



Senior Tidings

Crawford County Council on Aging, Inc.

August 2009

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

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

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Topics of Interest

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Council on Aging...notes

Preparing to leave the hospital...

The Council on Aging receives a lot of inquiries regarding discharge options when preparing to leave a hospital setting. It's important for individuals to know what their options are before returning home. Refer to page 4-5 for *Medicare's Discharge Planning Checklist* to help you plan for a safe discharge.

Cell Phone Recycling: We have been collecting used cell phones as a fundraising project. This year we will also be accepting *small electronics* (Old Games Systems-Play station, X-box, Nintendo, etc.; iPods, Laptops; Digital Cameras; and of course cell phones and their accessories) in hopes of keeping additional toxic waste out of the trash.

Don't forget to drop off your used cell phones & accessories:

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



Donations for the Council on Aging newsletter, *Senior Tidings*, are always appreciated. The number of newsletters printed monthly has greatly increased over the past year. The mailing cost for each home is estimated to be **\$5.00 per year**. All donations should be sent to the Council on Aging, 200 S. Spring St., Bucyrus 44820. Thank you for your support!



Health & Nutrition....



Pets, Trip & Falls

Having a pet around the home can be comforting, but having a critter underfoot can be dangerous. At the Centers for Disease Control and Prevention, Judy Stevens said that nearly 87,000 people each year are hurt in falls involving a pet. Falls

are most common among young children and adults aged 35-54.

"But the highest injury rates occurred among people 75 and older. These falls often caused fractures, which have very serious effects for older adults." said Stevens.

Dogs were more likely than cats to

cause falls, often by tripping, pushing or pulling people. People also fell over pet items. Owners should reduce clutter and get dogs obedience training to reduce behaviors that can lead to falls.

The study is published in CDC's *Morbidity and Mortality Weekly Reports*.

This Prevention Corner tip brought to you by the Daily HealthBeat Tip, HHS. For more information, go to www.hhs.gov.

Don't Dry Out- Make Sure You Drink Enough Water



You may wonder if you've been drinking enough water, especially when it's hot out. There's a lot of confusing advice out there about how much you really need. The truth is that most healthy bodies are very good at regulating water. Elderly people, young children and some special cases, like people taking certain medications, need to be a little more careful. Here's what you need to know.

"Water is involved in all body process," says Dr. Jack M. Guralnik of NIH's National Institute on Aging. "You need the proper amount for all those processes to work correctly."

The body regulates how much water it keeps so it can maintain levels of the various minerals it needs to work properly. But every time you breathe out, sweat, urinate or have a bowel movement, you lose some fluid. When you lose fluid, your blood can become more concentrated. Healthy people compensate by releasing stores of water, mostly from muscles. And, of course, you get thirsty. That's your body's way of telling you it needs more water.

At a certain point, however, if you lose enough water, your body can't compensate. Eventually, you can become dehydrated, meaning that your body doesn't have enough fluid to work properly. "Basically, you're drying out," Guralnik says.

Any healthy person can become dehydrated on hot days, when you've been exercising hard or when you have a disease or condition like diarrhea, in which you can lose a lot of fluid very quickly. But dehydration is generally more of a problem in the elderly, who can have a decreased sensitivity to thirst, and very young children who can't yet tell their parents when they're thirsty.

How much water does your body need? Guralnik says you have to consider the circumstances. "If you're active on a hot day, you need more water than if you're sitting in an air conditioned office," he explains. An average person on an average day needs about 3 quarts of water a day. But if you're out in the hot sun, you'll need a lot more than that.

Signs of dehydration in adults are being thirsty, urinating less often than usual, having dark-colored urine, having dry skin, feeling tired or dizziness and fainting.

If you suspect dehydration, drink small amounts of water over a period of time. Taking too much all at once can overload your stomach and make you throw up. For people exercising in the heat and losing a lot of minerals in, sports drinks can be helpful. But avoid any drinks that have caffeine.

Remember, the best way to deal with dehydration is to prevent it. Make sure to drink enough water in situations where you might become dehydrated. For those caring for small children or older people with conditions that can lead to dehydration, Guralnik advises, "You need to prompt the person to drink fluids and remind them often. It's not just a one-time problem."

Wise Choices Dehydration: What To Do??



If you suspect someone is suffering from dehydration or a heat related illness:

- Get the person out of the sun and into a cool place.
- Offer fluids like water, fruit and vegetable

juices.

- Urge the person to lie down and rest.
- Encourage the person to shower, bathe or sponge off with cool water.
- Watch for heat-stroke, which is especially dangerous and requires emergency medical attention. Look for a body temperature above 104° and symptoms such as confusion, combativeness, faintness, bizarre behavior, staggering, strong rapid pulse, dry flushed skin, lack of sweating or unconsciousness.

Source: *NIH News in Health*, National Institute in Health, Department of Health and Human Services, July 2009.

Federal Stimulus & COBRA premium assistance



People on Medicare do not qualify for this assistance, but you may have spouses or other family member that could qualify. The questions and answers that follow will help you understand how this can work for people who qualify under federal COBRA law.

1) The stimulus package signed by the President included a temporary COBRA premium reduction. What's it all about?

The American Recovery and Reinvestment Act of 2009 temporarily reduces the premium for COBRA coverage for eligible individuals. COBRA is a federal law which allows certain people to extend employer-provided group health coverage, if they would otherwise lose the coverage due to certain events such as divorce or loss of a job.

Individuals who are eligible for COBRA coverage because of an involuntary termination from employment, occurring from Sept. 1, 2008 through

Dec. 31, 2009, and who elect COBRA, may qualify for a reduced premium. ARRA allows eligible people to pay only 35% of their full COBRA premium for up to 9 months.

2) To which plans does the premium reduction apply?

It applies to all group health plans sponsored by private-sector employers or unions which are subject to the COBRA rules under the Employee Retirement Income Security Act of 1974 (ERISA). It also applies to:

- Plans sponsored by state or local governments subject to continuation provision under the Public Health Service Act.
- Federal Employee Health Benefits Program (FEHBP) plans, and
- Group health insurance plans required by Ohio law to provide comparable continuation coverage.

3) Who is eligible to receive the COBRA premium reduction?

People who meet each of the requirements below qualify to receive this help.

- Those eligible for COBRA continuation coverage any time from Sept. 1, 2008 through Dec. 31, 2009;
- Those who elect COBRA coverage (when first offered or during the additional election period provided by ARRA); and
- Those who were terminated involuntarily from employment any time from Sept. 1, 2008 through Dec. 31, 2009.

Those eligible for other group health coverage (examples: a new employer's plan or a spouse's plan) or Medicare are **NOT** eligible for the premium reduction.

Note: Involuntary termination of employment includes downsizing, layoffs, being told not to come

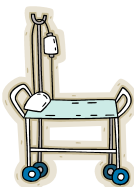
back until further notice and being fired.

Note: If the termination of employment was for gross misconduct, the employee and any dependents generally would **NOT** qualify for COBRA or the premium reduction.

If you're in need of more information regarding **Federal stimulus & COBRA premium assistance**, you may call the Council on Aging.

ARRA also extends QI help under Medicare Savings Program

Eligible people on Medicare benefit directly from the federal stimulus package thanks to the act's extension of the Qualified Individual (QI) program. QI assists certain limited-income beneficiaries by paying their Part B premium, and has been extended through Dec. 31, 2010.



Medicare Answers....

Preparing to Leave the Hospital....

While your loved one is in a hospital or skilled nursing facility, the staff is planning for the day they go home or to another facility. You're an important member of the planning team.

Ask to see the plan of care. Talk about treatment options, and be aware of Medicare's discharge appeal rights. Most importantly, make sure your loved one's wishes are known.

Medicare's Discharge Planning Checklist can help you plan for a safe discharge. Get a copy at www.medicare.gov.

1. **Do you know where you will get care and who will be helping you after you are discharged? You may be at home or in another setting.** *Ask the staff to explain your options and make sure they understand your wishes.*
2. **Do you understand your health condition (s)?** *Ask what is likely to happen with your health.*
3. **Do you know what problems to watch for and how to handle them?** *Ask what to do and who to call if you have problems.*
4. **Do you know what each of your prescription drugs does? Do you know how to take them, and what side effects to watch for?** *Ask who you should call if you have questions; tell the staff what prescription drugs, over-the-counter drugs, or supplements you took before you came to the hospital or other health care setting; ask if you should still take them after you leave.*
5. **Do you know what medical equipment (like a walker) you will need?** *Ask who to call if you have questions about your equipment after you leave.*
6. **Do you know which of the items below you will need help with and for how long?** *Bathing, dressing grooming. Using the bathroom; shopping for food, making meals, doing housework, paying bill; getting to doctors appointments, picking up prescription drugs.*
7. **Do you feel comfortable doing other tasks that require special skills like using medical equipment, changing a bandage, or giving a shot?** *Ask someone to show you if you're not sure, then show them you can do these tasks; ask who to call if you need help.*
8. **Question for the family member or other caregiver:** Do you understand what help the patient will need from you? (This may be some or all of the items from Question 6 or 7). Are you able to give that help? *If you aren't able to give that help, ask the staff to change the discharge plan so you both get the help you need.*
9. **Are you worried about how you or your family are coping with your illness?** *Ask to speak to a therapist of find out about support*

groups, if needed.

10. **Do you know what doctor or other healthcare provider to call if you have questions or problems?** *Write down their names and telephone numbers.*
11. **Do you know what appointments and tests you will need in the next several weeks?**
12. **Do you have written discharge instructions that you understand, your list of drugs, and summary of your current health status?** *Bring this information with you to your follow-up appointments.*
13. **If you will get services from a home health agency, compare the agencies in your area.** *Visit www.medicare.gov/HHCompare/Home.asp. People with Medicare can also call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-468-2048.*
14. **If you will get services in a nursing home, compare the nursing homes.** *Visit www.medicare.gov/NHCompare.Home.asp. People with Medicare can also call the same number listed above. If possible visit the nursing homes. For a tip sheet on what to look for when visiting a nursing home, visit www.medicare.gov/Nursing/Checklist.pdf.*
15. **Do you understand how much of your prescription drugs, equipment, and services will be covered by your insurance and what you will have to pay?** *Ask to speak to a social worker about possible resources to help with insurance or payment.*

Important note: If you have Medicare and feel you are being asked to leave a hospital or other health care setting too soon. You may have the right to ask for a review of the discharge decision by an independent reviewer called a Quality Improvement Organization (QIO). The QIO can explain your appeal rights. To get the number for the QIO in your state, call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-468-2048.

Retiree Insurance Pays Secondary to Medicare

Mrs. P first became eligible for Medicare when she turned 65 in September 2003. At the time, she was still working and received health insurance through her employer. Mrs. P decided not to enroll in Medicare Part B because she likes the coverage she was receiving from her employer, did not have to see the doctor very often, and did not want to pay the extra monthly premium for more coverage that she felt she did not need at the time. In June 2007, Mrs. P retired from her job but continued receiving insurance from her former employer. Then, in September 2008, Mrs. P went to the doctor for her annual mammogram but her insurance denied payment for the service. When she called her retiree insurance benefits manager, Mrs. P was told that she needed to enroll in Medicare Part B before it would pay for her outpatient doctors' services.

Mrs. P didn't understand why this would be, so she called the Medicare Rights Center for help. The Medicare Rights Center hotline counselor explained to Mrs. P that when you retire, even though you may still be getting insurance through the same employer and even from the same insurance company, your coverage changes. If you are eligible for Medicare, retiree insurance is secondary and will pay only after Medicare has paid. If you do not take Medicare Part B, your retiree insurance will pay very little for doctors visit, sometimes nothing at all. In most cases, you should take both Medicare Part A and B to ensure the most complete health coverage. (Before signing up for Medicare Part D drug coverage, find out whether or not your retiree coverage works with Part D. Not all retiree plans allow you to take Part D).

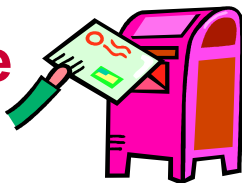
Luckily, Mrs. P was still in her 8-month special enrollment period that began the month she retired. You can enroll in Medicare without penalty at any time while you have coverage from your (or your spouse's) current employer and for eight

months after you lose your coverage or you (or your spouse) stop working, whichever comes first. The counselor warned that she should act fast; if she missed this opportunity she would not be able to enroll until the General Enrollment Period, which runs from January 1 to March 31 each year, with coverage starting July 1. She would also have to pay a late-enrollment premium penalty equal to 10 percent of the Part B premium for every full 12-month period she did not have Medicare after she was first eligible and did not have coverage from a current employer.

The hotline counselor advised Mrs. P to call Social Security right away to enroll in Medicare Part B, which she did. Mrs. P also told her doctor that she was enrolling in Medicare to cover her services. When her coverage began, Mrs. P asked her doctor to bill her insurance again for her mammography services, but this time to bill Medicare. Medicare covered 80 percent of the approved cost of Mrs. P's mammogram, and this time, Mrs. P's retiree insurance covered the remainder of the cost after Medicare paid.

Source: *Medicare Watch*, Medicare Rights Center, Vol. 12, No. 13: June 30, 2009.

Marci's Medicare Answers....



Dear Marci,



My mom is 70, relatively healthy, and I've just started to help her with insurance issues. What are the most important things for me to know about Medicare and what other key information should I find out?

—Raj (Minneapolis, MN)

Dear Raj,

First find out how your mom gets her Medicare coverage (directly from the government or a pri-

vate plan), and whether she has any other insurance (for example, employer or retiree coverage). Then assess whether your mom's health care needs are covered. Can she afford her health care currently and if she were to get sick in the future? Can she afford long-term care if she needs it?

You may have to bring up some uncomfortable topics with your mom, such as end-of-life issues and finances. While it may be difficult to have these discussions, it is important that you talk to your mom before she has a health crisis to ensure she gets the best possible care.

—Marci

Dear Marci,



My mom passed away and my dad is a bit frail. He could really use some help with the cooking and cleaning. Will Medicare pay for this?

—Hallie (Tallahassee, FL)

Dear Hallie,

Only in extremely limited instances. If your father were to become homebound and require skilled care, Medicare would pay for a home health aide to primarily provide personal services (like bathing and dressing). The home aide might also provide some additional services like cooking and cleaning ("custodial services"). Medicare will only directly cover custodial services as part of end-of-life (hospice) care. Overall, Medicare covers very few long-term care services.

—Marci

Dear Marci,



My mom has terminal cancer and I'm the primary person at home with her. Will Medicare compensate me for the time

I've taken off work to care for her?

—Naomi (Arvada, CO)

Dear Naomi,

Unfortunately, Medicare will not compensate you. However, since your mom has a life-threatening illness, she may qualify for Medicare's hospice benefit, and this benefit will cover you to take a short break by paying for your mother to stay in a Medicare-approved hospital or skilled nursing facility ("respite care"). Be aware that you may have the right to take unpaid leave from work, without losing your job, to take care of your mother.

—Marci

Dear Marci,



My mom is having a hard time getting around, even in her own home. We were thinking about installing some grab bars in the bathroom and a stairlift to reduce the chance of her falling. Will Medicare pay for this?

—Francine (Cambridge, MA)

Dear Francine,

Medicare will never cover home modifications because these are not considered strictly "medically necessary." However, Medicare will 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.

—Marci

Dear Marci,



I get sunburned very easily and have been getting screened for skin cancer

since I was young, I will be eligible for Medicare this summer, and I would like to know if Medicare will cover these screenings.

—Olivia

Dear Olivia,

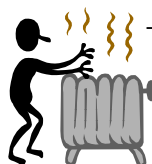
No, Medicare will not cover screenings for skin cancer. If, however, you see a suspicious-looking mole, you should make an appointment with your doctor as soon as possible. Medicare will cover a diagnostic doctor's visit and any diagnostic tests your doctor considers medically necessary. You may be able to find a doctor who will give you a free skin cancer screening by visiting the American Academy of Dermatology's website.

(www.aad.org/public/exams/screenings/index.html)

—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; Vol. 8, Issue 22, 23, 25, & 26. To speak with a counselor, call (800) 333-4114. To subscribe to "Dear Marci," MRC's free educational e-newsletter, simply e-mail dear-marci@medicarerights.org.

Home Energy Assistance



The Home Energy Assistance Program (HEAP) is a federally funded program administered by the Ohio Department of Development Office of Community Service (OCS). It is designed to help eligible low-income Ohioans meet the high costs of home heating. If you are eligible for assistance. The amount of your one-time HEAP benefit will depend on federal funding levels, how many people live with you, total household income and the primary fuel you use to heat your home. In most cases. The one-time benefit will be a credit applied to your energy bill

by your utility company (or fuel vendor).

Eligibility requirements: applications for the 2009-2010 Regular HEAP program will be accepted August 1, 2009 through May 31, 2010. The total household income of an applicant must be at or below \$18,952.50 /year equaling \$1,579/month income for a single person; \$2,125/month income for a couple).

What is required to be mailed with your completed & signed application?

- **Proof of income for the past twelve (12) months**
- **A copy of a recent fuel/utility bill.**

Applications can be obtained by contacting HEAP toll-free at 1-800-282-0880 or contact the Council on Aging.

Long-Term Care Insurance



What is the Ohio Partnership for Long-Term Care Insurance? The Ohio Partnership for Long-Term Care Insurance is an initiative between the State and private insurance companies to encourage Ohioans to plan for their long-term care needs. The partnership established “partnership policies” which provide coverage for long-term care needs and also allows Ohioans the ability to obtain “Medicaid Asset Protection”, a benefit not available with other policies sold in Ohio.

How did the partnership programs begin?

Partnership program began in 1992 in four states (CA, CT, IN, NY) as Robert Wood Johnson Foundation Grants. Results from the piloted partnerships show increases in the sale of affordable, high-quality private long-term care insurance to moderate income consumers most likely to deplete assets and rely on Medicaid for long-term care.

The Deficit Reduction Act of 2005 allows states to

pursue public-private partnerships for long-term care insurance coverage aimed at providing options to consumers under certain conditions. Ohio Revised Code (ORC) 5111.18 required the Ohio Department of Job & Family Services, (ODJFS) to establish a partnership for long-term care insurance by September 1, 2007.

Do people really need long-term care insurance? Since Medicare and other standard health insurance policies do not pay for the majority of long-term care services, people without long-term care insurance must often deplete their assets to pay for their care. The average monthly cost of long-term care in Ohio is estimated to be over \$4,200.

Those without long-term care insurance will typically pay out-of-pocket for long-term care until their assets are low enough to qualify for Medicaid. Currently, Ohioans must reduce assets to \$1,500 (individual) or \$2,250 (couple), before they can get Medicaid to finance their long-term care.

How do I know if long-term care insurance is right for me? Generally, financial planners recommend considering long-term care insurance if you:

- Own total financial assets of at least \$75,000 (not including your home or your car);
- Have annual retirement income of at least \$25,000 to \$35,000 for an individual or \$35,000 to \$50,000 for a couple.
- Are able to pay premiums without financial difficulty. While premiums are designed to remain level based on your age at the time you buy, think about whether you would be able to afford premiums if there should be an increase in the future; and
- If one of your major financial goals is to leave an inheritance to your children, grandchildren, or other heirs.

Some people buy long-term care insurance for rea-

sons other than to protect income or assets. They also buy for peace of mind, greater independence, greater ability to receive care at home, and greater choice of care options. So these financial guidelines may not strictly apply if your reasons for buying insurance are more about care choices than about passing on financial resources to your heirs.

What is Medicaid Asset Protection? This benefit is only available to those who purchase “qualified partnership policies.” Medicaid asset protection simply allows Medicaid applicants to keep more assets and still potentially qualify for Medicaid coverage. Upon application for Medicaid, the total assets a person may keep is the combined total of the Medicaid asset limit and the total amount paid by a partnership policy.

Partnership policyholders who need Medicaid to help pay for long-term care can apply at any time. Ohio’s Medicaid program can help pay the difference between what the policy covers and what is owed, provide assistance once the policy is exhausted. In both cases, the benefit of Medicaid asset protection will be provided. The more the partnership policy pays, the higher the asset protection.

How does Ohio’s partnership program work?

For example, a single individual whose partnership policy has paid \$100,000 toward nursing home or community-based long-term care would potentially be able to obtain Medicaid coverage and still retain \$101,500 worth of assets.

What are the features of Ohio’s partnership program? Ohio’s partnership program includes the following features:

- Medicaid Asset Protection
- Long-term care insurance policies that offer enhanced inflation protection
 - ⇒ For ages 60 or younger-includes a compound inflation benefit (a minimum of three percent compound of consumer price index)

- ⇒ For ages 61-75-includes some form of an inflation benefit (a minimum of three percent simple or consumer price index)
- ⇒ For ages 76 and older-no purchase of an inflation benefit is necessary

- Ability to exchange certain policies purchased on or after August 12, 2002 for a qualified partnership policy.
- Reciprocity with states interested in allowing buyers to claim Medicaid Asset Protection in a state other than the one in which the Partnership was purchased.
- Support toward the ability to access Medicaid even when the partnership policy is not exhausted.

Who makes up Ohio’s Partnership Project Team?

The project team was formed to guide the development of the partnership. It includes: ODJFS, Ohio Department of Insurance, Ohio Department of Aging, Ohio AARP, Genworth Financial, Association of Philanthropic Home, Housing and Services for the Aging, Ohio Association of Health Underwriters, Ohio Health Care Association, and the ODJFS Director’s Association. Ohio is one of 10 states to receive a grant through the Centers for Health Care Strategies (CHCS) to inform Ohioans about the availability of partnership policies.

For more information, visit www.ltc4me.ohio.gov or contact 1-800-686-1578. Information is also available at local area agencies on aging or local county departments of job and family services.

Source: Ohio Department of Insurance, 2009.



Save More Money...



Turn off most costly electronic gadgets

Household appliances and electronics contribute to a majority of the expenses seen on monthly electric bills. What consumers may not know is a significant portion of that expense could be a result of items that are not even used.

Computers, Video game consoles, digital clocks, televisions, refrigerators and cell phones still use power even when they are "off." This status is referred to as vampire or standby power. Items that use a remote control, have an external power supply like an AC adaptor, digital display, battery charger or soft-touch key pad are all examples of standby power products that have the effect of driving consumers' electric bills up.

The amounts of power these items use when they are in standby mode can be startling. According to the Lawrence Berkeley National Laboratory, a digital cable box with DVR capabilities uses more than 40 watts of electricity when it is turned off. While most devices use much less electricity while in standby, combined they can account for up to 10 percent of your monthly electricity bill.

Some standby power is necessary. Modern conveniences likely would not be as convenient without it. It enables monitoring of refrigerator temperatures, allows use of remote controls, keeps digital clocks running and charges cellular phones. But most standby power is wasteful because of inefficient AC adaptors.

While it may be impossible to eliminate standby power, there are several ways to reduce the amount that is used in a consumer's home. To cut the amount of standby power used, unplug products that are not regularly used. Consumers can also attach several similar items, like computer equipment, to a power strip and turn it off while away. Items like cable boxes and Internet modems, which rely on standby power to send information, should be connected to a different circuit so the connection is not lost.

Consumers also can search for ENERGY STAR-rated products. These items use energy more efficiently and must meet specific requirements for standby power to earn an ENERGY STAR rating.

Common household appliances can add up to several dollars per month even when they are off.

<u>Product</u>	<u>Watts -On</u>	<u>Watts-Off</u>
<u>Desktop Computer</u>	74 W (on); 2.8 W (sleep mode)	21 W (off)
<u>Notebook Computer</u>	30 W (charged) (on); 8.9 W (off)	15.9 W (off)
<u>Digital Cable Box w/ DVR</u>	44.4 W (on)	43.5 W (off)
<u>Microwave</u>	1,433 W (on)	3 W (off)
<u>Cellular Phone</u>	3.7 W (charging) (on); 2.2 W (charged) (off)	
<u>Cable Modem</u>	6.3 W (on)	3.8 W (off)
<u>DVD Player</u>	9.9 W (on)	1.6 W (off)

Source: *Consumers' Corner*, Office of the Ohio Consumers' Counsel, April 2009.

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