



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

E-mail: coa@rroho.com

Website:
crawfordcountyaging.com

Topics of Interest

- A Window to Your Health, pg. 2-3
- Marci's Medicare Answers, pg. 3-5
- Medicare info., pg. 5-7
- Social Security Freeze, pg. 7-8
- Reverse Mortgage, pg. 8-9
- BBB Senior Alert, pg. 9-10
- Funds to help make gas payments, pg. 10-11
- Positive Aging Expo, pg. 11
- VITA acknowledges sponsors, pg. 11

Senior Tidings

Crawford County Council on Aging, Inc.



June 2009

Council on Aging....notes

Senior Citizens Day.... Crawford County Fair

The Crawford County Council on Aging & Heartland of Bucyrus, will be sponsoring "*Senior Citizens Day*" at the Crawford County Fair on **Thursday, July 23rd, 2009**. We are getting ready for the big day, loaded with entertainment, lunch, informational booths, door prizes, and much more. We will not be accepting reservations until Monday, July 6th. Tickets will be available for pick-up after this date. Mark your calendar....we look forward to seeing you!

Summer Crisis Program

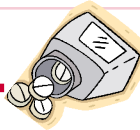
The Summer Crisis Program is designed to help qualified households pay for summer cooling. The program applies to electrical utilities only and is available from July 1

through Aug. 31, 2009. This program is administered by Ohio Heartland Community Action. Call the last week of June to schedule an appointment, 1-866-861-6421.

Households must have a gross annual income of 175% of FPL or below and meet one of the following: (1) family member who is at least 60 years old; or (2) provide physician documentation of medical necessity.

Benefits allow a one-time payment assistance of up to \$100. The benefit must result in continuation of service for 30 days and/or receipt of a fan or A/C. You do not need a disconnection notice to be eligible for the program. One air conditioning unit per household (for households that have not received an air conditioning unit in the last 3 years).

Health & Nutrition..



Over-the-counter Medications *Serious Drugs with Serious Risks if You Don't Read the Labels*

Even though more than 100,00 over-the counter (OTC) medications, such as pain relievers, antacids or cold medications, do not require a doctor's prescription and can be bought

at most stores. They are serious drugs with real risks when misused. Usually, when we think about drug interactions or serious problems concerning medicines, we think about prescription drugs, but consumers need to be aware that OTC medicines are real medicines. They must

be taken with care, either alone or in combination with other OTCs or prescription medicines.

Sixty-seven percent of Americans age 50 and older take, on average, four prescription drugs every day. Older Americans use a third of all OTC medicines purchased, according to AARP. Each year, 243,000 older Americans end up in the hospital because of reactions caused by combining OTC and prescription medicines.

Consumers with chronic medical conditions, such as diabetes, heart disease or high blood pressure, are at increased risk for significant, and sometimes serious, drug interactions involving OTC medications. Older consumers also are at greater risk because they are usually combining more medications than younger individuals.

Combining aspirin with blood-thinners like Warfarin (Coumadin) can lead to excessive bleeding. Certain antacids may prevent many medications, like antibiotics, blood-thinners and heart medications from being absorbed into the blood as they should be. The decongestants found in many cold remedies can dangerously increase blood pressure for people taking anti-hypertension medications or MAO inhibitors, a type of antidepressant.

To avoid harmful OTC drug interactions, consumers should:

- Read the labels of all OTC and prescription medicines to ensure they are taking the correct dosage and are aware of potential side effects;
- Know the benefits as well as the potential risks of both prescription and OTC medications. Look specifically for the section called “warnings” on the labels of OTC medicines; and
- Talk to their doctor or pharmacist before taking any new medication-prescription or OTC. Ask whether it is safe to take with other medications, vitamins, foods or herbal products and keep a record of all OTC and prescription drugs and share it with their doctors and pharmacist.

Consumers can also avoid adverse drug interactions by buying all their OTC and prescribed medications at one pharmacy. Pharmacies have a built-in process of drug interaction alerts. If a consumer fills all of his prescriptions at one pharmacy, they have all the necessary information to alert the consumer if a medication will interact badly with something he is already taking.

To help support consumers, safe and appropriate use of OTCs, the National Council on Patient Information and Education sponsors the [Be MedWise](#) Web site, which offers information, resources and MedWise Toolkit to educate consumers about the proper use of nonprescription medicines.

Source: *Agging Connection*, Ohio Department of Aging, April 2009.



A Window to Your Health Your Eyes Reveal a Bigger Picture

Your vision seems great. Your eyes feel completely fine. So you may be putting off that visit to the eye doctor. But if you haven't seen your eye care professional in a while, you might have an eye problem that you don't know about.

“Many eye diseases have no early warning signs,” says Dr. Janine Austin Clayton. An ophthalmologist and deputy director of NIH's Office of Research on Women's Health. “You may not notice anything. So it's critical to have your eyes examined on a regular basis.”

A comprehensive dilated eye exam involves looking at all the parts of your eye. It also tests eye movement, the reaction of your pupil to light and the fluid pressure inside your eyes.

“It's critical to pay attention to your eye health, because eye health actually is a reflection of overall health,” Clayton says. Changes in the eyes, for example, can tip a doctor off that you have diabetes.

Comprehensive dilated eye exams can catch problems that could lead to blindness and visual impairment while they can still be halted or reversed. If you have glaucoma or diabetic eye disease (a group of eye problems that can accompany diabetes), you may notice a problem only when it's too late to regain your lost vision.

Glaucoma, for example, first affects your side, peripheral vision, which can be hard to notice. If left untreated, the vision loss will continue to move toward the center of your vision. "It's a painless process," Clayton says, "much like hypertension or high blood pressure can be painless."

Having regular eye exams can help detect eye diseases in their early stages, when they can still be treated. Regular eye exams are important for everyone, but especially for African Americans over age 40, those with a family history of eye diseases, people with diabetes and everyone over 60.

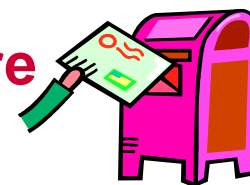
An eye exam can also spot uncorrected refractive errors, meaning your eye is out of focus. Uncorrected refractive errors affect more than 11 million Americans, according to a recent study by NIH's National Eye Institute. Eye care professionals usually prescribe eyeglasses or contact lenses to solve the problem. More than 150 million Americans now use corrective eyewear.

How often you should have your eyes examined depends on your age, family history and other risk factors. Your eye care professional can tell you when your next exam should be.

If you haven't had an eye exam for a while, now's the time. Your eyes are an important part of your health. Healthy vision can help keep you safe while you're driving, participating in sports and taking part in recreational activities. It can also help you maintain a healthy and active lifestyle well into your golden years.

Source: *NIH, News in Health*, National Institutes of Health, Department of Health & Human Services, May 2009.

Marci's Medicare Answers....



Dear Marci,



I have insurance from my employer and I now qualify for enrollment in a Medicare private drug plan (part D). Should I sign up for Part D?

—Ken (Ithaca, NY)

Dear Ken,

If you have drug coverage from a current or former employer or a union, whether you should enroll in the Medicare drug benefit depends on the quality and generosity of your employer coverage and whether or not your employer coverage works with the Medicare drug benefit (it often will not).

—Marci

Should I enroll in the Medicare drug benefit (Part D) if I have employer/retiree drug coverage?

If you have drug coverage from a current or former employer or a union, whether you should enroll in the Medicare drug benefit depends on

- The quality of your employer coverage;
- Whether or not your employer coverage works with the Medicare drug benefit (it often does not).

If you have coverage that is as good as or better than Medicare's drug benefit ("creditable") and you like it, you can keep it. You will not pay a penalty to join a Medicare private drug plan later as long as you have not been without your creditable coverage for more than 63 days. Find out from your employer whether your coverage is as good as Medicare's drug benefit.

You should get a notice from your employer every year letting you know how your employer benefits

are changing, whether or not your drug coverage (for both you and your family members who receive that coverage). If your coverage is not as good as Medicare's, you might want to consider the Medicare drug benefit. You may have to pay a penalty if you enroll after you are first eligible. If you are not notified about whether your drug coverage is creditable, ask the company that provides your insurance for this information in writing. You will not have to pay a penalty if you can show that you received inadequate information about whether your drug coverage was creditable.

However, whether or not you can have Medicare drug coverage in addition to your employer coverage depends on your employer plan. If you want to keep your employer benefits, and are considering joining a Medicare drug plan, make sure you ask your employer if you can have both types of coverage. Many employer plans do not work with the drug benefits. You could lose all your employer benefits (both health and drug) if you join a Medicare private drug plan.

The notice of creditable coverage that you should receive from your employer every year will let you know whether you would be able to get your coverage back if you disenroll from your Part D plan, if enrolling in a Part D plan would cause you to lose your employer coverage.

If you later decide you want to drop your employer coverage and get the Medicare drug benefit, you will get a Special Enrollment Period (SEP) to switch to a Medicare private drug plan. This SEP will generally be whenever your employer normally allows you to make changes to your health benefits.

Source: MedicareInteractive.org; Section VI., question 2 of 9.

Dear Marci,



My mother has been in the hospital for five days and is about to be released. Her doctor wants her to go into a nursing home instead of going home. Will Medicare pay?

—Betty (Oak Park, IL)

Dear Betty,

Medicare will pay for up to 100 days of care in a “skilled nursing facility” (SNF) if your mother needs daily skilled nursing or therapy services after a hospital stay of at least three days. You may hear a SNF referred to as a nursing home, convalescent hospital or rest home—but be aware that not all facilities that go by these names are Medicare-certified.

If your mother continues to need long-term care and wants to remain in a SNF after she has exhausted her Medicare SNF benefit, she will probably need to find resources other than Medicare to help pay for these services.

—Marci

Dear Marci,



My doctor says I should be able to leave my nursing home (skilled nursing facility or “SNF”) in two weeks. My stay has been covered by Medicare and my understanding is that I qualified because I was in the hospital first. If I leave the nursing home and then need to go back into it. Will I need to return to the hospital again for Medicare to cover my stay?

—Alisha (Pittsburgh)

Dear Alisha,

It depends whether Medicare will require a hospital stay before it covers another stay in the SNF (or another one) will depend on how long you have been out of the SNF when you need to return.

—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 13, 18, & 19. 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.

Medicare Information....

"Observation Stays" In Hospitals Prevent Medicare Coverage of Certain Services

The use of "observation stays" in hospitals raises concerns about the level of coverage and quality of care provided to people with Medicare during and after hospitalizations, according to *The Chicago Tribune*.

"Observation stays" allow hospitals to provide lower-cost care to patients who may not be sick enough to warrant admission to the hospital, but who may still require diagnostic tests and short-term treatment that prevents them from being released after a hospital doctor's initial evaluation. However, while observation stays should be 24 to 48 hours, certain patients remained in observation care for several days, even when their doctors requested inpatient care, the newspaper found.

People who are in the hospital for "observation stays" are considered outpatients, and are therefore responsible for coinsurance for services received rather than the cost of the Medicare hospital deductible for inpatient care. It is difficult to predict the cost of coinsurance for outpatient care. If a patient does not have supplemental insurance that helps pay the cost of co-payments, their costs can be very high. Also, an outpatient may not receive Medicare coverage for expensive skilled nursing care subsequent to an "observation stay" in a hospital, care that can cost thousands of dollars. Medicare covers skilled nursing care only after an inpa-

tient hospital stay of at least three days.

Medicare does not require hospitals to inform Medicare patients when they are in observation care, which may lead to confusion for patients who strongly believe they are inpatients but are then responsible for copays or the costs of rehabilitative care subsequent to their hospital stays.

The number of "observation stay" in hospitals for people with Medicare are increasing, according to *The Chicago Tribune*. Some experts say many hospitals use "observation stays" because they fear being accused of fraud if they submit a bill for an inpatient stay that does not meet Medicare's coverage standards for those services.

Source: *Medicare Watch*, Medicare Rights Center Vol. 12, No. 6: March 24, 2009.



Case Flash: Medicare Will Not Cover Durable Medical Equipment In A SNF When It Is Not Covering The Stay

Mrs. G, who has Original Medicare, was in the hospital for a broken leg and then went to stay in a skilled nursing facility (SNF) for rehabilitation. A SNF is a Medicare-certified facility that provides skilled care at a less intensive level than would be provided in a hospital. A SNF can be a nursing home, or part of one, but it is generally not a retirement home, rehabilitation center or assisted living facility. Because Mrs. G required skilled nursing care, rehabilitative therapy, Medicare paid for her stay. A need for skilled nursing care is required for Medicare to cover a SNF stay. During her stay, she required a wheelchair, when she was also covered by the SNF benefit.

After a few weeks, Mrs. G's SNF terminated her therapy because her doctor believed she no longer needed daily skilled care. Because Mrs. G did not feel quite ready to return home, her family decided to pay out-of-pocket to continue her SNF care. The SNF agreed to let Mrs. G stay, however, Mrs. G now needed a walker, and they told her that she

would have to pay for it out-of-pocket. Mrs. G wondered why Medicare would not cover her walker when it had covered her wheelchair. She called the Medicare Rights Center national hotline to ask why this should be.

A hotline counselor explained to Mrs. G that when Medicare was covering her SNF stay, her wheelchair was covered under the SNF benefit. A wheelchair is considered by Medicare to be “durable medical equipment” (DME). Such equipment is covered under the SNF benefit. Now that she no longer qualified for SNF coverage, the only way to get Medicare to cover a new piece of DME (in this case a walker) would be under Medicare’s “durable medical equipment” (DME) benefit. Unfortunately for Mrs. G, Medicare pays for equipment under the DME benefit only when its main purpose is for use inside of your home. The problem was that Medicare did not consider the SNF facility to be Mrs. G’s home.

Under the DME benefit, Medicare will consider only certain locations “home.” These include your *own house, apartment, or a relative’s home*, a home for the aged or some other type of institution that does not provide skilled nursing care. Even though Mrs. G was sleeping and eating at the SNF, Medicare would not consider it her home because her primary purpose in being there, and the primary purpose of facility, was for medical care.

Mrs. G would need to pay for her walker out-of-pocket until she moved out of the SNF and in with her family in a house that Medicare would consider her home. She could prepare for her move home by finding a supplier that takes Medicare through which she could get a walker that Medicare would cover. She could use Medicare’s durable medical equipment supplier finder (<http://www.medicare.gov/Supplier/Home.asp>) to compare prices among suppliers in her area. And choose a supplier who accepts Medicare.

Source: *Medicare Watch*, Medicare Rights Center, Vol. 12, No. 9: May 5, 2009.

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:

- **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 nursing care on a part-time (less than eight hours a day) or intermittent basis (as little as once every 60 days to as much as daily, for three week periods. If there is a predictable end to your need for care) and/or you need skilled therapy services (physical, speech, occupational therapy). 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 need only occupational therapy, you will not qualify for the Medicare home health benefit. However, if you qualify for Medicare coverage of home health care on another basis, you can also get occupational therapy.
- **Third**, you must have a plan of care approved by a doctor.
- **Fourth**, you receive your care from 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 provides 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 helps you with social and emotional concerns related to your illness; certain **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 "**durable 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) unless they are part of other home health aide personal care services you receive if you need skilled nursing and/or skilled therapy, or meals delivered to your home. To get most prescription drugs covered, you need to join a Medicare private drug plan (Part D).

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. At the end of the 60 days, the HHA, with approval from your doctor, 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, go to Medicare Interactive Counselor at www.medicareinteractive.org. Medicare Interactive Counselor is a resource of health care informa-

tion and assistance in the United States for people with Medicare.

Source: *Medicare Interactive*, June 2009.

Social Security Freeze Impacts Part B Premium



Due to the economic downturn, Social Security recipients will likely not receive a cost of living (COLA) increase in a development with financial implications for some people with Medicare, who will be subject to higher Part B and Part D premiums.

Part B premiums are expected to rise over the next two year, however, three quarters of people with Medicare will be protected from these increases by the "hold harmless" provision of the Social Security Act. In order to mitigate the financial impact of increasing Part B costs on people with Medicare, the provision ensures that the increase in Part B premiums cannot exceed the COLA for a given year for people with Medicare who have the premium deducted from their Social Security checks. With no COLA predicted for 2010, Part B premium will be frozen for these people.

However, premiums for the remaining 25 percent of people with Medicare, including the wealthiest, who already pay a higher Part B premium, and those with low incomes who have their premiums paid by Medicare Savings Programs, will be subject to unusually large increases over the next two years to compensate for the decrease in revenue caused by the "hold harmless provision." The Part B premium for 2009 is \$96.40, but the Congressional Budget Office estimates that the basic premium will rise to \$119 in 2010 and \$123 in 2011.

States also face an increased financial burden as a result of Part B premium increases that states will pay through Medicare Saving Programs for qualifying low-income people with Medicare. Since these premiums are not deducted from Social Se-

curity checks but paid directly by state governments, states will be subject to the higher premium. Moreover, a low-income individual who is dropped from an MSP during 2010 is not protected by the hold harmless provision and must pay the higher premium.

New Medicare enrollees will also pay the higher premium, as will currently enrolled high-income people with Medicare who now pay a higher premium based on their income.

In addition, there is no provision that protects people with Medicare from increased Part D premiums, which are also predicted to rise next year. This means that people participating in Part D might see an increase in premium expenses even while experiencing a freeze in their monthly income.

Reverse Mortgage....



Reverse Mortgage: Is It Right For You?

Whether seeking money to finance a home improvement, pay off a current mortgage, supplement their retirement income or pay for healthcare expenses, many cash-poor, older Americans are turning to reverse mortgages.

A reverse mortgage allows seniors, 62 and older, to convert their home equity into ready cash. It is a loan against a person's home that the individual does not have to pay back for as long as he continues to live there. While living in his home, the person is still responsible for the usual expenses of maintaining the home, such as property taxes, insurance and repairs.

It's just the opposite, or reverse, of a regular home mortgage in which the borrower uses income to repay the loan and build up home equity. With a reverse mortgage, the lender sends the borrower cash and the borrower makes no repayments. The amount the consumer owes get larger and his home equity shrinks.

The mortgage must be repaid in full, including all interest, fees and other charges, when the borrower dies, sells the home or permanently moves away. Any remaining equity belongs to the person or his heirs. The borrower may owe a lot of money and his home equity may be very small, if the consumer has had the loan for a long time, or if his home's value has decreased, there may not be any equity at the end of the loan.

Credit scores and income are not considered in the loan qualification process for a reverse mortgage. A borrower can receive cash in a single lump sum payment, as a regular monthly cash advantage, as a credit line account or as a combination of these payment methods. Income from a reverse mortgage generally does not affect Social Security or Medicare benefits. If a senior receives more in payments than the home is worth, the person will never owe more than the value of the home, according to the Federal Trade Commission.

However, anyone considering a reverse mortgage needs to study the issue. Reverse mortgage proceeds could impact your Medicaid eligibility. The mortgage fees are high and your debt will continue to increase as interest is charged to the outstanding balance of the loan. The interest is not tax deductible until the loan is paid off. Unlike regular home mortgages, as your home equity is used up, there will be fewer assets to leave to your heirs.

Reverse mortgages make sense for some, but for others, there may be better solutions than tapping into your home equity. AARP has developed five questions to help you decide if a reverse mortgage is right for you.

Do you really need a reverse mortgage? What would you do with the money you would get from one? Are the needs you intend to meet really worth the high cost of these loans? If anyone is trying to sell you something and recommending you use a reverse mortgage to pay for it, that's generally a good sign that you don't need it and shouldn't be



buying it.

Can you afford a reverse mortgage? These loans are very expensive and the amount you owe grow larger every month. The younger you are when you take out a reverse mortgage, the more the compound interest will grow and the more you will owe. These loans can be especially costly if you sell and move just a few years after taking one out.

Can you afford to start using up your home equity now? The more you use now, the less you will have later when you may need it, for example, to pay for future emergencies or health care needs. You may also need your equity to pay for future home repairs or a move to assisted living. If you are not facing a financial emergency now, then consider postponing a reverse mortgage.

Do you have less costly options? Do you have other financial resources that you could use instead of taking out a loan? If you could easily make the monthly payments on a home equity loan or home equity line-of-credit, these alternatives are much less costly than a reverse mortgage. Have you looked into the costs and benefits of selling your home and moving to a less expensive one?

Do you fully understand how these loans work? Reverse mortgages are quite different from other loans. Before considering one. Do your homework.

Many lenders require that you have free debt counseling prior to applying for a reverse mortgage. The U.S. Department of Housing and Urban Development (HUD) has housing counseling agencies available nationwide to provide information, counseling and a free referral to a list of FHA-approved lenders. Call toll free, **1-800-569-4287**, for the name and location of a HUD-approved housing counseling agency near you.

Source: *Aging Issues*; Ohio Department of Aging; A column from the director of the Ohio Department of Aging, April 2009.

BBB Senior Alert....

The One-Time Economic Payment

Who: Those receiving SS, SSI, Railroad Retirement and Veterans benefits.

What: Will receive a one-time payment of \$250.

When: By the end of May 2009.

Where: Sent by mail, direct deposit or Direct Express—the way you receive benefits now.

Why: It's part of the American Recovery and Reinvestment Act signed Feb. 2009.

Scams Reported to BBB

Phone: Seniors are being called by crooks and told their personal information needs to be verified in order to receive the payment.

What to do: Don't talk to them—just hang up.

E-mail: Seniors are being e-mailed by scammers asking for personal information and/or are provided a link to a phony Social Security website, that looks very real. They want seniors to provide their personal information.

What to do: Delete the e-mail or forward it to spam@uce.gov.

Door-to-door: We are receiving more and more reports of nicely dressed women (sometimes men) showing up out of the blue, stating they are from Social Security. Unfortunately, some seniors are giving over their personal information to these crooks.

What to do: Call the police!

Social Security will never call, e-mail or go door-to-door to verify your Social Security number or bank account number.

If you are unsure of any contact, just call the BBB at 419-531-3116 or 1-800-743-4222.

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

Pavers Are Going Door-to-Door! Beware!

Every year there are con men knocking on seniors' doors. **Every year** we issue warnings about dealing with these people. **Every year** seniors hire them and get scammed by them.

We recently received a complaint: Two men came to a senior's home saying they had driveway sealant left over from another job. They gave her a flier showing that they were a BBB Accredited Business Member. After sloppily applying a little sealant, they said they ran out and had to get more. The senior gave them a check for \$400.

You know "the rest of the story," they never came back. The senior called her bank, the check was cashed. She called our office but all she could provide us with was a name and disconnected phone number. We assured her the company was definitely **NOT a BBB Accredited Business** and forwarded her complaint to law enforcement.

If someone comes to your home and offers to seal the driveway, fix the chimney, paint the garage, etc., our BBB suggests the following:

1. Most reputable companies *don't* go door-to-door saying they have left over sealant or paint. Don't open the door, especially if "your gut" says don't open it.
2. Make sure your back door and all other doors are locked. We have received reports where these crooks have entered homes and stole while the home owner was busy at the front door.
3. If they ask to use the restroom, just say, "No." Often times they ask if their child could use the restroom. Unfortunately, they teach their children to steal at a very young age.

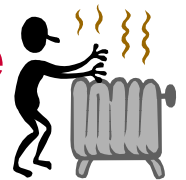
Before doing business with any unknown company, get the company name, address, phone number and call us for their report at: 419-531-3116 or toll free 1-800-743-4222 or www.bbb.org.

Source: *Better Business Bureau.*

Fake "HUD" Website **<http://bailout.hud-gov.us/>**

This website is deceiving the public by using the HUD name in its website. This website is NOT affiliated with the "U.S. Department of Housing and Urban Development." DO NOT provide your personal information to requests from this website

Funds to help make gas payments....



Natural gas customers served by Columbia Gas of Ohio and Duke Energy who experience difficulty keeping up with their home heating expenses have assistance options available through two funds established by the utilities following agreements with the Office of the Ohio Consumers' Counsel (OCC) and approved by the Public Utilities Commission of Ohio (PUCO).

Columbia Gas

Approximately \$2.1 million in emergency assistance is available for families earning from 175-200 percent of federal poverty guidelines (from \$37,500-\$42,400 annually for a family of four) after the OCC and other parties negotiated an agreement with Columbia to use federally awarded interstate pipeline refunds.

Households earning below 175 percent of the poverty guidelines have the ability to apply for assistance through another fund created through an agreement amount the OCC, Columbia and other parties. The "*rate case fuel fund*" will be offered to customers who have exhausted all other assistance programs, such as the Home Energy Assistance Program (HEAP) for the next five winter heating seasons through 2013.

Both funds are administered by local community action agencies which accept applications, determine eligibility and distribute the available money.

Source: *Consumers' Corner*, Office of Ohio Consumers' Counsel, May/June 2009.

Positive Aging Expo....

Save the Date-Tuesday, June 23, 2009

Ohio District 5 Area Agency on Aging, Inc.
presents the second annual



SUMMER FUN!! POSITIVE AGING EXPO

Fairhaven Hall-Richland Co. Fairgrounds

10:00 a.m.-3:00 p.m.

Food, Fun, Door Prizes,
Entertainment

How can you age positively?

How can you help others age positively?

COME LET US SHOW YOU!

Call (419) 522-5612 or (800) 522-5680
Ext. 1157 or Ext. 1114 for information

VITA....Volunteer Income Tax Assistance



The Crawford County VITA
proudly acknowledges the following
2008-2009 partners for their assistance:

George Atkinson-site assistance; *Bucyrus T-F*-, publicity; *Council on Aging*-publicity, scheduling, transportation; *Crawford County Society for Crippled Children & Adults*- grant sponsor; *Crestline Library*-publicity; *Crestline Golden Age Center*-publicity; *Galion Inquirer*-publicity; *Galion Golden Age Center*-publicity; *General Electric Company*-Pat Gabrie, Tom Schifer-computers & monitors; *Holy Trinity School*-equipment, storage, site; *Mark Loescher*-technical assistance; *Television Access 6*, Bucyrus, Crestline, & Galion-publicity; *Tomorrows Business Machines*-copier rental.

Cell Phone Recycling:

We have been collecting used cell phones as a fundraising project. This year we will also be accepting small electronics 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!

2009 Council on Aging Board of Trustees Officers

Jerry Shawber, President
Dr. Donald Wenner, Vice President
Linda Schiefer, Secretary
Ed Snyder, Treasurer

Board Members

Gary Cole	Jean Hayes
Elaine Henderson	Janet Herman
Lois Kehres	Libby McPeck
Dr. Antonio Rondon	Maxine Shifley
James Stump	Edward Wise
Dale Wolfe	Mark Yosick