

**PERSONAL SERVICE CONTRACTS FOR THE ELDERLY  
REVISITED**

By Scott M. Solkoff<sup>1</sup>

*Minerva Thomas was found on the concrete pavers surrounding the swimming pool at her assisted living facility. She had been laying in the hot Florida sun for hours. Because the facility staff seemed to have lost Minerva that morning, nobody is really sure how she came to be left there (this despite the fact that Minerva had wandered from the facility twice before). What is certain is that Minerva was severely burned, delusional and feverish.*

*After an extended stay in the hospital, Minerva was to be discharged to a skilled nursing facility. Her condition had so deteriorated as a result of her burns that she could no longer stay at the ALF. The family resolved that no matter what happened, they could never trust a facility's paid staff to alone care for Mom like they would. Mom needed an assurance that she would be cared for. The family wanted to help.*

*Just prior to Minerva's admission to the SNF, she contracted with her daughter, Diane, to pay Diane a lump sum payment of money in exchange for personal care services for the rest of Minerva's life. In truth, Diane and her brother, Blair, were performing much of the services contemplated by the agreement before their mother asked to enter into the contract. Now, however, Diane was legally bound to provide these services, could be compensated for them, and would step up her time commitment even more.*

These are the facts of *Thomas v. Department of Children & Families*<sup>2</sup>, a Florida intermediate appellate case which overturned the government's denial of Medicaid benefits when Minerva applied for those benefits after entering into the agreement with her daughter. In the end, Minerva achieved Medicaid eligibility and the money transferred to Diane was used to help keep Diane near her mother's side. Similar "personal care agreements" have since helped many elderly persons obtain care and protect against impoverishment in the face of the otherwise catastrophic costs of long-term care.

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<sup>2</sup>707 So.2d 954 (Fla. 4<sup>th</sup> DCA 1998).

## I. Introduction to Care Agreements

In the seven years since the author's article on personal service contracts was published in *The Elder Law Report*<sup>3</sup> and since his first presentation on the topic, along with Nicola Jaye Boone, at the 1998 NAELA Institute<sup>4</sup>, there have been changes in the way lawyers prepare these agreements and in the way the various state Medicaid programs treat them. This article serves to explain the concept of personal service contracts and discusses implementation strategies. The article first covers the philosophy and architecture of the agreements themselves. After the fundamentals, the article then travels into an advanced planning strategy using escrow agreements with the personal care agreement.

For the purpose of these materials, a personal service contract is an agreement between an elder and one or more people who promise to provide to the elder, personal care services for the rest of the elder's life or for a specified shorter duration. In long-term care planning, in addition to their promise of lifetime care, these agreements act to preserve the elder's financial resources that would otherwise have to be exhausted prior to obtaining any help from the government for the otherwise catastrophic costs of a nursing home, assisted living or home care.

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**“Those Americans who have saved their money receive little or no benefit from their own financial resources. The accumulation of assets is penalized. Elderly people must spend substantially everything they own to access quality long-term care. This is anti-capitalism. It is anti-American. It is anti-person.”**

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Simply put, the elder makes one lump-sum transfer of assets to a caregiver (or maybe to an escrow agent as discussed below) in exchange for that caregiver's promise of care. So long as the transaction is for fair market value, the government cannot disqualify the elder for Medicaid long-term care benefits. In doing this with a trusted family member, a professional caregiver or a friend, the elder has a promise of lifetime care and perhaps an understanding, albeit non-binding, that the caregiver will use that money for the elder if it is needed to make the elder's life better.

Sometimes, however, these agreements sometimes harm the very person whom the contract seeks to protect. If an unscrupulous person serves as “caregiver,” the elder can be left penniless and even with the best of intentions, these agreements can break down.

Like most planning options, the personal service contract is not without risk. Nefarious individuals may attempt to use the contract in an attempt to fleece the elder of his or her life savings. These “caregivers” may, in fact, have no

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<sup>3</sup>Scott M. Solkoff, *Personal Service Contracts in Long-Term Care Planning*, Elder Law Report (1998).

<sup>4</sup>See Nicola Jaye Boone & Scott M. Solkoff, *Personal Service Contracts in Long-Term Care Planning*, NAELA Advanced Elder Law 1998 Institute (National Academy of Elder Law Attorneys 1998).

intention of providing the care services. . . . Another risk, however, is that a well-meaning care provider may stop providing care services because of illness, a change in residence, death or another legitimate reason.<sup>5</sup>

Care agreements can be a tremendous asset to an elderly client who is facing total impoverishment due to the costs of long-term care. In our country, elders are literally forced into spending their life savings in order to receive home care, assisted living or skilled nursing care. Only when those assets are almost completely exhausted (down to \$2,000.00 using 2005 figures) may the elder apply for public help. By that point, with no financial resources remaining, the elder is totally dependent on government dollars and restrictive payment rules. The elder who has “spent-down” all of his or her resources has no money left to pay for care that the government will not supply. Because government services fall well short of actual need, it is potentially life-threatening to be left without supplemental funds.

In a perfect world, elders would not have to face total impoverishment in order for the community to come to their aid. And in a perfect world, elders would not have to transfer assets to a caregiver to ensure access to care. In the long-term care world, it is, however, far from a perfect world. While we have a wonderful country in so many special ways, in America, our rules and laws penalize those who have saved money by singling out the savers to pay for their own cost of care while others, already indigent, qualify for government assistance. Those Americans who have saved their money receive little or no benefit from their own financial resources. The accumulation of assets is penalized. Elderly people must spend substantially everything they own. This is anti-capitalism. It is anti-American. It is anti-person.

With the personal service contract and certain other planning devices, American elders seek to obtain more and better care by using their own dollars and the government’s dollars. In doing so, the American elder, gets the benefit of his or her savings and can afford the care that will make their last days, months or years better. While the government pays the base costs of skilled nursing upon Medicaid eligibility, the elder who has protected his or her savings, can pay for all those things for which the government will not pay — at least this is the goal.

The author co-presented on personal care agreements as part of a joint symposium with Canadian elder care experts. The personal service contract can and does work well in the United States but a careful understanding of the problems in other countries can lead to still better results. When personal service agreements break down, there are reasons. To understand the causes of failed agreements and the design of successful ones, this article will cover first the fundamentals and then delve into more advanced strategies.

## I. Fundamentals of the Personal Service Contract

A personal service contract is an agreement between an elder and one or more people who promise to provide to the elder, personal care services for the rest of the elder’s life. In consideration of this agreement, the elder transfers a lump-sum payment to the caregiver(s) or to an escrow agent in advance of the provision of services. The contract may seek to prolong the

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<sup>5</sup>Scott M. Solkoff, Elder Law Report at 3.

elder's residence within the community and, if and when the elder becomes a nursing home resident, seeks to provide greater assurance of continued quality care. The caregivers can be professional care providers, friends or family members. No matter who serves as caregiver, payment from the elder, made in one lump sum, is not an uncompensated transfer giving rise to Medicaid disqualification. When an elder transfers assets under a proper contract, the elder is receiving a fair market value return on his or her investment -- namely, the binding promise of care for the rest of the elder's life. As there is no uncompensated value as a result of the transfer, there is no period of Medicaid ineligibility.

### III. Benefits of a Personal Service Contract

Understanding the benefit of the personal service contract is not only important for its public policy implications and for its explanation to the client but in its explanation to the state Medicaid agency. The personal service contract is not an investment with which the case workers are ordinarily familiar. The work of the attorney may not stop at the preparation of the document but may include explaining the valuation and utility of the transaction to the case worker.

The case worker is likely to have been poisoned by state and federal policy of doing everything possible to keep elderly Americans from receiving public help for long-term care. While the case workers should be public servants, ushering people through the system, they usually see themselves instead as keeping the purse-strings tied because the government has committed so little to the nation's long-term care pocketbook. Due to this penurious perspective, the case workers are looking for reasons to keep elders out of the system rather than helping them through it.

The personal service agreement will be novel to the caseworker and their usual first impression is that this is simply an ill-motivated scheme to let a wealthy person qualify for a needs-based benefit. The fact is that there are important benefits to the agreement and it is a completely legitimate (and now court-sanctioned) method of protecting the infirm elderly.

#### a. Personal and Public Benefit of Greater Care

The benefits of a personal service contract include practical estate planning benefits. Above all, however, is the belief that through provision of a paid caregiver, the elder will receive a higher level of responsive and personalized care. In turn, with this stepped-up level of care, the elder is more likely to be able to stay at home and to stay *out* of a nursing home. If and when the elder must enter a nursing home, the care provider is there to ensure a higher level of care than would be attained by the elder were he or she without an advocate/care provider. It is an unfortunate truth that those nursing home residents without such advocacy are often neglected in favor of those who have constant and vocal visitors. The personal service contract is a means of better assuring quality care through one's last days.

Many elders are blessed by children, friends or other family members who may be voluntarily providing services similar to those contemplated by the personal service contract. What the contract does is to provide a legally enforceable guarantee that those services will be provided. A personal service contract can bring great peace of mind to an elder.

In these ways, the elder wins out and the government should be pleased as well. It serves the public good to keep people out of nursing homes for as long as possible and, once a person does enter a nursing home, the public benefit continues to be served through greater protection of the elder. Costs are kept down and people are better cared for. The only gripe the government could have is that the money paid to the caregiver may otherwise have kept the elder off the public dole. However, on balance, there may be no greater desire than to ensure that you or a loved one will be cared for in the last years or days of life. To deny any person that right would be antithetical to any notion of justice or social sustenance.

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There can be no doubt that these agreements may break down and that, when they do, they act against public policy, having harmed the elder at least financially. Because these agreements can break down, great care must be taken in their drafting and judgment exercised as to their applicability for a specific elder.

In nations that provide for the long-term care of their citizens, public policy considerations for the care agreements are less counterbalanced by need than in the United States. Indeed, if it were not for Medicaid considerations, I know that, in my Disability and Elder Law practice, I would as yet not have had occasion to discuss or recommend the use of personal care agreements.

b. No Medicaid disqualification

As a general rule of Medicaid qualification, an applicant who has made an uncompensated transfer of assets (a gift) will be ineligible for Medicaid benefits for a period of time depending on how much was transferred and when. 42 U.S.C. § 1396p (c)(1)(E) provides that an applicant who has made such a disqualifying transfer will be ineligible for Medicaid benefits for a period of months equal to the amount of the uncompensated transfer divided by the average monthly cost of nursing home care in the applicant’s locale. An uncompensated transfer occurs when anything less than fair market value is received in exchange for the transfer of assets.

A personal service contract does not trigger a period of ineligibility because it provides services of fair market value to the amount of transferred assets. The personal service contract

does not arbitrarily assign a value to the care services. Rather, as is discussed below, the contract takes great pains to ensure that the elder receives equal value for his or her transfer of assets.

The personal service contract is an investment and not a gift. As such, transfers made in consideration of the contracted-for services are outside the Medicaid transfer rules. Once it is established that fair market value is received in exchange for the promise of care, no criminal penalties can fairly attach to those who give advice regarding the personal service contract. *See* 42 U.S.C. § 1320a-7b(a) (making it a crime to advise as to transfers which create a period of ineligibility).

c. No probate

When an elder enters into a personal service contract, the elder transfers assets that may otherwise have had to pass through probate. If the care provider(s) happen to be the elder's heirs, the elder has effectively passed the assets to their heirs without probate. Just as Elder Law and estate planning attorneys often counsel clients on trusts, asset sharing, gifting and other probate avoidance tools, so too can the personal service contract avoid the expense and time of a probate proceeding by making an *inter vivos* transfer of otherwise probateable assets.

d. Tax Considerations

The care provider(s) do have to pay income tax on any payments received through the contract. Depending on the tax bracket of the care provider(s), this can amount to a sizeable tax burden. If the payment is made directly to the caregiver, the caregiver will have a large tax burden in the year that lump-sum payment was received. If done through a Medicaid-qualified escrow agreement (discussed *infra*), the payments can be received over time, thereby reducing a lump-sum tax shock.

Tax considerations fall squarely in the benefit column for the elder. There is no gift tax charged on the transfer of assets because fair market value is received in exchange for the transfer. There is no gift. Moreover, for elders who would otherwise be facing state and/or federal estate taxes, the transferred assets are removed from the estate -- transferred for consideration prior to death.

#### IV. The Contract

People often pay others for the provision of limited care services. Doctors are paid for periodic medical care. Home health care aides are paid for general care assistance. Accountants are paid to prepare tax returns. People sometimes even pay lawyers. With rare exception, however, services are paid for as they are received.

If a lump-sum payment is to be made in advance of the services, a contract is important to bind the service provider(s) to the provision of such services and to detail the expectations of the parties. A second reason to prepare a detailed contract is for purposes of Medicaid qualification. If an elder transfers assets to another with the expectation that the recipient will provide future services, the Medicaid agency will likely look askance at the transaction. With a detailed

contract, however, the state Medicaid agency has a means to value the services and, since mutual obligations are evidenced by the contract, the transaction is legitimized. The contract must be explicit as to its terms. There is no room for vagaries. Vagaries can trigger disqualification for Medicaid benefits by bringing into question the fair market value of the transaction.

Margaret Isabel Hall, an attorney in British Columbia, speaking of problems with care agreements in Canada, states that, in Canada, the agreements “almost always involve informal, oral promises.”<sup>6</sup> She writes that “[w]here the ‘agreement’ remains a vague, oral promise - beneath the legal radar - the parties will not have thought through the ramifications of the agreement they are creating and where these ramifications have not been talked through and provided for they can become pitfalls.”<sup>7</sup> This is certainly my experience as well but when taken in a Medicaid context, the failure to have a written agreement, evidencing fair market value, can be fatal to eligibility.

If not done in a Medicaid planning context, proper valuation is important only to the parties. In other words, a government actor does not need to be impressed with fair market valuation. I share with you below, the method for detailed valuation, I use for Medicaid purposes. It is not necessary to follow a formulary if acting outside of a Medicaid context. In the Canadian agreements to which Margaret Isabel Hall refers, proper valuation is therefore an important determiner of fairness and equity but not relevant for government benefits.

For the purpose of protecting the elder and ensuring Medicaid eligibility, practitioners should therefore hold the following discussion up to state rules:

a. Services to be Provided

Services should be separately enumerated. It is not sufficient to state that the care provider must provide “personal care services” or some other generic obligation. By separately enumerating the services, the parties have better documented their expectations and have provided a better touchstone for valuation of the services.

All services should be contracted for on an “as needed” basis and this should be explicit in the contract. It may not be fruitful, for example, for the care provider to continue grocery shopping if and once the elder is placed in a skilled nursing facility. The major premise of the contract is to provide the services that the elder needs for as long as the elder needs them. These needs may change from time to time. Moreover, each person may have different needs and desires. Upon consultation with the elder (or the elder’s duly authorized representative), draft a contract that serves the individual client. Consider language similar to the following:

Services: ELDER contracts to receive and PROVIDER agrees to provide the following personal support and maintenance services, over the lifetime of ELDER, on an “as needed basis”:

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<sup>6</sup>*Id.*

<sup>7</sup>*Id.*

a. Monitor Health Care: PROVIDER shall monitor ELDER's health status, emotional and physical condition with regular communications with health care providers, attendance at care plan meetings and all such other methods of monitoring ELDER's health care as and when appropriate or meaningful for the Elder's care, safety and maintenance.

b. Secure Health Care: PROVIDER shall attempt to secure qualified health care professionals, including doctors, nurses, nurse's aides, therapists, etcetera, to aid in diagnosis, treatment, palliation, cure and remedy of ELDER's health, physical and emotional status as may be deemed necessary due to illness, discomfort or mental health as is found to exist from time to time.

c. Personal Needs: PROVIDER will periodically assess the personal needs and desires of ELDER as to social, physical, entertainment, hobby, personal hygiene, beauty maintenance and other personal factors and shall seek to provide the services of others, equipment, apparatus, supplies, goods and wares so these needs and desires are met.

d. Visitation: PROVIDER will periodically visit with ELDER, wherever ELDER shall be, to provide the services required of PROVIDER herein, to provide social interaction and entertainment and, further will seek visitations of family and friends of ELDER with ELDER.

e. Financial Management: PROVIDER will assist ELDER in investments, bill-paying, and daily money management to the extent funds of ELDER are available therefor and to the extent PROVIDER may have access to such funds to accomplish such services.

f. Deal with Others: PROVIDER shall act as ELDER's spokesperson and/or shall aid any other agent of ELDER in dealing with health care providers and others, assuring ELDER freedom of communication and decision-making as is appropriate under the circumstances.

g. Resident's Rights: PROVIDER shall oversee the safeguard of resident rights and benefits of ELDER while ELDER may be a resident in a hospital, assisted living facility or skilled nursing facility.

Some care providers offer home care and meals as in the case of the elder living with an adult child/care provider. As appropriate, lodging and meals should be listed as well. Another paragraph may address individualized wishes of the elder. Consider the following:

ELDER's personal wishes: PROVIDER will obey and satisfy all of ELDER's personal desires if feasible, practical and responsible (in the sole judgment of PROVIDER), including but not limited to: (a) preparation and delivery of homegrown fruits to ELDER; (b) clean, cut and polish ELDER's fingernails; (c) receive and read mail for and to ELDER; (d) correspond for ELDER with ELDER's family and friends; (e)



accompany ELDER on a trip to Vancouver, British Columbia, once each year to visit with ELDER's sister; (f) arrange for and accompany ELDER on outings to the beach, for ice cream and for walks in the park.

b. Term

The term of the contract is for the life of the elder.<sup>8</sup> The elder is seeking assurance that care will be monitored and provided for the rest of his or her days. The provider is agreeing to be paid a pre-determined sum of money in exchange, therefore, for services of an unknown term of time. Since the duration of the contract is yet unknown, an assessment of the elder's life expectancy is necessary to be certain that the elder is getting his or her money's worth (i.e., fair market value) upon a transfer of assets.

The Health Care Financing Administration (HCFA), in its policy mandate, Transmittal Number 64, promulgated a set of life expectancy charts used to determine Medicaid qualification (most often for the use of annuities). Some states reiterate these life expectancy charts in their own rules.<sup>9</sup> To use the charts, the elder's age is located under the male or female chart and the government's estimate of life expectancy is thereby obtained. New charts were adopted by the Social Security Administration (SSA) and those charts were updated on June 16, 2004. To access the new charts, go to: <http://www.ssa.gov/OACT/STATS/table4c6.html>

Whether the charts are adopted by state rule or not, the SSA charts are an appropriate benchmark for determining life expectancy. The charts are reliable to Medicaid case workers because they were promulgated for the purpose of determining Medicaid eligibility and they were developed by the government. In determining life expectancy, however, it may not be sufficient to stop at the SSA charts.

For example, a 77 year-old woman has a 10.67-year life expectancy according to the government charts. That is to say that an average 77 year-old woman is expected to live, on average, another 10.67 years. Consider now a 77 year-old woman who has recently been fallen by an unrelenting and serious heart condition. The physicians, reluctant to give a meaningful prognosis, say only that "her days are numbered." The state Medicaid authority could argue, in such a case, that the HCFA charts are not an appropriate benchmark because objective medical findings would place the elder at a significantly lower life expectancy than for that of an average 77 year-old woman. In turn, the valuation of the personal care services would be lower than if the government charts were used alone.

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<sup>8</sup>Personal service contracts may also be for a term certain less than the life expectancy of the elder but are often insufficient to accomplish the client's Medicaid planing goals. For a discussion on "lifecare contracts" which expire when the elder is no longer able to perform two activities of daily living, see Patricia Jo Wilkinson, *Uses, Terms and Provisions of Lifecare Contracts for Elders*, NAELA 1996 Symposium (National Academy of Elder Law Attorneys 1996).

<sup>9</sup>See e.g., Manual 165.22, Florida Department of Children and Families.

In cases where the elder's medical condition does evidence a departure from the government's life expectancy charts, other showings of life expectancy could be obtained. The elder could obtain an assessment from a qualified health care professional. This assessment would consider the life expectancy of an average person of the elder's age and would then adjust the numbers to account for the elder's actual physical condition. When using the government's life expectancy tables without a downward adjustment, some practitioners obtain statements from a medical expert that there is no reason to believe that the elder will depart from a standard life expectancy.

In the author's own practice experience, these extra steps have proven unnecessary. Reliance on the charts should be enough and the *Thomas* case only supports this view.

c. Consideration and Valuation

The personal service contract should include the formula used to determine the value of the enumerated services. All terms should be explicit. Rather than a simple recitation of the assets to be transferred by the elder in consideration of the services, the contract should, in its terms, explain how this figure was determined.

i. Executory Nature of Contract

The personal service contract herein described is an executory contract. An executory contract is one where the obligation remains to be done in the future. With the personal service contract, the elder is making advance payment for services to be rendered during the future term of his or her life. In this way, the elder is not so much contracting for the services themselves but for the *promise* that those services will be provided in the future. With a proper formula for valuation, the mere promise to perform the services constitutes valuable consideration for the transfer of assets.

ii. Determining Fair Market Value

The following formula is used to determine the maximum the elder might properly transfer as fair market value for the promise of lifetime personal care services:  $W \times H \times 52 \times L = C$  where "W" is the wage paid to the care provider per hour; "H" is the number of working hours per week reasonably expected of the care provider; "52" is the number of weeks in a year; "L" is the elder's life expectancy; and "C" is the maximum amount of compensation that would be a fair market value exchange for the promise of services.

"W," the hourly wage, should represent that dollar amount that is reasonable in the community for payment of similar care providers. Geriatric care managers and professional guardians provide services that are the same as or similar to those detailed in the personal service contract. In the author's Southeast Florida community, geriatric care managers charge anywhere from \$75.00 to \$125.00 an hour for their services. Guardians for incapacitated elders are awarded by the courts, \$30.00 to \$55.00 an hour for their work. It can be stipulated in the contract, then, that a reasonable rate for a family member or other non-professional caregiver would be in the range of \$20.00 to \$25.00 per hour, well below the rates charged by other

providers of similar services. The contract itself can recite the charges that are customary in the community, thereby providing further documentation that the hourly rate assigned to the care provider is a reasonable one.

To determine the number of hours that the care provider might reasonably expect to work (“H” in the formula), the contract also looks to what is reasonable within the community. The amount of time a geriatric care manager or professional guardian spends with a particular client can vary greatly. Also, the geriatric care manager or guardian may employ other people to assist them in caring for the elder. Often, a home health aide is placed in the elder’s residence while the guardian or geriatric care manager does other tasks. The responsibilities detailed in the personal service contract will include tasks done by the professionals themselves and some tasks that are often delegated by the professionals to their agents. Therefore, while the guardian or geriatric care manager may be working 5-15 hours per week on behalf of their elder client, others may be performing similar services for 20, 30, 40 hours or more. The “H” value -- the number of hours expected of the care provider under the contract -- should account for the following: (a) what is reasonable in the community; (b) how much care the elder desires/requires; (c) how much the care provider wants to or is capable of working; and (d) how much money the elder can or wants to pay. Know that “H” represents an average number of hours expected to be worked. There may be some weeks where the care provider need only put in two or three hours per week and other weeks that call for forty hours or more.

The wage per hour (W) is multiplied by the number of hours per week (H), then by 52 weeks in a year and then by the life expectancy of the elder (L). For example, assume that a 77 year-old woman is willing to pay \$25.00 per hour to the care provider and that it is estimated the care provider will work an average of 10 hours per week. Our formula is \$25 per hour times 10 hours per week, times 52 weeks in a year, times 10.83 years, or:

$$\$25 \times 10 \times 52 \times 10.83 = \$140,790$$

With these values, the care provider could receive a maximum of \$140,790.00 as payment for the provision of personal care services under the contract. If the care provider were to receive more than this amount, the transfer would be uncompensated as to that amount exceeding the \$140,790.00 cap. In other words, a transfer of \$140,790.00 would be a fair market value exchange on the elder’s investment for personal care services. The elder could pay less than this amount but not more. The care provider can accept less than fair market value in exchange for his or her services but the elder cannot pay more. If the care provider is to receive less than the maximum, the contract should explain the determination of fair market value and then state that the care provider has agreed to accept less as full and complete payment.<sup>10</sup>

Some contracts might also take into account the time value of the transferred assets.

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<sup>10</sup>It should be explicitly stated in the contract that the elder considers the price to be fair market value. The state may look to the parties’ expectations when determining whether fair market value has been received. Note also that while these fair market value computations may be helpful outside of a Medicaid context, the fair market value formula described here is not necessary but for Medicaid.

Depending upon local rules and custom, the local Medicaid office may want a discount provided to the elder who is paying all of the fee in one lump-sum payment rather than over time. The provider is earning interest on the money over time rather than the elder earning and benefitting from the interest. In other words, were it not for the lump-sum advance payment, the elder would be paying over time and thereby retaining more earnings. On the other hand, inflation might have allowed for a greater fee for next year's services than is contemplated by the present fee structure. If inflation is taken into account, the elder might actually be getting a better deal now than he or she would have if payments were made as services were provided. For these reasons and despite the absence of any such provision in the law (discussed below), some practitioners deem it prudent to value the contract after taking into consideration the time value of the money.

iii. Method of Payment: Lump Sum or Staged Transfers

Payment should be made in one lump sum whether directly to the provider or to an escrow agent. Periodic payments may complicate eligibility for Medicaid should the elder require benefits prior to full payment.

In order to protect the elder from a nefarious caregiver or from a the dangers inherent in paying even an honest person in one lump-sum, it would be desirable to instead pay over time in "staged" transfers. This staged transfer of assets will make it so that the caregiver does not get paid until and as the services are provided. Unfortunately, this will not work where Medicaid is a goal. If the elder's countable asset (say a security or real estate) has not been fully transferred, then it is still deemed countable for Medicaid eligibility purposes to the extent it is not transferred.

The more attractive alternative to giving the caregiver a lump-sum payment is an "escrow" remedy where a third party holds the asset pending the caregiver's delivery of services. Escrow transfers should be given some serious consideration because, if workable, they could accomplish all of the goals of the lump-sum contract without all of the risk to the elder. There are significant benefits when a third-party holds the transferred assets in escrow.

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The third party would be the depository and would pay the assets, over time, to the care provider as and when the services are being provided. If the care provider stops providing services, the escrow agent could stop making payments to that care provider. The escrow agreement or the contract itself could provide for a successor caregiver.

Under the escrow concept, elder transfers lump sum to an escrow agent. Escrow agent, pays caregiver over time. One problem is determining the frequency and amount of the payments made by the escrow agent to the caregiver. One method would be to treat the account like an IRA account and divide the principal by life expectancy and then make regular distributions. For example, if the elder is an 84 year-old woman with a life expectancy of 7.08

years and there is \$100,000.00 in the kitty, then  $\$100,000.00 \div 7.08 = \$14,124.30 \div 12 = \$1,177.02$  per month to the caregiver.

What happens though, if the elder dies in 2 years rather than in 7.08 years? What happens to the rest of the money not paid to the care provider during the elder's life? Presumably, it would go directly to the care provider at this point because the care provider fulfilled his or her contractual obligations by providing lifetime care. What happens if the elder dies in 12.6 years rather than 7.08 years? Well — the payments could be recalculated every year based on life expectancy. That way, the money does not run out until actual death (as opposed to actuarial death).

The escrow agreement would have to provide that the elder has no access to the monies during lifetime and, if there is any possibility of reversion to the elder's estate, it must be noted that the government will have a right to recover those monies to the extent necessary to reimburse the state for Medicaid payments made on behalf of the elder. In order for fair market value to be maintained, the escrow agreement must be very concise in its mandate that the funds are only available to pay the care provider or a successor.

This escrow method helps protect the elder from broken promises. It also allows the care provider to take his or her payments over time rather than in one lump sum which could be a major income tax advantage.

The escrow agreement is therefore a valuable method of protecting the elder. However, in an Elder Law context, one very important benefit is lost. In most planning scenarios, it is desired that the caregiver be able to use the transferred assets to make the elder's life better. If the payment is made directly to the provider, the provider, though under no legal obligation to do so, might deposit all of the money (after holding aside that portion necessary to pay taxes) in an account that can then be accessed by the provider, in the provider's sole discretion, to pay for things for the elder that the government will not or cannot provide.

In Elder Law representations, a key goal is to assist the elder in accessing the best care possible. If the money is inaccessible and tied up in an unforgiving escrow agreement, the elder has no ability to benefit from that money outside of the care services being provided by the caregiver. On the other hand, as has been the case with all but one of my representations, the caregiver, if in possession of the transferred assets, may use those assets to buy a better quality of life for the elder. With the escrow agreement, the caregiver would only be able to access the money, and have the ability to use it for the elder, as the periodic payments come due.

Whether doing a direct payment to the provider or using an escrow agent, payments may be made by the elder with real and/or personal property.

If real property is to be transferred as full or partial satisfaction of the contract price, the attorney must determine whether the local Medicaid office will be valuing the property at the assessed value or at its fair market value<sup>11</sup>, the latter of which may be significantly higher. If the

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<sup>11</sup>SSI rules require real property to be valued at its assessed value. See SI 01140.100D.2,

real property is to be valued at assessed value, the only necessary documentation would be the tax bill. If the real property will be valued at fair market value, it is advisable to obtain two appraisals showing fair market value based on recent sales of comparable properties. These appraisals need not necessarily come from a licensed real estate appraiser. A statement of fair market value on a real estate broker's letterhead with attached "comparables" should be sufficient.

Whether it be real property, personal property or a combination of both, the transfer to the provider(s) or escrow agent should be made upon or after execution of the contract.

iv. Provider not responsible for costs

The contract should contain a paragraph stating that the provider is not responsible for any costs of the elder's care. Whether the care is being provided under the contract or whether the care involves medical bills, costs of residence, etc., the contract should make clear that the provider is not responsible for payment of those bills or costs. Instead, the contract should contain provision that the elder remains responsible for all costs of care and that the provider shall be reimbursed for any costs he or she advances on behalf of the elder. This is important not only to memorialize the understanding of the parties but to prevent future claims against the provider.

Herein lies a big issue for the Medicaid planner. The ideal situation for the elder would be to transfer assets to a trusted family member or friend who would then promise to provide future care. To many elders and planners, the promise of future care may be somewhat beside the point; the fact being that money that would otherwise have had to been exhausted on institutional care is now with a trusted family member or friend. The hope is that the family member or friend will actually use the transferred assets for the benefit of the elder. There is no legal obligation in the caregiver to use the transferred monies for the elder for if there were, the payment would not be a payment at all and the transferred assets would be deemed available to the elder. Still, that is often the hope and in the right situations, this is, in fact, what happens. Money that would otherwise have gone to a nursing home goes to help the elder have a better life by paying for an aide, massage therapy, whirlpool treatments, non-covered medications, a private room and other vital services that will make a difference in quality of life.

The danger, of course, without using an escrow agreement, is that the caregiver can skip town with the money. Now — instead of the health care system fleecing the elder of his or her life savings, this nefarious caregiver beats the government and facilities to the punch. Or ... more benignly, a well-intentioned caregiver predeceases the elder and the assets become subject to the caregiver's beneficiaries, creditors and costs.

b. Who can Contract?

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Program Operation Manual System (POMS) which some states have adopted by state rule. As Medicaid law cannot be more restrictive than the SSI rules, 42 U.S.C. § 1396 a(n)(2)(A), practitioners have a good argument for using the assessed value. Still, some states, in practice, require valuation at fair market value and this standard often goes unchallenged.

Any person competent to enter into a contract may be the care provider. While many tasks can arguably be conducted from afar, the personal service contract is designed for a care provider who is local to the elder. As for execution by the elder, the elder should sign if at all possible. If the elder is no longer capable of signing, the elder's agent may sign in the elder's stead. This may be a legal guardian, an attorney-in-fact or any other person who has been delegated the right to contract on behalf of the elder. If necessary, the care provider and the elder's agent may be the same person, but, as this is likely to raise flapping red flags of self-dealing at the state agency, it should only be done if absolutely necessary and if permitted by state power of attorney law. This issue is dealt with by Mike Pyle in his materials accompanying this presentation.

c. Personal Nature of Contract

A non-assignability clause might be included in the body of the contract. Consider language as follows:

Personal Nature: Neither party to this Agreement may assign, transfer, convey, hypothecate or otherwise alienate any rights or benefits, damages, costs and/or expenses he or she is to obtain or could obtain under this Agreement to any third party. This Agreement is for services unique to both ELDER and PROVIDER. Neither party shall have any obligation to act as to any third party.

Recognize, however, that if styling an escrow arrangement (discussed *supra*), a Successor caregiver may be necessary.

V. After the contract has been signed and payment made ...

The personal service contract is a real deal, not a sham transaction. As such, the provider must fulfill his or her obligations under the contract. The best way to prove that contract responsibilities are being met is for the care provider to keep detailed time sheets. Should the state ever question fair market value or the provision of care, the time sheets provide evidence that care is being provided.

VI. Problems with the personal service contract

Whenever a method exists to get a lump sum of money from the elderly, bad people get in line (or they move to Florida). A personal service contract holds the potential for great abuse and should be handled accordingly. Moreover, even with the best of intentions, unintended consequences can be caused by a care provider's death, illness or other unavailability. With any estate planning option, there are pros and cons. On balance, the personal service contract has been proven a useful service to the elder but here are some things for which to beware:

a. Disgruntled heirs: Beneficiaries of the elder's estate may receive less or no inheritance as a result of the transfer of assets to the care provider. Practice tips on handling and preventing disgruntled heirs in Medicaid planning are widely available and beyond the scope of

this article. Suffice it to say here that the attorney should seek consensus, document everything and, if appropriate, advise the heirs to seek separate counsel.

b. Liability of caregiver for injuries sustained by elder: Because the care provider is responsible for monitoring and, in some cases, providing care, the care provider is exposing him or herself to personal injury claims. Language can be included in the contract to evidence the elder's intent that such liability not be assumed but this language is likely to be of little avail as waivers of negligence are often held to be unenforceable or are easily defeated.

c. Taxes: A capital gains issue may arise when the elder's assets are sold or transferred in satisfaction of the contract. Also, payment to the care provider is chargeable as income to the caregiver.

d. Red Flags with the agency: It is in the client's best interest to have a smooth and quick Medicaid approval process. If, in the attorney's opinion, the personal service contract is likely to raise red flags at the agency, thereby delaying or jeopardizing eligibility, another planning option may be more appropriate. For example, annuities are known by most case workers to be a non-countable asset. It may be tougher to explain the personal service contract to a Medicaid case worker. At present, at least two states have struggled with the personal service contract as it relates to Medicaid qualification (*see below*).

e. Risk and Enforceability: As has been discussed above, there are great risks whenever lump sum transfers of an elder's assets occur.

In most Elder Law representations, however, an elder who is contemplating a personal service contract with a friend or family member, would have been more glad to gift the money to that person were it not for Medicaid transfer penalties. With a detailed and written personal service contract, the elder at least has some enforceable promise of care.

The risk of assets transfers is always an issue in long-term care planning. The client and practitioner must weigh these risks against other facts of long-term care in America. For example, for many elders, the money being considered for transfer under the contract is money that would have had to go directly to the nursing home. Albeit while the money to the nursing home would have been paid over time, most elders would be penniless in short order. With the personal service contract, at least the elder has a fighting chance that their own hard-earned savings will be used to provide better care.

## VII. Case Law and Applicable Rules

At the beginning of this article, the Medicaid transfer rules were discussed and it was shown that so long as fair market value is received in exchange for a transfer of assets, no disqualification period can properly be imposed. Since the assets transferred pursuant to the personal service contract are precisely tied to the fair market value of the services, the personal service contract should be viewed as outside of the Medicaid transfer rules. It is an investment or purchase and not a gift. The Medicaid rules support this view and two states, Florida and Washington, have administrative or judicial rulings that uphold the use of a personal service contract in a Medicaid context. Mike Pyle, in his materials attends to the law and agency rulings



supporting the use of personal service contracts.

## VIII. Conclusion

The personal service contract is a valid means of achieving security for the elder client while protecting against Medicaid ineligibility when the client pays for that security.

The personal service contract allows an elder to contract with others for the promise of lifetime care. If the elder lives beyond his or her life expectancy, the care provider must still provide care. In such a case, the elder made a good deal. If the elder dies earlier than expected, the care provider made a good deal. So long as the contract is carefully drafted to consider valuation, life expectancy and the services to be provided, there should be no period of Medicaid ineligibility when the elder pays for the personal care services.

Having come to terms with the Medicaid consequences of care agreements, the elder and the elder's advisor must assess the risk inherent in such a transaction. Due consideration must be given to the client's goal of accessing the best care possible at end of life. While escrow agreements may be a good method of better protecting the elder from failed care agreements, it must also be recognized that the assets transferred to the escrow agent will now be inaccessible for the elder's care. With the direct-pay care agreement, there is at least an expectation, albeit without legal justification, that the elder will be able to benefit from his or her own money.

The goal, as it always is, with the Elder Law client, is to maximize the elder's resources to access a better quality of life. To this end, the personal service contract succeeds in an otherwise unforgiving system of elder care.

“Exhibit A”

707 So.2d 954

District Court of Appeal of Florida,  
Fourth District.

Minerva THOMAS, Appellant,  
v.  
FLORIDA DEPARTMENT OF CHILDREN AND  
FAMILIES, Appellee.

No. 97-1433.

March 25, 1998.

Applicant sought medicaid benefits for nursing home pursuant to state's institutional care program. The state department of children and families denied application, and applicant appealed. The District Court of Appeal, Stevenson, J., held that fact that applicant had entered into lifetime contract with her daughter for health care and personal services did not warrant denial of benefits.

Reversed and remanded.

Nicola Jaye Boone of McCarthy Summers Bobko McKey Wood & Sawyer, P.A., Stuart, and Scott M. Solkoff of the Law Office of Jerome Solkoff, Deerfield Beach, for appellant.

Richard E. Doran, General Counsel, and Herschel C. Minnis, Assistant General Counsel, Tallahassee, and Colleen Farnsworth, Assistant District Legal Counsel, West Palm Beach, for appellee.

STEVENSON, Judge.

Minerva Thomas, the appellant, challenges a decision of Florida's Department of Children and Families denying her application for Medicaid benefits pursuant to Florida's Institutional Care Program ("ICP"). Prior to applying for these nursing home benefits, Thomas entered into a lifetime contract with her daughter, whereby her daughter agreed to supervise appellant's health care and to provide personal services to her mother in exchange for \$67,725. The Department's denial of Thomas' application for ICP benefits was based on its determination that Thomas had received less than fair market value for the \$67,725. We reverse.

Both federal law and the Department's own regulations provide that a transfer of assets shall not render a Medicaid applicant ineligible for benefits, if he or she can establish that "the individual intended to dispose of the assets either at fair market value, or for other valuable consideration." 42 U.S.C. § 1396p(c)(2)(C)(i); *see also* Florida Department of Children & Families Resource Manual § 1630.20.00. During the proceedings below, the only evidence presented was that Thomas had in fact paid fair market value for the services contract; thus, the hearing officer's finding that Thomas had not received fair market value for the exchange is without record support. We, therefore, reverse and remand for further proceedings consistent with this opinion.

REVERSED and REMANDED.

GLICKSTEIN and SHAHOOD, JJ., concur.