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If you have Parkinson's disease, you may face some unique legal and financial challenges. That's why it's important to consult with an elder law attorney who can help you plan for your future care and protect your rights. Below are a few detailed notes that are not complete but give an idea of what is available.

- Get your legal affairs in order.
  It's important to have a plan in place for your future care and finances.
  - will,
  - durable power of attorney,
  - health care proxy,
  - living will.
  - HIPPA Release

These documents allow you to appoint someone you trust to make decisions on your behalf if you become incapacitated.

- How to pay for care
  - Understand your insurance coverage.
  - Medicare does not cover custodial care or long-term care.
  - Employer provided retirement Health Insurance may not be the correct choice when LTC is needed.
- Know your rights.
  - You have rights as a patient with Parkinson's disease, so make sure you know what they are.
  - For example, you have the right
    - to access quality care,
    - to participate in your treatment decisions,
    - to refuse treatment, and
    - to seek a second opinion.
    - to privacy and confidentiality,
    - to file complaints, and

- § to seek legal recourse if your rights are violated.

- Consider long-term care options.

  It's important to consider your long-term care options early on so you can make informed decisions about your future care.
  - Long-term care refers to the services and support you may need if you have difficulty performing daily activities, such as bathing, dressing, eating, or moving around.
  - Long-term care options include home care, assisted living, nursing home care, and hospice care.
- Get help with government benefit planning.
  - Social Security Disability Insurance (SSDI),
  - Supplemental Security Income (SSI),
  - Medicare,
  - Medicaid
  - Veterans Affairs (VA) benefits.

  An elder law attorney can help you with government benefits planning and ensure that you're taking advantage of all available resources.

- **Veterans Benefit Administration**

"Low Income" Pension with Aid & Attendance

This is a low-income pension with spousal increment and aid and attendance. The benefit will allow the veteran to receive a monthly monetary payment, often due to the unreimbursed medical expenses the veteran or spouse incurs during the month. The VA includes IRA and Qualified Funds as an included resource for the net worth determination. The maximum net worth a veteran may have is $150,538.00 to obtain this benefit. Upon the death or divorce of either spouse, the payment of the pension will reduce. The survivor of a Veteran in need of a Pension will need to reapply for a survivor's pension.

$2,642.00 — Maximum for a Veteran & Spouse
$1,760.00 — Maximum for a Surviving Spouse Under DIC
$2,229.00 — Maximum for a Single Veteran

- In order to qualify for this benefit, the veteran must meet the requirements below:
  - Required Length of Service
  - The Veteran started on active duty before September 8, 1980, and served at least 90 days on active duty with at least 1 day during wartime, or
  - The Veteran started on active duty as an enlisted person after September 7, 1980, and served at least 24 months or the full period for which the veteran was called or ordered to active duty (with some exceptions) with at least 1 day during wartime, or
  - The Veteran, an officer and started on active duty after October 16, 1981, and hadn't previously served on active duty for at least 24 months.
  - Must be a Veteran of the Wartime Period
  - World War II (December 7, 1941, to December 31, 1946)
- Korean conflict (June 27, 1950, to January 31, 1955)
- Vietnam War era (November 1, 1955, to May 7, 1975, for Veterans who served in the Republic of Vietnam during that period. August 5, 1964, to May 7, 1975, for Veterans who served outside the Republic of Vietnam.)
- Gulf War (August 2, 1990, through a future date to be set by law or presidential proclamation)
- Must not have a dishonorable discharge,
- Must meet yearly family income and net worth limits set by Congress.

- Upon approval, two checks will be issued: a lump sum payment starting the month after the informal application until the award date and a monthly pension check.

- **VA Healthcare**

  This is a program offered to all enrolled Veterans.
  - a full range of preventive outpatient and
  - inpatient services
  - Home Base Primary Care,
  - prescription medications, and possible relocation to the
  - State VA Nursing Home

- **Veterans Health Administration**

Geriatric and Extended Care Copay Rates

- Ø Geriatric and extended care copay rates begin on the 22nd day of care during any 12-month period.
- Ø There is no copay for the initial 21 days.
- Ø The copay amount is based on the level of care and financial information. Refer to the table below for 2023 copay rates:

Level of care	Types of care included	Copay amount for each day of care
Inpatient care	▪ Short-term or long-term stays in a community living center (formerly called nursing homes) ▪ Overnight respite care (in-home or onsite care designed to give family caregivers a break, available up to 30 days each calendar year) ▪ Overnight geriatric evaluations (evaluations by a team of health care providers to help you and your family decide on a care plan)	Up to $97
Outpatient care	▪ Adult day health care (care in your home or at a facility that provides daytime social activities, companionship, recreation, care, and support) ▪ Daily respite care (in-home or onsite care designed to give family caregivers a break, available up to 30 days each calendar year) ▪ Geriatric evaluations that don't require an overnight stay (evaluations by a team of health care providers to help you and your family decide on a care plan)	Up to $15
Domiciliary care for homeless Veterans	▪ Short-term rehabilitation ▪ Long-term maintenance care	Up to $5

V [1]

[1] "2023 VA Health Care Copay Rates," Veterans Affairs, 2023, https://www.va.gov/health-care/copay-rates/.

- **Veterans Health Administration**
  Financial Assessment
  - determines if the Veteran is eligible for enrollment
  - whether or not the Veteran would be required to pay copays for care or prescription medication.
  - The VA is required by law to collect this information.

The VA provides no-cost care to:

- Veterans who cannot afford to pay for their care (Pension with Aid & Attendance),
- Veterans with catastrophic medical conditions,
- Veterans with a disability rating of 50 percent or higher, or
- For conditions that are officially rated as "service connected."

Blending Medicaid Managed Care and VA Long-Term Care is still a safety net to provide funding for Home and Community Based Care. Veterans receive blended Long Term Care Services and Support. Nursing Home needed funding is also in place (State Veterans Home as well).

- **Veterans Health Administration**
  VA Catastrophically Disabled Veteran
  A Veteran is considered to be Catastrophically Disabled when they have a severe injury, disorder, or disease that permanently compromises their ability to carry out the activities of daily living.

  - The disability must be of such a degree that the Veteran requires personal or mechanical assistance to leave home, get out of bed, or requires constant supervision to avoid physical harm to themselves or others.

  - Veterans determined Catastrophically Disabled are placed into Priority Group 4 unless eligible for a higher Priority Group placement based on other eligibility criteria, such as being a compensable service-connected Veteran, a former Prisoner of War, a Medal of Honor, or a Purple Heart recipient. The determination of the Catastrophically Disabled is performed by a VHA doctor.

- Request upon enrollment into the VHA or, if enrolled, request now.

- **Veterans Health Administration**
- **VA Home Based Primary Care (HBPC)**
- HBPC is a unique model of home care that is very different in the target population, process, and outcomes from home care that is available under Federal and State programs such as Medicare and Medicaid. HBPC targets those with complex chronic diseases that worsen over time and provide cost-effective primary care services in the home.
- Note: Use of Home-Based Primary Care would preclude the use of community care Medicare Doctors as Primary providers of care. Veterans may see a Medicare doctor for a second opinion.

- **Veterans Health Administration**
  Program of Comprehensive Assistance for Family Caregivers
  Offered to Family Members of Veterans
  - This program provides respite for 60 hours of care a month
  - Program of Comprehensive Assistance for Family Caregivers, which, among other things, provides certain benefits to eligible veterans who have incurred or aggravated serious injuries during military service and to their caregivers.
  - This part also implements the Program of General Caregiver Support Services, which provides support services to caregivers of covered veterans from all eras who are enrolled in the VA healthcare system.

- **Veterans Health Administration**
  VA Medical Foster Care Homes
  Medical Foster Care Homes are private homes that provide supportive care to veterans in a non-institutional setting.
  - The Veteran must be utilizing the VA Home Based Primary Care to be accepted into a VA Medical Foster Care Home.
  - The Home-Based Primary Care program monitors the placement and verification that appropriate day-to-day care is delivered.
  - It is noted that the Veteran is charged from their income, however, the VHA full payment of care at a state veterans nursing home at no cost.

- **VA Healthcare**
- **VA Veteran Directed Care (VDC)**
- The VDC program provides veterans with opportunities to self-direct their LTSS and continue living independently at home.
  - Eligible veterans manage their own flexible budgets, decide what mix of goods and services best meet their needs, and hire and supervise their own workers.
  - This additional funding has been provided by Administration on Community Living to provide a budget of approximately $2,500 to a Veteran to increase access to HCBS which enables them to serve the growing demand of veterans who prefer independence at home over living in a nursing facility.

- Through an options counselor, the Aging and Disability Network Agency provides facilitated assessment and care service planning, arranges fiscal management services, and provides ongoing counseling and support to veterans, their families, and caregivers. This program may be used with the Program of Comprehensive Assistance for Family Caregivers. The VA Veteran Directed Care program has been used in the past with Florida Medicaid and VA Pension benefits. Currently, at a local level, VA nurse case managers are not making this available with Florida Medicaid.

  Note: Acceptance into this program prohibits the use of the VA Homemaker / Home Health Aide Program. The American Disability Act provides legal protection for the disabled in many settings, including health care. Even those on Medicaid are receiving Home Care Based Services under the settings rule that provides for long-term services and supports in the home. However, because Medicaid is the payer of last resort, and VA denies utilization of Medicaid, the care plan is not providing comprehensive caregiver support in the manner in which it was meant to be implicated.

- **State of Florida**
- **Veterans Nursing Home**

Baldomero Lopez State Veterans' Nursing Home is a skilled nursing facility for Veterans in need of nursing home care. If a Veteran's service-connected disability rating is 70% or higher, the VA will pay for the veteran's nursing home care if the veteran qualifies as having a service-connected disability at 70% or more, or 60% and unemployable and in need of such care. Currently, there is a waitlist for bed availability.

Under Florida law it is not necessary to be a wartime veteran only for one with military service with an honorable discharge to gain access to the State of Florida Veterans Nursing Home. §1.01(14) Fla Stat(14)

- **Veterans Benefits Administration**
  Compensation
- **Service-Connected Disability**

This is a monthly tax-free payment to Veterans who got sick or injured while serving in the military and to Veterans whose service made an existing condition worse.

The Veteran may qualify for VA disability benefits for physical conditions (like a chronic illness or injury) and mental health conditions (like PTSD) that developed before, during, or after service.

A Veteran whose parent(s) are dependent upon him for financial support may be paid additional benefits. The dependent parent benefit is paid based on need. The parental relationship must be established, and it must be verified that the parent(s) are financially dependent upon the Veteran in order to qualify.

- **VA Compensation**
  VA Special Monthly Compensation

Additional compensation greater than your percentage rating,
Special Monthly Compensation may provide payments that are greater than the 100% rating. VA Compensation benefits are very similar to worker's compensation. The focus is on employability. However, Special Monthly Compensation is available to address noneconomic factors such as personal inconvenience, social inadaptability, or the profound nature of a disability.VA

will pay Special Monthly Compensation for being bedridden, housebound, or in need of the aid and attendance of another person.

If a Veteran is service-connected at 100% or less and meets one of the following criteria, *additional* SMC payment can be considered:

- Ø Housebound
- Ø Bedridden
- Ø Requires the aid and attendance of another person

v The amount of SMC varies depending on the level of disability. SMC-L designation if:

- Ø Have lost sight in both eyes (blindness), or
- Ø Are permanently bedridden, or
- Ø Need daily help with basic needs (like eating, dressing, and bathing)

v **Veterans Health Administration**
504 Rehabilitation Act
Integrated Setting Requirement

- Ø "Section 504 of the Rehabilitation Act of 1973, as amended, which prohibits discrimination based on disability in any program or activity conducted by Federal agencies. This requirement is to ensure accessibility to VA facilities, programs, activities, services, and benefits to the public, including Veterans, their families, and beneficiaries."

v **Veterans Health Administration**
Office of Resolution Management, Diversity & Inclusion (ORMDI)
The External Civil Rights Discrimination Complaints Program

The Office of Resolution Management Diversity Inclusion (ORMDI) is the VA's liaison with the Department of Justice (DOJ) for addressing issues of discrimination in federal programs and activities. Through the External Complaints Program, civil rights discrimination complaints may be filed against VA under Title VI of the Civil Rights Act of 1964 and other similar statutes, such as Title IX of the Education Amendments of 1972, Age Discrimination Act of 1975, Section 504 of the Rehabilitation Act of 1973, and various Presidential Executive Orders.

Section 504 prohibits **discrimination on the basis of disability** under any program or activity receiving federal financial assistance or under any program or activity conducted by any Executive agency.

ORM's External Civil Rights Discrimination Complaints Program, or ECP, has oversight responsibility for the processing of external discrimination complaints and serves as the intake office for these complaints. When a complaint is received in the ECP, it is forwarded to the appropriate Administration or staff office for investigation.

- **The VHA Office of Health Equity (OHE)**

  The VHA Office of Health Equity is charged with reducing disparities in health and health care affecting Veterans and enabling all Veterans to achieve equitable health outcomes.

  The mission of OHE is to understand differences across many groups of Veterans and to work to eliminate non-clinical differences related to:

  - Racial or ethnic group
  - Gender
  - Age
  - Geographic location
  - Religion
  - Socio-economic status
  - Sexual orientation
  - Mental health
  - Military era
  - Cognitive, sensory, or physical disability

- Medicare Home Health.

  Home health claims are suitable for Medicare coverage if they meet the following criteria:

- A physician has signed or will sign a care plan, certifying that the services are medically necessary; the physician must also certify that there has been a face-to-face encounter with the patient within 90 days prior to the start of care or within 30 days after the start of care.

- The patient is homebound. This criterion is generally met if non-medical absences from home are infrequent and leaving home requires a considerable and taxing effort, which may be shown by the patient needing personal assistance or the help of a wheelchair or crutches, etc. Occasional "walks around the block" are allowable. Attendance at an adult day care center or religious services is not an automatic bar to meeting the homebound requirement.

- The patient needs skilled nursing care on an intermittent basis (less than 7 days per week but at least once every 60 days) or skilled physical therapy, speech therapy, or continuing occupational therapy. Daily skilled nursing care is available for periods of 21 days or less (with extensions in exceptional circumstances when the need for additional daily skilled nursing is finite and predictable).

The care must be provided by, or under arrangements with, a Medicare-certified provider.

- **Medicare**
- **Coverable Home Health Services**

If the triggering conditions above are met, the beneficiary is entitled to Medicare coverage for home health services. There is no coinsurance or deductible. Home health services include:

- Part-time or intermittent nursing care provided by or under the supervision of a registered professional nurse;
- Physical, occupational, or speech therapy;
- Medical social services;
- Part-time or intermittent services of a home health aide and;
- Durable medical equipment (DME) and medical supplies

- **Hospice**
- **Routine Home Care**
- The hospice is paid the routine home care rate for each day the patient is under the care of the hospice and not receiving one of the other categories of hospice care. This rate is paid without regard to the volume or intensity of routine home care services provided on any given day and is also paid when the patient is receiving outpatient hospital care for a condition unrelated to the terminal condition.

- **Hospice**
- **Continuous Home Care (Hospice CHC)**
- Continuous Home Care – The service is only available during a period of crisis and only as necessary to maintain the terminally ill individual at home.

  - A minimum of 8 hours must be provided.
  - Nursing care must be provided for more than half of the period of care and must be provided by either a registered nurse or a licensed practical nurse.
  - Continuous home care is not intended to be used as respite care.
  - The hospice provides a minimum of 8 hours of care during a 24-hour day, which begins and ends at midnight.
  - This care need not be continuous, i.e., 4 hours could be provided in the morning and another 4 hours in the evening, but care must reflect the needs of an individual in crisis.
  - Homemaker or home health aide (also known as a hospice aide) services may be provided to supplement the nursing care.

- **Hospice**
- **Respite Care**
- Respite care is short-term inpatient care provided to the individual only when necessary to relieve the family members or other persons caring for the individual at home.

  - Respite care may only be provided in a Medicare-participating hospital or hospice inpatient facility or a Medicare or Medicaid-participating nursing facility.
  - Respite care may be provided only on an occasional basis and may not be reimbursed for more than 5 consecutive days at a time.
  - Respite care provided for more than 5 consecutive days at a time must be billed as routine home care for day 6 and beyond, and the patient may be liable for room and board charges for day 6 and beyond.[2]

- **Medicaid**

  Organization and Management

  - Established by the Social Security amendments of 1965 as Article XIX of the Social Security Act, Medicaid is a joint federal-state program of medical assistance for low-income individuals who are aged, blind, disabled, or who are members of families with dependent children (42 USC §139b). To be eligible for Medicaid in Florida, individuals must be citizens of the United States (or permanent resident aliens) and must reside in Florida. Both state and federal tax revenues finance the Medicaid program.

  - Florida's State Medicaid Agency is currently the Agency for Health Care Administration (AHCA). However, eligibility is determined by the Department of Children and Family Services (DCF). Eligibility for Medicaid is based on very stringent income and resource rules.

- Payor Source for Medical Services

[2] 40.2.2 - Respite Care (Rev. 188, Issued: 5-1-14; Effective: 8-4-14; Implementation: 8-4-14)

- Ø Medicaid is the last payor source for services provided to the individual. If the services provided are covered by another payor source, that payor source must be billed first.

- Ø Payor Sources: Traditional Medicare, Medicare Advantage - Part C, Supplemental Insurance, Worker's Compensation, Long Term Care Insurance, Veterans Health Administration, Medicaid

- Ø Level of Care is determined by the Department of Elder Affairs (DOEA)

Medicaid

- v **Medicaid Managed Medical Assistance, SMI, & LTC Medicaid**
- v With Federal approval, Florida obtained a waiver for Medicaid long-term care. This is known as Florida's Statewide Medicaid Managed Care (SMMC) program. The SMMC is an umbrella policy that covers different aspects of medical contracts that are dependent on medical needs. The Long-Term Care (LTC) program, the Managed Medical Assistance (MMA) program, Serious Mental Illness (SMI) specialty plans, and a dental services plan all fall under the scope of the SMMC. Managed Care Organizations (MCOs) contract with the Agency for Health Care Administration (AHCA) to provide long-term care services to Medicaid recipients as well as provide services under the MMA. The MCO selected by the enrollee at the time of Medicaid approval will be considered a comprehensive plan.

- v The goals of the LTC program are to:
  - Ø Provide coordinated LTC services to members across different residential living settings.
  - Ø Enable members to remain in their homes through the provision of home-based services or in alternative placement, such as assisted living facilities.[3]
  - Ø The goals of the MMA program are to provide:
  - Ø Coordinated health care across different healthcare settings.
  - Ø A choice of the best-managed care plans to meet recipients' needs.

[3] List pulled from Provider Manual - Simply Healthcare Plans. https://provider.simplyhealthcareplans.com/docs/gpp/FLFL_SMH_ProviderManual.pdf?v=202204061636

- Ø The ability for health care plans to offer different, or more, services. The opportunity for recipients to become more involved in their health care.[4]
- Ø

MCOs are motivated to reduce nursing home placement through the use of strong case management to save medical cost exposure. The MCO will provide various services that are based on the enrolled facts, the case manager, and the organization selected.

Three-Part Test
Medicaid Eligibility in a Nursing Home or
Home and Community-Based Services

1. Level of care –
   Must be in need of Skilled, Intermediate 1, or Intermediate 2 care.
   a. Skilled – Services provided under the direction of a physician on a 24-hour basis.
   b. Intermediate 1 – Services provided for the patient who needs extensive care and is more than mildly incapacitated.
   c. Intermediate 2 – Services provided for the patient who is mildly incapacitated and whose condition allows for considerable independent activity.

2. Income
   $2,742.00 is the maximum income cap for the applicant
   No income cap for the spouse of the applicant unless also an applicant

3. Countable Resources
   $2,000.00 in countable resources is the maximum limit allowed for the applicant.

   $148,400.00 in countable resources is the maximum limit allowed for the spouse of an applicant unless also an applicant.

[4] *Id.*

Understand Medicaid eligibility.

- Medicaid can be an important resource for people with Parkinson's disease, but it's important to understand the eligibility requirements.
  - Ø Medicaid is a federal and state program that provides health care coverage for low-income individuals and families.
  - Ø However, Medicaid has strict income and asset limits that vary by state.

  An elder law attorney can help you determine if you qualify for Medicaid and how to apply for it.

Americans with Disability Act (ADA)

The risk of potential health care expenses may be limited due to the Supreme Court decision in *Olmstead v. L.C.,* which held that the institutionalization of people who could be cared for in community settings was a violation of Title II of the Americans with Disabilities Act (ADA). The movement to expand Home and Community Based Services has occurred alongside the shift to more patient-centered and consumer-driven models of care, which seek to honor the preferences of the individual and often can be less expensive.

504 Rehabilitation Act

Integrated Setting Requirement

As stated in the Integrated Setting Requirement of the 504 Rehabilitation Act,

> "A federal agency or a recipient of federal financial assistance within the meaning of § 504 of the Rehabilitation Act[5] must administer programs and activities in the most integrated setting appropriate to the needs of qualified individuals with disabilities.[6] and must do so in a manner that does not result in the unjustified segregation or isolation of individuals with disabilities.[7] Under the integration mandate, public entities are required to provide community-based services to persons with disabilities when (1) such services are appropriate, (2) the affected persons do not oppose community-based treatment, and (3) community-based services can be reasonably accommodated, taking into account the resources available to the entity and

[5] 29 U.S.C.A. § 794
[6] 28 C.F.R. §§ 39.130(d), 41.51(d)
[7] Thorpe v. District of Columbia, 303 F.R.D. 120, 88 Fed. R. Serv. 3d 274 (D.D.C. 2014)

the needs of other persons with disabilities.[8] Individuals who must enter institutions to obtain Medicaid services for which they qualify face a risk of institutionalization, as required to state a claim under the Rehabilitation Act for denial of participation in a program."[9]

Community Spouse's Monthly Income Allowance

A community spouse's monthly income allowance depends on the amount of monthly income available to the community spouse and the amount of excess shelter costs the community spouse must pay. The actual community spouse monthly income allowance is equal to how much the state's MMMNA plus the community spouse's excess shelter costs exceed the community spouse's income. The minimum monthly maintenance needs allowance is currently $2,289.00.[10]

The formula for determining the Community Spouse Income Allowance is: (State's MMMNA + community spouse's excess shelter costs) - (the community spouse's total gross income) = (the community spouse's income allowance).

The community spouse's income allowance is the total amount that can be allotted to the community spouse from the institutionalized individual. The state's MMMNA plus CS excess shelter cost cannot exceed the state's cap on CS income allowance (see Appendix A-9). The institutionalized individual's personal needs allowance and deduction for therapeutic wages is deducted prior to deducting the community spouse's income allowance. The community spouse can refuse all or part of the allowance. The total amount of the community spouse allowance is always included in the budget for the community spouse during the hearing process when determining if the community spouse qualifies for an increase in the community spouse resource allowance. **If there is court-ordered support against an institutionalized spouse (for monthly support income for the community spouse), the community spouse's monthly income allowance cannot be less than the amount ordered.**

[8] Hampe v. Hamos, 917 F. Supp. 2d 805 (N.D. Ill. 2013); Hiltibran v. Levy, 793 F. Supp. 2d 1108 (W.D. Mo. 2011)
[9] Pashby v. Delia, 709 F.3d 307 (4th Cir. 2013); Haddad v. Dudek, 784 F. Supp. 2d 1308 (M.D. Fla. 2011)
[10] ACCESS Manual Appendix A-9: SSI-Related Medicaid Coverage Groups Financial Eligibility Standards: April 2022

COFS Unconnected to Divorce!*Court Order For Support Unconnected To Divorce

The *Court Order for Support* will allow the community spouse to receive income from the spouse in need of care. Medicaid will honor the amount ordered, assess a $0.00 patient responsibility, and fully pay for the care needs at the skilled nursing facility or home care..

In an effort to protect the court, as well as husbands and wives from fraud and abuse, all parties involved in court proceedings for support are required by procedural rules to exchange certain financial records referred to as "mandatory disclosures." The requirement may (and will be) waived by the parties, to preclude the need to exchange their own records between themselves. However, the procedural rules also require the parties to each file a *Financial Affidavit*, and by rule this requirement may not be waived.

It is anticipated that there will be one hearing in front of the Judge, likely by Zoom, to "prove up" the case and for the Court to receive and enter the previously prepared and agreed *Stipulated Final Judgment*.

- Consider estate planning.
- Estate planning is an important part of preparing for your future care and finances.
  - Estate planning involves creating a plan for how you want your assets and property to be distributed after your death.
  - It also involves minimizing the taxes and fees that may be imposed on your estate. An elder law attorney can help you create an estate plan that reflects your wishes and protects your beneficiaries.
- Know your options for paying for long-term care.
- There are several options for paying for long-term care, including Medicaid, Medicare, private insurance, personal savings, family support, or reverse mortgages.
- Each option has its own advantages and disadvantages, so it's important to weigh them carefully and consult with an elder law attorney before making a decision.

v