

LIFE CARE PLANNING
FOR
“THE REST OF YOUR LIFE”
2020

- ISSUES
- OPTIONS
- PITFALLS

BY

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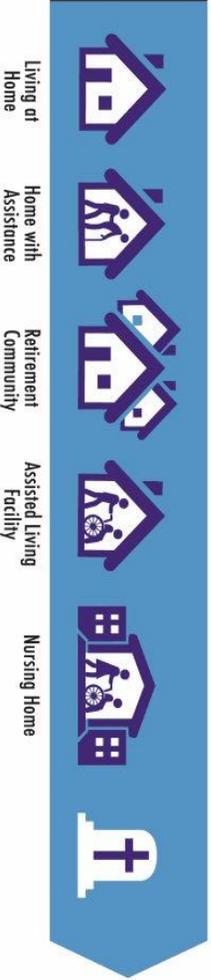
Amy has been a legal assistant since 1994, and began specializing in guardianship, Medicaid, and long-term care planning in 1996. Amy just completed her certificate of completion in Elder Care Coordination from Stockton University Venter on Successful Aging.

The Life Care Continuum

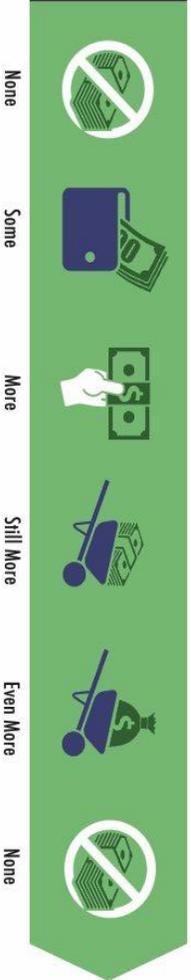
Health and Ability to Function



Home Sweet Home



Cost of Care



Public Benefits and Resources

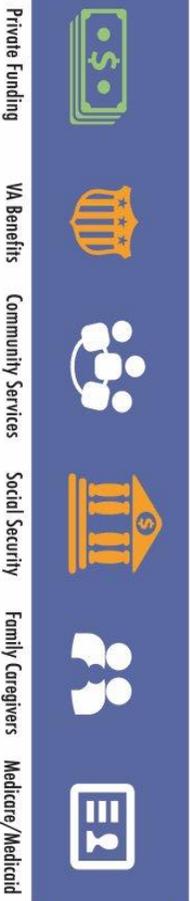


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Life Care Planning

Introduction:

In 43 years of practicing estate planning, I have focused primarily on how to effectively distribute my clients' estates at passing to avoid probate and disputes. During the last 20 years, I have begun emphasizing planning to ensure the estate you have earned during your life is used to optimize your quality of life until you pass away. Not one client has told me that they wanted to die in a medical facility hooked up to some machine and yet many of my clients who have passed away, have had that awful experience. How do you feel about this?

We are eager to take time to plan for vacations; Where will we go? How will we get there? What do we take with us? What will we do when we arrive? ---- no one that I know has planned for what could be the most important trip of our lives, the one that almost everyone will take – our “end-of-life” journey.

If taking a vacation is worth investing time to plan, the end our lives, if we want them to happen according our plans and preferences, need planning. Yes, you can plan the “rest-of-your-life”/”end-of-your-life” as to health care and quality of life choices. Maybe not the “how”, but certainly how it does or doesn't not happen. For example, if you would rather die peacefully in your own home, that can be planned for in a way that is legally effective and enforceable.

You may not be able to plan to the same degree of detail that you do for a vacation, but “rest-of-your-life”/”end-of-your-life” planning can be done to insure what you do and do not want to happen is legally and affectively in place – down to the range of detail you desire.

For example, do you care if you pass away in a medical facility

hooked up to some machine, or would you rather pass peacefully in your own home surrounded by family? Would you prefer to be cared for in a highly regimented care facility, or do you want to ensure that you have the greatest possibility of being cared for in your own home?

Some of us will take the “rest-of-your-life”/”end-of-your-life” journey through the path of catastrophic illness. While we will not likely know if or what it could be, we can plan for how, where, and with whom, it happens. We can ensure that what we do not want to happen in our treatment does

The “Rest of your Healthcare Life” can be planned for ahead of time.

not occur and that our preferences, especially related to quality of life issues are honored.

The “rest-of-your-life”/”end-of-your-life” planning is the process of making your choices and preferences legally and practically affective to the greatest degree possible. The legal tools used in this process are comprehensive durable powers of attorney and living trusts.

If you have worked hard to have a “good life”, it is worth your attention and effort to make sure you finish well --- by your terms and not by anyone else’s. Don’t let a stranger decide how you finish, plan today.

This “Little Blue Booklet” is an introduction to the issues, options, and pitfalls that will arise in your “rest-of-your-life”/”end-of-your-life” or catastrophic illness journey.

Primary Planning Goals:

Like planning a vacation, the individual options available for life care

planning can be overwhelming and complicated. When broken down into its essential parts, a clear strategy emerges. Successful life care planning can be broken down into three primary goals:

#1 – Selection of proper residential placement [where you are going and how you will get there], and finding a successful long-term fit based on physical needs and personal preferences;

#2 – Selection of how you want to receive care;

#3 – Selection of a financial plan [how much will it cost and how to pay for it].

Planning Steps – Catastrophic Illness

Start with the “Planning Steps for End-of-Life Planning” (above) and then add the following:

Diagnosis and Prognosis

- A “diagnosis” is the name given to your condition. What is your diagnosis – specifically? (multiple diagnosis?)
 - Research your diagnosis for predictable development; common medications and treatments, best physicians in the area.
 - What non-Western Medical Culture treatments are available?
- A “prognosis” tells where the “diagnosis” is now and where it is going in the future. “Life expectancy” is a key measure of a prognosis.
 - What likely developments/challenges are going to occur, and what are your established plans to deal with them?
- Proactive Steps:
 - Begin to measure and track your physical and cognitive functionality and plan for anticipated changes in any care needs.
 - Given your diagnosis and prognosis, what is important to you as you take this journey (be as specific as possible)

- Identify available resources: caregiving, financial, legal, relationship, physical, emotional.
- Establish and/or modify comprehensive Powers of Attorney.
- Is it important to you to limit the suffering your family experiences with you?

Placement and “Needs Analysis”

In order to make plans for the above primary goals, residential placement, care needs, and financial preparation, some essential information must first be obtained:

Diagnosis of Physical and Cognitive Challenges

The first key area of information necessary to make a solid long term care plan is the determination of any potential physical or cognitive challenges existing [what will the quality of your journey be like? Will you go by airplane or have to hitchhike?].

If you are going to have physical or cognitive challenges you must have an accurate diagnosis of the challenges you are facing. For example, if you have been diagnosed with “dementia”, you will need to know which of the many kinds of dementia you have. Just as it is not effective for your doctor to just tell you that “you are sick”, a specific diagnosis will allow you to better plan for future challenges that will arise. Planning without this information, it’s like trying to plan a vacation without knowing how you are going to travel. As we age, we understand that is not just the quantity of life that is important, but more so the quality of life. Knowing how your quality of life may be affected by some diagnosis is critical to a successful planning process.

The next important piece of information we need is the **prognosis for**

any physical or cognitive challenge. If our quality of life is going to be affected by the progression of a physical or cognitive challenge, then the more information we have about future developments will improve our ability to craft an effective plan. The difficulty here is that most doctors are reluctant to give any prognosis or life expectancy anticipated. But, if they are asked in terms of using such information to better plan a life journey and its financial consequences, they will usually provide a qualified opinion based on their experience. For example, a “prognosis” may tell us how we will be able to proceed on some of our journey or what assistance may be required to maintain an optimal quality of life as you travel to your destination.

You may be surprised to know that there are professionals who can provide a comprehensive assessment of needs and consequences of any diagnosis and prognosis. These professionals are called **geriatric care managers**. Their written assessments are called “care plans” and cover suggestions for present circumstances and suggestions for future needs. Not only are these plans created by caring people who are very experienced in the planning process, but their “neutral” perspective helps overcome many of the natural limitations and biases of family members. Additionally, if you implement any of their specific suggestions, expenses incurred can become tax deductible.

Planning Steps – End-of-Life Planning

“Where do you want to go in life”

- Where do you want to live?
 - Climate
 - Lifestyle

- What is your residential preference?
 - Home, condo, specific community
 - “Must have”
 - “Deal killers”
- What amenities are important?
- What relationships are important?
- Personal Quality of Life Preferences.

Where are you now?

- Location, residence, amenities
- “What is bothering you now?”

What barriers need to be overcome?

- Physical functionality?
- Cognitive functionality?
- Financial?
- Prior commitments?
- Relationships?

What are your medical goals and values?

- What kind of treatment do you want to avoid?
- Have you picked a good doctor?
- Do you prefer comfort over long life?
- How would you like to be cared for if illness arrives?
- Is independence or being supported more important to you?
- Do you prefer a shorter higher quality of life, or just long life?

Do you have a comprehensive Health Care Power of Attorney?

Medications

“Prescription drugs are an overlooked factor when planning for retirement. When used appropriately, medications help promote healthy aging physically, mentally, and financially.”

*Dr. Steven E. Rubin, M.D.
Board-certified Adult Psychiatrist
Geriatric Specialist*

One of the problems often encountered in geriatric care is the presence of numerous, often conflicting, medications. For persons with cognitive challenges, medications often decrease overall functionality at the cost of giving temporary relief of symptomatic issues.

A basic tenant of a comprehensive care plan is to minimize medications and eliminate unnecessary or damaging prescriptions whose “benefit” is outweighed by the consequences of their presence.

Anything unnatural put in the body comes with cost or consequence. If the body is to have the opportunity to heal itself, it must first not have to deal with the consequences of additional challenges.

While we would like to assume that medications prescribed are done with careful consideration as to consequences and interaction with other medications, often medications are directed to deal with some present issues without regard to other medications or overall long-term impact.

- Any form of anesthesia given to someone with cognitive issues is a very serious risk, not only for present health, but also for the time it takes for the brain to process and recover.
- Medications directed to make someone “more manageable” to caregivers for without any benefit to a patient is an improper direction.

“Wonder drugs” like steroids and antibiotics can actually take a person with cognitive challenge on a harrowing and dangerous experience, sometimes resulting in them being labeled as “combative” or “dangerous” --- thereby limiting their potential placement options --- even though the prescription was well-intended.

Types of Residential Placements

Home: Clearly, the most desired of the placement options is your own home. It is familiar and emotionally the most desired option, especially if you are experiencing any form of dementia. Before considering other options, consider bringing in someone to assist with areas of present needs. This will be more cost effective than other options until you reach a level of assistance approaching 24 hour care. Even when 24 hour care is needed, if it can be afforded, staying in your own home is usually the best and most emotionally supportive environment.

Additionally, this is the best place for a “hospice” level of care to be provided, if needed, and especially if there is support from family and/or community resources.

Assisted Living: This option can either be like being in an apartment complex or staying at a hotel that has its own restaurant. The level of care available is usually limited, but you can supplement with your own care givers. To some extent, this option is limited to a range of people that can effectively deal with the limited care giving or medical treatment provided by assisted living. The challenge with assisted living facilities is usually finding the right “social fit”. Some folks want to be left alone and do not want to be social by going to group meals or encouraged to participate in

group activities. This option can allow husband and wife to continue to live together.

Costs can range from **\$3,500 to \$6,000 per month**.

Group Home: If staying in your own home is physically or financial impractical, consider living in a “group home”. This placement is a regular single-family home or larger home where several folks, usually with similar challenges, live with someone who resides in the home with them to provide care, prepare meals and provide other services.

The challenge with group homes is finding the right fit. There are over 150 group homes in Washoe County, so you will need someone who is familiar with these facilities to select the one that best suits your needs both physically and emotionally. This is another service that can be provided by a geriatric care manager.

Costs can range from **\$2,500 to \$4,000 a month**.

Skilled Nursing Care: This is the highest level of care provided outside of a hospital environment and is also the most expensive level of care (**\$7,000 to \$10,000 per month**). All other care options should be exhausted before this level of care is considered.

Care Givers: Hire only qualified, licensed, and insured care givers. All others are a false bargain and could subject you to significant liability from injuries, wage and hour claims, and other unhappy results. Use an agency if possible and interview prospective care givers for best results.

Legal Planning Tools

Durable Powers of Attorney: These are **must have** documents that can save you thousands of dollars and many headaches. There are two kinds: one for *health care* and one for *financial management*. Without these forms two bad things can happen: either a stranger may wind up making decisions for you; or, because there is no one with authority, no decision can be made without going to court. There are two things that powers of attorney cannot do: grant authority to make residential placement, or effectuate a Spousal Resource Allocation to assist with Medicaid qualification.

Revocable Living Trusts: While some people use these only to avoid probate, a better use is to make detailed provisions for how you want your assets used during your life (or how you don't want them used, such as residential placement outside of your home) or how you want your estate managed after you pass away for the benefit of someone who would not be served by an outright distribution. Make sure you get thorough advice before considering a trust.

Wills: Remember, all property over \$25,000 in value passing by use of a Will (to someone other than a spouse) creates some forms of probate. Almost all property of significant value can easily be passed on by use of beneficiary designations, even cars and real property.

“Special Needs Trusts”: If you leave property to someone who is receiving governmental assistance, your gift may disqualify them from receiving benefits until after your gift is spent, after which they may need to requalify for their benefit. Not a good result! Consider using a Special Needs Trust to “supplement” their governmental benefit which will not disqualify them. This is also a trust used for leaving a gift to a spouse who is receiving Medicaid. If your spouse qualifies for Medicaid, your estate plan should be updated to include a Special Needs Trust.

*You have insurance in case your home catches fire or you are in an auto accident; where is your insurance if you have health care needs tomorrow?
-- A LIFE CARE PLAN*

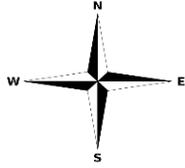
Nevada “POLST” form (Provider Order for Life-Sustaining Treatment)

This state-authorized form provides a means for the selection of choices regarding, “Medical Interventions”, and “CPR”, “Artificial Nutrition”. Although it is somewhat duplicative of options in state-authorized powers of attorney, this form has a key element that makes it more effective than similar provisions contained in power of attorney --- it is signed by your doctor after meeting with you and legally becomes “a doctor’s order”. It is highly recommended that everyone complete this form in addition to powers of attorney.

INCOME TAX PLANNING AND LONG TERM CARE EXPENSES

1. Payment of costs of long term care for a “chronically ill” individual is a deductible medical expense.
2. Covered are expenses to provide necessary diagnostic, preventive, therapeutic, treating, mitigating, rehabilitative, and maintenance, or personal care services. (I.R.C. §7702B(c)(1)).
3. Care must be provided pursuant to a plan of care prescribed by a physician, registered nurse, or licensed social worker.
4. A chronically ill person has either a severe functional or severe cognitive impairment.
5. Functional impairment - certification that individual needs substantial assistance with two or more of six activities of daily living and need was for at least 90 days.
6. Cognitive impairment - requires substantial supervision to protect his or her health or safety. “Severe cognitive impairment means a deterioration or loss in intellectual capacity that is measured by clinical evidence and standardized test that measure: (1) short/long term memory; (2) orientation to people, places, or time; and (3) deductive or abstract reasoning.” (H.R. Conf. Rep. No. 104-736 at 117 (1996)).
7. Must be certified annually.
8. Need record keeping and a formal plan of care must be followed to obtain deduction for in-home care.
9. No deduction is available for services provided by a spouse or other relative who is not a licensed professional.
10. Cost of obtaining guardianship may be deductible.

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