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# Senior Tidings

Crawford County Council on Aging, Inc.



May 2010

## Older Americans Month....

Each May is observed nationwide as **Older Americans Month**. Together with **Senior Citizens Day** (the third Tuesday in May-May 18 this year), Older Americans Month is a celebration of the contributions our older citizens have made to society, and is a chance for communities to give back and recognize the accomplishments of their elders. It also is a time to promote aging actively and encourage everyone, regardless of age, to live to the fullest. Older Americans Month and Senior Citizens Day have a history dating back to 1977.

Ohio's theme for Older Americans Month 2010 is: "**Age Strong! Live Long!**"

Today's seniors are shrugging off traditional stereotypes. They are living healthy and active lives, engaged in multiple endeavors. They are employees and employers, students and teachers. They are volunteers, leaders and mentors. And, by being all these things, older Ohioans are supporting their communities and the state, and making a difference in the lives of others. They are celebrating their uniqueness and redefining what it means to grow old.

### Older Americans Month Photo Contest

What does it mean to Age Strong and Live Long? Can you show it in a picture?

Take a picture that you believe embodies the theme "*Age Strong! Live Long!*" and share it with us via our page on Facebook. We'll select three winners to post on the Web site before Senior Citizens Day (May 18).

Limit one submission per person. Photo must comply with Facebook's terms and conditions. Deadline to submit is May 9, 2010.

You may also enter by mail to: Ohio Department of Aging, ATTN: Communications Division, 50 W. Broad St./19th Fl., Columbus OH 43215-3363.

Please note, we cannot return photos we receive.

### History of Older Americans Month and Senior Citizens Day

In April, 1963, President John F. Kennedy met with the National Council on Senior Citizens. Their meeting was the foundation for an annual observation of May as Senior

Citizens month. Their meeting was the foundation for an annual observation of May as Senior Citizens Month. Every President since has issued a formal proclamation during or before the month of May asking that the entire nation pay tribute in some way to older persons in their communities. President Jimmy Carter originated the title of Older Americans Month in his 1980 proclamation.

In 1963, only 17 million Americans were age 65 or older and about a third of them lived in poverty. Today, there are more than 36 million Americans over the age of 65, accounting for 12 percent of the total population, though only 10 percent live in poverty. The oldest of the baby boom generation began turning 60 in 2006. The U.S. Census Bureau estimates that, by 2050, 87 million Americans will be age 65 or older, accounting for 21 percent of the population.

### Older Americans Act

Congress passed the Older Americans Act (OAA) in 1965 in response to concern by policymakers about a lack of community social services for older persons. The original legislation established authority for grants to States for community planning and social services, research and development projects, and personnel training in the field of aging. The law also established the Administration on Aging (AoA) to administer the newly created grant programs and to serve as the Federal focal point on matters concerning older persons.



## Health & Nutrition....

### Keeping Bones Strong & Healthy

Our bones are alive. We might not think of them that way—but to keep themselves strong and usable, our bones are always changing.

“Bone is living, growing tissue,” says Dr. Joan McGowan, a scientist at NIH. “It’s constantly breaking down and building up. It keeps refreshing itself.”

But as you get older, your bones may be at increased risk for osteoporosis, when the bones become weak, fragile and more likely to break. And once they break, they take longer to heal. This can be both painful and expensive.

Current estimates suggest that around 10 million people in the U.S. have osteoporosis, and 34 million more have low bone mass, which places them at increased risk.

Osteoporosis is a “silent” disease. You may not realize you have it until a sudden strain, twist or fall causes a broken bone (also called a “fracture”). With osteoporosis, even a minor tumble can be serious, requiring surgery and hospitalization.

If you have osteoporosis, you can get a broken bone even though you haven’t fallen—by shoveling snow, for example. A spinal fracture; a break in one of the small bones in your back, may be subtle and go unnoticed. Or it may cause back pain, which you shouldn’t ignore.

“A large part of osteoporosis and fracture risk is inherited,” says McGowan. “If close relatives have suffered a fracture in their later years, this may be a clue to think carefully about your own risk. But diet and physical activity are major way to build and maintain the best possible skeleton.”

But no matter what your age, McGowan says, “It’s never too late to promote bone health,” Increase your load-bearing exercise, like walking, and make good food choices, rich in calcium and vitamin D.

Unfortunately, some factors are beyond your control. Women are more likely to have osteoporosis and related fractures, particularly Caucasian and Asian women. Osteoporosis becomes more common as you get older. Low body weight can also increase your risk. And so can certain medications (such as steroids) and certain diseases and conditions (such as anorexia nervosa, rheumatoid arthritis, gastrointestinal diseases, thyroid disease and depression).

“But even if you have osteoporosis, you can do

things to prevent fractures," McGowan says.

Talk to your doctor well before the age of 50 about your risk. One out of 2 women and 1 out of 4 men over age 50 will break a bone due to osteoporosis.

"We know that all women over the age of 65 should have a bone mineral density test," McGowan says. The test uses a tiny amount of radiation to look at how dense your bones are. It isn't painful, and there's usually no need to undress. However, she says that researchers haven't yet come up with universal recommendations about when you should get this test.



### Bone Health Tips

Research shows that there are several way to take care of your bone health:

- Get enough calcium and vitamin D in your diet at every age.
- Be physically active.
- Reduce hazards in your home that could increase you risk of falling.
- Talk with your doctor about medicines you are taking that could increase your risk for osteoporosis.
- If you are over 50 and break a bone, ask your doctor to screen you for osteoporosis.

Source: *NIH News in Health*, National Institute of Health, Department of Health & Human Services, [newsinhealth.nih.gov](http://newsinhealth.nih.gov), February 2010.

## Mother's Day is Coming

### Is Your Mother Able to Visit Your House?

A column from the director of the Ohio Department of Aging, Barbara E. Riley

Will you be traveling to visit a family member on Mother's Day? Is your mother coming to visit? Or will your family have to gather someplace else be-

cause an older family member is not able to climb the steps to your house?

One Dayton couple cannot visit her mother who lives in an older home. The stairs at every entrance and the bathroom that is not wheelchair accessible make it very difficult for her husband, who uses a wheelchair, to visit. Another couple must live apart. She is in a nursing facility while her husband continues to live in their apartment that is no longer accessible to her. Mother's Day and other holidays are spent in the nursing home.

Not only do structural barriers in homes prevent older adults and people with disabilities from aging in place in their own homes. They also make it difficult for people who need basic accessibility to visit family and friends, leading them to become socially isolated. Even if none of your family or friends currently has a disability, that can, and probably will, change.

The elderly population of the United States is large and growing rapidly. Since disability rates increase with age, this will bring substantial increases in the number of people with disabilities. Studies estimate that more than one in five (21 percent) of households will have at least one disabled resident in 2050. According to the Journal of the American Planning Association, 91 percent of newly built single family homes will have a resident or visitor with physical limitations or disabilities during the home's useful life. Many houses have steps at all entrances, narrow doorways, long and narrow hallways and lack an accessible bathroom on the main floor, features that can make it difficult for some people to get into or move around a home.

So, there is a new initiative to make homes more "visitable." Visitability means a home is designed so that it can be lived in or visited by people who have trouble with steps or who use wheelchairs or walkers. A house is visitable when it has:

- At least one outside entrance with no steps;

- Doors with at least 32 inches of clear passage space; and
- At least one outside entrance with no steps;
- Doors with at least 32 inches of clear passage space; and
- At least one bathroom on the main floor that you can access in a wheelchair.

The outside entrance with no steps does not have to be the front door. It can be the entrance from the attached garage. This can benefit people using baby strollers, coolers on wheels or appliance delivery men, as well as anyone with a disability. And, we are not necessarily talking about ramps. Ramps are good for retrofitting older homes, but with advance planning, proper design and grading, ramps are rarely necessary in new construction.

Visitability accommodates people of all sizes, ages and abilities, and allows families to age in place. A home designed and built with visitability features is less likely to need modifications to accommodate unexpected injuries and illnesses, as well as the slow-onset decreases in mobility that may come with age.

Designing for visitability when building a new home is cheaper than trying to remodel an existing home to meet the needs of an older owner. For example, the average cost nationally of including one zero-step entrance when building a new home is \$150. Estimates of the average cost to Ohio taxpayers to add a ramp to an existing home ranges from \$2,800 to \$5,000. Ohioans spend more than \$5 million annually in state and federal Medicaid funds, state MRDD capital funds and Ohio Housing Trust Funds to modify entrances and bathrooms in existing homes for people with disabilities. That figure does not include the costs incurred by families or funds from other sources such as the Ohio Rehabilitation Services Commission or charitable organizations.

Currently in Ohio, visitability is only considered in new homes when a buyer demands these features

prior to the construction of the home or if the builder receives financing from the Ohio Housing Finance Agency, which requires visitability. A majority of homes that are constructed today do not include visitability as a basic feature and would require costly retrofits to become visitable. While Ohio has enacted a Residential Building Code, which applies a uniform building standard to all single family homes, visitability features are not included. The Ohio Visitability Strategy Group, made up of state agencies, departments and commissions, was created to examine way to promote visitability in Ohio. You can find more information about visitability at [visitabilityohio.org](http://visitabilityohio.org) or [concretechange.org](http://concretechange.org).

So, where will your family celebrate, or be able to celebrate, Mothers Day? Not everyone has the resources to build new with visitability in mind. What you can do is look around your current home to identify any barriers, see what can be rectified easily and what would require more effort, then prioritize based on your family's needs. With some effort, you can help family and friends with disabilities feel welcome and able to visit, at the same time ensuring that your home will be comfortable and livable in the future.

Source: *Aging Issues*, Ohio Department of Aging, April 2010.

## Preventive Food Care...



### Keeping Older Adults on Their Feet

The average person will put several hundred tons of pressure on his feet in a normal day of walking and will walk the equivalent of five times around the Earth in his lifetime. Is it any wonder why our feet are more subject to injury than any other part of our bodies?

Foot ailments are among the most common of our health problems. Many people, including a lot of older people, wrongly believe that it is normal for their feet to hurt, but even among people in their

retirement years, many foot problems can be treated successfully and the pain of foot ailments relieved.

Normal wear and tear causes changes in feet. As individuals age, their feet tend to spread and lose the fatty pads that cushion the bottom of the feet. Additional weight can affect the bone and ligament structure. The skin and nails of the feet frequently become dry and brittle as people age, and numbness and discoloration can occur. These may be the first signs of such serious conditions as diabetes, arthritis or circulatory disease. Foot problems also can lead to knee, hip and lower back pain and undermine mobility. According to the U.S. National Center for Health Statistics, impairment of the lower extremities is a leading cause of activity limitation in older people.

For older people to live full, satisfying lives, they must be able to move around. Foot ailments can make it difficult or impossible for them to work or to participate in social activities. Preventive foot care can increase an older person's comfort, improve or maintain mobility and independence, limit the possibility of additional medical problems, reduce the chances of hospitalization and lessen requirements for other institutional care.

The American Podiatric Medical Association offers these recommendations to keep feet healthy:

- Don't ignore foot pain. If the pain persists, see a podiatric physician.
- Inspect your feet regularly. Pay attention to changes in color and temperature of your feet. Look for thick or discolored nails and check for cracks or cuts in the skin.
- Wash your feet regularly, especially between the toes, and be sure to dry them completely.
- Trim toenails straight across, but not too short.
- Make sure that your shoes fit properly. Purchase new shoes later in the day when feet tend to be at their largest, and replace worn

out shoes as soon as possible.

- Wear the right shoe for the activity that you are engaged in, such as running shoes for running.
- Alternate shoes. Do not wear the same pair of shoes every day.
- Avoid walking barefoot to prevent injury and infection. At the beach or when wearing sandals, always use sun block on your feet as well as the rest of your body.
- Be cautious when using home remedies for foot ailments. Self-treatment often can turn a minor problem into a major one.
- If you are a person with diabetes it is vital that you see a podiatric physician at least once a year for a check-up.

Foot ailments affect the quality of life and mobility of millions of Americans. Podiatrists can provide treatments in the office, your home, the hospital or a long-term care facility. Always consult your podiatrist when you have questions about foot conditions or what is covered by Medicare.

Source: *Aging Connection*, Ohio Department of Aging, April 2010.

## Health Reform & Medicare....



The final health care reform package closes the Part D "doughnut hole"—the gap in drug coverage during which people with Medicare must pay the full cost of their prescriptions out of pocket. All consumers who reach this coverage gap in 2010 will receive a \$250 rebate. Health care reform phases out the doughnut hole by decreasing the consumer's share of drug costs during the doughnut hole until it reaches 25 percent in 2020 for both brand-name and generic drugs. However, the phase-out works differently for brand-name and

generic drugs.

### A Timeline of Implementation

- Provides a \$250 rebate to people with Medicare in the doughnut hole. (The doughnut hole is the \$3,6000 gap in the drug benefit when consumers pay full price).
- Authorizes the Food and Drug Administration to approve generic versions of biologics, which treat diseases such as diabetes, and allows for generic versions to enter the market after 12 years. This means more affordable versions of biologics will be available to consumers.
- Improves care coordination for dual eligible's—people who are enrolled in both Medicare & Medicaid—through the creation of the new Federal Coordinated Health Care Office within the Centers for Medicare & Medicaid Services (CMS).
- Many provisions to reduce fraud within the Medicare program take effect, including tighter restrictions on physician self-referrals and requirements for claims to be filed within one year of service.
- Reduces updates to annual market baskets, which are used to determine annual payment adjustments, for home health care, inpatient hospitals, skilled nursing facilities, hospice and other Medicare providers, and adjusts market baskets to account for provider productivity.

### New Rules Set Refund Deadline

New Medicare rules will help low-income people with Medicare receive refunds for excess drug premiums and co-payments they paid after they became eligible for Extra Help, the program that helps pay Part D cost-sharing for consumers with limited incomes.

The new regulations set a 45-day limit for drug plans to reimburse new Extra Help recipients or

other payers, such as state pharmaceutical assistance programs (SPAPs) that paid members' drug premiums and co-payments. The reimbursements are for co-payments and premiums paid above Extra Help levels after the date an individual is eligible for Extra Help—the month they applied—but before the drug plan is informed about his or her Extra Help status.

For almost two years Medicare Rights has called for plans to reimburse consumers and SPAPs by a specified deadline, and to make sure the payments are for the correct amount. The new rules clarify drug plans' obligations to work with SPAPs to better account for reimbursements they are owed.

### New Regulations for Private Medicare Plans

New regulations issued in April 2010 will require all Medicare private health plans to limit, starting in 2011, the amount plan members spend on deductibles and co-payments for medical care over the course of the year. In addition, the Centers for Medicare & Medicaid Services (CMS) will continue policies that encourage plans to voluntarily include a lower annual out-of-pocket limit in benefit packages. About one-third of Medicare private health plan members are now enrolled in plans that have such a limit—the maximum for 2010 is set at \$3,4000.

Source: The Medicare Rights Center is a national, nonprofit consumer service organization that works to ensure access to affordable health care for older adults and people with disabilities through counseling and advocacy, educational programs and public policy initiatives. Vol. 1, Issue 6 & 7.

### Questions & Answers on Medicare & Health Reform

**I worked hard my whole life and I'm just getting by now. Why should I pay more for my Medicare to cover the uninsured?** You won't. There are no Medicare benefit cuts in either the House or the Senate passed health reform bills.

Health reform legislation will not increase the share you pay under Medicare for a doctor visit, hospital stay, prescription drug or any type of medical treatment.

**What about this “\$500 billion” in Medicare cuts? Where does that come from?** Both the House and Senate bills have over \$400 billion in Medicare saving over the next ten years. The largest portion of those savings comes from reducing the annual increase in Medicare payments to hospitals, skilled nursing facilities and home health agencies.

**Aren't those cuts too drastic? Will hospitals still be able to treat Medicare patients?** The major hospital associations have supported health reform, but only if the legislation succeeds in covering almost all uninsured Americans, who now show up at emergency rooms when they need treatment but can't pay for it. It is true that Medicare's independent actuaries have expressed concern that providers won't be able to meet the productivity target and people with Medicare might see reduced access to services. But the Medicare savings accrue over ten years, and Congress can revisit the payment rates if access problems begin to surface. Congress passed bills to moderate the Medicare cuts it had passed in 1997. The 1997 bill reduced Medicare spending by a higher percentage than the savings projected under health reform.

**Will I still be able to see my doctor? She said there was a 21 percent Medicare pay cut coming.** There are no pay cuts for doctors in health reform. There are Medicare pay cuts for doctors scheduled under current law that will take effect March 1 and in following years if Congress does not act. These cuts are required under a payment formula that was enacted in 1998. Congress has passed bills to override the scheduled cuts in past years, but those bills have increased the cost of completely eliminating the payment formula. The House voted in November to replace the current payment formula with a payment system that does not require a series of annual pay cuts. It is

now up to the Senate to act.

**I am in Original Medicare, but my sister-in-law joined a Medicare Advantage plan. Is she going to lose her coverage?** Medicare pays private “Medicare Advantage” health plans 14 percent more per enrollee than it costs to provide care for the same person under Original Medicare. Both bills would bring the payments to the companies providing these plans more in line with costs under Original Medicare. Medicare private health plans would still be required to provide coverage that was at least as good as Original Medicare. Plans that deliver high-quality care and are efficient would still receive payments from Medicare to fund extra benefits, such as dental cleanings or lower copays for hospital stays that some plans provide, but the bills would reform the current system of subsidies. Both House and Senate bills would restrict the ability of Medicare private health plans to charge more than Original Medicare for specific services. Any person with Medicare who sees a premium increase or benefit reduction in their Medicare private health plan can change to another plan or return to Original Medicare for coverage.

**How does all this get paid for? I'm worried about putting a burden on my grandkids.** The Congressional Budget Office (CBO) estimates that the combination of Medicare savings and increased revenues in both bills more than pays for coverage for the uninsured. As a result, both bills reduce the deficit over the first ten years as well as over the longer term, according to CBO. If your grandchildren lose their jobs, or cannot get health coverage through their employer, they will still be able to afford health insurance. The Medicare savings all improve the financial health of the Medicare trust fund, which is funded by payroll taxes and pays for inpatient hospital care and other services under Medicare Part A.

**It all sounds a little too perfect. Is there anything you don't like about the health reform bills?** No bill is perfect. We are concerned that the

Senate bill creates an independent board that is empowered to limit spending growth in Medicare. We think it is better to leave those decisions to Congress, which is accountable to people with Medicare.

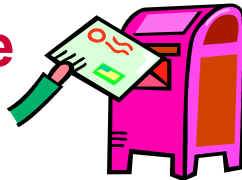
The Senate bill also increases the premiums for Part D drug coverage for the wealthiest 5 percent of people with Medicare (individuals earning over \$85,000 per year and couples earning more than \$170,000) who now already pay a higher Part B premium, and does not increase the Part D premium for higher earners. The House bill also help low-income people with Medicare by allowing them to receive the help with their Medicare costs even if they have a modest nest egg saved for retirement.

**I'm still skeptical. I'd like to see some facts and figures. Where can I learn more?** You can learn more on our Medicare and Health Reform webpage which includes a detailed side-by-side comparison on the House and Senate bills.

**One last thing. Who are you guys? There is a lot of spin out there. I don't like being spun.** You're right to be cautious. There are a lot of organizations and politicians who now claim to be defenders of Medicare who don't have a good track record of supporting Medicare.

The *Medicare Rights Center* is an independent, national, non-profit consumer service organization that works to ensure access to affordable health care for older adults and people with disabilities through counseling and advocacy, educational programs and public policy initiatives.

## Marci's Medicare Answers....



Dear Marci,



Dear Marci,

Does Medicare cover screenings for

## Alzheimer's and dementia?

—Sun

Dear Sun,

Yes, Medicare will cover medically necessary doctor visits and laboratory tests needed to diagnose any suspected disease or condition, including dementia or Alzheimer's disease. Some methods to diagnose dementia or Alzheimer's disease may include:

- Consultations with a primary care physician and possible other specialist.
- A mental status evaluation to assess your cognitive capabilities
- A physical examination
- A brain scan to detect other causes of dementia such as stroke
- A psychiatric evaluation
- A positron emission tomography (PET) scan to evaluate the cause of memory disorders that cannot be determined from any other diagnostic test

Medicare will cover 80 percent for your initial mental health visit, 80 percent for medication management and 55 percent for ongoing mental health treatment, such as psychotherapy.

—Marci

Dear Marci,



I heard that Medicare will stop paying for care in a psychiatric hospital after a certain number of days. Is that true?

—Evelyn

Dear Evelyn,

Yes. Medicare helps pay for inpatient mental health services in either psychiatric hospitals

(hospitals that treat only mental health patients) or in general hospitals. Your doctor will determine which hospital setting you need.

**If you receive care in a psychiatric hospital, Medicare helps pay for up to 190 days of inpatient care in your lifetime.** After you have reached your 190-day limit, Medicare may help pay for mental health care at a general hospital.

Your out-of-pocket costs are the same in a psychiatric hospital as they are in any hospital. If you enter a psychiatric hospital within 60 days of being an inpatient at a different hospital, you are in the same benefit period and do not have to pay the deductible again.

—Marci

Dear Marci,



**I have not worked long enough to get Social Security benefits, but my wife has. Does her work history qualify me for premium-free Medicare Part A?**

—Theodore

Dear Theodore,

It depends on your situation. If you develop a disability before the age of 65, and do not have enough work history, you cannot qualify for Social Security Disability (SSDI) based on your spouse's work history.

When you turn 65, you may be eligible for free Medicare Part A based on your spouse's work history if:

- You are currently married and your spouse is eligible for Social Security benefits (either retirement or disability). You must have been married for at least one year before applying.
- You are divorced and your former spouse is eligible for Social Security benefits (either retirement or disability). You must have been married for at least 10 years and you must be sin-

gle.

To date the federal government does not recognize domestic partners (neither opposite-gender nor same-gender) as spouses. Therefore, you cannot be eligible for Medicare based on the work history of a domestic partner.

Because Social Security and Medicare eligibility rules are complex, and there are some exceptions to the rules listed above, you should call Social Security at 1-800-772-1213 or, if Retirement Board field office to get the most accurate information regarding your particular situation.

—Marci

Dear Marci,



**I just had cataract surgery. Will Medicare cover it?**

—Jack

Dear Jack,

Yes. Although Medicare will not generally pay for routine eye care, it will pay for some eye care services if you have a chronic eye condition, such as cataracts. Medicare will cover:

- **Surgical procedures** to help repair the function of the eye due to cataracts. For example, Medicare will cover surgery to remove the cataract and replace your eye's lens with a synthetic intraocular lens.
- **Eye glasses or contacts, but only if you have had cataract surgery**, during which an intraocular lens was placed into your eye. Medicare ***will not*** cover a standard pair of untinted prescription eyeglasses or contacts if you need them after surgery. If it is medically necessary, Medicare may pay for customized eye-glass or contact lenses.
- **An eye exam to diagnose potential vision problems.** If you are having vision problems that indicate a serious eye condition, Medicare

will pay for an exam to see what is wrong, even if it turns out there is nothing wrong, even if it turns out there is nothing wrong with your sight.

Source: **Marci's Medicare Answers** is a service of the Medicare Rights Center ([www.medicarerights.org](http://www.medicarerights.org)), the nation's largest independent source of information and assistance for people with Medicare; April & May 2010. 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](mailto:dear-marci@medicarerights.org).

## Go Direct....



**Direct Deposit-** *The Best Way to Receive Federal Benefit Payments.* Half of American caregivers make health-related decisions for a love one, and a government survey finds an equal number help to manage the finances of the person needing their care. Yet, only 52 percent of caregivers receiving Social Security payments on behalf of the person they care for use direct deposit. Direct deposit is safer, easier and more convenient than getting a paper check in the mail. Yet despite the advantages, many people who rely on Social Security and Supplemental Security Income (SSI) still get checks.

Direct deposit is the best way to receive Social Security and SSI payments with direct deposit, the money goes straight into a bank account at the same time each month, giving recipients more control over their money. It eliminates the risk of stolen checks and forged signatures and helps protect recipients from identity theft. Plus, direct deposit provides people with immediate access to their money from virtually everywhere.

If every current federal benefit check recipient switched to direct deposit, it would save taxpayers about \$130 million a year. If the Ohioans receiving checks (more than 18 percent of Ohio benefit recipients) would switch to direct deposit, there would be an annual savings of \$4,864.890. Almost all the

money saved remains in the Social Security Trust Fund, benefiting Americans for years to come.

It is easy to sign up for direct deposit. Just call the Go Direct helpline at 1-800-333-1795, visit [www.GoDirect.org](http://www.GoDirect.org) to sign up online or stop in to a local financial institution or Social Security Administration office to make the switch.

Social Security and SSI recipients without bank accounts can sign up for prepaid *Direct Express Debit MasterCard*. The Direct Express card is simple and easy to use. Your federal benefits will automatically be posted to your account on payment day each month. The card can be used to make purchases, pay bills and get cash at retail locations and ATMs, nationwide. Sign-up is free, no credit check is required, there are no monthly fees and most services are offered free of charge. If your card is lost or stolen, it will be replaced. The Direct Express card eliminates the need to carry large amounts of cash. To sign up, call toll free 1-877-212-9991 or visit [www.USDirectExpress.com](http://www.USDirectExpress.com).

Direct Deposit and Direct Express cards are a safe and convenient alternative to paper Social Security checks.

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