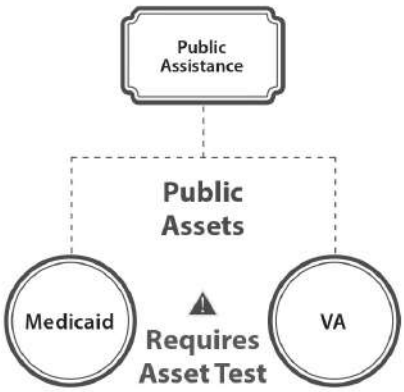
3) Public Assistance



For those whom long-term care policies do not work, a third resource to pay for long-term care costs is via Public Assistance or Public Assets. They are Medicaid and Veterans Affairs (VA) benefits. These two options are only available to those with very limited assets at the time of application. Also, the quality of life provided by these two options is generally poor unless you have other protected assets to supplement the income. Planning to rely on Medicaid or VA without other protected assets is not advisable. Let's look at the two in closer detail.

Medicaid

Medicaid (Government Benefit or Assistance) pays for medical and long-term care costs for those who meet their three requirements: functionality (applicant must functionally or physically need medical or long-term care assistance), income (applicant's income must be insufficient to cover the costs), and resource eligibility (applicant must have spent down their own assets to allowable limits [very low]).

Let's look at each of those requirements individually.

1. The first requirement is that you actually need the assistance of a caregiver, such as in a nursing home, your own home, or another setting. You are automatically approved if you apply while living in a nursing home because your needs are obviously strong enough to require accommodation in that setting. For those not living in a nursing home, we suggest you speak to an Elder Law Attorney knowledgeable in Medicaid requirements because qualifications vary from state to state.

2. Income is the second requirement for Medicaid, and the definition is strict. Referred to as MAGI (Modified Adjusted Gross Income), it is calculated by adding your household's Adjusted Gross Income and tax-exempt interest income together. You should be able to qualify for long-term care under Medicaid as long as your income is below the MAGI threshold (or slightly above to compensate for other medical expenses). It is also still possible to qualify for benefits if your income exceeds the MAGI threshold under what's called the Medically Needy Program.

3. The final requirement for Medicaid eligibility involves your assets, and varies for couples or single people. If you are married, you must only have $2,000 in assets to your name. However, your spouse can have: an unlimited amount of income, a home of any value, an automobile of any value, and other financial assets with specific limitations—and these limitations may be lower than you think. Refer to your Planning Center for updated information.

If you are single, you are still only allowed $2,000 in assets, but you are also allowed to own other assets like a home and a car. In this case, these assets have more limits than the spouse scenario, and the state will put a lien on some properties to recoup some of the cost they are paying toward your care.

The common misconception about Medicaid eligibility is that you and your spouse are not allowed to have any assets to qualify, but that isn't the case. You can legally transfer any amount of your assets to family members, because Medicaid does not look into the assets of other family members and it obviously can't tell you what to do with them.

The only caveat is **the "five-year lookback" rule**. If you gift assets within this period, you may end up making yourself ineligible for Medicaid for some time. With proper planning and preemptive action, your assets can be safely and legally transferred to your beneficiaries, allowing them to use those assets in your best interest while still allowing you to qualify for Medicaid.