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Oregon Medicaid offers variety of choices for care

By Julie Lohuis, Attorney at Law

When family members consider getting help for a relative who has become less independent, they may know that financial circumstances make Medicaid the obvious choice. However, they may not know that Medicaid in Oregon offers a variety of care options that promote both independence and dignity. Oregon has a "Medicaid waiver" that allows recipients to choose options ranging from nursing facilities, residential care facilities, assisted living facilities, adult foster care, adult day care, and in-home care. The choices outside of nursing facilities are commonly referred to as "community-based care." While it is empowering to have choices, finding the best care option can be confusing for everyone involved. Each option comes with its own issues.

Nursing facilities

If an elder needs specialized care or skilled nursing, he or she may need to be moved into a nursing facility. Nursing facilities provide the highest level of care for both short-term and long-term Medicaid recipients.

What supplies and services does the Medicaid rate cover in nursing facilities?

The Medicaid rate paid to the facility is intended to be an all-inclusive rate that includes services, supplies, and facility equipment. OAR 411-070-0085(2)(a). Generally, the rate covers all nursing and support services, activities and social services, management of personal incidental funds, special diets, room and board, laundry, basic grooming supplies, haircuts, transportation, and oxygen and oxygen equipment. Depending on the need of the recipient, the nursing facility may receive additional payment for more complex nursing services. OAR 411-070-0027.

However, OAR 411-070-0085(2)(b) also lists services and supplies that are *not* included in the basic Medicaid rate paid to the nursing facility. Remember that Medicaid recipients are also on the Oregon Health Plan (OHP), and many of the services and supplies listed in this portion of the rule are covered by OHP. For example, although the nursing facility does not pay for transportation to and from medical care, OHP does cover medical transportation. Other examples of supplies and services not paid for by the nursing facility but covered by OHP include dental, vision, mental health, and durable medical equipment.

If a service or supply is not covered by the nursing facility as part of the Medicaid rate, a family should ask whether or not it would be covered by OHP. If the resident makes a medically appropriate request and OHP denies authorization, the resident, or his or her representative, should consider an appeal of the decision. The appeal process will vary, depending whether the patient has an OHP "open card" or is in "managed care." An open

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card means that he or she can receive care from any doctor, as long as that doctor is willing to accept OHP. Open cards are also called "fee-for-service." Open card recipients may appeal through the Department of Human Services (DHS), and obtain a hearing before an administrative law judge with the Office of Administrative Hearings. Managed care plans are more common than open cards. A recipient in managed care receives services through plans such as Care Oregon, Tuality, or Providence. If the Medicaid recipient is denied a service by a managed care provider, the notice of denial will describe the appeal process. There is no guarantee that all services not paid for by nursing facility basic Medicaid rate will be covered by OHP, but it is an alternative that an attorney can explore with a client.

What amenities can family members finance?

Although the basic nursing home rate includes a long list of services, family members may want to improve the quality of the patient's life by providing amenities that are not available through Medicaid. There are no administrative rules that specifically address this issue; however, the general rule that the Medicaid rate is an all-inclusive rate still applies.

If the Medicaid recipient has a medical need for a private room, that room must be provided and paid for by the nursing facility. A family's concerns about a shared room often arise out of medical or behavioral problems that are not being adequately addressed by the nursing facility. If that is the case, the family should consider requesting a private room and asking the facility to cover the cost. The nursing facility cannot accept additional private payment to "upgrade" to a private room.

Family members can pay for some amenities not paid for by Medicaid. They can take residents out to dinner, to concerts, and on outings. These types of amenities can go a long way in improving the quality of life for the resident.

What if a nursing facility insists that someone other than the Medicaid recipient sign a guarantee of payment or that the resident pay privately before applying for Medicaid?

These types of arrangements are prohibited. A Medicaid nursing facility must accept Medicaid payment as payment in full. A nursing facility with a Medicaid contract may not require someone other than the resident to sign a guarantee of payment. OAR 411-070-0010(2)(c) states that a facility "must not require, solicit or accept payment, the promise of payment, a period of residence as a private pay resident, or any other consideration as a condition of admission, continued stay, or provision of care or service from the resident, relatives, or any one designated as a 'responsible party.'"

DHS regulates compliance with the rules discussed above and it reserves the right to deny, terminate, or not renew contracts with providers who violate the payment provisions. Patients and their families can report violations directly to their local adult protective services worker. They can also call the Office of Licensing and Quality of Care at 800.232.3020.

Community-based care

If an elder and his or her family would like to explore options other than nursing facilities, there are several community-based choices. Although the services covered by the Medicaid rate are similar to those for nursing facilities, not all the community-based choices provide skilled nursing care. It is important to know the abilities and limits of the care recipient when choosing where to live because some choices require a higher degree of independence than others. Some families may want to consult with a geriatric care manager who specializes in community-based placements.

Residential care facilities

Residential care facilities (RCFs) are an alternative to nursing homes that can offer a greater degree of independence for residents. They provide housing and support services for recipients who do not need twenty-four-hour nursing care. The administrative rules that establish standards of care in RCFs are found in Chapter 11, Division 55 of the Oregon Administrative Rules. Each resident is required to have a screening and a service plan that reflects both the resident's needs and decisions. OAR 411-055-0180.

The specific list of services that the RCF is required to provide is found at OAR 411-055-0210. Generally the RCF should provide room and board, all meals and modified special diets, personal and other laundry services, social and recreational activities, services to assist the resident in performing all activities of daily living twenty-four hours a day, and transportation for medical and social purposes. In addition, the RCF also must provide a wide variety of health services, including medication

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management and disbursement. RCFs are not required to have private bathrooms and kitchenettes, and residents may have to share rooms.

Assisted living facilities

Assisted living facilities (ALFs) are similar to RCFs because they provide housing and supportive services to recipients who do not need round-the-clock nursing care. ALFs can offer more independent living than RCFs because they provide both private bathrooms and small kitchens in the apartment. Many Medicaid recipients living in an ALF also have a private room. Chapter 411, Division 56 of the Oregon Administrative Rules governs the licensing and operation of ALFs. OAR 411-056-0015 sets forth the range of services the ALF must provide under the Medicaid rate. Like RCFs, ALFs provide intermittent nursing services for residents whose medical needs are stable and predictable.

Adult foster homes

Adult foster homes offer a unique care option for a Medicaid recipient. Instead of providing a large facility with many residents, adult foster homes operate in private residences and are limited to a maximum of five residents. Adult foster homes are licensed either by the state or the county, and the regulations governing them are found in Chapter 411, Division 50 of the Oregon Administrative Rules. Division 50 sets forth detailed requirements about services, and health and safety standards. The specific supplies and services that an adult foster home must provide are covered in OAR 411-050-0445. The rule sets forth detailed requirements for bathroom facilities, the size of rooms, and meals. A resident in an adult foster home generally will not have a private kitchen or bathroom.

In-home care

If a Medicaid recipient elects to receive in-home care, DHS will conduct an assessment to determine how many hours of care the recipient requires. The assessment determines the recipient's service priority level (SPL). There are eighteen possible SPLs, but only levels one through thirteen are currently funded by the state. OAR 411-015-0010. The activities of daily living, which are an important part of determining the service priority level, are defined in OAR 411-015-0006. Do not rely on old copies of the rule because it changes frequently. If an applicant is denied based on their SPL, an attorney should review the file and assessment and determine if an administrative hearing is appropriate.

Even if an applicant is at a funded SPL, the number of authorized hours may fall woefully short of meeting the recipient's needs. In situations like this, family members may want to cover the difference by paying for more hours of care. However, family members should be advised that paying for additional Medicaid-related care is not allowed under the Medicaid program for in-home care. OAR 411-030-0050(3)(d) states that the service plan developed by the case manager is considered full payment for services and additional payment to a home care worker for the same services is prohibited.

If the hours paid by DHS are not sufficient to cover the recipient's needs, the care recipient or his or her representative may want to ask for a new assessment, especially if the recipient's needs have changed or worsened. It can be helpful to have a caregiver be involved in the process. If the assessment does not appropriately adjust the hours of care, the family or recipient can file an administrative appeal.

Although family members may not supplement services provided by Medicaid, they can pay for tasks not considered a Medicaid service. For example, a family member could hire someone to come and take the recipient to a concert or play. The family must be careful that they are truly providing supplemental services, and not encroaching on Medicaid's decision about the activities of daily living. If there is a question about what Medicaid covers, the family could review the recipient's assessment or task list.

An important consideration for family members seeking to supplement Medicaid services for in-home care is the "natural supports rule." In Oregon, payment for in-home services is authorized only when resources (natural supports) are not available, not sufficient, or cannot be developed to adequately meet the needs of the individual. OAR 411-030-00401(1). For example, when a family member cares for a Medicaid recipient after work, DHS may reduce the total number of hours of compensated care by the number of hours the family member voluntarily provides care. This is a gray area, because certain applications of the rule may violate federal Medicaid law.

Federal Medicaid law prohibits states from taking into account the financial responsibility of any individual for any applicant or recipient of assistance unless the applicant or recipient is the individual's spouse or the individual's child under age 21. 42 USC §1396(a)(17)(D). State courts have recently invalidated rules that considered live-in caregivers financial resources. *Jensen v. Missouri Department of Health and Senior Services*, 186 SW3d 857(2006); *Gaspar v. The Department of Social and Health Services,* 12 Wn App 42 (2006). If this rule is applied to reduce the number of hours, a careful analysis of DHS's reasons for applying the rule is very important in determining whether or not federal law is at issue. Remember that the Medicaid recipient has forty-five days from the date of notice to request a hearing.

Finding the right fit

When considering what type of care setting is the best for a Medicaid recipient, it is important to understand the person's abilities and medical needs. The good news is that elders who in the past moved directly into nursing facilities now enjoy a greater degree of independence in less-restrictive settings. These opportunities have improved the quality of life for most Medicaid recipients and it is hoped the trend to increase independent choices will continue. ■

Questions and answers about developmental disability support services

By Jim Wrigley, Attorney at Law

People with developmental disabilities such as mental retardation, autism, or cerebral palsy frequently need assistance of different kinds in order to live active, productive lives in their communities. With the signing of the agreement in *Staley v. Kitzhaber* in 2000, Oregon embarked on a new approach to providing services to people with developmental disabilities. The agreement led to the establishment of a system under which support services are delivered through private, nonprofit brokerages, using a self-determination model that allows an individual with developmental disabilities choice and control of services through an individual budget.

Who is eligible?

An individual may be found eligible as either a person with mental retardation or a person with other developmental disabilities. To be found eligible as a person with mental retardation, there must be evidence that the individual had mental retardation before the age of 18. Other developmental disabilities are ones in which the individual does not have a significantly lower IQ, but requires training and support similar to that required by individuals with mental retardation. For example, some people with autism or cerebral palsy may fit into this category. There must be evidence that this disability existed before the age of 22.

In order to receive support services, individuals with developmental disabilities must apply to their local county developmental disabilities program. To determine eligibility, the county looks at school records, psychological evaluations, and other records from before the age of 18 or 22 that relate to the individual's disability. In the absence of such records, the county may consider current information. The county also considers adaptive assessments, because to be eligible the individual must have significant deficits in adaptive skills—skills such as working, learning, or performing basic activities of daily living.

All adults eligible for developmental disabilities services are entitled to receive support services, regardless of whether they qualify for the state's Medicaid waiver program. However, individuals who do not qualify for the state's Medicaid waiver program are not eligible for the same level of services as individuals who do.

How long does it take to begin receiving services?

There is a waiting list for support services, with certain groups receiving priority—for example, adults in crisis, people with aging caregivers, and students who are becoming too old for school. However, by the end of the upcoming biennium (2007-2009) the state is obligated under the *Staley* agreement to have enrolled everyone who is waiting for services. During the following biennium (2009–2011), services to individuals must begin within 90 days after determination of eligibility.

How does the planning process work?

When an individual needs support services, the individual's county case manager refers him or her to a brokerage. Brokerages are independent organizations that help to arrange and pay for support services. Each individual enrolled in a brokerage has a personal agent (PA), who is responsible for making sure that the individual's support needs are met. The PA helps develop an individual support plan, based on the needs identified through a person-centered planning process. This process, which typically involves family and others important to the individual, is intended to ensure that the plan reflects the individual's needs and wishes. The plan must take into account not only services funded by the developmental disabilities system, but also unpaid natural supports, such as assistance from family members or neighbors, as well as other publicly funded services such as food stamps.

What role does the personal agent play in implementing the plan?

The PA is responsible for ensuring that the plan is carried out and services are coordinated. The individual who receives the services is legally the employer of service providers, but the brokerage acts as the fiscal agent and pays them.

What benefits are available?

Because they are tailored to the individual, plans may contain many possible types of services. A plan might cover assistance with basic care needs such as bathing, assistance with house cleaning, assistance and instruction regarding getting around the community, and engaging in community activities. It might also include job coaching or behavior consultation and support .

The financial benefits available to individuals for support services range from $3,840 to $20,000 per year. The basic benefit for individuals eligible for the Medicaid waiver is $9,600 per year. For individuals not

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eligible for the Medicaid waiver, the basic benefit is $3,840. More money is available to some individuals who through a formal assessment process are determined to have long-term, significant support needs.

Some individuals may require more support than the brokerage support services system can provide. Comprehensive services, typically 24-hour residential care in a foster home or group home, are available to a limited number of individuals. In addition, in unusual cases, comprehensive services costing more than $20,000 per year can be offered in the individual's home.

Where can I get more information?

The Oregon Advocacy Center, together with the Oregon Council on Developmental Disabilities, and the Oregon Department of Human Services, recently developed a brochure entitled "A Roadmap to Support Services." It is available on the web at **www.oradvocacy.org**. This brochure gives a fuller picture of how the developmental disabilities support services system works.

The state rules governing support services are found at OAR 411-340-0010 through 411-340-0180. ■

For the past ten years, Jim Wrigley has been an attorney at the Oregon Advocacy Center, the state protection and advocacy agency for people with disabilities. He represents many people with developmental disabilities. He was one of the attorneys for the plaintiffs in Staley v. Kitzhaber, *which led to the establishment of the current developmental disabilities support services system.*

Important elder law numbers

as of October 1, 2006

Supplemental Security Income (SSI) Benefit Standards	Eligible individual.....$603/month Eligible couple.....$904/month
Medicaid (Oregon)	Long term care income cap.....$1,809/month Community spouse minimum resource standard..... $19,908 Community spouse maximum resource standard.....$99,540 Community Spouse Minimum and Maximum Monthly Allowance Standards.....$1,650/month; $2,488.50/month Excess shelter allowance..... Amount above $495/month Food stamp utility allowance used to figure excess shelter allowance.....$292/month Personal needs allowance in nursing home.....$30/month Personal needs allowance in community-based care.....$136/month Room & board rate for community-based care facilities..... $468.70/month OSIP maintenance standard for person receiving in-home services.....$604.70 Average private pay rate for calculating ineligibility for applications made on or after October 1, 2006.....$5,360/month
Medicare	Part B premium..... $88.50/month Part B deductible..... $124/year Part A hospital deductible per illness spell.....$952 Skilled nursing facility co-insurance for days 21-100.....$119/day

Outstanding warrant can lead to loss of government benefits

By Jenny Kaufmann, Attorney at Law

People are sometimes shocked to find that an outstanding warrant for unpaid parking tickets can cause them to lose Social Security benefits. The Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA) brought significant changes to eligibility for Supplemental Security Income (SSI), food stamps, and Adults and Families with Children (AFDC), including the prohibition of payment of benefits for any individual who is alleged to be a fugitive felon or probation violator.[1] Congress extended the prohibition of payment to most veterans benefits[2] and finally to all Social Security benefits.[3] (Family members who are not fugitive felons or probation violators remain eligible for cash payments through Social Security.) When the restriction on payment of cash benefits was extended to include Title II Social Security benefits, Congress included a good-cause exception to the nonpayment provisions if the underlying criminal offense was nonviolent and not drug-related. Fortunately, the eligibility restrictions do not apply to healthcare benefits paid through Medicare, Medicaid, or Department of Veterans Affairs. However, the payment restrictions for Social Security and SSI cash benefits have had a significant impact on the elderly and persons with disabilities.

The statute itself defines a fugitive felon or probation violator as someone who is "(a) fleeing to avoid prosecution or custody or confinement after conviction, under the laws of the place from which the person flees, for a crime, or an attempt to commit a crime, which is a felony of the laws of the place from which the person flees, or in the case of the State of New Jersey is a high misdemeanor under the laws of such state, or (b) is violating a condition of probation or parole under Federal or State law." 42 U.S.C. § 1382(e)(4) (2002).

Social Security has promulgated regulations and policies implementing the statute that narrowly define both parts of the statute. See 20 CFR §§ 404.471 (proposed) and 416.1339. Many advocates believe that the suspension of benefits has not proven itself to be the useful law enforcement tool that Congress intended. Instead it has served only to penalize some of the most vulnerable members of our society, because it leaves them without the vital cash assistance they need to pay for their basic needs and because the jurisdiction from which they are alleged to be fleeing will not pay for them to be extradited. The Social Security Administration's Office of the Inspector General reported in its June 2002 Fact Sheet, Fugitive Felon Program, that of 77,933 SSI recipients with outstanding warrants, only 7,951 were arrested.

What the law says

Part B of the statute is the most punitive, because it merely requires the violation of a condition of probation or parole of any offense, no matter how trivial. In Oregon this includes misdemeanors and violations, as well as local warrants intended to keep a person out of the charging jurisdiction. It could mean the mere failure to pay a fine, keep an appointment, or obtain permission to move and have supervision transferred to the new jurisdiction.

Part A is more complicated because it requires the individual to actually be fleeing to avoid prosecution, or custody or confinement. 20 CFR §404. (proposed) and §416.1339(b)(1)(I). It also requires that the underlying crime be a felony, as defined by the law of the place where the offense was committed.

How Social Security applies the law

The regulation promulgated by the Social Security Administration (SSA) for SSI and the one proposed for Title II benefits appear straightforward and basically restate the statute.[4] Suspension of benefits is effective on the first day of the "month in which a warrant or order for the individual's arrest or apprehension, an order requiring the individual's appearance before a court or other appropriate tribunal … is issued by a court or other duly authorized tribunal on the basis of an appropriate finding that the individual" is fleeing or has fled to avoid prosecution. *Id.* (emphasis added).

It is the day-to-day practice of SSA, through the policies found in its Program Operations Manual System (POMS) that is problematic and viewed by many advocates as purely punitive. POMS defines "fleeing" as requiring an active warrant without a specific finding of intent to flee. This interpretation has been and continues to be successfully challenged in federal court.

How the courts have interpreted SSA regulations

The courts, with more experience in criminal law and using a plain language interpretation, have consistently found that an intent to flee must exist in order for a beneficiary to fall under the fugitive felon rules. *See Fowlkes v. Adamec*, 432 F.3d 90 (2nd Cir., 2005), *Hull v. Barnhart*, 336

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F.Supp. 2d 1113 (D. Ore. 2004); *Garnes v. Barnhart*, 352 F.Supp. 2d 1059 (N.D. Ca. 2004); *Thomas v. Barnhart*, 2004 WL 1529280 (D.Me. June 24, 2004); *Blakely v. Commissioner,* 330 F.Supp. 2d 910 (W.D. Mich. 2004).

The act of fleeing requires intent and under the SSA regulations, benefits cannot be suspended unless there is a warrant or order issued by a court or other authorized tribunal upon the basis of a finding that the individual fled or was fleeing to avoid prosecution. *Fowlkes,* 432 F.3d 90, 97. *Fowlkes* specifically rejected SSA's interpretation of the statute, as articulated in POMS, finding that the "plain language of the statute and its implementing regulation do not permit the construction contained within the manuals." Id. at 96. Further, the court held that the word fleeing "is understood to mean the conscious evasion of arrest or prosecution." *Id.* at 96. Finally, the court noted that the commissioner's own regulation, 20 CFR § 416.1339(b)(1), "may be stricter than the statute, insofar as is provides" that a suspension is not effective until there is "a warrant or order issued by a court or other authorized tribunal on the basis of a finding that an individual fled or was fleeing from justice. The regulation does not permit the agency to make a finding of flight; rather it demands a court or other appropriate tribunal to have issued a warrant or order based on a finding of flight." Id. SSA has issued Acquiescence Ruling 06-1(2) to implement *Fowlkes* but it is applicable only in the Second Circuit.

The good-cause exception to the nonpayment provision

The good cause provision of the Social Security Protection Act (SSPA) provides for both mandatory exception for good cause under very specific conditions, and discretionary good-cause exception as provided by the Commissioner of SSA. Mandatory good cause exists whenever the court finds an individual not guilty, dismisses the charges, vacates the warrant, or issues any similar exonerating order related to the criminal offense or probation/parole violation. POMS GN 02613.025(B)(1). A request for mandatory good cause can be made at any time. If mandatory good cause is found, the individual's benefits will be reinstated and all suspended payments repaid.

The SSA Commissioner has provided for a very narrow application of discretionary good cause, under limited circumstances. POMS GN 02613.025(B)(2). The crime must be nonviolent and not drug related, and the individual must not have been convicted of any subsequent felony since the warrant was issued. If these conditions are met, good cause will be granted if: (a) the law enforcement agency where the warrant was issued will not extradite or is unwilling to act on the warrant, or (b) the warrant is the only one that exists, was issued 10 or more years before SSA matched the information, and the individual lacks the mental capacity to resolve the warrant, is incapable of managing payments, is legally incompetent, has a representative payee, or resides in a long term care facility. Often it is difficult for the beneficiary to obtain documentation that the foreign jurisdiction will not extradite. (The SSA, however, does know whether or not the foreign jurisdiction will extradite because once it discovers the presence of a warrant, it contacts the appropriate law enforcement agency and provides it with the name and contact information for the "fugitive.") It is only after the law enforcement agency fails to pick the person up (usually 90 days later) that a suspension notice will be issued.

The SSA Commissioner also clarified the effect of plea bargains in these cases. When an individual is charged with a felony but then pleads guilty to a lesser charge, the underlying felony charge is considered dismissed and the mandatory good cause provisions will be applied. POMS GN 02613.025(B)(3).

The individual must, however, affirmatively request good cause under the discretionary provisions. The request must be made within 12 months either from the date of the Advance Notice of Suspension, after receiving the initial award notice, or after receiving an initial determination of suspension under the fugitive felon or probation/parole violation suspension notice. A beneficiary's benefits will continue if he or she requests good cause within the due process period (10 days for SSI benefits; 30 days for OASDI (Title II) benefits). POMS GN 02613.025(B)(3). The burden is on the beneficiary to establish good cause. Field offices often have not accepted the initial offering of proof because it was not on court or law-enforcement letterhead, even though court dockets showing the dismissal or vacating of a warrant are supposed to be adequate. As a practical point, advocates should realize that many court orders and dockets dealing with a warrant are form orders with little identifying information and by themselves are insufficient to satisfy the field office. The beneficiary usually has to request a letter from the court or law enforcement agency. The evidence must be submitted within 90 days or good cause will be denied. Any denial can of course be appealed, but the loss of benefits continues until the appeals process is completed, and that can take years.

Outstanding warrants can cause hardship

The fugitive felon (or fleeing felon) rules have been detrimental to a significant number of individuals whose only source of income is Social Security or SSI benefits. Many do not have the resources or ability to resolve outstanding warrants. It is important to remember that affirmative steps must be taken early in the suspension process and that it often takes more than 90 days to resolve the warrant. Many larger cities and jurisdictions are well aware of the problems facing these beneficiaries and some even have designated staff to

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help. Nonetheless, when there is an outstanding warrant, it just takes time to gather and present the evidence needed to prove that the person in question has had no significant or recent legal problems and to negotiate a settlement with the prosecutor in that jurisdiction. In the interim, government-paid medical benefits which are unaffected by the fugitive felon rules should continue and may even be expanded because of the loss of income. ■

Footnotes

1. Pub. L. 104-193, 110 Stat 2105 §202 (Supplemental Security Income), §821 (Temporary Assistance for Needy Families and Food Stamps), §903 (Housing Assistance)
2. Pub. L. No. 107-103 §505(a)(1), 115 Stat. 995 (2001)
3. Social Security Protection Act (SSPA), Pub. L. No. 108-203 (2004)
4. The Social Security Administration proposed new rules to implement Pub. L. 108-203 on December 5, 2005. Fed. Reg. Vol. 70, No. 232, 72411-72416 (Dec. 5, 2005). The proposed rules would change the Title II rules to amend 404.401(d)(5) by adding a "new reason" for the nonpayment of benefits and a new provision, 404.471, on the nonpayment of benefits unless one of the good-cause exceptions can be applied. Finally, the NPRM amends the SSI fugitive felon rule, 416.1339, to provide for the good cause exceptions. No final rules have been published.

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Examples of problems caused by outstanding warrants

Jane Doe was well known in her small town in eastern Oregon for being the "town drunk." In order to keep her out of town, the local law-enforcement agency would issue a local warrant every couple of years. Jane had lost both of her upper limbs after being hit by a bus and her only source of income and help was SSI and Medicaid. After having left town, as requested, the local warrant was re-issued and Jane lost her SSI benefits and almost lost her housing. She was forced to return "home" and was promptly asked to leave.

Twelve years ago, Tom Jones, a person with AIDS, was convicted of driving under the influence in Florida. He moved to San Francisco thinking he had fully served his sentence. However, he had failed to complete three hours of community service, a technical violation of his probation. A warrant was issued but Florida refused to extradite him and he was unable to pay for a ticket back to Florida, nor was he able to travel because he was supposed to undergo double hip-replacement surgery. He lost his income and had to fight for reinstatement of Medi-Cal.

Frank Smith, a resident of Valdosta, Georgia, was indicted in Portland more than twenty years ago, without his knowledge, for allegedly manufacturing and delivering a controlled substance. He now has emphysema and severe asthma and is on an oxygen machine, unable to travel. His disability benefits were terminated even though Oregon did not want him back in the state and refused to pursue the charges.

Mary Martin, a great-grandmother, lost her SSI benefits for failing to complete the terms of her 1973 probation on drug charges.

Bobby-Jo Smith fled his abusive home in Georgia approximately ten years ago and moved to California. His family, ashamed of his homosexuality and wanting to make sure he did not return to their hometown, accused him of theft and filed charges with the local law enforcement agency. A warrant was issued for his arrest if he returned to Georgia. His SSI benefits were terminated until he was able to prove that the charges were unfounded.

New Developments in Elder Law

By Cynthia L. Barrett, Attorney at Law

Deficit Reduction Act of 2005: Transfers and payment for care during the penalty period

Oregon moved swiftly to implement the Deficit Reduction Act of 2005 (DRA) restrictions on transfers. Its new forms for transfer penalty denial of benefit and hardship waiver are causing some buzz. The state expects someone who plans to seek return of assets through a hardship waiver to get legal counsel and to cooperate with the state's efforts to recover the assets.

If a client plans pre-Medicaid transfers to someone other than a spouse, disabled child, or caretaker child—the most common blessed transfers permitted by 42 USC 1396p(c)(2)—an Oregon elder law attorney will want to avoid making a hardship application during a penalty period.

All states are reviewing their administrative rules, statutes, and CMS-approved plans to determine what modifications are needed to implement the DRA-mandated eligibility changes, and Medicaid transfer planning is in a state of flux.

Under the new DRA rules the likely focus will be on

1. waiting out the five-year look-back period after significant transfers, hoping not to need care or retaining sufficient assets to privately pay for care if needed
2. holding on to some assets, which are placed in a noncountable form, to pay for care during the mandatory disqualification period after application

There are two steps for a post-DRA transfer strategy:

1. Make a transfer of part of the countable (or exempt, depending on the facts) resources.
2. Keep some assets (countable or exempt), and plan to "convert" those assets to an income stream when "otherwise eligible" for Medicaid, then apply for benefits and start the penalty period running. The client uses the income stream to pay for care during the penalty period, applying again when the penalty period is over.

The most common income stream conversion techniques will be land sales contracts, short-term commercial annuities, and promissory notes. Some interesting wrinkles on the conversion techniques are being tried. In New York, several Medicaid applicants have transferred assets and simultaneously converted retained assets to a grantor retained annuity trust (GRAT), have applied and been denied because of the transfers, and are waiting out their penalty period. They will apply again when the penalty period imposed by the earlier transfers has ended. The GRAT makes as much sense as a commercial annuity or promissory note, and allows the assets to be held in a secure form by an independent trustee who doles back the funds to pay for needed care during the disqualification period.

Some elder law attorneys are concerned that funds loaned to children under promissory notes might never make it back to the elder during the disqualification period. In Ohio, some Medicaid applicants are transferring assets, then loaning the retained assets to a corporation, taking back a promissory note. Then, the clients apply for Medicaid, are denied for the transfers, and now wait out the penalty period using the note payments for needed care. Loaning the funds to a business entity controlled by a third party is more secure than loaning the funds to family members, who might divert the funds needed by the elder for care during the penalty period. As far as I have heard, these innovative techniques are still untested in Oregon.

Transfer strategies (other than the blessed transfers described above) will require the lawyer to determine which assets can be retained and converted to the care-payment income stream, and when exactly to trigger the start of the transfer penalty. The client will need careful monitoring during the entire five-year look-back period after the transfers. If the penalty period is not triggered as expected, or the client runs out of money during the penalty period, the Oregon hardship waiver requires that the client try to get the assets back. If its bill is unpaid, a nursing home may sue the transferees. See *Beverly HealthCare Brandywood v. Betty L. Gammon, et al*. 2005 Tenn. App. Lexis 502 (2005) where the nursing home was award-

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This is the first in a series of columns that highlight trends in the practice of elder law, both locally and nationally, and direct the practitioner to helpful resources including recent cases, administrative rules, and Web sites.

This issue's topics:

- *Deficit Reduction Act of 2005 and its effect on transfer strategies*
- *Mental health parity administrative rules*
- *California conservator law changes*
- *New Private Letter Ruling about special needs trusts and IRAs*
- *Estate recovery in the news*

New developments

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ed judgment for unpaid care costs and attorney fees against the transferee children after the elder's Medicaid benefits were denied.

Where transfers that create a penalty period are part of clients' planning, lawyers are creating an income stream to pay for care during the planned period of transfer. The client who transfers assets needs a payment source during the disqualification period. The client relies on long-term-care insurance or converts retained assets to a short-term stream of income to pay for care, using a commercial annuity, a grantor retained annuity trust (GRAT), a nonnegotiable promissory note (to responsible child or to independent entity created to be the debtor), or a land sales contract of all or partial interest in exempt residence. These income streams are owned by the client who has transferred other assets, are fully disclosed, and do not in and of themselves create another period of disqualification. The elder law attorney helps make sure a commercial annuity meets the requirements of the DRA, or drafts the GRAT, promissory note, or land sales contract. If the client makes a loan to a newly created independent entity, the lawyer will set up that entity to help protect the funds against pilfering or business risks during the penalty period.

Mental Health Parity: new administrative rules

Mental health parity laws vary tremendously from state to state. New administrative rules that implement the 2005 legislative session's mental health parity bill are effective January 1, 2007. ORS 743.556 requires group health insurance policies to cover expenses arising from treatment for chemical dependency and mental or nervous conditions "at the same level as, and subject to limitations no more restrictive than, those imposed on coverage or reimbursement of expenses arising from treatment for other medical conditions." What does this mean to our clients, in practice? To get a good sense of the changes, we have to dive into the testimony and the July 17, 2006, *Summary of Testimony and Recommendation* by hearing officer Lewis Littlehales.

Go to the State of Oregon insurance division Web site at **www.cbs.state.or.us/ins**, search for "mental health parity," and find links to helpful material, including the new rules (OAR 836-053-1404, 836-053-1325-1330), industry training materials with industry questions and state answers, and SB 1 Advisory Committee meeting minutes. The Littlehales document is at **www.cbs.state.or.us/external/ins/rules/attachments/recently%20proposed/id13-2006_recommendation.pdf**

The mentally ill walk our streets like ghosts. There were 8,000 precommitment investigations last year in Oregon, resulting in 4,000 hearings, and 800 civil commitments, according to Oregon Civil Commitment Coordinator Jerry Williams, who co-presented with me at a Bend mental health conference in September. Relatives and friends of the mentally ill frequently consult elder law attorneys to plan for, or respond to the crises of, a mentally ill person.

If the family has resources, the elder law attorney may recommend a guardianship. The commitment process is dropped as the guardianship begins. In some cases, I recommend the commitment continue while the family gains the advocacy role as guardian. There is an intricate pattern of guardian/commitment processes, that merits deep analysis by elder law attorneys.

California licenses professional fiduciaries; requires fiduciary classes; prohibits fees from guardianship estate for unsuccessful opposition

In late September, Governor Schwarzenegger signed four California bills that dramatically changed the conservatorship landscape. The Professional Fiduciaries Act, SB 1550, creates a Professional Fiduciaries Bureau that will license and regulate professional fiduciaries effective July 1, 2008. The Omnibus Conservator and Guardian Reform Act, AB 1363, will reform court rules, require educational classes for all fiduciaries and *prohibit fees from the estate for unsuccessful opposition to a guardian petition* UNLESS the opposition was in good faith. SB 1716 will require more court review and home visits by court investigators. SB 1116 creates a presumption that the personal residence is the least restrictive appropriate residence for the protected person, and 15 days notice before removal from the home.

IRAs and special needs trusts: new private letter ruling

A disabled public benefit recipient is often named as an individual beneficiary of a deceased parent's IRA. The IRA is an available resource and must be reported to the benefit agency and spent down. Elder law attorneys usually recommend withdrawing the entire IRA, paying the income taxes, setting up a payback special needs trust, and funding the new trust with the net IRA proceeds after payment of income taxes.

Could the entire inherited IRA be diverted to a special needs trust? That is precisely what a very clever lawyer did, as shown in the Internal Revenue Service's Private Letter Ruling 200620025 (2/21/2006). The guardian for the disabled IRA beneficiary petitioned for establishment of the usual form of payback special needs trust. 42 U.S.C. 1396p(d)(4)(A). The trustee then sought permission from the IRS to use the disabled beneficiary's life expectancy payout for annual distributions from the new inherited IRA to the payback special needs trust. The

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IRS concluded that the payback trust (with the son as the sole beneficiary) was a grantor trust, so that the transfer of the disabled beneficiary's share of the father's IRA to an inherited IRA benefiting the trust was not a sale or disposition for federal income tax purposes.

The IRS permitted the inherited IRA to be transferred by means of a trustee-to-trustee transfer, from the father's IRA to a new IRA set up and maintained in the name of the deceased taxpayer to benefit his son, through a special needs trust. The IRA allowed the guardian/trustee for the disabled beneficiary of an IRA to use the life expectancy payout for an inherited IRA made payable to a payback special needs trust [42 U.S.C. 1394p(d)(4)(A)] created as a receptacle for the IRA payments. The new trust was fully discretionary, and permitted accumulation of income.

Estate recovery in the news

Oregon's reputation for aggressive estate recovery is deserved. Oregon's Estate Administration Manager Roy Fredericks reported in a recent presentation that:

- Oregon recovered $20,000,000 in 2003.
- 10 to 15 percent of the Oregon recovery was from surviving spouses' estates.
- 20 to 25 percent of the total recovery was from survivorship interests including life estates, living trusts, and annuity remainders.
- Oregon recovers $14 for every $1 invested in the program.

Many states have little estate recovery enforcement. Michigan, despite CMS efforts and federal law, still has *no* estate recovery whatsoever. Louisiana has one staff person in its estate recovery department, and a liberal hardship policy. Georgia passed legislation exempting the first $100,000 of an estate from recovery, but CMS sent a letter in August 2006 to the Georgia Medicaid agency insisting the agency disregard the state exemption amount. California has eliminated recovery from "irrevocable" life estates (just what, pray tell, would a *revocable* life estate look like?), after initially adopting rules permitting such recovery. The California Department of Human Resources issued the following statement withdrawing life estate enforcement:

> "After the filing of R-32-00 (PDF; 337kb) with the Office of Administrative Law, the Department of Health Services (Department) continued to review and analyze the numerous public comments that had been received during the second public comment period for the package. As a result of that analysis, a policy decision was made to amend a portion of R-32-00 through regulations package R-14-04. The amendment will result in the removal of recovery efforts against the value of life estate only interests. The Department has now determined that during the short period of time in which R-32-00 as currently enacted will be in effect, it will not be cost effective for the Department to initiate or pursue recovery against life estate only interests. This decision is based on balancing the anticipated small dollar value associated with recovery for the few months R-32-00 would be in effect prior to the filing of R-14-04, against information obtained from advocates that the legality of life estate only interest recoveries would be challenged in the courts."

Oregon adopted expanded estate recovery against survivorship assets, including life estates, as well as probate assets, more than ten years ago. No Oregon elder law attorney encourages remainder interest gifts and retention of life estates. However, retention of life estates may become part of a post-DRA transfer strategy. A penalty period is generated by the transfer of the remainder interest, but the transferor who lives in the family home may plan to sell the life estate later, when otherwise eligible, to generate an income stream to pay for care during the penalty period. Oregon permits recovery against retained life estates, so planning to sell the interest to generate cash for needed care during the penalty period makes sense. (See *State of Oregon v. Willingham*, **www.publications.ojd.state.or.us/A126258.htm**)

To get a nationwide flavor of estate recovery and its economic impact, review the federal Department of Health and Human Services policy brief, *Medicaid Estate Recoveries* (September 2005) available with four other policy briefs on Medicaid payback at **aspe.hhs.gov/daltcp/reports/estaterec.htm.** ■

Report from Agency and Professional Relations subcommittee

By Sam Friedenberg

The Agency and Professional Relations subcommittee met with representatives of the Department of Human Services (DHS) on August 31, 2006. A number of issues were discussed and are summarized below.

Income-first rule

The Deficit Reduction Act of 2005 (DRA) mandated the income-first rule. This rule requires the ill spouse to contribute all his or her income to the healthy spouse before the state will allow the allocation of assets to increase the community spouse resource allowance (CSRA). Inevitably, the community spouse ends up with income instead of needed assets. A close reading of the DRA, however, suggests that the income-first rule may be mandated only in agency determinations or hearings. No reference to income-first appears in DRA provisions addressing court orders.

The income-first rule can leave the community spouse with fewer assets and most certainly with lower income when the institutionalized spouse dies. This is especially unfair if the community spouse is younger than the institutionalized spouse, has less Social Security income, and no survivorship rights to the institutionalized spouse's pension.

The APR subcommittee has requested that DHS consider exceptions to the income-first rule in court support cases where the community spouse can show probable harm from strict application of the rule. The subcommittee noted that other states have elected the more liberal interpretation on CSRA computation (the first $99,540) and DHS has the flexibility to make exceptions in compelling cases. DHS will consider this request.

Income cap trust

OAR 461-180-0044 makes the effective date of an income cap trust (ICT) the first day of the month in which it is signed. Though the rule is new, DHS states that this has always been its policy. Practitioners claim this has not been the agency's consistent practice.

A client may be unaware that he or she needs an ICT until late in the month, and the paperwork may not be signed until the next calendar month. Meanwhile, the client may be accumulating very high daily-care costs in a hospital. DHS noted that the Providence system and OHSU have designated employees to help Medicaid applicants. In other settings, such as Emanuel Hospital, the situation is less formal.

The APR subcommittee requested that DHS consider changing this rule to eliminate reliance on the calendar month and instead provide an effective date that treated clients equally regardless of when in the month they needed Medicaid services. One proposal is to allow the trust to be in place within 30 or 60 days of the Medicaid request.

Disqualifying transfers

DRA mandated a new method for determining when the period of ineligibility begins for a disqualifying transfer. OAR 461-140-0296(3) captures the beginning of the period of ineligibility depending on whether the client lives in a "standard living arrangement" (essentially at home and not on Medicaid or on SSI-linked Medicaid) or a "nonstandard living arrangement" (in a nursing home or receiving waivered services in any setting). The rules were discussed in the *Elder Law Newsletter* Summer 2006 (vol. 9, No. 3) issue.

DHS has concluded that for the purposes of transfers, the relevant living arrangement is the one in existence at the date of request for Medicaid and not at the time of the transfer. Hence, DHS will be eliminating OAR 461-140-0296(3)(c) and will review all post-July 1, 2006, transfers under OAR 461-140-0296(3)(d). That rule begins the period of ineligibility the later of (1) the month following the month the asset was transferred or (2) the date of request for Medicaid as long as client submits an application and would otherwise be eligible but for this disqualification period. This change is a big setback for clients living in the community (standard living arrangement) who wish to gift assets. A new rule will be noticed this fall to be effective January 1, 2007.

DHS expects some people will make disqualifying transfers and apply for benefits for the purpose of beginning the period of ineligibility. We were told that DHS has instructed offices to process applications, including service priority assessments, and code on DHS computer records all information necessary to establish the beginning period of ineligibility. This will allow the client and DHS to know when the penalty begins and ends.

Transfer penalty divisor

On October 1, 2006, the figure used to determine a period of ineligibility rose to $5,360.

Annuities – state as beneficiary

DRA requires that in some instances commercial annuities name the State of Oregon as death beneficiary. Apparently some companies issuing annuities are requiring the tax identification number (TIN) of the state. DHS has decided to use the TIN for the Estate Administration Unit. That number is available upon request.

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Elder Law Section holds annual meeting

The annual meeting of the membership of the Elder Law Section of the Oregon State Bar was held at the Oregon Convention Center in Portland on Friday, October 6, 2006.

Chair Jane Patterson called the meeting to order and presented the slate of nominations for officers and Executive Committee members. Nominations were accepted from the floor. The membership elected officers and Executive Committee members for 2007.

2007 Officers

Chair: Steven Heinrich
Chair-elect: Ryan Gibb
Secretary: Penny Davis
Treasurer: Sylvia Sycamore
Past Chair: S. Jane Patterson

New Members at Large

with terms through December 31, 2008
Daniel Robertson
Andrea Shartel
Ellyn Stier

Continuing Members at Large

with terms through December 31, 2008
Gary L. Vigna
Brian Haggerty

with terms ending December 31, 2007
J. Geoffrey Bernhardt
Susan Ford Burns
Sam Friedenberg
Leslie Kay
Stephen Owen
Brian Thompson

Treasurer Kristianne Cox reported that the section has 556 members, which exceeds the goal of 540. ■

Chair Jane Patterson calls the Section's annual meeting to order

APR Report

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LTC insurance-state partnership

DRA set guidelines for states to modify Medicaid eligibility rules for clients with qualifying long term care insurance. Essentially, a client would be allowed to keep resources equaling the amount of care paid for by the insurance. This project will take some time and it is unclear when rules will be proposed.

Current LTC insurance policies may not meet the requirements of the future state plan. Similarly, policies purchased between now and the final rules may also not qualify. Clients should be aware that while it is reasonable to assume that insurance companies will allow convertibility, it is not certain. Clients with policies or considering policies should inquire about the convertibility of their product. ■

High tech comes to elder care

One of the new technologies that has emerged as an option for caregivers or concerned family members with aging parents is the "home monitoring system."

The system operates around the clock and requires no input from the person being cared for. It works through small wireless motion sensors (not cameras) placed in key locations throughout the elder's home to collect and analyze information on activities of daily living, such as getting out of bed, using the bathroom, eating, and taking medicine. The system establishes the person's normal routines so that it can quickly detect when there are changes to those patterns. When something out of the ordinary occurs, such as a person failing to leave the bedroom in the morning or remaining in the bathroom too long (which could indicate a fall or other emergency), alerts are automatically sent to the caregiver via phone or e-mail. Family members can also check on the elder's patterns anytime via the system's secured Web site.

Some companies that offer this type of product are QuietCare, Healthsense, and GrandCare. Initial costs range from $300 to $2,000, with monthly fees from $50 to $90.

Annual Elder Law Section CLE program provides wealth of useful information

By Karen Knauerhase

The Elder Law Section held its annual daylong CLE seminar on October 6 at the Oregon Convention Center. A total of 201 attorneys attended the program, titled **The Elder Law Experience.** The seminar emphasized practical tips and strategies for experienced elder law attorneys, though the information provided was useful for attorneys in all stages of practice.

Steven Seymour began the day with a presentation on fiduciary responsibility. Referring to the children's book *Where the Wild Things Are*, Mr. Seymour discussed the attorney's role and responsibility in taming "wild" fiduciaries and beneficiaries. He also discussed warnings and advice for fiduciaries, including the use of letters of instruction for fiduciaries.

Brian Thompson reviewed drafting under the new Uniform Trust Code, including tips for use with special needs trusts and income cap trusts.

Dr. Maureen Nash, a geriatric psychiatrist with Tuality Forest Grove Hospital, and the Honorable Rita Batz Cobb, Washington County Circuit Court Judge, discussed dementia and competency in their presentation, *A Prescription for Guardianship.* Dr. Nash treats patients at the only dedicated acute geriatric psychiatry unit in Oregon. Dr. Nash taught attendees about the different types of dementia and their symptoms, including a lengthy discussion of Alzheimer's disease. Attendees also learned the difference between legal capacity, medical competency, and informed consent.

Cinda Conroyd, Penny Davis, Michael Edgel, and Sam Friedenberg discussed *Medicaid Changes and Challenges after the Deficit Reduction Act of 2005.* The panel presentation covered the Medicaid provisions of the DRA, Oregon rule changes, and the effect these changes will have on clients and planning options.

Representing Clients in Administrative Proceedings was the topic of the presentation by Stephen Skipton from Lane County Legal Aid and Advocacy Center in Eugene. He explained changes to Oregon's administrative hearing process as a result of the DRA, and how transfer penalties and hardship waivers are likely to be affected. He also shared practical advocacy tips with the group.

During the final presentation of the day, Tim McNeil enthusiastically explained *Ethics: Referrals and Responsibilities*, warning attendees of the risks of negligent referrals and attorney negligence.

For information about video replays of the program in your area, contact the Bar's CLE video replay hotline at 800.452.8260, ext. 502. The hotline is updated each Tuesday for that week's video replay schedule.

Audio and videotapes will also be available from the OSB CLE order desk at 503.684.7413 or 800.452.8260, ext. 413. ■

Deficit Reduction Act Panel: (l to r) Sam Friedenberg, Penny Davis, Cinda Conroyd, and Michael Edgel.

Mark Williams and Brian Haggerty

Valerie Vollmar and Steven Heinrich

Resources for elder law attorneys

EVENTS

Living with Alzheimer's Disease:
Help for Today & Hope for Tomorrow
October 28, 2006/8:30 a.m. to 3:30 p.m.
Good Samaritan Hospital, Corvallis
www.alznet.org

NAELA Certification Review Course
November 2, 2006
Salt Lake City, Utah
For more information on the NAELA Certification Review Course or NELF Certification Exam, visit the NELF Website at **www.nelf.org** or contact Lori Barbee, NELF Certification Coordinator at 520.881.1076, ext. 120 or lbarbee@naela.com.

NAELA 2006 Advanced Elder Law Institute:
"Re-Visioning the Practice"
November 2 to 5, 2006
Salt Lake City, Utah

Planning the Basic Estate
OSB seminar
November 3, 2006/8:45 a.m. to 4:30 p.m.
Oregon Convention Center, Portland
Planning, drafting and problem-solving for the basic estate, including: drafting basic wills, gifts to minors, advance directives, practice organization, working with clients with diminished capacity.
www.osbar.org

Estate Planning: Defective Trusts, Family Limited Entities, and Other Ways to Get into Trouble with the IRS
MBA CLE Seminar
Tuesday, November 7, 2006/3:00 to 5:00 p.m.
World Trade Center/Auditorium, Building 2
26 SW Salmon, Portland
This seminar on estate and business succession planning is designed to identify techniques and provide an update for the general and advanced estate planner.
www.mbabar.org

Reverse Mortgages: Staying at Home 101 and the DRA
NAELA teleconference
November 16, 2006/Noon to 1:30 p.m. PT
The #1 concern of seniors is..."I Want to Stay in My Home"...the solution may be one of the 'new' reverse mortgages...and why the DRA '05 loves that idea! Registration deadline November 1.
www.naela.com

Alzheimer's Disease and Other Dementias:
The Emerging Pandemic Affecting Your Practice
OSB seminar
November 17, 2006/ 8:45 a.m. to 4:30 p.m.
DoubleTree Hotel Lloyd Center, Portland
Learn how your practice will be affected by clients with dementia.
www.osbar.org

Estate Planning for Protected Persons and People with Disabilities
OLI Seminar
December 1, 2006/8:55 a.m. to 4:00 p.m.
Oregon Convention Center; Portland
Tools for planning for disability, as well as legal and medical perspectives on how to assess capacity
law.lclark.edu/org/oli

Magical Mystery Tour: Introduction to IRA and Retirement Plan Basics
NAELA teleconference
December 14, 2006/ Noon to 1:30 p.m.
Learn the basics of dealing with IRAs and retirement plans in estate and elder law, including required beginning dates, required minimum distributions, inherited IRAs and spousal rollovers.
www.naela.com

INTERNET

Elder Law Section Web site

www.osbar.org/sections/
elder/elderlaw.html

The Web site has useful links for elder law practitioners, past issues of the *Elder Law Newsletter,* and current elder law numbers.

Elder Law Section Electronic Discussion List

All members of the Elder Law Section are automatically signed up on the list, but your participation is not mandatory.

How to use the discussion list
Send a message to all members of the Elder Law Section distribution list by addressing it to: eldlaw@lists.osbar.org.

Replies are directed by default to the sender of the message ONLY. If you wish to send a reply to the entire list, you must change the address to: eldlaw@lists.osbar.org, or you can choose "Reply to all."

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Senior Law Project advisory committee seeks members

Are you interested in increasing and improving access to the legal system for elders in Multnomah County? If so, consider becoming a member of the Senior Law Project (SLP) advisory committee.

SLP is a volunteer program that Legal Aid Services of Oregon has operated since 1978. The program provides a free 30-minute consultation with a lawyer. Anyone who is 60 years or older, or married to someone over 60, qualifies for the service.

The advisory committee meets once a month and is charged with helping to guide and influence the policies of the SLP.

If you are interested in becoming a member, or would like more information, please contact Lynne Lloyd at 503.224.4086.