BH Newsletter

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Comparison of Charitable Giving Options

by Timothy Bergland

Gifting to charitable entities provides many clients with a sense of fulfillment from knowing that they are helping individuals less fortunate than themselves by donating a gift on their behalf. In addition to this good feeling that many donors receive, donors also are able to obtain an income tax deduction during their lives and/or an estate tax deduction on their death. These tax benefits, in many cases, are extremely valuable and sometimes even drive the transaction. Over the years, attorneys and accountants have developed a variety of gifting strategies using several vehicles to take advantage of these tax deductions. These strategies can become extremely complicated and sometimes costly. The advantage of using these strategies is that in some cases, the client can still benefit from the asset being gifted.

The following is a list of several of the available gifting options. These options are discussed in the order of their simplicity and therefore the lower cost to complete the transaction.

1. **Outright Gift of Cash**. A client wishing to make a donation can simply transfer cash, write a check or authorize a credit card charge to or on behalf of a charity. These gifts are fully deductible up to 50% of the client's Adjusted Gross Income with a 5-year carryover if the deduction exceeds this 50% limitation.

2. **Life Insurance**. Donors can irrevocably assign a life insurance policy to a charity. This assignment generates an income tax deduction for the policy's cost basis or cash surrender value, not the death benefit. In addition, the continuing premiums are also deductible on policies that are not paid-up.

3. **Outright Gift of Long-Term Capital Gain Property**. Some clients desire to transfer appreciated property. The charity receives the property in kind. The donor deducts the fair market value of the property up to 30% of AGI. Again, any excess deduction can be carried over for 5-years. The client recognizes no capital gains tax on the appreciation of the property transferred.

4. **Charitable Gift Annuity**. Donors transfer a gift to a charity and receive back a stream of income for life or a number of years. Income amount is based on age(s) of beneficiary(ies) or the term of agreement and is partly tax-free when received. If appreciated property is given, some of the capital gain is recognized ratably over the term of donor's life expectancy. Donor can deduct immediately the value of the property given, minus the present value of the income stream from the annuity, subject to the percentage limitations.

5. **Charitable Remainder Annuity Trust (CRAT)**. These are complicated Trusts that receive a gift and pay income to donor or other beneficiary at a minimum 5% of initial principal for life or for a term of up to 20 years. The donor recognizes no capital gains tax when appreciated property is transferred to the trust and can deduct the present value of charity's remainder interest, subject to the 50% or 30% limitation.

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Medicare Drug Benefit Calculator

What does the new Medicare drug benefit mean to you? Use this online tool to find out. Visit http://sites.stockpoint.com/AARP/drugbenefit.asp, type in the total dollar amount spent annually on prescription drugs, and click Calculate.

Who Should Use This Tool?
Current and future Medicare beneficiaries enrolled in traditional fee-for-service Medicare with no supplemental drug coverage can use this tool to compare their current out-of-pocket prescription drug spending, or a hypothetical future amount of out-of-pocket drug spending, with projected out-of-pocket spending under the Medicare drug benefit. (Note: The benefit does not go into effect until 2006.)

Who Should Not Use This Tool?
Beneficiaries with annual income below $14,450/individual and $19,500/couple, or 150% of the projected 2006 federal poverty level may experience lower prescription drug costs because Medicare will provide special assistance to many low-income beneficiaries. Get details about low-income benefits in their guide to the ways that the Medicare drug benefit helps beneficiaries.

Older Americans with retiree health coverage, individual health insurance, medigap coverage or other supplemental drug coverage will not be able to compare their current drug spending with projected out-of-pocket spending under the Medicare drug benefit. Calculations apply only to individuals who pay 100% of their prescription drug costs.

Comparison of Charitable Giving Options

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6. **Charitable Remainder Unitrust (CRUT).** Like CRAT's, these Trusts receive gifts and pay income to donor or other beneficiary at least 5% of the annual value of the trust principal, either for life or for a period of years up to 20. Increase in principal increases the income stream. Again, no capital gains are recognized when appreciated property is transferred to the trust. Like the CRAT, the donor can deduct the present value of charity's remainder interest, subject to the 50% or 30% limitation.
7. **Using Qualified Assets (Pre-Income Taxed).** Using assets like a 401K or IRA as a way to make a gift to avoid both income taxes and estate taxes.

The use of complex estate planning vehicles to make charitable contributions generally provide the significant benefits to individuals who wish to shelter a large portion of assets from either estate and/or income taxes. The more complex the vehicle used, however, the more costly the transaction. These trusts require legal fees and cause administrative burden. Therefore, the use of these complex estate planning vehicles should only be contemplated when the donor is making a relatively large contribution. If the donor, for example, is setting up a CRUT with $50,000.00 the estate and gift tax savings could be outweighed by the transaction cost in establishing the trust and the yearly additional accounting cost mandated to prepare tax returns and insure that the distributions are in compliance with the terms of the trust. Contact us if you would like more information about how to maximize your charitable giving, or if you would like to discuss how to use the options in conjunction with special needs planning.

More Medicare Information

Medicare Changes That Could Effect You by AARP is a booklet about The Medicare Prescription Drug, Improvement and Modernization Act of 2003, which was signed into law in December 2003, and makes major changes to Medicare, the nation's health insurance program for people age 65 and over and some persons with disabilities. These changes include a new voluntary prescription drug benefit, changes to the program that deal with private health plans in Medicare (known as Medicare+Choice), new coverage, and changes in costs. Many people have questions about how these changes will affect them, how and when they will occur, and what steps people must take to get these new benefits. This booklet outlines the highlights of the Medicare law, and what these changes could mean to you and is available online at http://assets.aarp.org/www.aarp.org_/articles/legislative/prescriptiondrugs/medicare_changes.pdf.

We are happy to help you with any questions or concerns you may have on how these complicated changes may impact your benefits.

Medicare Prescription Drug, Improvement and Modernization Act of 2003

President Bush signed landmark Medicare legislation into law during a White House ceremony on December 8, 2003. The bill passed by the House and the Senate is a compromise of separate bills passed by the chambers earlier in 2003. Many of its provisions will directly impact the six million persons with disabilities under age 65 who receive Medicare benefits.

The Act provides a prescription drug benefit for all Medicare beneficiaries effective January 2003. It establishes a two year moratorium on current benefit caps on physical, occupational and speech therapies, a new "Homebound" demonstration project, and a pilot program in six metropolitan areas in which traditional, fee-for-service Medicare would compete with private health plans.

New Prescription Drug Benefit

The new prescription drug benefit is purely voluntary—i.e. beneficiaries are not required to participate. Beginning in 2006, Medicare beneficiaries would pay an estimated average premium of $35 per month and an annual deductible of $250 for prescription drug coverage; beneficiaries would have to pay for 25 percent of their annual prescription drug costs that do not exceed $2,250 and 100 percent of their costs between $2,250 and $5,100; Medicare would cover 95 percent of their costs that exceed $5,100.

The legislation contains several provisions to assist low-income beneficiaries with costs associated with the new drug benefit. Medicare beneficiaries with annual incomes that do not exceed $12,000 and modest assets would not pay a premium or deductible for prescription drug coverage. However, they would have to make co-payments of $1 for generic medications and $3 for brand-name treatments. Families USA has prepared a chart entitled "Drug Benefit and Cost: What Will the New Medicare Drug Benefit Look Like for Consumers?" that details provisions of the legislation, which can be found on their website.

In April 2004, Medicare beneficiaries will be able to purchase prescription drug discount cards, which will provide estimated discounts of 15 percent or more on the price of their medications, until the prescription drug benefit takes effect in 2006.

Coverage of Dual-Eligibles

All Medicare beneficiaries, including dual-eligibles (those who receive both Medicare and Medicaid benefits) will be covered by the new prescription drug benefit. However, the Act contains a provision which may leave dual-eligibles with disabilities with significant health care needs worse off than they are now. Currently, when both Medicare and Medicaid cover a benefit, Medicare serves as the primary benefit, and Medicaid "wraps around" that coverage. For example, Medicaid fills in the gaps in the Medicare benefit or pays for cost sharing associated with the benefit. Under the new Medicare legislation, states will be prohibited from using Federal Medicaid funds to either pay for a drug a dual-eligible needs that may not be on the Medicare drug benefit list of covered drugs (known as a "formulary") or assisting the dual-eligible beneficiary with cost-sharing payments. The Arc and UCP will work with other Medicare advocates to repeal or revise this provision in the years ahead.

Therapy Caps

The Act includes a provision for a two-year moratorium on the therapy caps (which currently limit access to physical, occupational, and speech therapies), for calendar years 2004 and 2005. In addition, the Act requires the General Accounting Office (GAO) to conduct a study to identify conditions and diseases that would justify waiving the therapy cap permanently.

Homebound Demonstration Project

Under current Medicare rules, Medicare beneficiaries who are dependent on Medicare home health services to stay alive may only leave their homes for very limited purposes (e.g. medical visits, religious services or funerals). Under the new Medicare Act, the Department of Health and Human Services (HHS) is required to institute a 2-year demonstration project in 16 states. No more than 15,000 Medicare beneficiaries covered by the Homebound Rule may participate in the demonstration, which will lift the rule's strict requirements.

Premium Supports Pilot

The Act establishes a pilot program, beginning in 2010, which will require traditional, fee-for service Medicare plans to compete, directly on price, with private health plans, in six metropolitan areas. It is anticipated that Medicare beneficiaries in areas covered by the pilot will have to pay more to remain in fee-for-service Medicare since healthier beneficiaries will opt to participate in less costly private plans, raising premium costs for traditional fee-for-service Medicare plans. The Act requires Medicare to cap premium increases at 5 percent per year and includes safeguards to exempt the oldest and lowest-income beneficiaries.

Durable Medical Equipment

The Act includes a competitive bidding demonstration project in metropolitan areas for durable medical equipment (e.g. wheelchairs, scooters and other mobility devices). The Act also institutes a freeze in payments to providers of durable medical equipment.

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Frequently Asked Questions about Changes to Medicare

How will the Medicare drug discount cards work?
Anyone eligible for or enrolled in Medicare Part A, or enrolled in Medicare Part B, is eligible to participate in the discount card program. Discount cards will be available as early as spring of 2004, but no later than June. Private companies will administer the program and each program can offer different benefits, so it will pay to shop around for the discount card that best meets your needs. Discounts are estimated to be worth about 15%. Programs can charge a one-time enrollment fee of no more than $30 per person. You can enroll in a discount card program anytime before January 1, 2006, but you can only be enrolled in one program at a time. You can switch programs, but you will have to pay another enrollment fee if you do. You will be able to enroll over the phone.

There are special discount card benefits for those below 135% of poverty. Those individuals will not have to pay the enrollment fee. In addition, they will receive a $600 annual credit on their cards that can be used at pharmacies to purchase prescription drugs. If they are below 100% of poverty, they will have a 5% copay. Those between 100% and 135% of poverty will have a 10% copay. People are excluded from the $600 benefit if they are on Medicaid, or covered under a group health plan, federal employees health plan or veterans health plan. However, people on spend-down Medicaid are eligible for the $600. The credit is an annual benefit, so $600 will be received in 2004, and another $600 in 2005. Any unused balance for 2004 can be carried over to 2005, unless you switch discount cards. To receive the $600 credit, you must visit the office of the Family Independence Agency in your county, or a local Social Security Administration office, in order to prove that you are eligible. Next spring, look for television, radio or newspaper ads, or special mailings announcing the availability of Medicare discount cards. At that time, the Medicare Medicaid Assistance Program (MMAP) will publish a comparison guide of all the cards available in Michigan. You can contact MMAP at (800)-803-7174. The 28 firms selected to provide the cards were announced on March 24, 2004. A website comparing the cards, the drugs, the offer and prices will be available at www.medicare.gov by the end of April, or you can call 1-800-633-4227.

I already have a Medicare supplemental insurance policy that provides some drug benefits. Do I have to change my policy?
No, but you might be better off if you did. If the drugs you take are covered, the new Medicare benefit is better than the drug benefits offered through Medigap policies H, I and J. Plans H and I have a $250 deductible, but pay only 50% of drug costs up to $1,250. Plan J also has a $250 deductible, but pays only 50% of drug costs up to $3,000. Compare your Medigap policy with the Part D benefit and decide which is better for you. If you want to switch to the Medicare drug benefit, you are guaranteed the right to purchase a different Medigap policy that doesn't include prescription drugs. You cannot have a Medigap policy with drug coverage if you are also enrolled in a medicare drug plan. People that become eligible for Medicare after January 1, 2006 will not be allowed to purchase Medigap plans that include prescription drugs.

I'm in a Medicare HMO. Will the drug benefits I get through the HMO change as a result of this new law?
Yes. HMOs in Michigan must improve their drug benefits to match the benefits provided through the new law. To encourage HMOs to join or stay in Medicare, they will be receiving higher payments from the government starting in 2004.

I'm interested in the new Medicare PPOs. How would they work?
Preferred Provider Organizations (PPOs) will offer beneficiaries a network of participating providers, but will allow beneficiaries to use non-participating providers and still get some reimbursement (unlike HMOs). Out-of-pocket expenses will be less if you use participating providers. PPOs can join Medicare beginning in 2006, and they have to offer benefits in large multi-state regions. It is not yet known whether any PPOs in the Great Lakes region would be willing to participate in Medicare. PPOs must offer a single deductible for Part A and Part B benefits, and catastrophic limits for both in-network and out-of-network expenses. PPOs will also be part of the Medicare Advantage Program.

I've heard there are new benefits added to Medicare Part B. What are they?
Beneficiaries whose Medicare coverage begins on or after January 1, 2005 will be able to get one initial physical examination, subject to the deductible and cost-sharing requirements. For all beneficiaries, blood tests to detect cardiovascular disease and diabetes will be covered beginning January 1, 2005. Also added as an approved in-home therapy is intravenous immune globulin for the treatment of primary immune deficiency diseases.

I've read that for the first time, Medicare will be means-tested. What does this mean?
It's misleading to say that Medicare will be means-tested. The term "means-tested" is usually applied to a program in which people are enrolled or excluded based on their income and/or assets. This is not happening to Medicare. People who are eligible for Social Security retirement benefits will still be eligible for Medicare when they reach 65, regardless of their income or assets. What is true, for the first time, Medicare Part B premiums will be higher for individuals with an annual income of $80,000 for a single person or $160,000 for a couple.

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Ensuring that your anatomical gifts are honored

by Timothy Bergland

There is a great need for organ donors in Michigan. Currently there are 2,497 patients waiting for transplants in Michigan. Year to date 66 individuals have received organ transplants while 8 individuals died waiting. The Gift of Life Donor Registry has 679,175 registered individuals who are willing to donate their organs to rectify the situation.

In recent years many of our clients have tried to help by indicating their wish to make anatomical gifts in their Patient Advocate Designation. The Patient Advocate Designation is the legal document whereby an individual appoints a love one or trusted companion to make medical decisions on their behalf if they ever become unable to do so. Through the use of this Patient Advocate Designation individuals can be confident that their wishes will be honored even if they are unable to consent themselves. This could help avoid the unfortunate case of Terri Schiavo, the Florida woman whose family is fighting about her care. Had Ms. Schiavo had a Patient Advocate, her wishes would have been clear and the lengthy court battle and loss of privacy may have been avoided. This case illustrates how important Patient Advocates are–even for young adults as Ms. Schiavo was only 27 years old when she was injured (see article entitled "Terri Schiavo Case Shows The Importance of Planning").

A Patient Advocate Designation is a very effective way to insure that wishes regarding anatomical gifts are allowed too. However, problems can occur if an individual dies suddenly and the Patient Advocate Designation is not on file with the hospital where the death is pronounced. If this is the case, it may take too much time to locate the Patient Advocate and by then the time the organs are viable for transplant may have passed. In addition, under this time of crisis the Patient Advocate may not be thinking that the recently deceased party wishes to make this organ donation.

A secondary device to insure that organ donation occurs is by indicating such on a driver's license. Under Michigan license registration process individuals are able to indicate if in fact they wish to be an organ donor. Again, the same problem can occur if the driver's license is not located promptly. Failure to locate the driver's license in a timely manner could again lead to unnecessary delay and the needed organs could lose their viability.

Michigan's First Person Consent Legislation passed in the summer of 2003 provides another option known as donor registry. Since the establishment of this law, if an individual dies in Michigan, the hospital is required to contact the donor registry to ascertain if in fact the individual wishes to have hisorgans donated. Further, if there is an anatomical gift designation in the registry that anatomical gift designation is irrevocable by the family members or a Patient Advocate. In other words, the donor wishes will be adhered to even after his death, even if the family members or Patient Advocate subsequently decide that is not what the donor would have wanted.

The Gift of Life Donor Registry is an excellent service to be used when individuals are contemplating donating their organs. To sign up with the donor registry you simply need to fill out a postcard and submit it to the registry. The registry will take information on the postcard and will input it into the system to insure that all hospitals in Michigan have access to your wishes. Anyone interested in obtaining a card can contact Timothy P. Berglund or contact the Gift of Life Donor Registry directly at 1-800-482-4881.

Terri Schiavo Case Shows The Importance of Planning

For weeks during the fall, the news was filled with the highly public battle between Terri Schiavo's husband and her parents over whether to remove her from life support. The publicity of this particular case was extraordinary, but in fact many, many people agonize over what decisions to make about treatment of a loved one in extreme circumstances. They struggle to determine what treatments should be used to prolong the person's life, whether doctors should provide medication to relieve pain even though it might hasten death, and how to balance the person's treatment with his dignity.

Of course, family members are forced to make these decisions at a time when they are least well-equipped emotionally to do so, when they are upset over the condition of a loved one. The added stress of having to make health care decisions (and sometimes, of figuring out who should be the one to make them) can cause people to break down from the anxiety.

There is a simple solution to this, and that is to make your preferences known now, and to record them in a document so there won't be any question of your desires if you're ever in such a situation. Actually, you'll probably want to create three documents:

1. A ***Patient Advocate Designation*** names someone who will have authority to make health care decisions for you in such a situation. Alternates can be named as well.

2. A ***Durable Power of Attorney*** names someone who can manage your financial affairs if you become incapacitated.

3. A ***Values History Form*** allows you to declare your preferences regarding health care and treatment. It can provide clear and convincing evidence of your preferences and should be discussed with your named Agent and Patient Advocate. Copies can be provided to Successor Agents and, if you have filled yours out, we'd like to have a copy safeguarded for you in our files. If you need another copy to update yours, please let us know.

Post Majority Child Support

by Lynn Gates

In Michigan, child support means the court ordered payment of money for a child including the payment of medical, dental and health care expenses, child care expenses and educational expenses. By statute, the Court may order post majority supports for a child only between the ages of eighteen and nineteen and one-half if the child is:

1. regularly attending high school full time;
2. has a reasonable expectation of graduating from high school; and
3. is living full time with the payee of support or at an institution.

Factors one through three are interpreted by the school's attendance and academic standards.

The Court may not order child support after a child reaches nineteen and one-half years of age unless the parents reach an agreement. This is true even if the child has a disability or is otherwise unable to support him or herself.

The Michigan Court of Appeals addressed the lack of post majority child support for a parent caring for an adult child with a disability in the context of a divorce. The Court considered the added expense and responsibility of caring for an adult child with a disability in determining the spousal support (alimony) for the caretaker parent. The Court may, therefore, based on the facts of each case, ordered spousal support to assist with the child's expenses related to their disability.

Planning for a child with a disability may require the child support to cease upon the child's eighteenth birthday in order to maximize various state and federal benefits available. Support may not stop prior to age eighteen. Parents may not bargain away a child's right to support because the Court views child support as the child's and not the parent's right.

Between the ages of eighteen and nineteen and one-half, the three factors must be considered, and interpreted, to best assist the family's financial situation. The possible award of spousal support based, in part, upon caring for a child with a disability would also be considered only with considerations to SSI, Medicaid and services available by and through the Family Independence Agency and Community Mental Health Agencies.

We are happy to provide consultation to families attempting to resolve these issues, either through your family law attorney or by direct representation.

Medicare Prescription Drug, Improvement and Modernization Act of 2003

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Other provisions

The legislation, which will cost approximately $400 billion over 10 years also:

* Gives private health plans $12 billion in subsidies to encourage them to participate in Medicare;
* Establishes subsidies (approximately $70 billion) for employers that continue to provide prescription drug coverage to retirees after the Medicare prescription drug benefit takes effect;
* Provides $25 billion in increased funding for rural Medicare providers; and
* Allows the establishment (costing approximately $6 billion) of tax-preferred health savings accounts for all individuals.

COMMUNITY-BASED MEDICAL ASSISTANCE PROGRAMS IN MICHIGAN

Programs Available for the Elderly and Individuals with Disabilities

Presenters: *Elizabeth Luckenbach Brown, Arthur L. Malisow and Patricia E. Kefalas Dudek*

Medical Assistance funds a wide variety of programs for the elderly and for individuals with disabilities who live in the community. Becoming familiar with each and understanding their eligibility rules will allow you to direct your clients to programs that will actually help them. This program will give you a quick introduction to the eligibility rules for SSI (Supplemental Security Income), the Medical Assistance (MA) Deductible program, and a variety of community-based long-term care programs – including CADI, AC, EW and CAC. We will discus the process for determining whether or not a client is "disabled", the appeal process for SSI and all of the Medical Assistance programs. Finally, the rules surrounding estate recovery for community services will be covered. Social workers, attorneys, nurses, CPAs, and CFPs will find this seminar valuable.

Location: Friday, June 4, 2004 from 8:00 am to 3:45 pm, Holiday Inn North Campus, 3600 Plymouth Road, Ann Arbor, MI 48105

For more information, visit website: www.meds-pdn.com or call 715-836-9900

Michigan Department of Community Health

MDCH

Beneficiary Eligibility Bulletin

Effective March 1, 2004, the Michigan Department of Community Health (MDCH) is implementing the following changes for the Medicaid Home Help Services program. All of the policy changes must be applied to any new case openings on or after March 1,2004, and to any ongoing cases as of June 1,2004.

Background

FIA is the administrative agent for the MDCH Home Help Services program. The policies and procedures related to the program are contained in the FIA Adult Services Manual. (The Adult Services Manual is available online at http://www.mfia.state.mi.us/olmweb/etiasm/asm.pdf.)

Eligibility Criteria

Home Help services are only available to beneficiaries who are identified as medically and/or physically disabled, or cognitively impaired by a Medicaid enrolled physician, occupational therapist, physical therapist and/or nurse practitioner. To determine continued eligibility for the Home Help program, a Medical Needs form (FIA 54A) must be completed annually, by any of the provider types listed in this paragraph. The updated FIA 54A must be submitted to the Family Independence Agency (FIA) as part of the next redetermination process. Copies of the FIA 54A can be obtained from the Adult Services Worker at the local FIA office. To qualify for Home Help services, the beneficiary must require assistance with at least one Activity of Daily Living (ADL) and this ADL need must be assessed at a Level 3 or greater. ADL's are:

Eating Bathing Toileting Grooming Dressing
Mobility and Transferring

An ADL need may be established in any of the following ways:

1. Have an ADL functional need authorized by an FIA Adult Services Worker; or
2. Have a functional need for an ADL performed by relatives, friends etc. with no reimbursement required; or
3. Require equipment or assistive technology to accomplish an ADL. This requirement must be documented by an FIA Adult Services Worker; or
4. When necessary, have a request authorized through an exception made by the Department of Community Health, Long Term Care Systems Development Section.

Once the need for assistance with an ADL has been determined, or an exception request has been granted, a qualifying beneficiary is then eligible for any authorized home help service.

Coverage Limitations for Instrumental Activities of Daily Living (IADL's)

Monthly hours for specific IADL's are limited to a maximum of:
5 hours for shopping,
7 hours for laundry,
6 hours for housework, and
25 hours for meal preparation.

The IADL of shopping and errands has been redefined as shopping for food and other necessities of daily living. These new limitations will take effect for an individual beneficiary at the earlier of the next FIA reassessment of the beneficiary's needs or June 1, 2004. NOTE: The reasonable time schedule for all ADL's, and for the IADL medication, remain the same.

Home Help Agencies

A Home Help Service Provider is considered an agency when all of the following criteria are met:

1. is a Medicaid enrolled Home Health agency OR;
2. has incorporated status in the State of Michigan AND;
3. has or have applied for a tax identification number AND;
4. employs or contracts with two (2) or more persons to provide home help services

Rates

Home Help individual provider rates and agency rates that were in effect as of June 1, 2003, remain in effect.

Policy Exceptions

Exceptions to the policies may only be made by the Michigan Department of Community Health, Medical Services Administration (MDCH/MSA). In addition, exceptions to the individual provider hourly rates and agency rates may be considered by MDCH/MSA for complex care cases.
The following information must be included when submitting a rate exception request:

1. a description of the beneficiary's prescribed complex care needs
2. the specialized training the provider has received from a clinical practitioner in order to meet the beneficiary's prescribed needs
3. current ASCAP assessment
4. current Reasonable Time and Task Schedule

The exception request with supporting documentation must be submitted by the FIA Adult Services Worker to MDCH, Long Term Care Systems Development Section at the address noted below for approval/denial of the exception.

Long Term Care Systems Development Section
MDCH/Bureau of Medicaid Financial Management
P.O. Box 30479
Lansing, Michigan 48909-7979
Fax: (517) 335-7959

Important Policy Change To Adult Home Help

The final policy changes to the Home Help program were released by the Michigan Department of Community Health (DCH) in January and will take effect starting March 1, 2004. Here's what you need to know:

1. Wages will not change. All rates in effect as of June 1, 2003 remain in effect;

2. The policy puts a cap on hours for Instrumental Activities of Daily Living (IADL) activities. These changes will start June 1, 2004 or earlier if the consumer's needs are reassessed before that date. Monthly caps are:
   Housecleaning 6 hours Laundry 7 hours Meal preparation 25 hours; and
   Shopping 5 hours (shopping is limited to shopping for "food and other necessities of daily living")

3. To be eligible to receive assistance from Home Help with IADL activities, a consumer must also need assistance with at least one Activity of Daily Living (ADL). These activities are mobility, dressing, grooming, eating, toileting, transferring and bathing. A person is considered to need help with an ADL if:
   * A Home Help worker helps with an ADL now;
   * The person uses a piece of assistive technology such as a wheelchair, crutches, canes, shower chair or assistive dressing device to accomplish the ADL;
   * The person receives unpaid assistance from a family member or friend with the ADL;
   * The FIA worker certifies the need for ADL assistance; and
   * An exception is made by the Department of Community Health, Long Term Care Systems Development Section.

How to appeal changes in your services: Advocates worked for a consumer-initiated exception process so that people who have greater needs can request additional assistance, but the Department rejected this request. If your services are cut, or if you are denied services because you do not have at least one ADL need, you need to ask your FIA worker to request an exception from DCH, or you can request a Medicaid hearing. Advocates are available statewide to assist you in the appeals process. To find the nearest advocate, call United Cerebral Palsy of Michigan at (800) 828-2714.

Share your story. Please contact an advocate through the above number to record your story on the statewide database which will be used to document how this policy change affects consumers. If you would like to enter your information yourself, go online to www.copower.org/homehelp/index.php.

See full Policy Memo on page 7

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