Western Connecticut Area Agency on Aging

WCAAA Crier

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INSIDE THIS ISSUE

Staff Editor:
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MEDICARE RIGHTS CENTER
Getting Medicare right

Differences between Original Medicare and Medicare Advantage Plans

People with Medicare can get their health coverage either through Original Medicare or a Medicare Advantage Plan. Here's a look at the differences between these two options.

Original Medicare

- The traditional program administered directly through the federal government.
- Includes **Part A** (hospital) and **Part B** (medical) coverage if you enroll in both.
- You pay a deductible and/or coinsurance when you get health care (usually 20% of the Medicare-approved cost for outpatient care).
- Most people pay a monthly premium for Part B. There's no Part A premium if you have at least 10 years of United States work history.
- You can go to any doctor or hospital in the country that accepts Medicare.
- No referrals needed to see specialists; no prior authorization for services.
- You can buy a **Medigap** plan as supplemental coverage.
- If you want Medicare drug coverage, you must buy a separate Prescription Drug Plan (PDP) from a private insurance company.

Medicare Advantage Plans

- Plans sold by private insurance companies that provide Medicare benefits.
- Must cover the same Part A and Part B benefits as Original Medicare. Some also cover extra benefits such as vision and dental care.
- The most common types are **HMOs** (Health Maintenance Organizations), **PPOs** (Preferred Provider Organizations) and **PFFS** (Private-Fee-for-Service) plans.
- You still have Medicare but you're no longer in Original Medicare—you're in a private plan that typically has different costs and restrictions.
- You pay a deductible and/or copay for services (usually a fixed copay, like $15 per office visit).
- You still pay Medicare premiums, and your plan may charge an extra premium.
- You typically are required to use doctors and hospitals in the plan's network.
- You may have to choose a Primary Care Physician, get referrals to see specialists, and/or get prior authorization for certain services.
- You can't buy Medigap supplemental insurance to help pay your out-of-pocket costs.
- Plans must have yearly limits on your out-of-pocket health care costs (an out-of-pocket maximum), after which you pay nothing for the rest of the year.
- If you want Medicare drug coverage, sign up for a plan that includes both health and drug coverage, called a **Medicare Advantage Prescription Drug Plan** (MA-PD). You usually can't have a separate Part D plan, unless you're in a Medicare **Medical Savings Account** (MSA) or a **PFFS** plan.

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Differences between Original Medicare and Medicare Advantage Plans *continued from page 1*

	Original Medicare	Medicare Advantage Plans
Costs	You pay **Medicare premiums**, **deductibles**, and **coinsurances** (usually 20% of the Medicare-approved cost for outpatient care).	You pay **Medicare premiums** and **your plan's premium,** if it charges one. Your plan sets its own **deductibles** and **copays** (usually a fixed cost for each office visit). You may pay the full cost if you don't follow your plan's rules.
Supplemental insurance	**You can buy a Medigap policy**. (But only at certain times, depending on where you live.)	**You can't buy a Medigap policy** to help pay your out-of-pocket costs in a Medicare Advantage plan.
Covers extra services like vision and dental?	**No.** Covers medically-necessary inpatient and outpatient health care. Doesn't cover certain services such as routine vision, hearing or dental care.	**Maybe.** May cover some services Original Medicare doesn't cover such as routine vision, hearing and dental care. All plans must cover the same inpatient and outpatient services Original Medicare covers.
Lets me see providers nationwide?	**Yes.** You can go to any doctor or hospital in the U.S. that accepts Medicare.	**Usually not**. Most people have HMOs, which typically have local networks of providers you must use for the plan to cover your care. PPOs and PFFS plans should cover care you get outside the network, but you will pay more.
Need referrals to see specialists?	**No.** You don't need a referral.	**Maybe.** You often need to get a referral from your Primary Care Physician if you want to see a specialist.
Covers drugs?	**No,** but if you want Medicare prescription drug coverage, you can buy a separate Part D plan.	**Usually.** Most plans include Part D drug coverage. You usually can't get a separate Part D plan if you have a Medicare Advantage plan (some exceptions).
Out-of-pocket limit?	**No.** There's no cap on what you spend on health care.	**Yes.** Plans must have an annual out-of-pocket limit, which can be high but protect you if you need expensive care. The plan pays the full cost of your care after you reach the limit.

Definitions

Premium: The monthly fee you pay to have Medicare
Deductible: What you must pay before Medicare starts paying for your care
Copayment / Coinsurance: The amount you pay for each service
Part A: Medicare hospital insurance for inpatient care **Part B:** Medicare medical insurance for outpatient care **Part D:** Medicare drug coverage
Medigap: Supplemental insurance that helps pay your out-of-pocket costs in Original Medicare

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The Connecticut Tech Act Project's Assistive Technology Loan Program

The Connecticut Tech Act Project's Assistive Technology Loan Program (ATLP) assists Connecticut residents with disabilities and older adults to obtain the assistive technology devices and services they need to enhance independence and productivity in the community, education and employment. Eligible applicants may borrow from $500 - $30,000, at a low interest rate, for up to 10 years depending on the life of the device. The ATLP can be used for a broad range of devices such as assistive listening devices, magnifiers, computers and software, scooters, stair lifts, modified vehicles, and much more. To find out more about the Assistive Technology Loan Program visit www.CTtechact.com/loan or call 860-424-5619.

Dear Marci,

MEDICARE RIGHTS CENTER
Getting Medicare right

Volume 15, Issue 26 • December 26, 2016

What insurances pay primary to Medicare?

I have Medicare Part A and Part B, but I also have another health insurance policy from my current job. How does Medicare work with my other coverage, and do I need to tell my doctor if I have more than one type of insurance?
- Cole (Lafayette, CO)

Dear Cole,
Your current employee insurance may pay primary to Medicare. Whether it will pay primary or not depends on how you are eligible for Medicare and how many people work at the company that provides the insurance.

Insurance from your or your spouse's current employment pays primary to Medicare if you (a) are eligible for Medicare because you are 65 or older and the company has **20 or more employees**, or (b) are eligible for Medicare because you have received Social Security Disability Insurance (SSDI) payments for more than 24 months and the company has **100 or more employees**.

Note that if you have Medicare because you have received SSDI payments for more than 24 months, the insurance based on current employment can also be from a family member's current work. This is an important distinction, because if you are eligible for Medicare due to age, the current employment-based coverage can only be from your or your spouse's current work.

Insurance from current employment can be from a private company (such as a bank or small business), a union, or a Small Business Health Options Program (SHOP) plan, which is a type of current employee coverage available through the Health Insurance Marketplace. If you or your spouse are **currently working** for the federal government and covered by Federal Employee Health Benefits (FEHB), the rules are the same. FEHB always pays primary to Medicare because the federal government has more than 100 employees.

Insurance from your or your spouse's current employment pays secondary to Medicare if you (a) are eligible for Medicare because you are 65 or older and the company has **fewer than 20 employees**, or (b) are eligible for Medicare because you have received SSDI payments for more than 24 months and the company has **fewer than 100 employees** (note that if you have Medicare due to disability, the insurance based on current employment can also be from a family member's current work).

Cole, you should inform your doctor about any different insurance that you have in order to avoid any billing or coverage problems. You can do this by showing your different health insurance cards at the front desk to ensure that your file is up to date. It is important to let your providers know which insurance is primary and which is secondary so that there are no problems. If your secondary insurance is billed first, for example, you may experience coverage denials or other difficulties accessing services because your secondary insurance will not pay until the primary insurance does.

If you have questions about how your other insurance works with Medicare, you can contact the Benefits Coordination and Recovery Center (BCRC) at 855-798-2627 (TTY/TTD: 855-797-2627). Call the WCAAA if you cannot obtain information from the BCRC.
- Marci

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Dear Marci,

Volume 25, Issue 25, December 12, 2016

Can I delay my Medicare enrollment?

I'm turning 65 soon and I'm still working. Do I need to enroll in Medicare Part B when I'm first eligible, or can I delay it?
- Riley (Albany, OR)

Dear Riley,
Deciding to delay Part B enrollment depends on a number of factors. Some people may want to delay Medicare Part B enrollment because they already have coverage from another source, and they do not want to pay the Part B premium on top of what they already pay for their other coverage. Before delaying Part B enrollment, you should consider the following questions.

1. Will I have a Part B Special Enrollment Period (SEP) to sign up for Medicare later? You must have access to a Part B SEP to be able to enroll in Part B outside of your Initial Enrollment Period (three months before, the month of, and three months after your 65th birthday month) or the General Enrollment Period (January 1 through March 31 each year; coverage becomes effective July 1). If you have a Part B SEP, then you will not have a late enrollment penalty for delaying Part B enrollment.

The Part B SEP begins when you are first eligible for Medicare and are covered by insurance as a result of your, your spouse's, or in some circumstances, your family member's current work. You have this SEP while you are covered by insurance from current work, and it extends for eight months after the coverage or work ends, whichever is sooner. If you use this SEP to enroll, then you will not have a late enrollment penalty for delaying Part B enrollment.

You cannot use this SEP if you delay Medicare enrollment while covered by retiree insurance from a former employer, COBRA, or

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Dear Marci, *continued from page 3*

retiree FEHB. If you delay Medicare Part B enrollment while covered by any of those types of insurance, you will have to wait for the General Enrollment Period (January 1 through March 31 each year; coverage becomes effective July 1) to enroll in Medicare and you may have a late enrollment penalty.

2. Will my other coverage pay primary or secondary to Medicare? If your other health insurance coverage will pay secondary to Medicare once you are eligible, then it is usually not advisable to delay Medicare Part B enrollment. Secondary insurance pays only after the Primary insurer has paid, and an insurance that is secondary to Medicare may refuse to pay for care and may take back any primary payments that it has made.

Your insurance from current employment may pay primary to Medicare. Whether this type of insurance will pay primary or not depends on how you are eligible for Medicare and how many people work for the company that provides the insurance. Insurance from your or your spouse's current employment pays primary to Medicare if you are eligible for Medicare because you are 65 or older and the company has **20 or more employees.** Insurance from your or your spouse's current employment pays secondary to Medicare if you are eligible for Medicare because you are 65 or older and the company has **fewer than 20 employees.**

Riley, before you make a decision about Medicare Part B, you should always contact Social Security by dialing 800-772-1213 or visiting your local Social Security office. Call the WCAAA (203) 757-5449 if you can't obtain information from Social Security.
- Marci

Information source: medicare.gov. This information is republished with permission from the Medicare Rights Center. www.medicare interactive.org

Qualified Medicare Beneficiary Indicator

Good News!

Consumers will be happy to hear that a new Federal regulation (CR9911) modifies the Medicare claims processing system to help providers identify the QMB status of patients. Many low income beneficiaries gaining assistance from QMB are not clear if they have to pay any co-payments and deductibles. Whether or not the provider accidentally bills the consumer without understanding the law or believes he/she is entitled to a payment, this should help clarify that those participating in the program should not receive any bills for services. Services include Part B professional claims, Durable Medical Equipment, prosthetics, orthotics and supplies claims. Also included are outpatient institutional types of bills, home health claims, if the revenue code for the line itemize TOB 012x, 013x, 014x, 022x,023x, 034x, 071x, 072x, 074x,075x, 076x, 077x, and 085x and some home health claims and skilled nursing facility claims.

The QMB indicators will initiate new messages on the Remittance Advice that reflect the beneficiary's QMB status and lack of liability for Medicare cost-sharing with three new Remittance Advice Remark Codes. The codes will indicate no deductible, no coinsurance and no co-payments may be collected from these patients. This should result in a clearer picture for both patient and provider of how the QMB program works.

Article by Darylle Willenbrock, WCAAA Staff
Information source: Dept. of Health and Human Services , Center for Medicare & Medicaid Services, Medicare Learning Network

Advisory Council Seeks New Members

The mission of the Western Connecticut Area Agency on Aging, Inc., is to develop, manage and provide comprehensive services for seniors, caregivers and individuals with disabilities through person-centered planning in order to maintain their independence and quality of life. We have an Advisory Council, whose goals include sharing valuable information about WCAAA services with the people of our communities and providing advice to the WCAAA Board of Directors regarding the seniors' needs in our 41 town area. We need to increase the membership of the Council. If you or an area consumer live or work in the towns we represent, and are interested in becoming a member of the Advisory Council, or would like to recommend a co-worker, friend or neighbor, please call Debby Horowitz directly at 203-757-5449 ext.125. The Advisory Council meets for about an hour on the second Thursday of the month at 9:30am at the WCAAA office, 84 Progress Lane in Waterbury.

Article by Debby Horowitz, WCAAA Staff

Assistive Technology Center - Jitterbug Cell Phone

- Big buttons with large, legible numbers make dialing effortless
- No contracts, no cancellation fees. Powered by one of the nation's most dependable wireless networks
- Plans start as low as $14.99/month, now with double minutes.
- 100% U.S.-based Customer Service
- Backlit keypad assists visibility in low-light areas & bright color screen makes it easy to see phone numbers, text messages and photos
- Dedicated 5Star button provides one-touch access to medical alert service
- Long-lasting battery and hearing aid compatible (M4/T4 rating) with a powerful speaker so that conversations are loud and clear
- Health & Safety Packages include 5Star Medical Alert Service, Urgent Care, Personal Operators and Great Call Link app helps you stay connected with family and friends. Learn more about our Health & Safety Packages below.
- Backlit Keypad, Big buttons with large legible numbers make dialing effortless
- Long Lasting Battery
- Built in Camera
- Powerful Speaker
- Easy to Navigate: Simple YES/NO menu buttons, DISPLAY: External Display 1.3-Inch Color LCD
- Dedicated 5Star button provides one-touch access to medical alert service
- Voice Dial: Quickly access contacts, Headset Jack: Standard 3.5mm
- BATTERY CAPACITY: 1,000 mAh MEMORY, Built-in Storage: 1 GB (portion occupied by OS)

The Jitterbug cell phone is now on display at our Assistive Technology Center located at the WCAAA, 84 Progress Lane, Waterbury, CT 06705. Please call Charlene to make an appointment at 203-757-5449.

TIA'S (TRANSIENT ISCHEMIC ATTACKS)

Many seniors have heard of TIA's not knowing exactly what they were or how serious they can be. Some people refer to them as "mini-strokes" although it is more accurately characterized as a "warning" stroke! TIA's are caused by a blood clot - the only difference between a stroke and a TIA is that the TIA blockage is temporary - occurring rapidly and lasting a relatively short time - usually 1 - 5 minutes. When the TIA is over, it usually causes no permanent injury to the brain.

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2017 Benefits Quick Guide (rev 2/28/17)

CHOICES 1 (800) 994-9422

Medicare Part A 2017 Premium, Deductibles & Co-pays			2017 Medicare Part B Premiums & Deductibles	
Part A Premium	(30-39 quarters) (< 30 quarters)	$227 per month $413 per month	**PART B** for those held harmless (when total premium is removed from SS check as of 1/17)	**$109** per month **All others: $134** per month
Hospital Deductible	(per benefit period deductible)	$1,316	**Those with annual incomes:** $85,001-$107,000 (single) or $170,001-$214,000 (married)	**$187.50** per month Part D (add $13.30 to premium)
Hospital Co-pays	Days 61-90 Days 91-150	$329 per day $658 per day	$107,001-$160,000 (single) or $214,001 - $320,000 (married) For those over these amounts…	**$267.90**per month Part D (add $34.20 to premium) **Visit www.ssa.gov**
Skilled Nursing facility Co-Pay	Days 21-100	$ 164.50 per day	**Part B Deductible**	**$183** per year

Medicare Savings Program (MSP) (rev . 3/17)				SSA COLA .3%	SSI $735 (one) or $1103 (couple)
Program	**Status**	**Income Limit**	**Status**	**Income Limit**	**NO ASSET LIMITS FOR MSP** **No Estate Recovery after 1/1/10**
QMB (Q01) 211% FPL	**Single**	$2,120.55 / mo	**Couple**	$2,854.83 / mo	
SLMB (Q03) 231% FPL	**Single**	$2,321.55 / mo	**Couple**	$3125.43 / mo	**DSS Benefits Line: 1-855-626-6632**
ALMB (Q04) 246% FPL	**Single**	$2,472.30/mo	**Couple**	$3,328.38/ mo	
Medicaid (Husky C) (for those 65+, blind or with a disability)	**Single**	$972.49 (region A) $862.38(reg. B & C)	**Couple**	$1483.09 (reg. A) $1374.41 (reg. B & C)	**Income listed includes Husky C unearned income disregard of $339/single & $678/couple if each has unearned income** **Assets: $1600 single; $2,400 couple**
Husky A (155% FPL)	**For one**	MAGI- $1557.75/mo	**For two**	MAGI-$2097.50/mo	With children under 19 yrs (eff. 3/17)

If you qualify for MSP, you will automatically qualify for Extra Help and the lower co-pays for Part D

Medicare Part D Low Income Subsidy (LIS) for 2017

LIS CO-PAYS FOR MEDICATIONS:

$3.30 - FORMULARY GENERIC DRUGS

$8.25 - FORMULARY BRAND NAME DRUGS

Medicaid recipients up <u>≤</u> 100% FPL: $1.20 /$3.70

- Max $17 per month

Medicaid Waiver/permanently in SNF–no co-pays

LIS Benchmark Premium for CT- $34.83 (2017)

Max Income/Assets for Partial Subsidy (3/17)

LIS **Single**	$1,528*	Assets under $13,820 *includes $20 disregard
LIS Couples	$2,556 *	Assets under $27,600

CT residents should consider applying for LIS through MSP which has no asset restrictions and higher income limits.

<u>FPL</u>	<u>Single</u>	<u>Couple</u>
100% FPL	$1005	$1,358
150% FPL	$1006-1256	$1693-$2030

Medicaid Expanded Benefits (3/17)

HUSKY D

Household size	MAGI Monthly Income
1 person	$1386.90
Couple	$1867.14

No asset restrictions
Age 18-64 without Medicare
No spend down, MAGI income
Apply at www.accesshealthct.com

Supplemental Nutrition Assistance Program <u>(SNAP) (eff. Oct 2016)</u>

Single person 185% FPL gross income - **$1832/ mo (max benefit $194)**

Couple 185% FPL income – **$2,470 / mo (max benefit $357)**

There is no asset limit EXCEPT for members who are 60 years old or a person with a disability whose gross income is more than **185%** of the Federal Poverty Level.
(asset limit over 185%: $3,250)

CT Health Insurance Exchange
Access Health CT

Benefits Center- 1-855-805-4325

<u>www.accesshealthct.com</u>

Next Open enrollment
Nov 1, 2017 – Jan 31, 2018

<u>DSS applications are mailed to:</u>

DSS Connect Scanning Center
P.O.Box 1320
Manchester, CT 06045-1320

<u>Or apply online:</u>
www.connect.ct.gov

DSS Benefits Line:
1-855-626-6632

CT Energy Assistance Program (CEAP) 10/16 Currently accepting applications

Household Size	60% median income
1 person	$33,880.60
2 people	$44,305.40
3 people	$54,730.20
4 people	$65,166.00
5 people	$75,579.80
6 people	$86,004.86

***Vulnerable households receive a <u>higher basic benefit:</u>** Vulnerable Households include a household member who is age 60+ or a person with a disability, or child under age 6. ($590 versus $535)

<u>Asset Limits apply:</u> www.ct.gov/staywarm

Homeowners - $15,000 **First date of delivery: 11/9/16**

Renters – $12,,000 **Eligible for winter protection shutoff: 11/1/6-5/1/17**

Households (including renters) with up to 60% of median income can qualify if their rent is more than 30% of gross income.

Households with liquid assets that exceed these amounts may qualify if gross income, when added to excess liquid assets, is within guidelines.

Funded in part by the Administration for Community Living Grant Rev.2/28/17

CT Home Care Program for Elders (CHCPE)	Functional Criteria	Income Guidelines	Asset Guidelines
State Funded - Level 1 Eff 7/15 – wait list only	One critical need	No income ceiling-	Individual:$36,270 Couple:$48,360 (eff 1/17)
State Funded - Level 2	Skilled nursing home level of care*	No income ceiling- 9% cost share	Individual:$36,270 Couple:$48,360 (eff 1/17)
Medicaid Waiver – Level 3 300% of SSI ($735) (updated 1/1/17) Applied Income starts at $2,010 (3/1/17)	Skilled nursing home level of care**	$2,205/month Only the individual's income is counted toward eligibility	Individual -$1600 Couple - $3200 (both receiving services) $25,780.00(one receiving services)1 /17 A higher asset amount may be allowed when a spousal assessment is done (Excess home equity limit:$840,000)
Medicaid – Level 5 (3/17)	1 or 2 critical needs	$1507.50 month (150% FPL)	Individual: $1,600
*Supervision or cueing ≥ 3 ADLs + need factor; hands-on≥3 ADLs; hands-on≥2 ADLs + need factor. Need factors: Behavioral or cognitive impairment requiring daily supervision to prevent harm or assistance with prescribed medications beyond setting up of pills.			
Call 1-800-445-5394 to make referrals or refer online https://www.ascendami.com/CThomecareforelders/default Eff 7/1/16 allowed max Irrevocable funeral service account $8,000; life insurance of face va lue $1500; 5 year look back Community Spousal Protected Amount: Minimum $24,180 and maximum $120,900 (1/17) Maximum Monthly Maintenance Needs Allowance: $3,022.50 (1/17). Minimum: $2,002.50 (7/16)			

APPLICATION FILING and ENROLLMENT PERIODS:

MEDICARE A & B INITIAL ENROLLMENT - Is 7 months long. Begins three months before the month you turn 65, the month you turn 65 and three months after. The enrollment date will affect the start date of Medicare.

SPECIAL ENROLLMENT PERIOD- For those who are still working at age 65 and covered by employer coverage through their own or spouse's active employment. A SEP for Medicare Part B begins the month after the employee coverage ends or employment ends (whichever comes first) and lasts for eight months (Individuals on Medicare due to ESRD do not receive a SEP). The SEP for Medicare Part D is 63 days.

GENERAL ENROLLMENT PERIOD MEDICARE PART B - First 3 months of every year (January 1 to March 31) Part B coverage won't begin until July 1st of that year. There will be a penalty for late enrollment. Individuals on MSP obtain Medicare Part B on the date the State starts paying for the Part B premium. You can request a retroactive buy in of Medicare B as far back as 6 months from the date of application for all 3 levels.

MEDICARE PART D & MEDICARE ADVANTAGE ANNUAL ELECTION PERIOD - October 15th through Dec 7th of every year. Coverage begins Jan. 1st of the following year. Late enrollment penalty applies if you did not enroll during your initial enrollment period and don't qualify for a SEP (MSP recipients are not subject to late enrollment fees).

MEDICARE ADVANTAGE PLAN DISENROLLMENT - January 1 and ends February 14, lasting for 45 days. The Annual Disenrollment period is designed to allow you to do one thing: Cancel your Medicare Advantage Plan membership and return to original Medicare. Once you cancel your Medicare Advantage Plan you have a couple of choices.

- Return to original Medicare and purchase a stand-alone Part D Plan.
- Purchase a Medigap policy and a stand-alone Part D Plan.

MEDICARE SAVINGS PROGRAMS - OPEN ENROLLMENT ALL YEAR LONG

MEDIGAP PLANS – CT is a continuous enrollment state. You can enroll in Medigap anytime during the year.

SNAP - Open enrollment all year long CT Energy Assistance Program - October 1 - April 15th.

RENTER'S REBATE PROGRAM - Apply annually Apr 1 – October 1. For renters aged 65+, 50+ of a surviving eligible spouse or 18+ yrs with a permanent disability. 1 year residency. No asset test. Hotline for questions: 860-418-6377

HEALTHCARE MARKETPLACE (Access Health CT)– Open Enrollment Nov. 1, 2017– January 31, 2018.

Funded in part by the Administration for Community Living Grant Rev.2/28/17

TIA'S (TRANSIENT ISCHEMIC ATTACKS) *continued from page 5*

According to the director of a primary stroke center, the body has naturally occurring clot-busting agents and eventually all clots will dissolve, but whether damage takes place, depends upon how long the clot remains in place. The medical director also stated that there should be no difference in response to a TIA or stroke - they are both considered medical emergencies, so dial 911 and tell the operator you think it may be a stroke.

Signs and symptoms of a stroke: (FAST)

F Face Drooping
A Arm Weakness
S Speech Difficulty
T Time to call 911

TIA'S (Continued)
Additional signs of a stroke may include:

- Sudden numbness or weakness of face, arm or leg
- Sudden confusion or trouble speaking
- Sudden trouble seeing in one or both eyes
- Sudden trouble walking, dizziness, lack of balance
- Sudden severe headache with no known cause

Article by : Marion Pollack, R.N., WCAAA Staff. Information Source: Excerpted from "Why Rush?" Stroke Connection 2009 (Science update October, 2012)

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Home Delivered Meals Eligibility for Title III Participants

The Home Delivered meal program can provide at least one nutritious meal per day to participants who are homebound or otherwise isolated or incapacitated. Meals may come as: hot, cold, frozen, quick-chilled, or shelf stable. Some special diets can be accommodated. The eligibility requirements are as follows:

- Individuals age 60 or older who are homebound because of illness or an incapacitating disability, or who are otherwise isolated;

- The spouse of an individual age 60 or older, regardless of age, if the receipt of the meal is in the best interest of the individual age 60 or older;

- Individuals less than 60 years old with disabilities who reside at home with a person age 60 or older who is a Title III-C home delivered meal recipient;

- In general, individuals receiving a congregate meal are not eligible to receive home delivered meals on the same day; and

- If a home delivered meal is received through a state funded program, an individual may not be eligible to receive home delivered or congregate meals paid for by Title III.

For information about this program or to register for Meals-on-Wheels please call the Western CT Area Agency on Agency, Monday-Friday, 8:00am-4:00 pm at 203-757-5449 or 1-800-994-9422 (if in our 41 town area region).

Article by Sandy Taylor, WCAAA Staff

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HEPATITIS C—VIRAL INFECTION

Hepatitis C is one of a family of viral infections that affect the liver. People who have Hepatitis A usually get over the virus—Hepatitis B and C (especially) can cause long-term effects on the liver leading to liver scarring (cirrhosis), liver failure or liver cancer. There is a vaccine to prevent Hepatitis B, but not Hepatitis C. Hepatitis B is transmitted through contact with infected blood, semen and other body fluids

Hepatitis C virus is spread through contact with blood from an infected person. A successful preventive vaccine for hepatitis C has yet to be developed. Transmissions of this disease are acquired through sharing contaminated needles, syringes or other injection drug materials. It also can be transmitted through sexual contact, inadvertent needle sticks or through the transfusion of blood or blood components.

Omitting alcohol from your diet will help by not causing additional liver damage. Your doctor usually will treat the condition, once diagnosed, based on your overall health situation and by monitoring your liver's condition. It may be recommended that you have hepatitis A and B vaccines to prevent additional liver injury. Some new, anti-viral drugs have been approved by the FDA called Sovaldi and Olysio, and are usually given with injectable drugs. They are working on an all-oral regimen and are in the late stages of clinical trials. Treatment courses will be shorter and the cure rates may be as high as 80—90 percent. That's very good news for those who suffer from this disorder.

Article by: Marion Pollack, RN
Information source: Mayo Clinic Health Letter March 2014

Town of Watertown
Falls Avenue Senior Center

Our thanks to the Falls Avenue Senior Center staff for providing this article. We will provide a senior center article in each CRIER.

The Falls Avenue Senior Center, 311 Falls Avenue in Oakville, offers recurring weekly activities for area adults 55 years of age and better. Our weekly healthy-living programs include Senior Exercise, Chair Aerobics, Chair Yoga, Dance for the Love of It-Dance for the Health of It and Zumba Gold. In addition to our ongoing programs, we offer special events throughout the month. This events include educational programs, social activities and entertainment. Our newsletter, which lists all of our programs, is available at the Falls Avenue Senior Center, 311 Falls Avenue in Oakville, the Town of Watertown Parks & Recreation Department and the Watertown Library. The newsletter also can be viewed online at www.watertownct.org under Departments (with a link to Recreation and then to the Falls Avenue Senior Center).

In April, our special events include LegsWork (a healthy vein program), Easter Cupcake Decorating, Birdhouse Painting, "How Not to Wait for an Emergency," Cooking with Corky, Dowsing, Entertainment by Walter Martin, Coloring Club, "Red, White & Blue" Patriotic Poetry Reading, "Mamma Mia" (the movie), EFT Tapping, the Oxford Senior Center Choral Group and "Fishing without Falling in Connecticut's Lakes & Streams."

Advance reservations are required for all special events and can be made by calling 860-945-5250 on or before the RSVP deadline. Please speak to a staff member when calling, as the center does not accept voice-mail reservations.

The WCAAA would like to continue to provide FREE unbiased information and assistance, as well as our publication, the "CRIER", to seniors, persons with disabilities and family caregivers. We are a non-profit organization and it is not always easy to find the funding to keep our publication going. A contribution of any amount enables the WCAAA to continue to provide these services. Contributions can be given in memory of someone or to honor someone. We would be glad to notify that person if you provide their name and address. **I'm happy to help. Enclosed is my tax deductible contribution.**

_____ $1 _____$2 _____$3 _____ $4 _____$5 _____ $ Other

From: _____ Address _____

In honor/memory of _____ Address _____

Mail to: WCAAA, 84 Progress Lane, Waterbury, CT 06705

Medicare Advantage Information and the Annual Notice of Change (ANOC)

Plan Annual Notice of Change (ANOC) - What is it?
If you're in a Medicare plan, your plan will send you a "Plan Annual Notice of Change" (ANOC) each fall. The ANOC includes any changes in coverage, costs, or service area that will be effective in January.
When should I get it? September
Who sends it? Your plan
What should I do if I get this notice?
- Review any changes to decide whether the plan will continue to meet your needs in the next year.
- If you don't get this important document, contact your plan.

Open Enrollment Period for Medicare Advantage and Medicare prescription drug coverage.
Each year, you have a chance to make changes to your Medicare Advantage or Medicare prescription drug coverage for the following year. There are 2 separate enrollment periods each year. **What can I do?**
- Change from Original Medicare to a Medicare Advantage Plan.
- Change from a Medicare Advantage Plan back to Original Medicare.
- Switch from one Medicare Advantage Plan to another Medicare Advantage Plan.
- Switch from a Medicare Advantage Plan that doesn't offer drug coverage to a Medicare Advantage Plan that offers drug coverage.
- Switch from a Medicare Advantage Plan that offers drug coverage to a Medicare Advantage Plan that doesn't offer drug coverage.
- Join a Medicare Prescription Drug Plan.
- Switch from one Medicare drug plan to another Medicare drug plan.
- Drop your Medicare prescription drug coverage completely. When? October 15–December 7

Medicare Advantage Disenrollment Period (January 1–February 14)

What can I do?
- If you're in a Medicare Advantage Plan, you can leave your plan and switch to Original Medicare.
- If you switch to Original Medicare during this period, you'll have until February 14 to also join a Medicare Prescription Drug Plan to add drug coverage. Your coverage will begin the first day of the month after the plan gets your enrollment form.

What can't I do?
- Switch from Original Medicare to a Medicare Advantage Plan.
- Switch from one Medicare Advantage Plan to another.
- Switch from one Medicare Prescription Drug Plan to another.
- Join, switch, or drop a Medicare Medical Savings Account (MSA) Plan.

Article by Judy Frank Fournier, WCAAA Staff. Information source: Medicare.gov

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Alzheimer's Support Groups

Alzheimer's Disease and other forms of dementia can be extremely difficult to cope with for a caregiver and the person diagnosed. Many caregivers struggle with taking care of their loved one with the disease and taking care of themselves. There are various ways to get this support. One way to consider self-help is by attending a support group. The Alzheimer's Association has a 24 hour, 7 day a week help line that offers phone support with Alzheimer's Association employees at any time to anyone who calls. The Alzheimer's Association 24-hour Helpline is 1.800.272.3900.

Another option the Alzheimer's Association offers is online. There are message boards and chat rooms that offer support to anyone who joins the online community. If someone likes a more personal setting or face to face conversations, there are lists of local support groups by town on the Alzheimer's Association website. These groups meet at different days and times, which makes finding a support group that fits your schedule easy because they are all in one list. Some welcome the person diagnosed and their caregiver for those who cannot leave their loved one alone. All options that the Alzheimer's Association offers are free of charge. To look at the list of support groups in your area, or register for the online community please go to the Alzheimer's Association website: www.alz.org and click the "support group" link.

The Alzheimer's Association website also has links and articles to a wide range of other resources. These links explain signs and symptoms, stages of the disease, the latest research updates, and links to help with legal and financial matters. This website is an extremely helpful tool to understanding the disease, learning what to expect, and planning for what can happen. For example, wandering is a very big concern for caregivers. The Alzheimer's Association has links to explain different options such as the Safe Return Bracelet focused on wandering, and finding a loved one who has gotten lost. There is a virtual library where caregivers can find books to help with support and advice, and an Alzheimer's Navigator that helps caregivers create a custom care plan and options. For further information on the Alzheimer's Association website you can click the link "Caregiver Center."

If you or anyone you know are in need of services for a person with Alzheimer's Disease or other forms of dementia, please call Western CT Area Agency on Aging and ask for the CT Statewide Respite Care Program or Jessica Warner at 203-757-5449 Ext. 114.

Article by Jessica Warner, WCAAA Staff. Information source: www.alz.org

ARE YOU BEING ABUSED?

There are many more people than we care to think about, who are having or have had some kind of an abuse issue, from a spouse, friend, caregiver, brother, sister or their own children. This is one of those topics most people tend **NOT to think and talk about**, except for the one experiencing the abuse and perhaps the person that sees it and **wants to help**.

The Protective Services for the Elderly Program (PSE) is designed to safeguard people **60 years and older** from physical, mental and emotional abuse, neglect, abandonment, and/or financial abuse and exploitation. This includes allegations of abuse or neglect of residents in long-term care facilities. There are different types of abuse. They are:

Abuse: The willful infliction of physical pain or mental anguish or the willful deprivation by a caretaker of services, which are necessary to maintain physical and mental health.
Neglect: The situation in which an elderly person is unable to take care of his or her needs or is being neglected by a caretaker responsible for providing services to maintain the person's physical or mental health.
Exploitation: The act or process of taking advantage of an elderly person, for monetary or personal gain.
Abandonment: Desertion or willful forsaking of an elderly person by a caretaker or the foregoing duties, or the withdrawal or neglect of duties and obligations owed an elderly person by a caretaker or other person.

Making a Report: Medical professionals, social workers, police officers, clergy, any person paid for caring for an elderly person by any institution, organization, agency or facility, **who believe an elderly person may be abused**, neglected, exploited, or abandoned, are required by law to report that information to the Department of Social Services Protective Services For The Elderly Central Intake Line at (888)385-4225. For after hour emergencies, please call 2-1-1. In addition friends, neighbors, family members, and acquaintances who suspect an elderly person is being abused, neglected, exploited or abandoned should call the number above. Any person who makes any report cannot be held liable in civil or criminal court when reports are made in good faith. These calls can be anonymous.

Once reported, a Department of Social Services worker meets with the senior and his or her family to determine unmet needs, and depending on the circumstances, develops a plan to address those needs. When necessary, staff will intervene immediately to safeguard the individual's health and well being.

Seniors may be afraid of what an abuser may do. If you know someone being abused please contact Protective Services at 888-385-4225 or the Western CT Area Agency on Aging at 203-757-5449. Let's keep our **SENIORS SAFE** and not afraid of abuse.

Articles by: Dawn Macary, WCAAA Staff
Information source: State of CT Dept of SS, Protective services for the Elderly, http://www.ct.gov/dss/cwp/view.asp?A=2353&Q=305232

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"CAN YOU HEAR ME" Look out for this one!!!

This scam does not just target older Americans. It targets all ages. This growing "can you hear me?" phone scam may be the scariest scam yet because it can make you a victim if you say just one word, "YES". If you receive a phone call from someone asking "can you hear me?," hang up. You're a potential victim in the latest scam circulating around the Country.

When "you say **"yes"** it gets recorded and they say that you have agreed to something," said Susan Grant, director of Consumer Protection for the Consumer Federation of America. **"I know that people think it's impolite to hang up, but it's a good strategy."** As the victim answers **"yes,"** his or her reply is recorded and that enables the scammer to use the recorded answer for signing up the victim for a product or service — and then demand payment (the Better Business Bureau (BBB) said). Scammers also can use the recorded answer to confirm a purchase agreement if it is ever disputed.

Be skeptical of strangers asking questions that would normally elicit a "yes" response. The question doesn't have to be "can you hear me?" It could be "are you the lady of the house?"; "do you pay the household telephone bills?"; "are you the homeowner?"; or any number of similar yes/no questions. A reasonable response to any of these questions is: "Who are you, and why do you want to know?". Best thing is "HANG UP". What can you do? If you suspect you have already been victimized, check your credit card, phone and cable statements carefully for any unfamiliar charges. Call the billing company -- whether your credit card company or your phone provider -- and dispute anything that you didn't authorize or propose. If they say you have been recorded approving the charge and you have no recollection of that, ask for proof.

Article by Dawn Macary, WCAAA Staff, Senior Medicare Patrol 203-757-5449

Western CT Area Agency on Aging
84 Progress Lane
Waterbury, CT 06705

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Please notify Western Connecticut Area Agency on Aging (WCAAA) if you change your address or decide you don't wish to receive an issue of the CRIER. Thank you.

WCAAA Mission Statement

The mission of the Western Connecticut Area Agency on Aging, Inc., an Aging and Disability Resource Center, is to manage and provide comprehensive services for seniors, caregivers and individuals with disabilities through person-centered planning in order to maintain their independence and quality of life.