-3:00 p.m.

<http://www.indianajustice.org/>

Indianapolis Legal Aid Society

Serving residents of Hamilton and Hancock Counties

Assistance possible for the following legal issues:
Adoption, Paternity, Visitation, Guardianship,
Support, Custody, Divorce, Housing,
Bankruptcy, and Debt Collection. No assistance for
fee-generating cases and criminal issues.

615 N. Alabama, Suite 122
Indianapolis, IN 46204
(317) 635-9538
(317) 631-4423 (f)

Office Hours: Monday-Friday 9:00 a.m.-5:00 p.m.
<http://www.indylas.org/index.php>

Neighborhood Christian Legal Clinic

Serving residents of Hamilton County

Assistance possible for the following legal issues:
Landlord/Tenant, Guardianship, Custody/
Visitation, Immigration, Bankruptcy, Child Support,
Housing/Foreclosure, Wills/Estate, Disability
Benefits, Discrimination, Consumer/Debt, and Tax
Controversies. No Criminal issues or Divorce cases.

Must attend the Intake to receive assistance:
Every Thursday

Registration begins at 12:00 p.m.
First Presbyterian Church of Noblesville
1207 Conner Street
Noblesville, IN 46060

Visit the website for more information: <http://www.nclegalclinic.org/intakeschedule.aspx>

Delaware County Bar Association

Serving residents of Delaware County

Delaware County Legal Aid
(765) 254-1606 (voice mail only)

Hancock County Legal Aid

Serving residents of Hancock County with a case in
Hancock County

Intake 2nd & 4th Wednesday at 3:00-4:30 p.m.
First Floor Courtroom of Courthouse in Greenfield
9 E. Main Street #302
Greenfield, IN 46140-2320

Must complete a Hancock County Legal Aid
application prior to meeting, which can be found
on the second floor outside the Clerk's office or on
the website at: <http://hancockcoingov.org/hancock-county-indiana-legal-aid.html>

American Civil Liberties Union of Indiana

Serving residents of Indiana

Assistance possible for the following legal issues:

Civil Liberties or Constitutional Rights Violations

1031 E. Washington St.
Indianapolis, IN 46202

(317) 635-4059 ext. 102
<http://aclu-in.org/>

Online form can be found at: <http://www.formstack.com/forms/?1157118-hfibE7kI4V>

Disability Legal Services of Indiana, Inc.

Serving residents of Indiana

Assistance possible for the following legal issues:
Adults and children with disabilities who have issues
in educational matters, probate, and disability law
compliance

5954 N. College Avenue
Indianapolis, IN 46220
(317) 426-7733
(317) 282-0608 (f)

Cannot offer legal advice or answer legal questions
over the phone

Visit the website to complete an intake form: <http://www.disabilitylegalservicesindiana.org/>

Hoosier Environmental Council

Serving residents of Indiana

Assistance possible for the following legal issues:
Environmental and Land-Use Issues

3951 N. Meridian, Suite 100
Indianapolis, IN 46208
(317) 685-8800
(317) 686-4794 (f)

<http://www.hecweb.org/about/legal-defense-fund/>

District G

Counties: Marion Only

These providers assist people who are low-income.



Heartland Pro Bono Council

Serving residents of Marion County

Heartland refers low-income individuals with civil legal needs to volunteer attorneys.

(317) 400-7435

<http://www.heartlandprobono.org/>

Indianapolis Bar Association

Legal Line: Second Tuesday of every month from 6:00-8:00 pm. (317) 269-2000. Phone-in only

Bankruptcy Legal Line: Second and Fourth Wednesday of the month from 12:00-1:00 pm.

(317) 269-1910. Phone-in only

<http://www.indybar.org/>

Indiana Legal Services - Indianapolis

Serving residents of Marion County

Assistance possible for the following legal issues: Family Law, Consumer Law, Senior Law, Housing Issues, and Public Benefits

Market Square Center
151 N. Delaware, Suite 1800
Indianapolis, IN 46204

(317) 631-9410

(800) 869-0212

(317) 631-9775 (f)

Telephone intake hours: Monday and Friday 9:00 a.m.-11:00 a.m.; Wednesday 1:00 p.m.-3:00 p.m.

Walk-in intake hours: Wednesday 9:00 a.m.-11:00 a.m.; Tuesday and Thursday 1:00 p.m.-3:00 p.m.
<http://www.indianajustice.org/>

Neighborhood Christian Legal Clinic

Serving residents of Marion County

Assistance possible for the following legal issues:

Landlord/Tenant, Guardianship, Custody/Visitation, Immigration, Bankruptcy, Child Support, Housing/Foreclosure, Wills/Estate, Disability Benefits, Discrimination, Consumer/Debt, and Tax Controversies. No Criminal issues or Divorce cases.

3333 N. Meridian Street
Indianapolis, IN 46208
(317) 429-4131

Must attend an Intake to receive assistance.

Please visit the website to see the Intake schedule: <http://www.nclegalclinic.org/intakeschedule.aspx>

Indianapolis Legal Aid Society, Inc.

Serving residents of Marion County

Assistance possible for the following legal issues: Family Law, Housing, Debt, Property, and Bankruptcy

615 North Alabama Street
Suite 122
Indianapolis, IN 46204
(317) 635-9538
(317) 631-4423 (f)

Office Hours: Monday-Friday 9:00 a.m.-5:00 p.m.
<http://www.indylas.org/>

Child Advocates, Inc.

Serving residents of Marion County

Assistance possible for the following legal issues: Child advocacy with GAL/CASA volunteers

8200 Haverstick Road, Suite 240
Indianapolis, IN 46240
(317) 205-3055
(317) 205-3060 (f)
<http://www.childadvocates.net/>

Protective Order Pro Bono Project

Serving residents of Marion County

Assistance possible for the following legal issues: Assists victims of domestic and intimate partner violence in obtaining and enforcing orders of protection

Indiana Coalition Against Domestic Violence
1915 W. 18th Street
Indianapolis, IN 46202
(317) 917-3685
(800) 538-3393
<http://www.icadvinc.org/>

American Civil Liberties Union of Indiana

Serving residents of Indiana
Assistance possible for the following legal issues:
Civil Liberties or Constitutional Rights Violations
1031 E. Washington St.
Indianapolis, IN 46202
(317) 635-4059 ext. 102
<http://aclu-in.org/>
Online form can be found at: <http://www.formstack.com/forms/?1157118-hfibE7kl4V>

Disability Legal Services of Indiana, Inc.

Serving residents of Indiana
Assistance possible for the following legal issues:
Adults and children with disabilities who have issues
in educational matters, probate, and disability law
compliance
5954 N. College Avenue
Indianapolis, IN 46220
(317) 426-7733
(317) 282-0608 (f)
Cannot offer legal advice or answer legal questions
over the phone
Visit the website to complete an intake form: <http://www.disabilitylegalservicesindiana.org/>

Hoosier Environmental Council

Serving residents of Indiana
Assistance possible for the following legal issues:
Environmental and Land-Use Issues
3951 N. Meridian, Suite 100
Indianapolis, IN 46208
(317) 685-8800
(317) 686-4794 (f)
<http://www.hecweb.org/about/legal-defense-fund/>

District H

*Counties: Clay,
Greene, Hendricks,
Lawrence, Monroe,
Morgan, Owen and
Putnam*

These providers assist
people who are low-
income.



District 10 Pro Bono Project, Inc.

Serving only residents of all counties in District H
Assistance possible for the following legal issues:
Family Law, Housing, Credit, and Public Benefits
P.O. Box 8382
Bloomington, IN 47407-8382
(812) 339-3610
(800) 570-1787
(812) 339-3624 (f)
Email: dist10probono@gmail.com

Indiana Legal Services, Inc. - Bloomington

Serving residents of Clay, Greene, Lawrence, Monroe,
Morgan, Owen, and Putnam Counties
Assistance possible for the following legal issues:
Family Law, Consumer Law, Senior Law, Housing,
and Public Benefits
214 S. College Avenue
Bloomington, IN 47404
(812) 339-7668
(800) 822-4774
(812) 339-2081(f)
Office Hours: Monday-Friday 8:30 a.m.-5:00 p.m.
<http://www.indianajustice.org/>

Indiana Legal Services, Inc. - Columbus

Serving 60+ years old residents of Clay, Greene, Lawrence, Monroe, Morgan, Owen, and Putnam Counties

Assistance possible for the following legal issues:
Senior Law issues

Area XI Council on Aging
1531 13th Street, Suite G
Columbus, IN 47201-1302
(812) 372-6918
(866) 644-6407
(812) 372-7846 (f)
<http://www.indianajustice.org/>

Indiana Legal Services, Inc. - Indianapolis

Serving residents of Hendricks County

Assistance possible for the following legal issues:
Family Law, Consumer Law, Senior Law, Housing, and Public Benefits

Market Square Center
151 North Delaware, Suite 1800
Indianapolis, IN 46204
(317) 631-9410
(800) 869-0212
(317) 631-9775

Spanish speaking staff available

Intake hours by telephone: Monday and Friday 9:00 a.m.-11:00 a.m.; Wednesday 1:00 p.m.-3:00 p.m.

Intake hours by walk ins: Wednesday 9:00 a.m.-11:00 a.m.; Tuesday and Thursday 1:00 p.m.-3:00 p.m.
<http://www.indianajustice.org/>

Indianapolis Legal Aid Society

Serving residents of Hendricks and Morgan Counties

Assistance possible for the following legal issues:
Adoption, Paternity, Visitation, Guardianship, Support, Custody, Divorce, Housing, Bankruptcy, and Debt Collection. No assistance for fee-generating cases and criminal issues.

615 N. Alabama, Suite 122
Indianapolis, IN 46204
(317) 635-9538
(317) 631-4423 (f)

Office Hours: Monday-Friday 9:00 a.m.-5:00 p.m.
<http://www.indylas.org/index.php>

Hendricks County Pro Bono Program

Serving residents of Hendricks County

Assistance possible for the following legal issues:
Family Law, Employment, Real Estate, Medicaid, Medicare, SSI, Consumer Warranty, Guardianships, and Protective Orders. No Criminal, Personal Injury, Traffic, Small Claims, Drivers licenses, and Bankruptcy.

Intake third Wednesday of month, 10:00 a.m.-12:00 p.m.

47 W. Marion St. (Southside of Courthouse)
Danville, IN
(317) 529-7293

Legal advice is not given over the phone

To obtain or submit an application for legal assistance on line, please go to:
<http://www.hendrickscountybar.org/legal-aid/>

Morgan County Legal Aid

Serving residents of Morgan County

Please attend an intake at 4:30 p.m. on third Wednesday of the month

Morgan County Courthouse, Second Floor
10 East Washington Street
Martinsville, IN 46151

Owen County Counsel in the Court

Serving residents of Owen County

Assistance possible for the following legal issues:
Family law

First and Third Friday of the month 10:00 a.m.-2:00 p.m.

Owen County Courthouse
60 S. Main Street #104
Spencer, IN

Monroe County Counsel in the Court

Serving residents of Monroe County

To receive assistance for family law issues please visit:
Every Friday 10:00 a.m.-12:30 p.m.

Monroe County Justice Building
301 N. College Avenue
Bloomington, IN 4704

To receive assistance for collections issues please visit:
Every Friday 1:30 p.m.-3:00 p.m.

Monroe County Justice Building
301 N. College Avenue
Bloomington, IN 4704

Indiana University Maurer School of Law Legal Clinics

Community Legal Clinic

Represents clients in Family Law cases. Referrals accepted: early January, May, and September

Indiana University Maurer School of Law
The Community Legal Clinic
211 S. Indiana Avenue
Bloomington, IN 47405
(812) 855-9229
(812) 855-5128 (f)
gphero@indiana.edu
<http://law.indiana.edu/about/outreach/community.shtml>

Protective Order Project

Assists victims of domestic violence in obtaining protective orders from the courts. Students and attorneys represent clients in civil cases.

Indiana University Maurer School of Law
The Protective Order Project
Indiana University School of Law
211 S. Indiana Avenue
Bloomington, IN 47405
(812) 855-4800
pop@indiana.edu
<http://www.law.indiana.edu/pop>

Family and Children Mediation Clinic

Provides pro bono domestic relations mediations (e.g., cases involve issues related to dissolution, custody, and parenting time). Monroe and Owen County Family Courts refer court-ordered cases to this clinic; however, this clinic also conducts pro bono domestic relations mediations if all parties involved consent.

Indiana University Maurer School of Law
The Family and Children Mediation Clinic
211 S. Indiana Avenue
Bloomington, IN 47405
(812) 855-9229
(812) 855-5128 (f)
gphero@indiana.edu
<http://www.law.indiana.edu/about/outreach/family.shtml>

Elder Law Clinic

Provides legal assistance to clients age 60 and older on a wide range of civil legal problems in areas like housing, consumer law, tax, advance directives, and family law.

Elder Law Clinic
c/o Indiana Legal Services, Inc.
242 W. 7th St.
Bloomington, IN 47404.
(812) 339-7668
(800) 822-4774
(812) 339-2081 (f)
jamie.andree@ilsa.net
jeff.gold@ilsa.net
<http://www.law.indiana.edu/about/outreach/elder.shtml>

Entrepreneurship Law Clinic

Provides business entrepreneurs legal assistance with financial planning, organization, licenses, agreements, regulatory and zoning compliance, and intellectual property issues.

Indiana University Maurer School of Law
The Entrepreneurship Law Clinic
211 S. Indiana Avenue
Bloomington, IN 47405
(812) 856-2809
needm@indiana.edu (Mark E. Need, Director)
www.law.indiana.edu/students/clinic/elmore.shtml

Tenant Assistance Project (“TAP”)

TAP uses law students supervised by an attorney to assist tenants facing immediate eviction. Tenants access TAP 1 or 2 days per week at the Monroe County Courthouse outside of the courtroom where evictions are held. Tenants receive advice and help on the day of their hearings identifying defenses, negotiating with landlords and presenting defenses to the court. TAP provides no extended representation and refers tenants needing it to other sources of legal assistance.

(812) 339-7668
jennifer.prusak@ilsa.net
<http://www.law.indiana.edu/about/outreach/tenant.shtml>

The Conservation Law Center

Provides legal services to nonprofit organizations and other clients in support of natural resource conservation.

Indiana University Maurer School of Law
The Conservation Law Center

211 S. Indiana Avenue
Bloomington, IN 47405
(812) 856-0229
(812) 855-1828 (f)
admin@conservationlawcenter.org
www.law.indiana.edu/students/clinic/conservation.shtml

Indiana University Student Legal Services

Provides legal services to currently registered IU Bloomington students.

703 East Seventh Street
Bloomington, IN 47405
(812) 855-7867
(812) 855-0555 (f)
<http://www.indiana.edu/~sls>

American Civil Liberties Union of Indiana

Serving residents of Indiana

Assistance possible for the following legal issues:
Civil Liberties or Constitutional Rights Violations

1031 E. Washington St.
Indianapolis, IN 46202
(317) 635-4059 ext. 102
<http://aclu-in.org/>

Online form can be found at: <http://www.formstack.com/forms/?1157118-hfibE7kl4V>

Disability Legal Services of Indiana, Inc.

Serving residents of Indiana

Assistance possible for the following legal issues:
Adults and children with disabilities who have issues in educational matters, probate, and disability law compliance

5954 N. College Avenue
Indianapolis, IN 46220
(317) 426-7733
(317) 282-0608 (f)

Cannot offer legal advice or answer legal questions over the phone

Visit the website to complete an intake form: <http://www.disabilitylegalservicesindiana.org/>

Hoosier Environmental Council

Serving residents of Indiana

Assistance possible for the following legal issues:
Environmental and Land-Use Issues

3951 N. Meridian, Suite 100
Indianapolis, IN 46208
(317) 685-8800
(317) 686-4794 (f)
<http://www.hecweb.org/about/legal-defense-fund/>

District I

Counties:

*Bartholomew, Brown,
Decatur, Jackson,
Jennings, Johnson,
Rush, and Shelby*

These providers assist people who are low-income.



Legal Aid-District Eleven, Inc.

Serving only residents of all counties in District I

1531 13th Street, Suite G330
Columbus, IN 47201
(877) 378-0358 (intake line)
(812) 314-2725 (intake line)
(812) 314-2721 (Plan Administrator direct line)
(812) 372-3948 (f)

help@legalaiddistrict11.org
<http://www.legalaiddistrict11.org/index.php>

Phone Intake Hours: Monday, Wednesday, and Friday 10:00 a.m.-12:00 p.m. and Tuesday and Thursday 1:00 p.m.-3:00 p.m.

Indiana Legal Services, Inc. - Bloomington

Serving residents of Bartholomew, Brown, and Jackson Counties

Assistance possible for the following legal issues:
Family Law, Consumer Law, Senior Law, Housing, and Public Benefits

214 S. College Avenue
Bloomington, IN 47404
(812) 339-7668
(800) 822-4774
(812) 339-2081 (f)
Office Hours: Monday-Friday 8:30 a.m.-5:00 p.m.
<http://www.indianajustice.org/>

Indiana Legal Services, Inc. - Indianapolis

Serving residents of Decatur, Johnson, Rush, and Shelby Counties

Assistance possible for the following legal issues:
Family Law, Consumer Law, Senior Law, Housing,
and Public Benefits

Market Square Center
151 North Delaware
Suite 1800
Indianapolis, IN 46204
(317) 631-9410
(800) 869-0212
(317) 631-9775 (f)

Spanish speaking staff available

Intake hours by telephone: Monday and Friday 9:00
am - 11:00 am; Wednesday 1:00 pm -3:00 pm.

Intake hours by walk-ins: Wednesday 9:00 am -11:00
am; Tuesday and Thursday 1:00 pm -3:00 pm.
<http://www.indianajustice.org/>

Indiana Legal Services, Inc. - Columbus

Serving residents 60+ years old of Bartholomew,
Brown and Jackson Counties

Assistance possible for the following legal issues:
Senior Law

Area XI Council on Aging
1531 13th Street, Suite G
Columbus, IN 47201-1302
(812) 372-6918
(866) 644-6407
(812) 372-7846 (f)
<http://www.indianajustice.org/>

Indiana Legal Services, Inc. - New Albany

Serving residents of Jennings County

Assistance possible for the following legal issues:
Family Law, Consumer Law, Senior Law, Housing,
and Public Benefits

3303 Plaza Drive
Suite 5
New Albany, IN 47150
(812) 945-4123
(800) 892-2776
(812) 945-7290 (f)

Intake hours: Monday 9:00 a.m.-11:00 a.m.
(General); Thursday 9:00-11:00 a.m. (Divorce)

<http://www.indianajustice.org/>

Indianapolis Legal Aid Society, Inc.

Serving residents of Johnson and Shelby Counties

Assistance possible for the following legal issues:
Adoption, Paternity, Visitation, Guardianship,
Support, Custody, Divorce, Housing,
Bankruptcy, and Debt Collection. No assistance for
fee-generating cases and criminal issues.

615 N. Alabama, Suite 122
Indianapolis, IN 46204
(317) 635-9538
(317) 631-4423 (f)

Office Hours: Monday-Friday 9:00 a.m.-5:00 p.m.
<http://www.indylas.org/index.php>

Johnson County Legal Aid

Serving residents of Johnson County

Assistance possible for general civil legal issues. No
income generating cases, disability, criminal,
custody, and driver's license issues.

Intake 2nd and 4th Tuesdays, 10:00 a.m.
Greenwood Public Library
310 S. Meridian Street, Greenwood
Intake 3rd Tuesday, 12:00 p.m.
Law Library, Johnson County Courthouse
Franklin, IN

Shelby County Legal Aid

Serving residents of Shelby County

Intake by appointment only
Monday-Thursday, 9:00 a.m.-11:00 a.m.

Evette Spurling
Room 201 Courthouse Annex
25 W. Polk
Shelbyville, IN
(317) 421-8030

American Civil Liberties Union of Indiana

Serving residents of Indiana

Assistance possible for the following legal issues:
Civil Liberties and Constitutional Rights Violations

1031 E. Washington St.
Indianapolis, IN 46202
(317) 635-4059 ext. 102
<http://aclu-in.org/>

Online form can be found at: <http://www.formstack.com/forms/?1157118-hfibE7kl4V>

Disability Legal Services of Indiana, Inc.

Serving residents of Indiana

Assistance possible for the following legal issues:
Adults and children with disabilities who have issues in educational matters, probate, and disability law compliance

5954 N. College Avenue
Indianapolis, IN 46220
(317) 426-7733
(317) 282-0608 (f)

Cannot offer legal advice or answer legal questions over the phone

Visit the website to complete an intake form: <http://www.disabilitylegalservicesindiana.org/>

Hoosier Environmental Council

Serving residents of Indiana

Assistance possible for the following legal issues:
Environmental and Land-Use Issues

3951 N. Meridian
Suite 100
Indianapolis, IN 46208
(317) 685-8800
(317) 685-4794 (f)
<http://www.hecweb.org/about/legal-defense-fund/>

District J

Counties: Dearborn, Fayette, Franklin, Jefferson, Ohio, Ripley, Switzerland, Union, and Wayne

These providers assist people who are low-income.



Legal Volunteers of Southeast Indiana, Inc.

Serving only residents of all counties in District J

318 N. Walnut Street
Lawrenceburg, IN 47025
(812) 537-0123
(877) 237-0123
(812) 537-7090 (f)
district12probono@legalvolunteers.com

Indiana Legal Services, Inc. - New Albany

Serving residents of Dearborn, Jefferson, Ohio, Ripley, and Switzerland Counties

Assistance possible for the following legal issues:
Family Law, Consumer Law, Senior Law, Housing, and Public Benefits

3303 Plaza Drive
Suite 5
New Albany, IN 47150
(812) 945-4123
(800) 892-2776
(812) 945-7290 (f)

Intake hours: Monday 9:00 a.m.-11:00 a.m.
(General); Thursday 9:00-11:00 a.m. (Divorce)

<http://www.indianajustice.org/>

Indiana Legal Services, Inc. - Indianapolis

Serving residents of Fayette, Franklin, Union, and Wayne Counties

Assistance possible for the following legal issues:
Family Law, Consumer Law, Senior Law, Housing,
and Public Benefits

Market Square Center
151 North Delaware
Suite 1800
Indianapolis, IN 46204
(317) 631-9410
(800) 869-0212
(317) 631-9775 (f)

Spanish speaking staff available

Intake hours by telephone: Monday and Friday 9:00
am - 11:00 am; Wednesday 1:00 pm - 3:00 pm.

Intake hours by walk-ins: Wednesday 9:00 am - 11:00
am; Tuesday and Thursday 1:00 pm - 3:00 pm.

<http://www.indianajustice.org/>

American Civil Liberties Union of Indiana

Serving residents of Indiana

Assistance possible for the following legal issues:
Civil Liberties or Constitutional Rights Violations

1031 E. Washington St.
Indianapolis, IN 46202
(317) 635-4059 ext. 102
<http://aclu-in.org/>

Online form can be found at: <http://www.formstack.com/forms/?1157118-hfibE7kI4V>

Disability Legal Services of Indiana, Inc.

Serving residents of Indiana

Assistance possible for the following legal issues:
Adults and children with disabilities who have issues
in educational matters, probate, and disability law
compliance

5954 N. College Avenue
Indianapolis, IN 46220
(317) 426-7733
(317) 282-0608 (f)

Cannot offer legal advice or answer legal questions
over the phone

Visit the website to complete an intake form: <http://www.disabilitylegalservicesindiana.org/>

Hoosier Environmental Council

Serving residents of Indiana

Assistance possible for the following legal issues:
Environmental and Land-Use Issues

3951 N. Meridian
Suite 100
Indianapolis, IN 46208
(317) 685-8800
(317) 686-4794 (f)
<http://www.hecweb.org/about/legal-defense-fund/>

District K

*Counties: Daviess,
Dubois, Gibson,
Knox, Martin,
Perry, Pike, Posey,
Spencer, Sullivan,
Vanderburgh,
Vigo, and Warrick*

These providers assist
people who are low-
income.



Volunteer Lawyer Program of Southwestern Indiana, Inc.

Serving only residents of all counties of District K.

915 Main Street, Suite 208
Evansville, IN 47708

To apply for services, please call:
Legal Aid Society of Evansville, (812) 435-5173
(Vanderburgh County residents only)

Indiana Legal Services Evansville, (812) 426-1295 or
toll free (800) 852-3477

Indiana Legal Services, Inc. - Evansville

Serving residents of Daviess, Dubois, Gibson, Knox,
Martin, Perry, Pike, Posey, Spencer, Vanderburgh,
and Warrick Counties

Assistance possible for the following legal issues:
Family Law, Consumer Law, Senior Law, Housing,
and Public Benefits

2425 North Highway 41
Suite 401
Evansville, IN 47711
(812) 426-1295
(800) 852-3477
(812) 422-7332 (f)

Intake hours: Tuesday 11:00 a.m.-1:00 p.m. and
Wednesday 9:00 a.m.-11:00 a.m.

<http://www.indianajustice.org/>

Indiana Legal Services Bloomington Office

Serving Sullivan and Vigo Counties

Assistance possible for the following legal issues:
Family Law, Consumer Law, Senior Law, Housing,
and Public Benefits

214 S. College Avenue
Bloomington, IN 47404
(812) 339-7668
(800) 822-4774
(812) 339-2081 (f)

Office Hours: Monday-Friday 8:30 a.m.-5:00 p.m.
<http://www.indianajustice.org/>

Indiana Legal Services, Inc. - Columbus

Serving residents 60+ years old of Sullivan and Vigo
Counties

Assistance possible for the following legal issues:
Senior Law

Area XI Council on Aging
1531 13th Street, Suite G
Columbus, IN 47201-1302
(812) 372-6918
(866) 644-6407
(812) 372-7846 (f)

<http://www.indianajustice.org/>

Legal Aid Society of Evansville Inc.

Serving residents of Vanderburgh County

1 NW MLK Blvd., Suite 105
Evansville, IN 47708-1828
(812) 435-5173
(812) 435-5220 (f)

Intake Hours: Monday-Friday 8:00 a.m.-11:30 a.m.
<http://www.evansvillegov.org/index.aspx?page=131>

American Civil Liberties Union of Indiana

Serving residents of Indiana

Assistance possible for the following legal issues:
Civil Liberties or Constitutional Rights Violations

1031 E. Washington St.
Indianapolis, IN 46202
(317) 635-4059 ext. 102
<http://aclu-in.org/>

Online form can be found at: <http://www.formstack.com/forms/?1157118-hfibE7kI4V>

Disability Legal Services of Indiana, Inc.

Serving residents of Indiana

Assistance possible for the following legal issues:
Adults and children with disabilities who have issues
in educational matters, probate, and disability law
compliance

5954 N. College Avenue
Indianapolis, IN 46220
(317) 426-7733
(317) 282-0608 (f)

Cannot offer legal advice or answer legal questions
over the phone

Visit the website to complete an intake form:<http://www.disabilitylegalservicesindiana.org/>

Hoosier Environmental Council

Serving residents of Indiana

Assistance possible for the following legal issues:
Environmental and Land-Use Issues

3951 N. Meridian
Suite 100
Indianapolis, IN 46208
(317) 685-8800
(317) 686-4794 (f)

<http://www.hecweb.org/about/legal-defense-fund/>

District L

*Counties: Clark,
Crawford, Floyd,
Harrison, Orange,
Scott, and Washington*

These providers assist
people who are low-
income.



Southern Indiana Pro Bono Referrals, Inc.

Serving only residents in all counties of District L

P.O. Box 94
New Albany, IN 47151
(812) 949-2292
(812) 949-2334 (f)
probono14@sbcglobal.net
<http://probono14.org/>

Please visit the website to complete an online
application

Indiana Legal Services, Inc. - New Albany

Serving residents of Clark, Crawford, Floyd,
Harrison, Scott, and Washington Counties

Assistance possible for the following legal issues:
Family Law, Consumer Law, Senior Law, Housing,
and Public Benefits

3303 Plaza Drive
Suite 5
New Albany, IN 47150
(812) 945-4123
(800) 892-2776
(812) 945-7290 (f)

Intake hours: Monday 9:00 a.m.-11:00 a.m.
(General); Thursday 9:00-11:00 a.m. (Divorce)

<http://www.indianajustice.org/>

Indiana Legal Services, Inc. - Bloomington

Serving residents of Orange County

Assistance possible for the following legal issues:
Family Law, Consumer Law, Senior Law, Housing,
and Public Benefits

214 S. College Avenue
Bloomington, IN 47404
(812) 339-7668
(800) 822-4774
(812) 339-2081 (f)

Office Hours: Monday-Friday 8:30 a.m.-5:00 p.m.

<http://www.indianajustice.org/>

Indiana Legal Services, Inc. - Columbus

Serving residents 60+ years old of Orange County

Assistance possible for the following legal issues:
Senior Law

Area XI Council on Aging
1531 13th Street, Suite G
Columbus, IN 47201-1302
(812) 372-6918
(866) 644-6407
(812) 372-7846 (f)

<http://www.indianajustice.org/>

American Civil Liberties Union of Indiana

Serving residents of Indiana

Assistance possible for the following legal issues:
Civil Liberties and Constitutional Rights Violations

1031 E. Washington St.
Indianapolis, IN 46202
(317) 635-4059

<http://aclu-in.org/>

Disability Legal Services of Indiana, Inc.

Serving residents of Indiana

Assistance possible for the following legal issues:
Adults and children with disabilities who have issues
in educational matters, probate, and disability law
compliance

5954 N. College Avenue
Indianapolis, IN 46220
(317) 426-7733
(317) 282-0608 (f)

Cannot offer legal advice or answer legal questions
over the phone

Visit the website to complete an intake form: [http://
www.disabilitylegalservicesindiana.org/](http://www.disabilitylegalservicesindiana.org/)

Hoosier Environmental Council

Serving residents of Indiana

Assistance possible for the following legal issues:

Environmental and Land-Use Issues

3951 N. Meridian

Suite 100

Indianapolis, IN 46208

(317) 685-8800

(317) 686-4794 (f)

<http://www.hecweb.org/about/legal-defense-fund/>

ADULT PROTECTIVE SERVICES

The Adult Protective Services (APS) Program was established to investigate reports and provide intervention and protection to vulnerable adults who are victims of abuse, neglect, or exploitation. APS field investigators operate out of the offices of county prosecutors throughout the state.

If the APS Unit has reason to believe that an individual is an endangered adult, the adult protective services unit shall investigate the complaint or cause the complaint to be investigated by law enforcement or other agency and make a determination as to whether the individual reported is an endangered adult. To be eligible for service under this program, an individual must be a resident of the state of Indiana, 18 years of age or older, physically or mentally incapacitated and reported as abused, neglected or exploited. Indiana is the only state in which the APS program is a criminal justice function.

For assistance statewide, contact:

Adult Protective Services Program Division of Aging
P.O. Box 7083, MS21
402 W. Washington Street
Room W-454
Indianapolis, IN 46207-7083
(317) 233-2182
(888) 673-0002
<http://www.in.gov/fssa/da/3479.htm>

Area 1 – Adams, Allen, DeKalb, Huntington, LaGrange, Noble, Steuben, Wells, Whitley:

Mental Health America
227 E. Washington Boulevard
Fort Wayne, IN 46802
(260) 422-6441
(800) 992-6978

Area 2 – Bartholomew, Brown, Decatur, Jackson, Jennings :

Bartholomew County Prosecutor
234 Washington Street
Columbus, IN 47201
(812) 379-1670
(812) 458-6329

Area 3 – Benton, Carroll, Clinton, Fountain, Montgomery, Tippecanoe, Warren, White :

Family Services Agency, Inc.
615 N. 18th Street, Suite 201
Lafayette, IN 47904
(765) 423-5361
(800) 875-5361
www.fsilafayette.org

Area 4 – Blackford, Delaware, Grant, Henry, Jay, Madison, Randolph:

Madison County Prosecutor
16 E. 9th Street
Anderson, IN 46016
(765) 641-9585

Area 5 – Boone, Hamilton, Hendricks, Marion:

Marion County Prosecutor & Investigators

Mail:

203 E. Washington, Suite 560
Indianapolis, IN 46204

Located:

129 E. Market Street, 6th Floor
Indianapolis, IN 46204
(317) 327-1403

Area 6 – Cass, Fulton, Howard, Miami, Tipton, Wabash:

Wabash County Prosecutor
200 Court Park
Logansport, IN 46947
(574) 753-7790

Area 7 – Clark, Floyd, Harrison, Scott:

Clark County Prosecutor
501 E. Court Avenue
Jeffersonville, IN 47130
(812) 285-6264

Area 8 – Clay, Parke, Putnam, Sullivan, Vermillion, Vigo:

Vigo County Prosecutor
33 S. 3rd Street
Terre Haute, IN 47807
(812) 462-3286

Area 9 – Crawford, Lawrence, Orange, Washington:

Washington County Prosecutor
806 Martinsburg Road, Suite 202
Salem, IN 47167
(812) 883-6560

Area 10 – Daviess, Dubois, Greene, Knox, Martin, Pike:

Daviess County Prosecutor
P.O. Box 647
200 E. Walnut Street
Washington, IN 47501
(812) 254-8681

Area 11 – Dearborn, Jefferson, Ohio, Ripley, Switzerland:

Dearborn-Ohio County Prosecutor
215 W. High Street
Lawrenceburg, IN 47025
(812) 537-8884

Area 12 – Elkhart, Kosciusko, Marshall, St. Joseph:

St. Joseph County Prosecutor
227 W. Jefferson Boulevard
10th Floor
South Bend, IN 46601
(574) 235-9544

Area 13 – Fayette, Franklin, Rush, Union, Wayne:

Wayne County Prosecutor
401 E. Main Street
Richmond, IN 47374
765-973-9394

Area 14 – Gibson, Perry, Posey, Spencer, Vanderburgh, Warrick:

Vanderburgh County Prosecutor
Civic Center Complex, Room 108
1 N.W. Martin Luther King, Jr. Boulevard
Evansville, IN 47708
(812) 435-5150

Area 15 – Hancock, Johnson, Shelby :

Shelby County Prosecutor
407 S. Harrison Street
Shelbyville, IN 46176
(317) 835-2798
(317) 392-6495

Area 16 – Jasper, LaPorte, Newton, Porter, Pulaski, Starke:

LaPorte County Prosecutor
813 Lincolnway
LaPorte, IN 46350
(219) 326-6808 (ext. 505)

Area 17 – Lake:

Lake County Prosecutor
2293 N. Main Street
Building B, First Floor
Crown Point, IN 46307
(219) 755-3863

Area 18 – Monroe, Morgan, Owen:

Monroe County Prosecutor
311 N. College Avenue, Room 211
Bloomington, IN 47404
(812) 349-2670

OMBUDSMAN & AREA AGENCIES ON AGING

The Indiana State Long Term Care Ombudsman Program provides advocacy and related services for consumers of long term care services, such as nursing facilities, residential care facilities, assisted living facilities, adult foster care homes and county operated residential care facilities, regardless of age or payer source.

To reach the state's ombudsman or for general information statewide, contact:

Arlene Franklin, Long Term Care Ombudsman
Indiana Family & Social Services Administration
Division of Aging
P.O. Box 7083
Indianapolis, IN 46207-7083
(317) 232-7134
(800) 622-4484
<http://www.in.gov/fssa/da/3474.htm>

The following resources are the Ombudsman and then the local Area Agency on Aging for those counties listed:

Area 1 – Jasper, Lake, Newton, Porter, Pulaski, Starke:

Northwest Indiana Community Action Corp.
5240 Fountain Drive
Crown Point, IN 46307
(219) 794-1829
(800) 826-7871
www.nwi-ca.com

Area 2 – Elkhart, Kosciusko, LaPorte, Marshall, St. Joseph:

REAL Services, Inc.
1151 S. Michigan
P.O. Box 1835
South Bend, IN 46634-1835
(574) 284-2644 (Ombudsman)
(574) 233-8205 (Area Agency on Aging)
(800) 552-7928
www.realservicesinc.com

Area 3 – Adams, Allen, DeKalb, Huntington, LaGrange, Noble, Steuben, Wells, Whitley:

Aging & In-Home Services of Northeast Indiana, Inc.
2927 Lake Avenue
Fort Wayne, IN 46805-5414
(260) 469-3161 (Ombudsman)
(260) 745-1200 (Area Agency on Aging)
(800) 552-3662
www.agingihs.org

Area 4 – Benton, Carroll, Clinton, Fountain, Montgomery, Tippecanoe, Warren, White:

Family Services Agency, Inc.
615 N. 18th Street, Suite 201
Lafayette, IN 47904
(765) 423-5361
(800) 875-5361
www.fsilafayette.org

Area IV Agency on Aging
P.O. Box 4727
660 N. 36th Street
Lafayette, IN 47903-4727
(765) 447-7683
(800) 382-7556
www.areaivagency.org

Area 5 – Cass, Fulton, Howard, Miami, Tipton, Wabash :

Area 5 Agency on Aging and Community Services, Inc.
1801 Smith Street, Suite 300
Logansport, IN 46947-1577
(574) 737-2169 (Ombudsman)
(574) 722-4451 (Area Agency on Aging)
(800) 654-9421
www.areafive.com

Area 6 – Blackford, Delaware, Grant, Henry, Jay, Madison, Randolph:

LifeStream Services, Inc.
P.O. Box 308
1701 S. Pilgrim Boulevard
Yorktown, IN 47396
(765) 759-1121 (ext. 145)
(800) 589-1121
www.lifestreaminc.org

**Area 7 – Clay, Parke, Putnam, Sullivan,
Vermillion, Vigo:**

West Central Indiana Economic
Development District, Inc.
P.O. Box 359
1718 Wabash Avenue
Terre Haute, IN 47808-0359
(812) 238-1561
(800) 489-1561

**Area 8 – Boone, Hamilton, Hancock, Hendricks,
Johnson, Marion, Morgan, Shelby:**

Indiana Legal Services
151 N. Delaware Street
Suite 1800
Indianapolis, IN 46204
(317) 631-9410 (ext. 2255)
(800) 869-0212

CICOA Aging & In-Home Solutions
4755 Kingsway Drive, Suite 200
Indianapolis, IN 46205-1560
(317) 254-5465
(800) 432-2422

Area 9 – Fayette, Franklin, Rush, Union, Wayne:

Area 9 In-Home & Community Service Agency
520 S. 9th Street, Suite 100
Richmond, IN 47374-6230
(765) 966-1795
(800) 458-9345
www.iue.indiana.edu/departments/Area9/

Area 10 – Monroe, Owen:

Area 10 Agency on Aging
7500 W. Reeves Rd.
Bloomington, IN 47404
(812) 876-3383
(800) 844-1010

**Area 11 – Bartholomew, Brown, Decatur, Jackson,
Jennings:**

Aging & Community Services of South Central
Indiana, Inc.
1531 13th Street, Suite G900
Columbus, IN 47201
(812) 372-6918
(812) 372-6918 (*Ombudsman, ext. 2760*)
(866) 644-6407

**Area 12 – Dearborn, Jefferson, Ohio, Ripley,
Switzerland:**

Ombudsman
P.O. Box 904
1531 13th Street, G900
Columbus, IN 47201
(812) 372-6918 (ext. 2781)
(800) 644-6407

LifeTime Resources, Inc.
13091 Benedict Drive
Dillsboro, IN 47018
(812) 432-5215
(800) 742-5001
www.lifetime-resources.org

**Area 13 – Daviess, Dubois, Greene, Knox,
Martin, Pike:**

Generations
P.O. Box 314
1019 N. 4th Street
Vincennes, IN 47591
(812) 888-5158 (*Ombudsman*)
(812) 888-5880 (*Area Agency on Aging*)
(800) 742-9002
www.generationsnetwork.org

Area 14 – Clark, Floyd, Harrison, Scott:

LifeSpan Resources, Inc.
P.O. Box 995
33 State Street, Suite 308
New Albany, IN 47151
(812) 948-6428 (*Ombudsman*)
(812) 948-8330
(888) 948-8330
www.lifespanresources.org

**Area 15 – Crawford, Lawrence, Orange,
Washington :**

Ombudsman
Southern Indiana Center for Independent Living
651 X Street
Bedford, IN 47421
(812) 277-9626
(800) 845-6914

Hoosier Uplands Economic Development
Corporation
521 W. Main Street
Mitchell, IN 47446
(812) 849-4457
(800) 333-2451
www.hoosieruplands.org

**Area 16 – Gibson, Perry, Posey, Spencer, Warrick,
Vanderburgh:**

Indiana Legal Services
2425 US 41 N., Suite 401
Evansville, IN 47711
(812) 426-1295 (ext. 3)
(800) 852-3477

Vanderburgh County
VOICES, Inc.
2425 US 41 N., Suite 405
Evansville, IN 47711-4070
(812) 423-2927

Southwest Indiana Regional Council on Aging, Inc.
P.O. Box 3938
16 W. Virginia Street
Evansville, IN 47737-3938
(812) 464-7817
(866) 400-0779
www.swirca.org

VETERANS' RESOURCES

Regional Benefit Office:

Indianapolis Regional Benefit Office
575 North Pennsylvania St.
Indianapolis, IN 46204

VA Health Care System

Northern Indiana Healthcare System:

Fort Wayne:

2121 Lake Avenue, 46805
(260) 426-5431
(800) 360-8387

VA Medical Centers

Fort Wayne:

2121 Lake Avenue,
Fort Wayne, Indiana 46805
(260) 426-5431
(800) 360-8387

Indianapolis:

Roudebush VA Medical Center
1481 W 10th Street
Indianapolis, 46202
(317) 554-0000

Marion:

1700 E 38th Street,
Marion, Indiana 46953
(765) 674-3321
(800) 360-8387

VA Outpatient Clinics

Crown Point:

Adam Benjamin, Jr. OPC
Jesse Brown VA Medical Center
9301 Madison Street
Crown Point, Indiana 46307
219-662-5000

Evansville:

Community Based Outpatient Clinic

Bloomington:

Bloomington VA Outpatient Clinic
455 South Landmark Avenue
Bloomington, Indiana 47403
(812) 336-5723

Goshen:

2014 Lincolnway East, Suite 3
Goshen, Indiana 46526
(888) 683-3019

Greendale:

Lawrenceburg (Dearborn) Community Based
Outpatient
1600 Flossie Dr.
Greendale, Indiana 47025
(812) 539-2313

Indianapolis:

Indy West
Richard L. Roudebush VA Medical
Center
1481 West 10th Street
Indianapolis, IN 46202
(317) 554-0000

Martinsville:

Martinsville Community OPC
2200 John R. Wooden Drive
Martinsville, IN 46151
317-554-0000 ext. 80147
or 317-988-4498

Muncie/Anderson:

Muncie/Anderson VA OPC
2600 W White River Blvd
Muncie, IN 47303
765-284-6822 Or 765-284-6822

New Albany:

VA Healthcare Center
811 Northgate Blvd.
New Albany Indiana 47150
502-287-4100 or 502-287-4100

Peru:

Peru Community Based OPC
750 N Broadway
Peru, IN 46970
765-472-8907

Richmond:

Richmond Community Based
OPC
4351 South A St.,
Richmond, Indiana 47346
(765) 973-6915

Scottsburg:

VA Healthcare Center,
Scott County
1467 Scott Valley Drive
Scottsburg, IN 47170
877-690-1938 Or 877-690-1938

South Bend:

South Bend VA OPC
333 W. Western Ave
South Bend, IN 46601
866-436-1291 or 866-436-1291

Terre Haute:

Terre Haute VA OPC
142 W. Honey Creek Pkwy
Terre Haute, Indiana 47802
(812) 232-2890

West Lafayette:

West Lafayette VA OPC
3851 N. River Road
West Lafayette, Indiana 47906
(765) 464-2280

Veterans Centers

Crown Point:

Gary Area Vet Center
107 E. 93rd Ave
Crown Point, IN 46307
(219)736-5633 or (877)927-8387

Evansville:

Evansville Area Vet Center
311 N Weinbach Ave.
Evansville, Indiana 47711
(812)473-5993 or (877)927-8387

Fort Wayne

Fort Wayne Vet Center
5800 Fairfield Ave., Suite 265
Fort Wayne, IN 46807
(260)460-1456 Or (877)927-8387

Indianapolis:

Indianapolis Vet Center
8330 Naab Road, Suite 103
Indianapolis, IN 46268
(317)988-1600 Or (877)927-8387

South Bend:

South Bend Vet Center
4727 Miami Street
South Bend, IN 46614
(574)231-8480 Or (877)927-8387

National Cemeteries

Indianapolis:

Crown Hill
700 W. 38th Street, 46208
(317) 925-3800

Marion:

1700 E 38th St., 46952
(765) 674-0284

New Albany:

1943 Ekin Ave., 47150
(812) 948-5234

Helpful Websites

U.S. Department of Veterans' Affairs, www.va.gov

U.S. Department of Veterans Affairs - Insurance
Service, <http://www.benefits.va.gov/insurance/>

U.S. Department of Veterans' Affairs - National
Cemetery Benefits, www.cem.va.gov/

Indiana Department of Veterans Affairs - <http://www.in.gov/dva/>

Indiana Veterans Service Officers Association - www.invsoa.homestead.com

NOTES

BUYING A HOME

IMPORTANT THINGS TO REMEMBER

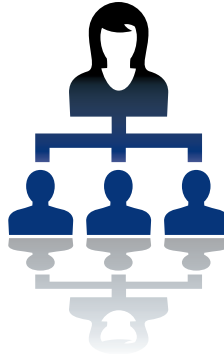


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