

SUCCESSFUL ELDERLAW PLANNING FOR YOU AND YOUR AGING LOVED ONES

Women's Business Council-Southwest
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Liza Farrow-Gillespie
(liza@fghlaw.net)

Julie E. Heath
(julie.heath@fghlaw.net)

Jennifer N. Lewis
(jennifer.lewis@fghlaw.net)

Farrow-Gillespie & Heath LLP
1700 Pacific Avenue
Suite 2640
Dallas, TX 75201
214-361-5600
www.fghlaw.net

Free Eldercare & Elderlaw Resources

Topic	Name	Website (http://www.---)	Phone	Description
Abuse	National “Do Not Call” Registry	donotcall.gov/default.aspx	888-382-1222	Register elder’s phone number to prevent telemarketing & scams; report violations.
Abuse	FTC Identity Theft Hotline	ftc.gov/bcp/edu/microsites/idtheft	877-438-4338	Report suspected identity theft phone-scams.
Abuse	Fair Credit Reporting Act consumer site	annualcreditreport.com	877-322-8228	Access to free annual credit report from each of the 3 nat’l agencies
Abuse	Texas Abuse Hotlines	txabusehotline.org	800-252-5400; 800-458-9858	Report suspected elder abuse in Texas.
Abuse	HHS National Center on Elder Abuse	ncea.aoa.gov	800-677-1116	Information on elder abuse; national abuse hotline.
Benefits	Medicaid Hotline for Texans	hhsc.state.tx.us/medicaid	800-252-8263	Medicaid information.
Benefits	Medicare Prescription Coverage (Part D) for Texans	texasmedicarerx.org		Texas information site for coordinating national Medicare D with state Medicaid benefits
Benefits	Medicare Parts A & B	ssa.gov/mediinfo.htm	800-772-1213	Information on applying for Medicare A & B
Benefits	Social Security Administration	ssa.gov	800-772-1213	Information & instructions to apply for social security benefits.
Employment	Texas Workforce Commission	twc.state.tx.us/customers/jsemp/jsempsubcrd.html	888-452-4778	Age & disability discrimination reporting and information
Employment	Equal Employment Opportunity Comm’n	eoc.gov	800-669-4000	Age & disability discrimination reporting and information

Topic	Name	Website (http://www.---)	Phone	Description
Employment	Federal Medical Leave Act info	dol.gov/esa/whd/fmla/		Information on taking FMLA leave to care for elderly parent
Finances	IRS Retirement Fund Guide	irs.gov/retirement/article/0,,id=137320,00.html		Information on IRAs, Roth IRAs, SEPs, etc.
Forms	Texas Probate	texasprobate.com/forms/		Links to statutory forms for power of attorney, medical documents
General Info	Texas Attorney General	oag.state.tx.us/elder/elder.shtml		Information and links for senior Texas consumers
General Info	Texas Department of Aging and Disability	dads.state.tx.us/		Information and links for
Guardianship	Elderlaw law firm site and blog	fordmath.com/guardianship/index.php		Excellent overview of guardianship proceedings in the Texas courts
Housing	SSA Nursing Home Comparisons	medicare.gov/NHCompare		Compare nursing home facilities, ratings, and infractions in any geographic area.
Housing	Fair Housing Act site	hud.gov/offices/fheo/FHLaws/		Housing discrimination reporting and information

Recommended Reading on Eldercare and Elderlaw

Author(s)	Title	Year
Hegland, Kenny & Fleming, Robert	<i>Alive and Kicking: Legal Advice for Boomers</i>	2007
Heiser, Gabriel	<i>How to Protect Your Family's Assets from Devastating Nursing Home Costs</i>	2007

TEXAS MEDICAL
POWER OF ATTORNEY

for

(name)

Instructions, Information, and Disclosure

THIS IS AN IMPORTANT LEGAL DOCUMENT. BEFORE SIGNING THIS DOCUMENT, YOU SHOULD KNOW THESE IMPORTANT FACTS:

Except to the extent you state otherwise, this document gives the person you name as your agent the authority to make any and all health care decisions for you in accordance with your wishes, including your religious and moral beliefs, when you are no longer capable of making them yourself.

Because "health care" means any treatment, service, or procedure to maintain, diagnose, or treat your physical or mental condition, your agent has the power to make a broad range of health care decisions for you. Your agent may consent, refuse to consent, or withdraw consent to medical treatment and may make decisions about withdrawing or withholding life-sustaining treatment. Your agent may not consent to voluntary inpatient mental health services, convulsive treatment, psychosurgery, or abortion. A physician must comply with your agent's instructions or allow you to be transferred to another physician.

Your agent's authority begins when your doctor certifies that you lack the competence to make health care decisions.

Your agent is obligated to follow your instructions when making decisions on your behalf. Unless you state otherwise, your agent has the same authority to make decisions about your health care as you would have had.

It is important that you discuss this document with your physician or other health care provider before you sign it to make sure that you understand the nature and range of decisions that may be made on your behalf. If you do not have a physician, you should talk with someone else who is knowledgeable about these issues and can answer your questions. You do not need a lawyer's assistance to complete this document, but if there is anything in this document that you do not understand, you should ask a lawyer to explain it to you.

The person you appoint as agent should be someone you know and trust. The person must be 18 years of age or older, or a person under 18 years of age who has had the disabilities of minority removed. If you appoint your health or residential care provider (e.g., your physician or an employee of a home health agency, hospital, nursing home, or residential care home, other than a relative), that person has to choose between acting as your agent or as your health or residential care provider; the

law does not permit a person to do both at the same time.

You should inform the person you appoint that you want the person to be your health care agent. You should discuss this document with your agent and your physician and give each a signed copy.

You should indicate on the document itself the people and institutions who have signed copies. Your agent is not liable for health care decisions made in good faith on your behalf.

Even after you have signed this document, you have the right to make health care decisions for yourself as long as you are able to do so and treatment cannot be given to you or stopped over your objection. You have the right to revoke the authority granted to your agent by informing your agent or your health or residential care provider orally or in writing or by your execution of a subsequent medical power of attorney. Unless you state otherwise, your appointment of a spouse dissolves on divorce.

This document may not be changed or modified. If you want to make changes in the document, you must make an entirely new one.

You may wish to designate an alternate agent in the event that your agent is unwilling, unable, or ineligible to act as your agent. Any alternate agent you designate has the same authority to make health care decisions for you.

THIS POWER OF ATTORNEY IS NOT VALID UNLESS IT IS SIGNED IN THE PRESENCE OF TWO COMPETENT ADULT WITNESSES. THE FOLLOWING PERSONS MAY NOT ACT AS ONE OF THE WITNESSES:

- (1) the person you have designated as your agent;
- (2) a person related to you by blood or marriage;
- (3) a person entitled to any part of your estate after your death under a will or codicil executed by you or by operation of law;
- (4) your attending physician;
- (5) an employee of your attending physician;
- (6) an employee of a health care facility in which you are a patient if the employee is providing direct patient care to you or is an officer, director, partner, or business office employee of the health care facility or of any parent organization of the health care facility;
- or
- (7) a person who, at the time this power of attorney is executed, has a claim against any part of your estate after your death.

I have received the above disclosure and have read and understand its contents.

Signature: _____

Date: _____

TEXAS MEDICAL POWER OF ATTORNEY
**DESIGNATION OF
HEALTH CARE AGENT**
for

_____ (name)

I, _____ (full name),
of _____ (residence address),
in _____ County, do hereby appoint my _____ (relationship)
_____ (name)
of _____ (residence address),
as my agent or “proxy” to make any and all health care decisions for me, except to the extent I state
otherwise in this document. **This medical power of attorney takes effect if I become unable to
make my own health care decisions and this fact is certified in writing by my physician.**

Limitations on the Decision-Making Authority of My Agent :

Designation of Alternate Agent
(optional)

If the person designated as my agent is unable or unwilling to make health care decisions for me, I designate the following persons to serve, **in the order listed and one at a time**, as my agent to make health care decisions for me as authorized by this document:

	FIRST ALTERNATE	SECOND ALTERNATE
Name:		
Address:		
Phone:		
Relationship:		

Original and Signed Copies: The original of this document is kept at my home. The following individuals or institutions have signed copies:

Duration: I understand that this power of attorney exists indefinitely from the date I execute this document unless I establish a shorter time or revoke the power of attorney. If I am unable to make health care decisions for myself when this power of attorney expires, the authority I have granted my agent continues to exist until the time I become able to make health care decisions for myself.

If applicable: This power of attorney ends on the following date: _____.

Prior Designations Revoked: I revoke any prior medical power of attorney.

Acknowledgment of Disclosure: I have been provided with a disclosure statement explaining the effect of this document. I have read and understand the information contained in the disclosure statement.

SIGNATURE

I sign my name to this Medical Power of Attorney Appointing Healthcare Agent:

Signature: _____

Date: _____

Statement of First Witness: I am not the person appointed as agent by this document. I am not related to the principal by blood or marriage. I would not be entitled to any portion of the principal's estate on the principal's death. I am not the attending physician of the principal or an employee of the attending physician. I have no claim against any portion of the principal's estate on the principal's death. Furthermore, if I am an employee of a health care facility in which the principal is a patient, I am not involved in providing direct patient care to the principal and am not an officer, director, partner, or business office employee of the health care facility or of any parent organization of the health care facility.

Signature of First Witness

Signature: _____

Print Name: _____

Address: _____

Date: _____

HIPAA AUTHORIZATION

Health Insurance Portability and Privacy Act of 1996
45 C.F.R. § 164.508
for

_____ (name of patient)

I, _____ (name),
an individual residing at _____,
(address), and whose date of birth is _____ (date of birth)
hereby authorize all Health Care Providers to disclose my Protected Medical Information to any and all of the following Authorized Persons:

Authorized Person	Address	Phone	Relationship

This disclosure shall include the ability to discuss Protected Medical Information with the person or entity who has possession of the Protected Medical Information. My Health Care Providers are expressly authorized to answer questions posed by my Authorized Persons and to openly discuss with them my condition, treatment, test results, prognosis, and everything pertaining to my health care, even if I am fully competent to ask questions and discuss this matter at the time.

I understand that the information used or disclosed pursuant to this Authorization may include information relating to: mental or behavioral health or psychiatric care; treatment for or history of drug or alcohol abuse; and information relating to sexually transmitted diseases, including HIV and AIDS. **It is my intention to give a full authorization to obtain any and all Protected Medical Information to the Authorized Persons named in this Authorization.**

Effective Date and Termination

This Authorization shall become effective immediately upon the date it is signed by me, as reflected below. It shall terminate on the first to occur of: (1) two years following my death or (2) actual receipt of written revocation of this Authorization. Proof of receipt of my written revocation may be by certified mail, registered mail, facsimile, or any other method evidencing actual receipt by the Health Care Provider. Revocation shall be effective only upon the actual receipt of the notice of revocation by the Health Care Provider. A Health Care Provider shall have no liability for action taken in reliance on this Authorization prior to actual receipt of the notice of revocation, and subsequent revocation shall have no effect with respect to information already used or disclosed prior to actual receipt of the revocation. This Authorization is not affected by my subsequent disability or incapacity.

Re-Disclosure

By signing this Authorization, I acknowledge that the information used or disclosed pursuant to this Authorization may be subject to re-disclosure by the person or persons whose name(s) is/are written above, and the information once disclosed will no longer be protected by the rules created in HIPAA. No Health Care Provider shall require my Authorized Persons to indemnify the Health Care Provider or agree to perform any act in order for the Health Care Provider to comply with this Authorization.

Rights of Authorized Persons to Enforce This Agreement

My Authorized Persons shall have the right to bring a legal action in any applicable forum against any Health Care Provider that refuses to recognize and accept this Authorization for the purposes I have expressed. Additionally, my

Authorized Persons are authorized to sign any documents that the Authorized Persons deem appropriate to obtain the Protected Medical Information.

No Conflicts with Other Authorizations

This Authorization is in addition to the other medical release authorizations I may have granted in the past or will grant in the future. It does not replace them. This Authorization may be relied upon by my Health Care Providers regardless of any real or perceived conflict with any Medical Power of Attorney or any Statutory Durable or General Durable Power of Attorney signed by me, whether prior to or subsequent to the date of this Authorization. I recognize and intend that this will result in multiple persons having the authority to obtain my Protected Medical Information. This Authorization is not intended to replace a Medical Power of Attorney, nor to grant any person the authority to make health care decisions based on this instrument.

Copy or Fax Valid

A copy or facsimile of this original Authorization shall be accepted as though it were an original document.

Waiver and Release of Health Care Providers

I hereby release any Health Care Provider that acts in reliance on this Authorization from any liability that may accrue from releasing my Protected Medical Information and for any actions taken by my Authorized Person(s).

Definitions

The term "Protected Medical Information" includes, but is not limited to, the following: All health care information, reports and/or records concerning my medical history, condition, diagnosis, testing, prognosis, treatment, billing information and identity of health care providers, whether past, present or future, and any other information which is in any way related to my healthcare. In this Authorization, the term also includes the terms "Individually Identifiable Health Information" and "Protected Health Information," as sometimes used in HIPAA.

The term "Health Care Provider" includes, but is not limited to, the following: Any doctor (including but not limited to a physician, podiatrist, chiropractor, or osteopath), medical specialist, psychiatrist, psychologist, dentist, therapist, nurse, hospital, clinic, pharmacy, laboratory, ambulance service, assisted living facility, residential care facility, bed and board facility, nursing home, medical insurance company or any other health care provider or affiliate, pathologist and medical examiner; and each of the above's patient record and billing departments, including any collection agency or other third party contracted by any of the above regarding any medical service. In this Authorization, the term also includes the term "Covered Entity," as sometimes used in HIPAA.

SIGNATURE

I sign my name to this HIPAA Authorization:

Signature:

Date:

STATE OF TEXAS

§

§

COUNTY OF _____

§

This instrument was subscribed and acknowledged before me by _____,

known to me, on this _____ day of _____, 20_____.

Notary Public, State of Texas