



Senior Tidings

Crawford County Council on Aging, Inc.

June 2008

Crawford County
Council on Aging, Inc.
200 S. Spring St.
Bucyrus, Ohio 44820

419/562-3050 or
1-800-589-7853

Hours:
8:30 a.m.-5:00 p.m.
Monday-Friday

[http://
crawfordcountyyaging.com//](http://crawfordcountyyaging.com//)

Topics of Interest

- Why be Shy about Incontinence?, pg. 3
- Health Tip...Smart about Sun Exposure, pg. 3-4
- 1-800-MEDICARE Changes, pg. 4
- Medicare's Home Health Care Benefit, pg. 4-5
- Skipping Doses Due to Cost, pg. 5
- Timelines for Part D Drug Appeals, pg. 6
- Part D-Sign Up, Sign On!, pg. 6-7
- Administration of Part D drugs covered, pg. 7
- New CMS rule, pg. 8
- Dear Marci, pg. 8-9
- Long-term Care Planning, pg. 10
- Utility Bills, pg. 11

Council on Aging...notes

Spring Con Men Are Here! Beware!



The Better Business Bureau has already received a report that an elderly man paid over \$25,000 for a new roof for his home. Now the man he paid is gone. All the senior has is a name (probably not real) and a cell phone number (now disconnected) that originated in North Carolina. With so little information, there is nothing the police or the BBB can do to help.

Every year there are con men that knock on seniors' doors.

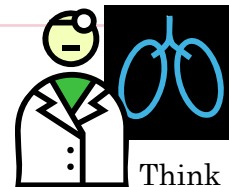
Every year warnings are issued about dealing with these people.

Every year seniors hire them and get scammed by them.

If someone comes to your home and offers to do odd jobs or large jobs (trim trees, paint house, seal the driveway, fix the chimney or roof), the BBB suggests the following:

1. For small jobs, agree on a price before the work starts. Only pay for the finished work after it meets with your approval.
2. On larger jobs, have the company write out their bid. This would include their name, address, phone number, work to be done, price and warranty.
3. Get other company estimates for the work you want done. **The door-to-door guys are notorious for charging outlandish amounts.**continued on pg. 11.

Health & Nutrition....



Coping With COPD.... *Sick Lungs Don't Show*

Chronic Obstructive Pulmonary Disease (COPD) is long-term blockage of air movement in the lungs. It includes emphysema and chronic bronchitis.

Think of the lungs like an upside down tree, with the wind-pipe (trachea) being the trunk, the bronchial tubes the branches and the air sacs as the leaves. Because there are millions of these tiny air sacs, a lot of damage can be done before a person notices breathing problems.

Because oxygen moves into the bloodstream through these tiny air sacs, when they are damaged we cannot get enough oxygen into our body.

A person with COPD may have either emphysema or bronchitis, but most people with COPD have both. Some may also have symptoms similar to asthma. In emphysema, there is damage to the walls of the air sacs in the lungs that prevents transfer of oxygen into the bloodstream. The lungs lose their ability to stretch, producing shortness of breath during activity. In chronic bronchitis the damage is in the breathing tubes (bronchial tubes), which become inflamed and swollen and produce large amounts of mucus, making it difficult to get air in and out of the lungs.

Causes of COPD

The most common cause of COPD is cigarette smoking. Other causes:

- Breathing in dust, chemicals and coal dust or silica at work
- Indoor air pollution from cooking fuels and heating in poorly ventilated homes
- Secondhand smoke
- Childhood lung infections
- About 2% of cases are inherited



Symptoms of COPD

The first symptom of COPD is usually coughing that produces mucus, followed by shortness of breath after activities such as climbing the stairs.

As breathing difficulties worsen, people with COPD may eventually get tired dressing and bathing, lose the ability to concentrate, and put strain on their heart because their lungs are not processing enough oxygen, causing swollen feet, ankles and legs.

Avoid Air Pollution and Pollen

People with lung disease may be affected by irritating substances in the air, or they may have al-

lergies to pollen. Inside or outside of the home they should always avoid dust, smoke, fumes from wood or coal burning stoves, and strong odors. People highly allergic to mold may have trouble breathing if exposed to it.

Stress Relief

Stress can make breathing more difficult. When people have trouble breathing, they may become anxious, which can make breathing even more of a problem. Relaxation techniques such as meditation, or tensing and relaxing muscle groups are very helpful.

Fast Facts:

- Every 4 minutes someone dies of COPD in the U.S.
- COPD is the 4th leading cause of death, but will be the third leading cause of death of 2020.
- 12 million individuals have been diagnosed with COPD and 12 million are symptomatic or developing COPD.

Slow Down

People with COPD need to conserve their energy so they don't become exhausted. Here are a few tips for doing that:

- Take it easy; move slowly.
- Sit while doing chores or other activities.
- Avoid lifting and bending; keep household items within easy reach.
- Rest after eating.
- Use a cart with wheels to carry things.
- Use a shower or stool and hose sprayer in the bathtub.

Quit Smoking!!!

If the person in your care is still smoking, the most important thing they can do is **STOP SMOKING.**

Keeping the Airways Clear

Ask the doctor or therapist about these methods to help clear the lungs of mucus:

- Diaphragmatic breathing and huff coughing.
- Special positioning—called *postural drainage* or *bronchial drainage* uses gravity to drain mucus from the smaller to the larger airways where it can be coughed out.
- Rhythmic clapping with cupped hands on the chest, back and ribs can be done while the person is positioned for airway clearance. Ask your doctor or therapist.
- Drinking enough caffeine and alcohol-free fluids every day helps keep the mucus thin.

Source: *The Comfort of Home*, Caregiver Assistance Newsletter, May 2008.

Resource for You

COPD Digest- for reliable information on COPD, get a free subscription to COPD Digest at www.copddigest.org

Better Breathers Clubs (part of the American Lung Association) www.lungusa.org. For club information. Click on “diseases” then “Services and Support”

COPD Foundation 1-866-316-COPD(2673) www.copdfoundation.org

Free educational materials, information, and support are available through the COPD Information Line and COPD Digest.

Why Be Shy About Incontinence?

Many people think of incontinence as a shameful secret, but you shouldn't suffer in silence if you have incontinence. You can take action to prevent or manage it. The first step is to talk with your health care provider.

“Incontinence” means losing control of your blad-

der or bowel movements. You may have trouble getting to the toilet in time. You may leak urine or stool unexpectedly when you sneeze or run. Some people who have incontinence may avoid social situations, fearing an embarrassing “accident.”

Incontinence can happen to anyone, but it's most common in women and older people. It can occur for many reasons, but it's not caused by aging. Women who've had children are especially at risk for incontinence. Sometimes other medical conditions, like diabetes or physical injuries, can make you lose control over urinary or bowel muscles and lead to incontinence. Treating these other conditions may help restore your control.

Many people can prevent incontinence by making simple lifestyle changes. Your diet, physical activity, weight and smoking behavior all play a role.

Remember, if you have incontinence, you're not alone. For millions of men and women nationwide, incontinence can be treated. Your doctor can help you find the approach that's best for you.

Learn more about incontinence by visiting the web page listed below. You can also contact 1-800-891-5390 or nkudic@ubfi.niddk.nih.gov for more information about bladder control. To learn more about fecal incontinence, contact 1-800-891-5389 or nddic@info.niddk.nih.gov.

Source: *NIH, News in Health*, March 2008.



Health Tip.... After a long winter, many of us are eager to soak up the sun's rays and rid ourselves of our winter palor. But too much sun can be dangerous.

Being smart about sun exposure is key to keeping your skin healthy. Here are some tips from the American Academy of Dermatology:

- **Generously apply a water-resistant sunscreen** with a sun protection factor (SPF) of at least 15 that provides broad-spectrum protection from both ultraviolet A (UVA) and ultraviolet B

(UVB) rays to all exposed skin. Reapply every two hours, even on cloudy days, and after swimming or sweating.

- **Use extra caution near water and sand** as they reflect the damaging rays of the sun, which can increase your chance of sunburn.
- **Avoid tanning beds.** Ultraviolet light from the sun and tanning beds can cause skin cancer and wrinkling. Instead, consider using a sunless self-tanning product (but continue to use sunscreen with it).

However, it is also important to get screened by a dermatologist to examine your entire body for suspicious moles and skin lesions to see if they could be cancerous. The American Academy of Dermatology's search tool allows you to see where you can get a free skin cancer screening. You should especially get screened if any of your existing moles fit the ABCDs of melanoma detection.

If you feel that you have a suspicious-looking mole, make an appointment with your doctor as soon as possible. Medicare Part B will cover a diagnostic doctor's visit and any diagnostic tests your doctor deems medically necessary.

Source: *Dear Marci/Medicare Rights Center*, May 5, 2008.

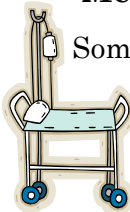
Medicare information....

1-800-MEDICARE Changes

After a successful test, CMS has changed the Integrated Voice Response (IVS) system that presents options to callers to MEDICARE. The new feature is that the IVS now asks the caller to enter his or her Health Insurance Claim Number (HICN) immediately following the welcome announcement. This change will allow 1-800-MEDICARE customer services to better serve callers and will allow additional personalization of IVR options for callers, depending on the caller's enrollment status. Obviously, callers without HICNs available will still get to customer service representatives.

Source: *SHIP Weekly Digest*, May 5, 2008.

Medicare's Home Health Care Benefit



Sometimes, people with Medicare need medical care at home. You may have just been discharged from the hospital; or perhaps you're dealing with a flare-up of a chronic ailment. Medicare covers care and treatment in your home if you meet specific criteria. Here's how Medicare's home health care benefit works:

First, your doctor must certify that you are homebound, and that home care is medically necessary. **Homebound means that it requires considerable and taxing effort for you to leave your home.** **Second**, you must need skilled physical, speech or occupational therapy services, or skilled nursing on an intermittent (less than seven days a week) or part-time (less than eight hours a day) basis. Skilled nursing services are those services that can only be performed safely and effectively by a licensed nurse. Tube feedings, catheter changes, management and evaluation of a patient's care plan are examples of skilled nursing. If you require only skilled nursing, you must either need it fewer than seven days a week (even as little as once every 60 to 90 days) or daily (seven days a week) for a short period of time (usually two to three weeks). *Your care must be provided through a Medicare-certified home health agency (HHA).*

Medicare's home health benefit pays in full for **skilled nursing** services. Medicare will cover the full cost of **physical, speech and occupational therapy** in your home to maintain your condition and prevent you from getting worse (*you do not need to have the potential to improve to receive these services*).

The costs of a **home health aide** are covered in full **only if** you are also receiving skilled nursing services in your home. A home health aide pro-

vides personal care services, such as help with bathing, dressing, and using the toilet. **If you require only personal care, you do not qualify for the Medicare home health care benefit.**

Medicare will also cover in full the cost of **medical social services** (such as counseling) that help you with social and emotional concerns related to your illness; the **medical supplies** (wound dressings, for example) used by the Medicare-certified home health agency; and **evaluations** by a skilled nurse or therapist. The Medicare home health care benefit covers 80% of the Medicare-approved amount for some **medical equipment**, such as a wheelchair or walker.

There are some home care services that are not covered by Medicare's home health care benefit. These include 24-hour care at home, homemaker or custodial care services (housekeeping services such as cooking, shopping, and doing laundry) or meals delivered to your home. Most prescription drugs are covered under Medicare's drug benefit (Part D) and not by the home health care benefit. (Medicare's hospice benefit, however, may pay for some of these items and services for people at the end of life).

If you are eligible for home health care benefits, a Medicare-certified home health agency will draw up a plan of care that describes the types of services that will be provided, how often you need those services, and for how long. A doctor must then approve the plan, which covers up to 60 days of care, and the doctor, in consultation with the HHA, must review and evaluate the plan at least every 60 days. At the end of 60 days, the HHA can draw up a new plan of care as long as you continue to qualify for the Medicare home health benefit.

To learn more about what is covered under Medicare's home health care benefit, log on to Medicare Interactive Counselor at the Medicare Rights Center's website at www.medicarerights.org/help.html. Medicare Interactive Counselor is a resource provided by the Medicare Rights Center, the largest

independent source of health care information and assistance in the United States for people with Medicare.

Part D Helps, but Sickest Still Skip Doses Due to Cost



The Part D prescription drug benefit has helped reduce the number of people with Medicare who skip doses or otherwise alter their medication regimen because of costs, but it has had little impact on the behavior of people with Medicare who have severe illnesses or disabilities, according to a new study published in the *Journal of the American Medical Association*.

The survey found modest declines after Part D began in 2006 in the number of people with Medicare who skipped doses, split pills or skimmed on food and other necessities because of the cost of drugs. The survey included people with Medicare enrolled in Part D and those who remain without drug coverage or who have drug coverage through an employer.

The results were less positive among people who have Medicare because of a disability or those in poor health or with multiple illnesses. Although these individuals were less likely to forgo spending on necessities after Part D began, there was no decline in skipping doses or other "cost-related non-adherence" to drug regimens. The authors explained that many of these individuals already had drug coverage through Medicaid prior to Part D. Also, individuals with serious health problems are more likely to have drug spending high enough to put them in the "doughnut hole," the gap in Part D coverage when enrollees must begin to pay the full cost of their drugs.

Source: *Medicare Watch*, a biweekly electronic newsletter of the Medicare Rights Center, Vol. 11, No. 9: April 29, 2008.

Medicare Part D....

Case Flash: Timelines for Medicare Prescription Drug Appeals

Mrs. B has received her Medicare health and drug benefits from a Medicare private health plan with prescription drug coverage (MA-PD) for the last two years. Last year, the plan covered all of her prescription medications at an affordable price. This year, however, her plan changed its formulary (list of covered drugs) so that an important and expensive pain medication was no longer covered. Mrs. B and her doctor had tried generic and other name-brand alternatives in the past, but only this particular medication worked for Mrs. B without causing serious side effects.

Mrs. B asked the plan to continue to cover her drug (an “exception” request). Mrs. B also asked her doctor to write a letter stating that this particular medication is medically necessary for her. Mrs. B faxed her exception request and the letter from her doctor to her plan’s claims department. Seventy-two hours later, the plan notified Mrs. B that her exception request had been denied.

Following the instructions on her plan’s notice of denial, Mrs. B then sent a request for a re-determination, or an appeal, to her plan. She again included her doctor’s letter of medical necessity, and mailed the request “return receipt” so she would have proof that the plan received her letter. Two weeks went by, and, although she received the confirmation receipt showing that her plan had gotten her request, Mrs. B heard nothing from the plan.

Mrs. B called the Medicare Rights Center’s hotline and spoke with a counselor about her situation. The counselor explained that the plan has seven days to respond to a re-determination request, unless you request a fast (“expedited”) review from the plan because you need the medication urgently. If the plan does not respond to you within the required timeframe, you can “escalate” your

request to the next level of appeal yourself. The counselor explained to Mrs. B that the next level would be to request a review from the Independent Review Entity (IRE). The IRE is an independent agency that works with Medicare to review appeals. The hotline counselor advised Mrs. B to send her letter and the letter of support from her doctor to the IRE for review, with a copy of her return receipt and a written explanation that the plan has never responded to her request for re-determination. Once the IRE receives your materials, it has seven days to respond to the request.

The hotline counselor further encouraged Mrs. B to write another letter to the Appeals and Grievance Department of the plan, to file a formal complaint (grievance). The counselor explained that while this letter was separate from the appeal and would not advance the appeal itself, it could be helpful to her and others like her in the long run to make a formal complaint. Plans must respond to grievances and also must report the number of grievances they receive to the Centers for Medicare and Medicaid Services (CMS).

A few days after submitting her request to the IRE, Mrs. B heard that her appeal was successful and that the plan would continue to cover the prescription for her.

Note: If Mrs. B’s plan had not responded to her initial request for an exception within the required 72 hours, Mrs. B could also then have escalated her appeal to the IRE.

Source: *Medicare Watch*, a biweekly electronic newsletter of the Medicare Rights Center, Vol. 11, No. 10: May 13, 2008.

Sign up, Sign On

Next year, there will be an even wider hole in the Medicare Part D prescription drug benefit, the part of the year when coverage stops and people with Medicare must pay the full price of drugs even as they continue to pay premiums. This year,

the gap, which is measured in out-of-pocket spending, is about \$3,216. In 2009, that gap increases to around \$3,454.

The gap is growing because the law mandates that the parameters of the benefit (the size of the deductible, the point at which initial coverage ends and the total out-of-pocket spending required before catastrophic coverage kicks in) track annual growth in drug costs per person under Part D. Those costs are rising by nearly 6 percent annually, much faster than the rate of inflation.

Why can't Medicare restrain the rising costs of prescription drugs instead of simply passing those costs on to consumers?

Answer: The law prohibits Medicare from negotiating lower drug prices.

The insurers tapped to offer Part D coverage (there is no option to receive drug coverage directly from Original Medicare) have been unable to negotiate significant discounts from drug manufacturers. And the discounts they have received have not translated into lower prices for consumers. As a result, people stuck in the Part D coverage gap pay the full price for their medicines. It's a lousy deal for consumers, but a windfall to drug manufacturers.

The lower prices the government can negotiate with pharmaceutical makers are just one reason people with Medicare deserve the option of receiving drug coverage directly through Original Medicare.

A drug benefit under Original Medicare would provide the simplicity, stability and security that have been absent under the privatized Part D benefit. Plans drop drugs from coverage, add new restrictions to the drugs they do cover, even as they hike premiums and co-payments. This year, over one million low-income people with Medicare were randomly assigned a new plan because their old plans were too expensive. We need to start organizing now so that people with Medicare can get the one

choice they really want, a *Medicare-run drug benefit*. There are two things you can do:

1. **Write to urge your senator or representative to cosponsor the *Medicare Prescription Drug Savings and Choice Act of 2007*.**
2. **Get the organization you are part of, whether it is a statewide group for people with disabilities or the tenants group at the local senior housing complex, to come out in support of a Medicare-run drug benefit.**

Source: Asclepios/MRC Advocacy, February 28, 2008-Vol. 8, Issue9.

Part D now covers Administration of Part D drugs

Medicare Part B will continue to cover the flu, pneumonia, and hepatitis B vaccines, plus any other vaccine (e.g. Tetanus) when directly related to the treatment of an injury or direct exposure to a disease or condition. Medicare Part D covers all vaccines generally not available under Part A or Part B.

Starting in 2008, Part D plans must cover all commercially available vaccines and the administration of the vaccine. Check the Part D plan formulary for covered vaccines. For example, the Herpes Zoster Vaccine to prevent shingles would be a Part D claim covering both the vaccine and the administration of the vaccine.

The Part D plan should generally charge one co-payment for the vaccine and its administration. If the administration of the vaccine is done out-of-network, the beneficiary may have to pay the provider up front, and then submit paper claims to the Part D plan for reimbursement.

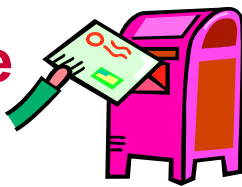
Source: OSHIIP News, May 2008.

Find out “reasonable & necessary” before the service is performed

A new CMS rule allows physicians and people on Medicare to discover whether a recommended service will be viewed as “*reasonable and necessary*” before the service is provided. The prior determination request to the claims contractor must include supporting documentation. The contractor will have up to 45 days to respond. Any determination the contractor makes is binding unless there is fraud or misrepresentation by the physician or beneficiary. **The rule, effective March 24, is 73 Fed. Reg. 9679.**

Source: OSHIIP News, May 2008

Marci’s Medicare Answers....



Dear Marci,



I fell and broke my arm two months ago, and my son says I should install safety rails in my bathroom. Will Medicare pay for it?

—Otto

Dear Otto,

No, Medicare will never cover home modifications (such as the installation of grab bars near the toilet or tub) or assistive devices (such as large-button telephones or flashing doorbell signals for the hard-of-hearing). **Medicare will, however, cover durable medical equipment (DME),** equipment that is medically necessary, able to withstand repeated use, and is generally not useful to someone in the absence of illness or injury. DME includes items like wheelchairs, walkers, scooters and hospital beds.

Dear Marci,

I’m on Medicaid and am about to turn 65 in a few months. Will my drugs be covered by Medicaid or Medicare?

—Meredith

Dear Meredith,



Once you have both Medicaid and Medicare, you must get your drugs covered by the Medicare prescription drug benefit (Part D). You will be automatically enrolled in a Medicare private drug plan if you do not choose one yourself. You will also automatically get “Extra Help,” federal assistance that pays for most of the costs of Medicare drug coverage. You do not need to apply for this assistance.

When you get the letter from Medicare telling you what plan you have been enrolled in, you should call 1-800-MEDICARE or visit www.medicare.gov to **make sure your assigned plan covers the drugs you need** and that the pharmacies you use regularly are part of that plan’s network. If not, ask the counselor to help you enroll in a different plan that meets your needs. People who have Medicaid are allowed to change Medicare private drug plans once a month.

—Marci

Dear Marci,



Up until this year, I had been enrolled in Original Medicare and had a Medigap plan as my supplement. I was convinced by an insurance agent to enroll in a Medicare Advantage PPO because my premiums would be lower. However, now my doctor won’t accept my new insurance. Can I go back to Original Medicare and still get my Medigap back?

—Agnes (Faribault, MN)

Dear Agnes,

Yes. If you dropped a Medigap policy to join a Medicare private health plan (HMO, PPO or PFFS) **for the first time and drop the new plan within 12 months**, you have the right to buy the Medigap policy you originally had so long as the same insurance company still sells it. If not, at a minimum, you have the right to buy Medigap Plans A, B, C or F. In some states, you may have additional rights.

—Marci

Dear Marci,



My husband just got diagnosed with shingles and has been really suffering from the symptoms. His experience has pushed me to go ahead and get the shingles vaccine for myself. Is this something Medicare would cover?

—Geraldine (Los Angeles, CA)

Dear Geraldine,

If you have a Medicare drug plan (Part D), then yes. When your doctor recommends a vaccine for something other than flu, pneumonia or hepatitis B (all paid for by Medicare Part B), the vaccine should be paid for by your Medicare drug plan (Part D). **All Part D plans must include all commercially available vaccines on their formularies, including the vaccine for shingles (herpes zoster).** Your Part D plan will pay for the vaccination itself and for you to get the shot (administration).

However, the amount you pay for your vaccination could vary based on where you get vaccinated. Before you get a vaccination, check coverage rules with your Part D plan and see where you should get your shot so that it will be covered for you at the lowest cost.

—Marci

Dear Marci,



I've been seeing lots of advertisements for long-term care insurance policies these days. How do I know when and if I should buy one?

—Gerald (Pascagoula, MS)

Dear Gerald,

Whether you should buy a long-term care insurance policy depends on your situation. You should carefully research all the policies available to you before deciding to purchase any long-term care insurance policy in particular.

While long-term care insurance policies may give you some freedom to make decisions about your long-term care, there are certain people for whom purchasing the policies is not appropriate. They can also be very expensive and are generally only sold to people who are in good health. There may be other ways to get coverage for long-term care.

—Marci

Source: *Marci's Medicare Answers* is a service of the *Medicare Rights Center* (www.medicarerights.org), the nation's largest independent source of information and assistance for people with Medicare; June 2008; Vol. 7, Issue 17: Week of April 28, 2008; Vol. 7, Issue 20: Week of May 19, 2008. To subscribe to "DearMarci," MRC's free educational e-newsletter, simply e-mail dear-marci@medicarerights.org.

Long-term Care Planning: Own Your Future....

Consumer surveys show that many people don't realize that health insurance, Medicare and disability coverage do not pay for most long-term care services. State Medicaid programs cover some long-term care services, but only for people who have a low income and few resources. The result is that most people who need long-term care end up paying for some or all of their care on their own.

Since approximately 70 percent of people over age 65 require some services and the likelihood of needing care increases as we age, planning ahead for long-term care needs becomes vital.

Yet, most people first learn about long-term care when they or a loved one need assistance. At that point, their options are limited by the immediate need for services, lack of information and insufficient resources to pay for preferred services. Planning ahead can ensure consumers a range of options and more choices in the care they receive with less impact on their bank accounts.

Steps to creating a solid plan for your long-term care needs include:

- **Making a financial plan-** Create a plan that takes into account your personal financial situation and family circumstances. While costs for nursing home care vary widely, they average about \$6,350 a month, mounting to \$60,000 to \$70,000, or more, annually. People who receive long-term care services at home spend an average of \$1,600 a month.
- **Giving clear direction-** Do your family members know your preferences regarding long-term care? Put your wishes in writing, just in case you cannot speak for yourself or lose the ability to make decisions for yourself. Vital documents such as living will, durable power-of-attorney for health care and health care proxy give you peace of mind and make sure your wishes are followed.

- **Seeking a support system-** Talk to someone who can help you make decisions before you need services. Sometimes family members or friends can help. For others, volunteers or agencies can provide assistance. Your church, doctor, local social service agency or hospital can also help you find out what services are available at no or low cost.
- **Focusing on your home-** How can your home be modified to accommodate your needs as you age? Homes that are easy to live in at age 50 can present problems later in life. Some improvements can be inexpensive, like removing throw rugs or replacing doorknobs. Bigger changes may include adding railing to outside steps or adding a bathroom to the ground floor. Most of these modifications will not only make your home safer for you, but also actually increase its value.
- **Considering long-term care insurance-** These policies can help pay for many types of long-term care, but they are not for everyone. Compare the costs and benefits of policies from different insurance companies when shopping. If you decide to buy, make sure you work with a reliable company that is licensed by the state to sell long-term care insurance.

The Area Agency on Aging can provide information about the services available in our area. Call toll-free 1-800-860-5799 to be connected to the agency serving our community and request a free long-term care assessment. A free, Ohio-specific long-term care planning guide, and other resources are available online at www.longtermcare.gov.

Source: *Aging Connection*, Ohio Department of Aging, April 2008.

Utility Bills....



Utility bills can be a valuable tool to reduce energy usage

Every month, utility bills come in the mail and consumers write checks to pay for the services they have received. But the next time you open an envelope with a utility bill enclosed, take a closer look. The information contained on the bill may be able to help you make decisions to become more energy efficient.

Utility bills are required to give information pertaining to how much natural gas or electricity has been used over a 12 or 13 month period. Some even relay weather data to show the role it may have played in monthly usage. With this information, an analysis of electric or natural gas usage patterns can be made and used to determine to what extent you may want to employ energy efficiency measures in your home.

Tactics to make your home more energy efficient include installing a high-efficiency furnace or boiler, setting back the thermostat, weather stripping, additional insulation and water heater blankets. There are several more ways to increase the efficiency of your home and the OCC has information available in the Smart Energy section of its Website, www.pickocc.org.

Optimum efficiency can be achieved through a home energy audit. After an analysis of your home, a certified contractor can give you the recommendations that will greatly improve the efficiency of your home. Customers of Duke Energy Ohio and FirstEnergy can also take advantage of programs that offer rebates for home energy audits or other programs to assist in energy reduction. Columbia Gas of Ohio customers should also have access to similar programs soon.

If consumers would like more information on tactics that could result in monthly savings on electric or natural gas bills or assistance in understanding

the charges on their bill. They can contact the OCC toll free at 1-877-PICKOCC (1-877-742-5622).

Source: *Consumers' Corner*, Office of the Ohio Consumers' Counsel, May/June 2008.

BBB Senior Alert....continued from pg. 11

4. Get company references and check the references. Are previous customers satisfied with their work?
5. Does the company carry Workers Compensation or medical and liability insurance? Keep in mind....if someone uninsured gets hurt working on your property, you could be held liable.

Then check out the company with the BBB at 419-531-3116 or toll-free at 1-800-743-4222 or www.bbb.org

Source: *Better Business Bureau Foundation* serving NW OH and SE MI, Inc., Faye E. Wenzlick, Director Smart Senior Program.

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