

Consumer Manual



UNITY HEALTH CARE

The Patient Rights Manual

A Guide for Patients
and Their Families:
Understanding Your Legal Rights
To Health Care



NATIONAL EYE INSTITUTE,
NATIONAL INSTITUTES OF HEALTH

USDA/KEN HAMMOND



A Publication of the
District of Columbia Bar
Health Law Section

District of Columbia Bar
1250 H Street NW
Sixth Floor
Washington DC 20005-5937
www.dcbar.org



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Important Notice: Legal Disclaimer

Please be aware that the information in this manual is not medical or legal advice. In other words, it is not the same as talking to a doctor or lawyer. In addition, it is possible that some of the information in this manual is incorrect, incomplete, or out-of-date. For this reason, you should not rely solely on information that you read in this manual. If you believe you have a medical problem or have a health-related question, you should contact a doctor or other health care provider. If you have a question or believe that you may need a lawyer, you should talk to a lawyer as soon as possible.

For help finding a lawyer, look at this manual's chapter called "Finding a Lawyer." It includes important contact information on free legal clinics and lawyer referral services in the District of Columbia, Maryland, and Virginia that can help you handle a legal problem.

About This Manual

There are many laws and regulations governing the health care services that you receive. This manual was written by area lawyers to tell you about these laws and regulations and to explain your rights – as a consumer of health care services – to receive quality care and what to do if you run into problems along the way. In addition, each chapter includes the names and contact information of local agencies and organizations that you can turn to for additional information and assistance.

While we have made every effort to provide you with up-to-date information, the law may have changed since this manual was published. We urge you to verify the information with the agencies and organizations listed in each chapter. In the meantime, we hope to update the information in this manual on a regular basis and to continue to make the manual available to residents in the District and surrounding areas.

This manual probably covers many more topics than you, your family, friends and neighbors are likely to need but it is our hope that, whatever the topic, you will quickly find the basic information that you need to answer important questions about your rights as a health care consumer and obtaining the services you need. Keep this book for future reference and share it with family and friends who are involved in your care.

Who We Are

The manual is a publication of the D.C. Bar Health Law Section. Under the guidance of the Section's Community Outreach Committee, area lawyers, paralegals, and law students volunteered their time to prepare the chapters that make up this manual. Individuals and organizations with health care expertise assisted along the way by reviewing the draft manual and giving us valuable feedback.

The Community Outreach Committee of the D.C. Bar Health Law Section organizes many legal and non-legal activities for the local community. Recent health-law community programs include a health care decision-making program for area residents, and the preparation of a directory of local practitioners who provide health law counseling to individuals and businesses on a pro bono (free) or moderate fee basis. Comments about this manual and suggestions for further public service activities should be directed to:

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Capacity to Make Health Care Decisions and Preparing an Advance Directive

Normally, you have the right to make decisions about your own health care. You can decide if you want or don't want the medical treatment your doctor offers you. Doctors and other health care providers have to respect your decisions. However, there may be a situation in the future in which you are so ill that you cannot decide for yourself whether or not you want treatment. This could be because you are terminally ill or unconscious. There is a way to make sure that if you can't make health care decisions, your loved ones or close friends are able to make the decisions for you. You can do this by creating an advance directive.

Read the section of this chapter for your state to find out how to create an advance directive and to learn about the choices you can make about your health care.

District of Columbia

A. Mental Capacity

1. Ability to Make Health Decisions

When you see a doctor or nurse in the District of Columbia, there is an understanding that you have the ability, or capacity, to make your own decisions. Capacity means that you understand what is wrong with you and you understand the treatment that the doctors are offering you.

Sometimes people can't understand what is wrong with them. They might not understand that they are sick, or understand the different ways that their sickness can be treated. This might happen if a person is unconscious or has been badly injured. When a person can't understand, it's called "incapacity," and the person is "incapacitated."

If you are incapacitated, you won't be allowed to make health care decisions for yourself. Someone else who can understand the choices will make the decisions. Just because you may have been put in the hospital for mental illness, have a disability, or have had a guardian appointed to you does not mean that you are unable to make health care decisions. The test for being able to decide your own treatment is whether you are able to understand what might happen if you do or don't get treated. You need to be able to understand what is wrong with you and be able to understand how the treatment given to you by your doctors is going to make you feel. If you do, then you are competent to make your own health care decisions, and you can say "yes" or "no" to treatment that is offered by your doctors without anyone questioning your decision. If you do not understand, then you do not have the capacity to make your own health care decisions.

Before someone else can make these decisions for you, two doctors have to decide that you are not able to make good decisions about your health care. At least one of the two doctors must be a psychiatrist. The doctors should give an opinion about how bad your incapacity is and how long they think it will last. The doctors can change their minds later if they think that you have regained your capacity.

If two doctors decide that you are incapacitated to make medical decisions, this does not mean that you are incapacitated to make decisions about other things. The doctors have made a decision only about your ability to make decisions about your own treatment, not about your ability to make decisions in other parts of your life.

2. Minors

In D.C., a minor is someone under the age of 18, or one who is 18 but is still in high school and is going to turn 19 before graduation. Generally, minors do not make decisions about their own health care. Instead, parents or a guardian are usually responsible for making the minor's health care decisions. However, a court can decide that a minor is mature enough to make his or her own health care decisions, without having to talk to or listen to his or her parents or guardians. This usually only happens if the minor is almost 18 and does not agree with his or her parents. The court decides on a case by case basis if a minor is mature enough to make these decisions, so there is no exact test. It is up to the court to decide.

B. Advance Directives

1. What is an Advance Directive?

If you are incapacitated, someone else will make health care decisions for you. But how will that person know what you want, or what you would do if you could decide? You can tell them ahead of time in a document called an advance directive.

As long as you are able to understand your choices and to communicate with your doctors, an advance directive doesn't change anything. You can still make all of your health care decisions. If you become incapacitated, though, your doctor, relatives, and friends will look at your advance directive to see what medical treatment you want. They have to do what the advance directive tells them.

There are several ways to prepare an advance directive. One way is to simply fill in answers to a pre-prepared advance directive form. You can ask your doctor to give you a form, or you may contact one of the sources provided at the end of this chapter for an advance directive form. You may also create an advance directive by just writing down your medical wishes. You have to sign and date your advance directive in front of two witnesses to make it legal. Any adult, except for family members, your doctor, or other hospital employees, may be your witnesses. Your witnesses have to sign the advance directive, too. After you complete your advance directive, you should give a copy to your agent, doctor, family members, and anyone who might make decisions concerning your treatment. In D.C., you are not allowed to make an advance directive by just telling people what you want. It has to be in writing to be legal.

In D.C., there are two common types of advance directives. One is called a living will and the other is a durable power of attorney for health care.

2. What is a Living Will?

A living will is one kind of advance directive. A living will tells people what kind of medical care decisions you would want or not want made if you couldn't make the decisions yourself. It is about your health care decisions only, and doesn't affect your property, money, or any information that you may have included in a last will and testament.

A living will only comes into effect if you are terminally ill (going to die) or permanently unconscious. Some common things that you may want to include in your living will are whether you would like to be kept alive by being given CPR, hooked up to a machine to help you breathe, or fed through a feeding tube. If possible, you should talk to your doctor and family about what choices are right for you.

3. What is a Durable Power of Attorney for Health Care?

A durable power of attorney for health care picks the person(s) you want to make medical decisions for you if you cannot make the decisions yourself. This is another type of advance directive you may choose to have. Durable power of attorney is used whenever you are not able to make your own health care decisions. It can be used for a short time such as if you are unconscious, even if you aren't dying.

The person you pick to make your medical decisions in your durable power of attorney is called your attorney in fact or your agent. This person is supposed to make the same medical decisions that you would make for yourself. It is important that your agent be someone you trust, such as a family member, and that he or she knows what you want. Giving someone the power to make health care decisions in this document does not give them the right to make any decisions regarding your property, possessions, or money.

4. What is a Do Not Resuscitate Order?

A do not resuscitate (DNR) order is another kind of advance directive. A DNR is a request not to have CPR if your heart stops or you stop breathing. You can use an advance directive form or tell your doctor if you would like a DNR order. Unless you have a DNR order, medical personnel will do CPR if your heart stops or if you have stopped breathing. Patients who are likely to have a DNR order are those who have cancer that has spread, people whose kidneys don't work well, people who

need a lot of help with daily activities, or people who have a bad infection, such as pneumonia, that requires them to be in the hospital. If you have one or more of these conditions, you may want to talk to your doctor about your CPR wishes.

5. Should You Have an Advance Directive?

Most advance directives are written by older or seriously ill people. However, even if you are in good health, you might want to think about writing an advance directive. An accident or serious illness can happen suddenly, and if you have an advance directive, your wishes are more likely to be followed. You can change or cancel your advance directive at any time, and an advance directive doesn't change anything unless you are incapacitated.

Maryland

A. Mental Capacity

1. Ability to Make Health Decisions

When you see a doctor or nurse in Maryland, there is an understanding that you have the ability, or capacity, to make your own decisions. Capacity means that you understand what is wrong with you and you understand the treatment that the doctors are offering you.

Sometimes people can't understand what is wrong with them. They might not understand that they are sick, or understand the different ways that their sickness can be treated. This might happen if a person is unconscious or has been badly injured. When a person can't understand, it's called "incapacity," and the person is "incapacitated."

If you are incapacitated, you won't be allowed to make health care decisions for yourself. Someone else who can understand the choices will make the decisions. Just because you may have been put in the hospital for mental illness, have a disability, or have had a guardian appointed to you does not mean that you are unable to make health care decisions. The test for being able to decide your own treatment is whether you are able to understand what might happen if you do or don't get treated. You need to be able to understand what is wrong with you and be able to understand how the treatment given to you by your doctors is going to make you feel. If you do, then you are competent to make your own health care decisions, and you can say yes or no to treatment that is offered by your doctors without anyone questioning your decision. If you do not understand, then you do not have the capacity to make your own health care decisions.

Before someone else can make these decisions for you, two doctors have to decide that you are not able to make good decisions about your health care. The doctors can change their minds later if they think that you have regained your capacity.

If two doctors decide that you are incapacitated to make medical decisions, this does not mean that you are incapacitated to make decisions about other things. The doctors have made a decision only about your ability to make decisions about your own treatment, not about your ability to make decisions in other parts of your life.

2. Minors

In Maryland, a minor is someone under the age of 18. Generally, minors do not make decisions regarding their own health care. Parents or a guardian are usually responsible for making the minor's health care decisions. However, a minor who is married or the parent of a child can make his or her own health care decisions.

B. Advance Directives

1. What is an Advance Directive?

If you are incapacitated, someone else will make health care decisions for you. But how will that person know what you want, or what you would do if you could decide? You can tell them ahead of time in a document called an advance directive.

As long as you are able to understand your choices and to communicate with your doctors, an advance directive doesn't change anything. You can still make all of your health care decisions. If you become incapacitated, though, your doctor, rela-

tives, and friends will look at your advance directive to see what medical treatment you want. They have to do what the advance directive tells them.

There are several ways to prepare an advance directive. One way is to simply fill in answers to a pre-prepared advance directive form. You can ask your doctor to give you a form, or you may contact one of the sources provided at the end of this chapter for an advance directive form. You may also create an advance directive by simply writing down your medical wishes. You have to sign and date your advance directive in front of two witnesses to make it legal. Any adult, except the person you name as your agent, may be your witness. Your witnesses have to sign the advance directive, too. After you complete your advance directive, you should give a copy to your agent, doctor, family members, and anyone who might make decisions concerning your treatment.

Another way to create an advance directive in Maryland is to tell your attending physician (the doctor who is in charge of treating you while you are in the hospital) and a witness the things that you would include in a written advance directive.

There are two common types of advance directives. One is called a living will and the other is called a durable power of attorney for health care. In Maryland, both a living will and a durable power of attorney for health care can be part of the same document. The durable power of attorney for health care part of the form is often called the "appointment of health care agent."

2. What is a Living Will?

A living will is one kind of advance directive. A living will tells people what kind of medical care decisions you would want or not want made if you couldn't make the decisions yourself. It is about your health care decisions only, and doesn't affect your property, money, or any information that you may have included in a last will and testament.

A living will only comes into effect if you are terminally ill (going to die) or permanently unconscious. Some common things that you may want to include in your living will are whether you would like to be kept alive by being given CPR, hooked up to a machine to help you breathe, or fed through a feeding tube. If possible, you should talk to your doctor and family about what choices are right for you.

3. What is a Durable Power of Attorney for Health Care?

A durable power of attorney for health care picks the person(s) you want to make medical decisions for you if you cannot make the decisions yourself. This is another part of advance directive form that you may want to fill out. Durable power of attorney is used whenever you are not able to make your own health care decisions. It can be used for a short time such as if you are unconscious, even if you aren't dying.

The person you pick to make your medical decisions in your durable power of attorney is called an agent. This person is supposed to make the same medical decisions that you would make for yourself. It is important that your agent be someone you trust, such as a family member, and that he or she knows what you want. Giving someone the power to make health care decisions in this document does not give them the right to make any decisions regarding your property, possessions, or money.

4. What is a Do Not Resuscitate Order?

A do not resuscitate (DNR) order is another kind of advance directive. A DNR is a request not to have CPR if your heart stops or you stop breathing. You can use an advance directive form or tell your doctor if you would like a DNR order. Unless you have a DNR order, medical personnel will do CPR if your heart stops or if you have stopped breathing. Patients who are likely to have a DNR order are those who have cancer that has spread, people whose kidneys don't work well, people who need a lot of help with daily activities, or people who have a bad infection, such as pneumonia, that requires them to be in the hospital. If you have one or more of these conditions, you may want to talk to your doctor about your CPR wishes.

5. Should You Have an Advance Directive?

Most advance directives are written by older or seriously ill people. However, even if you are in good health, you might want to think about writing an advance directive. An accident or serious illness can happen suddenly, and if you have an advance directive, your wishes are more likely to be followed. You can change or cancel your advance directive at any time and an advance directive doesn't change anything unless you are incapacitated.

Virginia

A. Mental Capacity

1. Ability to Make Health Decisions

When you see a doctor or nurse in Virginia, there is an understanding that you have the ability, or capacity, to make your own decisions. Capacity means that you understand what is wrong with you and you understand the treatment that the doctors are offering you.

Sometimes people can't understand what is wrong with them. They might not understand that they are sick, or understand the different ways that their sickness can be treated. This might happen if a person is unconscious or has been badly injured. When a person can't understand, it's called "incapacity," and the person is "incapacitated."

If you are incapacitated, you won't be allowed to make health care decisions for yourself. Someone else who can understand the choices will make the decisions. Just because you may have a disability or have had a guardian appointed to you does not mean that you are unable to make health care decisions. The test for being able to decide your own treatment is whether you are able to understand what might happen if you do or don't get treated. You need to be able to understand what is wrong with you and be able to understand how the treatment given to you by your doctors is going to make you feel. If you do, then you are competent to make your own health care decisions and you can say yes or no to treatment that is offered by your doctors without anyone questioning your decision. If you do not understand, then you do not have the capacity to make your own health care decisions.

Before someone else can make these decisions for you, two doctors have to decide that you are not able to make good decisions about your health care. One of the doctors may be a psychologist. The doctors can change their minds later if they think that you have regained your capacity.

If two doctors decide that you are incapacitated to make medical decisions, this does not mean that you are incapacitated to make decisions about other things. The doctors have made a decision only about your ability to make decisions about your own treatment, not about your ability to make decisions in other parts of your life.

2. Minors

In Virginia, a minor is a person under 18 who has not been emancipated. Generally minors do not make decisions regarding their own health care. Parents or a guardian are usually responsible for making the minor's health care decisions. Any minor who has reached the age of 16 and is living in Virginia or has a guardian living in Virginia can ask a court to decide that he or she is mature enough to make decisions and to emancipate him or her. Emancipated minors can make their own health care decisions without having to talk to or listen to their parents or guardians. The court decides on a case by case basis if a minor is mature enough to make these decisions, so there is no exact test. It is up to the court to decide.

B. Advance Directives

1. What is an Advance Directive?

If you are incapacitated, someone else will make health care decisions for you. But how will that person know what you want, or what you would do if you could decide? You can tell them ahead of time in a document called an advance directive.

As long as you are able to understand your choices and to communicate with your doctors, an advance directive doesn't change anything. You can still make all of your health care decisions. If you become incapacitated, though, your doctor, relatives, and friends will look at your advance directive to see what medical treatment you want. They have to do what the advance directive tells them.

There are several ways to prepare an advance directive. One way is to simply fill in answers to a pre-prepared advance directive form. You can ask your doctor to give you a form, or you may contact one of the sources provided at the end of this

chapter for an advance directive form. You may also create an advance directive by just writing down your medical wishes. You have to sign and date your advance directive in front of two witnesses to make it legal. Any adults, except your relatives and your spouse, may be your witnesses. Your witnesses should sign the advance directive too. After you complete your advance directive, you should give a copy to your agent, doctor, family members, and anyone who might make decisions concerning your treatment.

If you have a terminal condition and are going to die, another way you can create an advance directive is to tell your attending physician (the doctor who is in charge of treating you while you are in the hospital) and two witnesses the things that you would include in a written advance directive.

There are two common types of advance directive. One is called a living will and the other is a durable power of attorney for health care. In Virginia, both a living will and a durable power of attorney for health care can be part of the same document.

2. What is a Living Will?

A living will is one kind of advance directive. A living will tells people what kind of medical care decisions you would want or not want made if you couldn't make the decisions yourself. It is about your health care decisions only, and doesn't affect your property, money, or any information that you may have included in a last will and testament.

A living will only comes into effect if you are terminally ill (going to die) or permanently unconscious. Some common things that you may want to include in your living will are whether you would like to be kept alive by being given CPR, hooked up to a machine to help you breathe, or fed through a feeding tube. If possible, you should talk to your doctor and family about what choices are right for you.

3. What is a Durable Power of Attorney for Health Care?

A durable power of attorney for health care picks the person(s) you want to make medical decisions for you if you cannot make the decisions yourself. This is another part of the advance directive form that you may want to fill out. A durable power of attorney is used whenever you are not able to make your own health care decisions. It can be used for a short time such as if you are unconscious, even if you aren't dying.

The person you pick to make your medical decisions in your durable power of attorney is called your agent. This person is supposed to make the same medical decisions that you would make for yourself. It is important that your agent be someone you trust, such as a family member, and that he or she knows what you want. Giving someone the power to make health care decisions in this document does not give them the right to make any decisions regarding your property, possessions, or money.

4. What is a Do Not Resuscitate Order?

A do not resuscitate (DNR) order is a request not to have CPR if your heart stops or you stop breathing. You can create a DNR order by telling your doctor that you would like one. Unless you have a DNR order, medical personnel will do CPR if your heart stops or if you have stopped breathing. Patients who are likely to have a DNR order are those who have cancer that has spread, people whose kidneys don't work well, people who need a lot of help with daily activities, or people who have a bad infection, such as pneumonia, that requires them to be in the hospital. If you have one or more of these conditions, you may want to talk to your doctor about your CPR wishes.

5. Should You Have an Advance Directive?

Most advance directives are written by older or seriously ill people. However, even if you are in good health, you might want to think about writing an advance directive. An accident or serious illness can happen suddenly, and if you have an advance directive, your wishes are more likely to be followed. You can change or cancel your advance directive at any time and an advance directive doesn't change anything unless you are incapacitated.

Important Contact Information

Partnership For Caring (provides state-specific Advance Directive forms)

1620 Eye Street, NW, Suite 202

Washington, DC 20006

(202) 296-8071

1(800) 989-9455 (an information hotline dealing with end-of-life issues)

<http://www.partnershipforcaring.org/HomePage/>

DC Partnership to Improve End-of-Life Care (provides advance directive forms)

c/o DC Hospital Association

1250 Eye Street, NW, Suite 700

Washington, DC 20005

(202) 682-1581 ext. 3221

<http://www.dcha.org/EOL/eol.htm>

District of Columbia Bar, Health Law Section (conducts workshops on advance directives for groups in the community)

1250 H Street, NW

Sixth Floor

Washington, DC 20005-5937

(202) 737-4700

<http://www.dcbbar.org>

Childhood Vaccine Injuries

Vaccines are the best way to prevent children from getting particular diseases. Certain vaccines are recommended for every child. Your doctor or clinic has information about which vaccines are generally recommended. Parents who cannot afford to immunize their children should ask their doctors or clinics whether they participate in Vaccines For Children (VFC), a Federal program that provides free vaccines for children who cannot afford them. To learn more about VFC or other immunization information, contact the sources listed below.

Important Contact Information

Centers for Disease Control and Prevention
National Immunization Program
Mailstop E-05
1600 Clifton Road, NE
Atlanta, GA 30333
1(800) 232-2522 (National Immunization Hotline)
<http://www.cdc.gov/nip/vfc/>

Every day children receive vaccine shots. Side effects from the vaccine shots are usually mild and last only a short time. Such side effects include soreness in the area where the shot was given and fever. Some children have no side effects at all. Sometimes a child may have more serious side effects, like an allergic reaction. Vaccinations should not harm a child, but sometimes one does.

Before your child is given a vaccine, you should know about the benefits and risks associated with the vaccine. Every health care provider who gives a child a vaccine must provide the parent with a fact sheet for every single dose of every vaccine given to the child. This fact sheet explains the benefits and risks of each vaccine. This fact sheet is called a Vaccine Information Statement (VIS). More information about VIS is available from the address and phone number listed above and at <http://www.cdc.gov/nip/publications/VIS/>.

You should also be able to identify the symptoms that may result if a vaccine is harming your child. After your child gets his or her shots, look for any unusual conditions such as a serious allergic reaction, high fever or changes in behavior. Signs of a serious allergic reaction include problems breathing, hoarseness or wheezing, hives, paleness, weakness, a fast heartbeat, dizziness, and swelling of the throat. If your child has any reaction after receiving a shot, tell your doctor what happened. Ask your doctor, nurse or health department to report the reaction to the Vaccine Adverse Event Reporting System (VAERS). You may also report the reaction to VAERS yourself.

Important Contact Information

VAERS
P.O. Box 110
Rockville, MD 20849-1100
1(800) 822-7967
<http://www.vaers.org>

The National Vaccine Injury Compensation Program

Because vaccinations sometimes injure children, Congress enacted the National Childhood Vaccine Injury Act. In the event that a vaccine injures your child, he or she may be eligible to receive monetary damages through the National Vaccine Injury Compensation Program (VICP). The VICP is a program to pay damages to persons who have been injured by certain vaccinations. The VICP is a "no-fault" program, which means that people do not have to prove the maker of the vaccine or the person who gave the child the vaccine is at fault to receive payment. The program simply reviews the circumstances of any suspected vaccine-related injury and provides payment, if appropriate.

Payment for a claim is generally based on the Vaccine Injury Table. The Table provides a list of VICP-covered vaccines and the specific injuries and time frames in which the injuries must occur. Even where an injury listed on the Table is shown, no

payment will be made if the injury was the result of another cause not related to the vaccine. For a copy of the Table, visit <http://www.hrsa.gov/osp/vicp/table.htm>.

The VICP currently covers the following vaccines: diphtheria, tetanus and pertussis (DTP, DtaP, DT, TT, Td); measles, mumps and rubella (MMR or any component); polio (OPV or IPV); hepatitis B; haemophilus influenza type B (HiB); rotavirus; varicella; and pneumococcal conjugate. Claims for injuries relating to any of these listed vaccines must be filed under the VICP first. Claims for any vaccines not covered by VICP must be pursued by way of civil litigation.

Important Contact Information

National Vaccine Injury Compensation Program (VICP)

Parklawn Building

5600 Fishers Lane

Rockville, MD 20857

1(800) 338-2382

<http://www.hrsa.gov/osp/vicp>

A. Should You File a Claim Under the VICP?

Claims for vaccine injuries or deaths relating to vaccines covered by the VICP must first be filed under the VICP. You have the right to reject the decision of any claim filed under the VICP and pursue civil litigation by filing a lawsuit against the maker of the vaccine and/or the health care provider who gave your child the vaccine. In pursuing civil litigation, however, the standard of proof is heightened and there is a three-phase trial.

By accepting the judgment and compensation of a claim filed under the VICP, you give up the right to sue the health care provider who administered the vaccine and maker of the vaccine. If you reject the judgment and compensation, you keep the right to sue the health care provider who administered the vaccine and maker of the vaccine.

Additionally, if you do not think the compensation provided by the VICP is sufficient or if the vaccine is not covered by the VICP, you can file a civil lawsuit based on negligence or product liability. Civil litigation will usually take a significantly longer time to resolve and can result in a less certain outcome. If you are considering a civil lawsuit, it is strongly recommended that you consult an attorney.

B. Filing a Claim

If you believe your child has been harmed by one of the vaccines listed in the Table, you should file a claim under the VICP with the U.S. Court of Federal Claims in Washington, DC. Vaccine injury claims involving vaccines covered by the VICP must be filed under the VICP first, before a lawsuit can be filed against the maker of the vaccine and/or the health care provider who gave the child the vaccine. To be awarded money damages, the injury you claim must be one of the injuries listed in the Table.

You are not required to have an attorney represent you when you file your claim. It is a good idea, however, for a parent filing a claim to consult an attorney because the Court's rules are strict and specific and may be confusing or overwhelming to many parents. The VICP provides for the cost of hiring an attorney. This is true even if the Court does not award damages, as long as the claim was reasonable and made in good faith. This means that you normally will not have to pay for the attorneys' fees yourself as long as you rationally and truly believe that the injury exists and was caused by the vaccine. If you do hire an attorney, it is recommended that you come to a written agreement with the attorney that the attorney will only charge reasonable fees that will be paid through the VICP and not by you personally.

The first step in filing a claim for a vaccine-related injury or death is to file a petition for compensation with the U.S. Court of Federal Claims in Washington, DC. When the petition is filed, one of the doctors at the Department of Health and Human Services (HHS) reviews it to determine whether it satisfies the requirements necessary for compensation. The doctor then recommends awarding compensation or advises against it. The decision to award monetary damages is made through hearings before a "special master." A special master is an attorney appointed by the judges of the Court who interacts with

the parties in each case. The decision of the special master may be appealed to the Court, then to the Federal Circuit Court of Appeals, and ultimately to the United States Supreme Court.

Petitions filed under the VICP must include certain medical records and other materials listed below. If you do not provide the required records with the petition, it could delay the review of your claim.

1. Prenatal and Birth Records

- Mother's prenatal record
- Delivery record
- Birth Certificate
- Newborn hospital record including physicians/nurses notes and radiology/laboratory results

2. Medical Records Prior to Vaccination

- Vaccination record (including lot number and manufacturer, if available)
- Medication records
- Laboratory/radiology/EEG results
- Flow sheets (respiratory care/treatments)
- Clinic notes (such as Well-Baby or Well-Child visits)
- Private physician visits
- Growth charts

3. Post-Injury Hospital Treatment Records

- Admission/discharge summaries
- History and physical records
- Progress notes including physician/nurses notes

4. Post-Injury Outpatient Records

- History and physical records
- Progress notes (including physicians/nurses notes)
- Medication records
- Laboratory/radiology/EEG results
- Clinic notes
- All evaluations

5. Vaccine Adverse Event Report Form

(if submitted)

6. Long Term Records

- School records
- Consultation reports and evaluations

7. Death Records

- Death Certificate
- Autopsy report (if done)
- Autopsy slide

C. When to File a Claim

The law has a very strict time limit for filing a claim under the VICP for a vaccine-related injury or death. Claims for vaccine-related deaths must be filed within two years from the date of death and not more than four years after the first sign of the vaccine-related injury from which the death occurred. Claims for vaccine-related injuries must be filed within three years of the vaccination or the first sign of symptoms relating to the vaccination.

D. Where to File a Claim

Petitions must be filed with the U.S. Court of Federal Claims at the address provided below. Additionally, the VICP also requires that you send a copy of the petition to the HHS Secretary. The Secretary of HHS is considered the respondent (i.e., the opposing party or party who may question the truth of your claim) for every petition filed under the VICP. The Secretary's copy should be sent to the Director of the Division of Vaccine Injury Compensation at the address provided below.

Important Contact Information

Clerk
U.S. Court of Federal Claims
717 Madison Place, NW
Washington, D.C. 20005
(202) 219-9657

Director, Division of Vaccine Injury Compensation
Office of Special Programs
Parklawn Building
5600 Fishers Lane
Rockville, MD 20857
1(800) 338-2382

Going to Court (Filing a Lawsuit)

There are three ways in which claims for vaccine-related injuries may be pursued through civil litigation against the health care provider who administered the vaccine and/or the vaccine manufacturer: (1) where a claim filed under the VICP was dismissed or found not eligible for compensation; (2) where an award for a claim filed under the VICP was rejected; or (3) where the claim is for an injury resulting from a vaccine not covered by the VICP. Claims pursued through civil litigation are subject to certain statutory limitations including additional defenses, a three-phase trial and heightened burdens of proof for liability and punitive damages.

Accepting the judgment and compensation awarded for a VICP claim means that you cannot file a lawsuit against the health care provider who administered the vaccine and/or the maker of the vaccine for the injuries or death resulting from the vaccine. Rejecting the judgment and compensation means that you can file a lawsuit against the health care provider who administered the vaccine and/or the vaccine manufacturer for the injuries or death resulting from the vaccine.

Any claim for compensation relating to vaccines not covered by the VICP (e.g., lyme disease, anthrax and the like) must be pursued through civil litigation. This involves using traditional theories of liability such as negligence or product liability.

Vaccine Adverse Event Reporting System

If you believe your child has been injured by a vaccine, you may also want to consider filing a report with the Vaccine Adverse Event Reporting System (VAERS). This is a program jointly coordinated by the Centers for Disease Control and Prevention (CDC) and the Food and Drug Administration (FDA). This program helps monitor vaccine safety and adverse reactions caused by vaccines.

VAERS is separate from the VICP and is not associated with compensation or damages. Reporting a vaccine-related injury

or death to VAERS does not file a claim for compensation under the VICP. You must still file a petition with the U.S. Court of Federal Claims.

VAERS reports are usually filed by vaccine manufacturers and health care providers, but parents can also file them. A copy of the form for reporting a vaccine-related injury or death to VAERS can be obtained by contacting VAERS at the website or number listed below or at the following website: <http://www.fda.gov/cber/vaers/vaers.htm>. You may send the completed form to VAERS at the address provided below.

In addition, parents may obtain information about which vaccines have had VAERS reports filed. More information about VAERS is available by contacting VAERS at the number or website listed below.

Important Contact Information

VAERS
P.O. Box 1100
Rockville, MD 20849-1100
1(800) 822-7967
<http://www.vaers.org>

Children and Exposure to Lead Paint

Many houses and apartments built before 1978 have paint that contains lead (called "lead-based paint"). Lead from paint, paint chips and dust can cause serious health problems. If either or both of the following situations describes your family, you are at risk for lead poisoning and should read this chapter to identify your family's (or child's) medical risks and legal rights:

- Families with young children (under approximately 6 years of age) living in housing built before 1978
- Families with pregnant women living in housing built before 1978.

People living in housing constructed before 1978 are at the greatest risk for lead poisoning because the paints used in these homes are most likely to contain lead. People get lead poisoning by breathing or swallowing lead dust or by eating soil or paint chips containing lead. If your house has cracked paint, the risk is greater.

Exposure to lead can harm especially young children. Children are at greatest risk from birth to age six because their bodies are growing quickly. The major source of exposure for children is lead paint dust from deteriorated lead paint. Most childhood exposure occurs when children eat lead paint chips or put their hands or other objects covered with lead dust in their mouths. Exposure to lead paint can even harm babies before they are born. A pregnant woman should know that lead in her blood can pass to her unborn child.

To help prevent lead poisoning, wash children's hands before eating, bedtime and naptime, and after playing. Wash children's bottles, pacifiers and favorite toys at least every day. Clean floors, windowsills, and other surfaces at least every week.

If it is not detected and treated early, lead poisoning can cause many health problems including permanent damage to the brain and nervous system, reduced intelligence, slowed growth, hearing problems, headaches and behavioral and learning problems. People who appear healthy may actually be suffering from lead poisoning. Therefore, if you live in a potentially hazardous environment, you should have your home inspected and have your children tested for lead exposure.

You and your children can be tested for lead by performing a simple blood test. Consult your doctor or a local hospital to have this test performed. If you need assistance contacting a medical professional for lead testing, call 1(800) 424-LEAD (5323) or any of your state's contacts listed in this Manual. These organizations can also give you brochures on steps you can take to minimize the risks of lead poisoning.

Federal and state laws can tell you about and protect you from lead poisoning. The following is an overview of the federal law that applies to residents of all states and the District of Columbia. A summary of the separate laws in the District, Maryland, and Virginia follows and explains any additional protections you may have in your state. Also provided is a summary of the lead screening policies if your child is enrolled in Medicaid.

Your Right to Information Under Federal Law

If you are renting or planning to buy a home built before 1978, the Residential Lead-Based Paint Hazard Reduction Act of 1992 requires that you be informed of the risks of lead paint and on how to protect yourself from these risks. The seller or landlord of your home is required to notify you of all known lead paint in the building (including common areas of rental buildings, such as hallways). If the landlord or seller lies to you about the risks of lead, they can be subject to civil and criminal penalties. If you are buying a house, you are given a 10-day period to inspect the house for lead. Landlords, however, are not required to give this inspection period to renters. State and local laws may add further protection depending on where you live. The National Lead Information Center & Clearinghouse (NLIC) provides information and educational material about lead hazards and their prevention.

Important Contact Information

National Lead Information Center & Clearinghouse
1019 19th Street, NW – Suite 401
Washington, DC 20036
1(800) 424-LEAD (5323)
TDD 1(800) 526-5456
1(800) LEAD-FYI (532-3394) – Lead Hotline

District of Columbia

District of Columbia law requires residential property owners and landlords to keep their property lead-free if a child under eight years of age lives there. D.C. law also gives permission for local authorities to enter and inspect properties where there is reason to believe a lead danger exists. A high concentration of lead as indicated by a blood test is generally sufficient evidence. If you think there is a lead hazard in your building, notify the property owner and call the D.C. government using the telephone numbers listed below.

Important Contact Information

DC Lead Hotline
(202) 535-2690

National Lead Information Center & Clearinghouse
1019 19th Street, NW – Suite 401
Washington, DC 20036
1(800) 424-LEAD (5323)
TDD 1(800) 526-5456
1(800) LEAD-FYI (532-3394) – Lead Hotline

Alliance for Healthy Homes
227 Massachusetts Avenue, NE
Suite 200
Washington, DC 20002
(202) 543-1147
<http://www.afhh.org>

Maryland

Maryland law offers significant protections to renters before and during occupancy of a building if there are signs of lead hazards and also assists residents in moving out of a dangerous building if lead poisoning has been detected. The state agency for helping eliminate childhood lead poisoning is the Maryland Department of the Environment's Lead Poisoning Prevention Program.

A. Initial Protection Before You Move In

Maryland law provides enhanced protection for renters living in buildings built before 1950. Before you move into a house or rental unit built before 1950, the owner must provide you with information on lead risks and a copy of the lead inspection certificate. The property must be listed with the Maryland Department of the Environment and must have undergone a lead hazard repair, called the Full Risk Reduction Treatment, at the owner's expense. This treatment requires that there be no chipped or peeling paint, that doors and window wells and sills are clean and operate smoothly without flaking paint, and that floors are vacuumed and wet-washed to pick up lead dust.

B. Protections if Risk Factors and Signs of Poisoning Exist

Maryland law also offers protection to all renters who: (1) are pregnant or have a child under six years of age; and (2) either (a) have a blood lead level of 15 or more micrograms of lead per deciliter of blood, or (b) have chipped, peeling, and flaking paint in an older home. If you satisfy these conditions and send a written Notice of Defect to your landlord, the landlord usually must then either perform lead reduction treatments or pass a lead dust test in the next 30 days. You can get a Notice of Defect form from the Maryland website at <http://www.mde.state.md.us/CitizensInfoCenter/Health/lead/index.asp> or by calling the Maryland Lead Hotline at 1(800) 776-2706.

It is recommended that you mail the Notice of Defect to your landlord by certified mail, return receipt requested. You can hand deliver the Notice of Defect to your landlord if your landlord is willing to sign a statement that he or she received the notice. These formal methods of delivery are important if you later want to assert your rights against the landlord because they give you proof that you provided the proper notice.

Because of the risks associated with treatments to remove the lead hazards, pregnant women and children under six must not be in the house while such treatments or repairs are taking place. If you are required to leave during the treatment or repairs for more than 24 hours, the owner usually has to pay reasonable expenses for your housing and meals during that time.

It is against the law for the owner to attempt to evict you if you assert these rights. If the landlord does not adequately perform his or her legal obligations, you can put future rent payments in an escrow account and the landlord will not receive the money until he or she has complied with the law.

C. Children or Pregnant Women with a Blood Lead Level of 20+ µg/dl

Maryland law also offers protection to all renters who: (1) are pregnant or have a child under six years of age and (2) have a blood lead level of 20 or more micrograms of lead per deciliter of blood (µg/dl). If you satisfy these conditions, you may seek a Qualified Offer from the property owner or the property owner's insurance company. A Qualified Offer provides you with certain relocation and medical benefits. These benefits will pay a certain amount of medical expenses and provide for certain amount of money to live in lead-safe housing. However, if you accept this offer, you cannot sue for any damages in excess of the Qualified Offer. You have 30 days from the day you receive the Qualified Offer to decide whether to accept it or not. You should consult an attorney or legal aid office before accepting such an offer. If you need help understanding a Qualified Offer, call The Coalition to End Childhood Lead Poisoning at (410) 534-6447 or 1(800) 370-5323.

Important Contact Information

Maryland Lead Hotline
1(800) 776-2706

Maryland Department of the Environment
1800 Washington Boulevard
Baltimore, MD 21230
(410) 537-3000 or 1(800) 633-6101
TDD (410) 631-3009

Coalition to End Childhood Lead Poisoning
(410) 534-6447 or 1(800) 370-5323

Virginia

Virginia offers no additional protections to those available under federal law. However, Virginia residents may contact the state to identify problems and get a list of approved contractors who will test and remove lead based paints.

Important Contact Information

Lead Safe VA Program
Virginia Department of Health
Division of Child & Adolescent Health
1500 E. Main Street
Room 138
Richmond, VA 23218-2448
(804) 225-4463 or 1(800) 668-7987

Medicaid

The Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) service is Medicaid's health care program for children under the age of 21. Screening for lead poisoning is a required component of an EPSDT screen. Current policy requires a lead screening blood test for all Medicaid-eligible children at 1 year and 2 years of age. Children between the ages of 2 and 6 years should receive a lead screening blood test if there is no record of a previous test.

Important Contact Information

Centers for Medicare and Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244-1850
(410) 786-3000 or 1(800) 267-2323
TDD (410) 786-0727 or 1(866) 226-1819

Clinical Trials

What Is An Experimental Treatment?

An experimental treatment is a treatment that is still being developed and has not yet been proven to work. To gain the approval of the U.S. Food and Drug Administration (FDA) and to be able to market the new treatment, researchers must do studies to prove that the treatment is safe and effective for a particular disease or condition.

What Is a Clinical Trial?

A. A Clinical Trial Is a Study That Tests Whether an Experimental Treatment Is Safe and Whether It Works

A clinical trial is a study that tests an experimental treatment on people to determine whether that treatment is safe and whether it works. A clinical trial may take place in a hospital, a medical center, or in doctors' offices. Often a single trial involves people participating at a number of different sites. You might learn about a clinical trial from your doctor, from a poster or advertisement, or from other sources such as listings on the Internet. More information on clinical trial listings is found at the end of this chapter.

Before testing any experimental treatment in humans, researchers first test it in test tubes and on animals. Only after being tested in animals can these treatments be tested in humans.

There are four kinds of clinical trials:

- Phase I trials: the experimental treatment is tested in a very small group of people, often healthy people. The goal is to see if the treatment is safe for use in people with a particular disease and to find out what the right dose is.
- Phase II trials: the treatment is tested in a larger group of people to see if it works for a particular disease or condition, and to obtain further safety information.
- Phase III trials: the treatment is tested in an even larger group of people. The goal is to see whether the treatment works better than a placebo (a sugar pill), or whether it works as well or better than other treatments that are currently available for a particular disease or condition.
- Phase IV trials: once studies have shown that the treatment works, more studies may be conducted to study risks and benefits as the treatment is used over time, or to compare how the treatment works on people from different backgrounds.

In every study, there are certain limits on who can participate. For example, people may have to be within a certain age range, or they may have to have a certain disease or condition. If you meet these requirements, you can consider whether you want to participate in the study.

B. Pros and Cons of Participating In a Clinical Trial

1. Participating In the Study May Help You or Others

When you participate in a clinical trial, you may be given an experimental treatment that is not yet on the market. If you do receive the experimental treatment, and if the new treatment is better than current treatments for a disease or condition that you have, it is possible that your disease or condition might be improved by participating in the clinical trial. Whether or not there is a health benefit to you, your participation will help researchers determine whether the treatment is safe and whether it works. This information may help doctors treat other people in the future.

2. Experimental Treatments Are Not Guaranteed To Work

There is no guarantee that an experimental treatment will be safe or will work better than a currently-available treatment. The law prevents anyone from making such a guarantee.

3. All Clinical Studies Involve Some Risk

In any clinical study, you will be subject to some risks, such as the following:

- The experimental treatment you receive could have side effects that are potentially dangerous or permanent; and
- The treatment might not work for your disease or condition.

In some studies, an experimental treatment is compared to an existing treatment, so that everyone in the study gets some kind of treatment. In other studies, however, some of the people who participate could be given a placebo instead of the experimental treatment. A placebo is a sugar pill that looks exactly like the experimental medicine, but has no effect on health. In trials that use placebos, you and your doctor may not be allowed to know whether you received the treatment or the placebo until after the study is completed.

C. What Protections Are Available To Subjects In Clinical Trials?

1. U.S. Government Reviews the Study

Before researchers can begin a study, they must submit their study plan to the FDA, the government agency that oversees the development of new medical treatments in the U.S. In reviewing the proposed study, the FDA seeks to protect the people participating in the trial and make sure the potential benefits of the study outweigh the potential harm.

2. Local Institution Reviews the Study

An Institutional Review Board, or "IRB," is a group of medical experts — including both scientists and nonscientists — that oversees research involving humans. An IRB is usually affiliated with a university or hospital, and is responsible for ensuring that the benefits of the study outweigh the risks to you. The goal of the IRB is to protect the rights and welfare of the people who participate in the study.

In reviewing clinical studies, an IRB considers the procedures that will be followed in the study, as well as community values in the area in which the study will be conducted.

3. Researchers Must Obtain Your Informed Consent

Except in certain emergency situations, before you participate in the clinical trial, the law requires researchers to obtain your "informed consent." This process involves the researcher explaining to you the potential risks and benefits of the study in a way that you can understand, without pressuring you to participate.

Signing an informed consent document means that you understand the potential risks and benefits and that you made the decision to participate. Although the IRB is responsible for ensuring the adequacy of information in the informed consent document, IRB members are not usually present when a researcher provides the information necessary for informed consent.

Your informed consent must remain in effect throughout the study. This means that researchers must inform you if new information becomes available during the study that might affect your decision to participate. It also means that you have the right to change your mind and withdraw from the study at any time.

a. The Researcher Must Explain How the Study Will Work, the Potential Risks and Benefits of the Study, and What Alternative Treatments are Available

To adequately inform you about the study, the researcher must provide you with the following information:

- The purpose of the research, how long the study will take, a description of the procedures, and any experimental procedures;
- Any reasonably foreseeable risks or discomforts that you may experience;
- Any benefits to you or to others that may reasonably be expected;

- Alternative procedures or treatments that might be available to you;
- Medical treatments that are available if injury occurs, and whether those treatments involve any cost to you;
- Whom to contact for answers to questions about the research and your rights as a research subject, and whom to contact if you are injured in the course of the trial; and
- Participation is voluntary, and if you decide not to participate (or begin the study and later change your mind), there will be no penalty or loss of benefits to which you are otherwise entitled.

When appropriate, the researcher must also explain whether the experimental treatment would pose a risk to a woman or her fetus if the woman becomes pregnant; whether there are circumstances in which you could be removed from the trial without your consent; whether there are any costs to you for participating in the research; what consequences result if you withdraw early from the study and what procedures you must follow; that significant new findings that may influence your willingness to participate in the study will be provided to you; and the approximate number of people who will participate in the study. All of the above information is written down in the informed consent form that you receive.

If you do not understand English well, the researchers must provide you with informed consent information in your native language. At the end of the informed consent process, you must understand all the potential risks of participating in the study. Although researchers may tell you about potential benefits, they cannot make promises or guarantee that you will have good results.

b. The Researcher Must Answer Your Questions

Before you decide whether to participate in a study, the researcher should explain to you face to face how the study works. You should also be given a chance to read the informed consent document carefully all the way through. Complex scientific words must be explained to you in a way that you can understand. Finally, the researcher must answer any questions that you may have about the study, or how the study will affect your regular medical care.

c. You Retain Your Rights As a Study Participant

You Can Quit at Any Time With No Penalty. You can stop participating in the study at any time without penalty and without losing any benefits to which you are otherwise entitled. If you withdraw, however, you may lose access to the experimental treatment being used in the trial. Before you sign the informed consent document, the researcher will explain to you what will happen if you later decide to withdraw from the study. For example, the researcher may ask to continue monitoring you for a period of time after you stop using the experimental treatment.

If You are Injured, You Have Rights. In some studies, compensation is available for people who are injured during the study. As part of the informed consent process, you must be told whether money has been set aside to compensate those injured in the course of the study. Even in studies where no money has been set aside to compensate injured subjects, you still retain the right to see a lawyer and seek compensation in court if you believe you were injured by the experimental treatment.

d. Confidentiality and the Use of Your Medical Records

At the time you give your informed consent, you will also receive a written explanation of the kinds of medical information that will be collected from you in the course of the research study. Under federal law, the researchers must obtain your permission to use your medical information in the study, and to release that information to others involved in the study. People who can review your medical information often include the maker of the experimental treatment, and the FDA.

e. Costs and/or Payments to Subjects

The informed consent document must tell you about any costs to you associated with participating in the study. Usually, the organization that sponsors the trial, such as the National Cancer Institute or a pharmaceutical company, will pay for the research costs of the clinical trial.

If the study does involve some cost to you, insurance coverage may be available. Private health insurance and Medicare will usually pay for ordinary health care costs that you would have regardless of whether you are participating in a clinical

trial, such as doctor visits, laboratory tests, and hospital visits. However, insurance does not always pay for costs that are only related to the experimental treatment. For example, some private health plans do not cover some or all costs involved with clinical trials because they involve "experimental" or "investigational" treatments. Medicare pays for routine costs of a clinical trial if the trial meets certain requirements. Routine costs covered by Medicare include:

- Costs from services normally provided;
- Services required for the provision of the treatment being tested; and
- All services for care arising from the trial.

Medicare does not pay for:

- The treatment being tested in the trial;
- Services only needed for data collection; and
- Other common research costs usually provided for free by the sponsor.

In some studies, subjects are paid to participate. If this is the case, the informed consent must include information regarding any payment you will receive for participation.

f. You Can Ask About Other Ways of Getting the Experimental Treatment

If you have a serious or life-threatening disease for which an experimental treatment is being tested, but you do not qualify for any of the ongoing clinical trials, you may be able to obtain access to the experimental treatment through a "treatment IND." Treatment INDs must be approved by the FDA, and still require IRB approval and informed consent, so you will receive the same protections as with a regular clinical trial. For more information on treatment INDs, go to <http://www.fda.gov/oashi/patrep/treat.html>. In general, treatment INDs are listed along with regular clinical trials at <http://clinicaltrials.gov>.

g. You Make the Final Decision On Whether To Enter the Clinical Trial, Without Pressure

In the end, giving informed consent and entering a clinical trial must be voluntary. You must think about the potential risks and benefits and make your own decision. You should ask the following questions in deciding whether to participate:

- What is the goal of the study? What are the researchers trying to find out?
- What organization is in charge of the trial? Have they done similar trials before?
- What kinds of tests and exams are required? Do they require hospitalization? Do I need to travel to get to the study site?
- What benefits will I gain from the study? Do I have other treatment choices?
- What are the risks of the study? What are the side effects of the treatment?
- What kind of time commitment is required of me?
- Are there any costs to me?
- If the study does involve some cost to you, is the study covered by health insurance? Is it covered by Medicare?
- How will my privacy be protected during the study?
- What happens once the study is over? Do I need any followup monitoring? Will the study have any impact on my regular medical treatment?
- If the experimental treatment was helpful to me, will I be able to continue using it after the trial is over?
- Have I been provided with an informed consent form and a written description of how my medical information will be used?

Important Contact Information

Additional information on clinical trials is available from the following sources:

- Your regular doctor, who might know of a clinical trial that might interest you.
- For clinical trials related to a particular disease or condition, visit the website: <http://clinicaltrials.gov>.

- For clinical trials related to cancer, call 1(800) 4-CANCER or visit the website: <http://cancertrials.nci.nih.gov>.
- For clinical trials related to HIV and AIDS, call 1(800) 874-2572 or visit the website: <http://www.actis.org>.
- For information on participating in clinical trials at the National Institutes of Health, contact the Patient Recruitment and Public Liaison Office, Warren Grant Magnuson Clinical Center, National Institutes of Health, Bethesda, MD 20892-4754, call 1(800) 411-1222, or e-mail prpl@mail.cc.nih.gov.
- The FDA's Office of Special Health Issues provides general information on clinical trials. Call (301) 827-4460 or visit the website: <http://www.fda.gov/oashi/home.html>.

Additional information on health insurance coverage of clinical trials is available from the following sources:

- For information about health insurance coverage of clinical trials, generally, see the Patient Advocate Foundation's "Managed Care Answer Guide," found at http://www.patientadvocate.org/pdf/pubs/mc_answer-guide.pdf.
- For general information on the role of health insurance in clinical trials, write the American Association of Health Plans at 1129 20th Street, NW, Suite 600, Washington, DC 20036-3421, call (202) 778-3200, or visit <http://www.aahp.org>.
- For general consumer information and counseling, write the Health Insurance Association of America at 555 13th Street, NW, Washington, DC 20004, call (202) 824-1600, or visit <http://www.hiaa.org/cons/cons.htm>.
- For the telephone numbers of state insurance counseling hotlines, visit the website http://www.hiaa.org/consumer/state_insurance.cfm.
- For information about health insurance coverage of clinical trials related to cancer, write the Association of Community Cancer Centers at 11600 Nebel Street, Suite 201, Rockville, MD 20852, call (301) 984-9496, or visit <http://www.accccancer.org/main2001.shtml>.
- For information on Medicare coverage of clinical trials, call 1(800) MEDICARE, or visit <http://www.cms.hhs.gov/coverage/8d2.asp> and <http://cms.hhs.gov/coverage/default.asp>.

Consent to Treatment

In general, you have the right to control your own medical decisions and to have your decisions respected. You can decide if you want or don't want the medical treatment your doctor offers you. When you are a patient, your doctor should tell you about the nature of the proposed treatment, possible alternative procedures and the risks and benefits involved in accepting or rejecting a certain treatment.

Your doctor should tell you about all reasonable medical alternatives even if he or she won't provide the care because of a religious or moral objection. For example, some doctors object to providing contraception or honoring your wishes about end of life care. When you are picking a hospital, you should check to see if the hospital has any religious limits on the care it provides. If it does, you can either decide to pick a different hospital or decide that you still want to go to that hospital anyway.

Your doctor will need your consent before starting treatment in circumstances when there is some degree of risk, such as surgery.

There may be a situation in the future in which you are so ill that you cannot consent to a treatment yourself. In some instances, this may be because you are terminally ill or unconscious. If this ever happens to you, your medical decisions can be made by someone close to you. This is done by creating an advance directive.

If, after reading this chapter, you believe that your rights to control your own medical decisions have not been respected, you may want to talk to a lawyer. For information on how to find a lawyer, see this manual's chapter called "Finding a Lawyer."

District of Columbia

A. Your Rights

When you are a patient, you have the right to consent, or choose your treatment based on information given to you by your doctor. You also have the right to refuse treatment. Your doctors should tell you in non-technical terms of all treatment alternatives, goals, and the risks of each alternative. The doctor must make this information available even if it is not requested.

B. When Consent is Not Needed

Generally, a doctor will get your consent before implementing treatment. However, there are certain situations when consent to medical treatment is implied. The most common situation that gives rise to implied consent is an emergency. An emergency is a situation where delay would create grave damage to your health. If you are unconscious or otherwise unable to consent to emergency treatment and a family member cannot be located in a timely manner, the doctor may use his or her discretion in treating you if a second doctor agrees that treatment is necessary.

C. Incapacity

There may be a time when you will be incapable of making an informed medical decision due to a psychological deficiency or physical condition, such as being unconscious. However, in most situations, the doctor will assume that you are competent to make health care decisions. If you are unable to appreciate the nature or implications of a type of treatment, make a choice among alternatives, or communicate this decision clearly, you may be declared incompetent. Two qualified physicians, one being a psychiatrist, make this decision only after an examination. If you were to become incapacitated or declared incompetent, then your medical decisions can be made by someone close to you.

D. Living Wills

You may prepare a living will. This allows you to specify what types of treatments you wish to have or not to have if you become incapacitated due to a terminal illness. This document must be in writing and signed by two witnesses. You may revoke a living will at any time.

E. Durable Power of Attorney for Health Care

A durable power of attorney for health care is a document that you can use to give someone you know the power to make health care decisions for you. In D.C., the person you give this power to is called an attorney-in-fact. If you become incapacitated, this attorney-in-fact will be able to give consent to your medical treatment. This person will also have the right to request medical treatment be withheld if that is what you wish. Your attorney-in-fact is supposed to make the same medical decisions that you would make for yourself. It is important that this person be someone you trust, such as a family member, and that he or she knows your wishes. You may revoke a durable power of attorney at any time you are competent to make health care decisions. For more information on living wills and durable powers of attorney for health care, ask your doctor, or look at the chapter called "Capacity to Make Health Care Decisions and Preparing an Advance Directive."

F. If You Do Not Have an Advance Directive

Living wills and durable powers of attorney for health care are sometimes both called advance directives. Even if you don't have an advance directive, your doctor will try to contact someone to make medical decisions on your behalf. If there is no advanced directive, the following individuals will be permitted to consent to treatment on your behalf: (1) a court appointed guardian; (2) spouse; (3) an adult child; (4) a parent; (5) an adult sibling; (6) a religious superior; or (7) the nearest living relative. A surrogate decision maker cannot consent to certain medical procedures on your behalf, such as: abortion, sterilization, psychosurgery, convulsive therapy, behavior modification, experimental treatment or research, removal of organs under certain conditions, or withdrawal of life-saving treatment (unless it is clear you would have consented to this withdrawal).

G. Minors

A minor is any patient less than eighteen years old. A physician may not give treatment to a minor without consent from his or her parents. Exceptions are sometimes made if there is a medical emergency, the parents are not accessible, or the patient is nearly eighteen. A court may order treatment on a minor in the case of serious illness or injury despite religious objection.

Maryland

A. Your Rights

When you are a patient, you have the right to consent, or choose your treatment based on information given to you by your doctor. You also have the right to refuse treatment. Your doctors should tell you in non-technical terms of all treatment alternatives, goals, and the risks of each alternative. The doctor must make this information available even if it is not requested.

B. When Your Consent is Not Needed

Treatment may be performed without your consent when an emergency exists and someone authorized to give consent on your behalf is not immediately available. This usually occurs only if the doctor determines that there is a substantial risk of death or serious bodily harm and a delay would adversely affect your health. Informed consent is required for HIV testing, even if a health care worker has been exposed to the bodily fluids of a patient. However, a new law allows a hospital official to order an HIV test when you are unable to consent if a hospital worker has been exposed to your bodily fluids. Any test performed without your consent, though, will not become part of your medical records.

C. Incapacity

There may be a time when you will be incapable of making an informed medical decision due to a psychological deficiency or physical condition, such as being unconscious. However, in most situations, the doctor will assume that you are competent to make health care decisions. If you can't make a rational evaluation of the burdens, risks and benefits of medical treatment, or if you are unable to communicate a decision, you may be considered incompetent to make medical decisions. Incapacity must be certified by two doctors. Both doctors must personally examine you unless you are unconscious or completely unable to communicate. If you were to become incapacitated or declared incompetent, then your medical decisions can be made by someone close to you or a doctor may follow directions in your living will.

D. Durable Power of Attorney for Health Care

In Maryland, you may prepare an advance directive document appointing an agent to give consent on your behalf (known as a durable power of attorney for health care) if you are not capable of making a medical decision. Your agent is required to make health care decisions based on what is best for you. It is important that this person be someone you trust, such as a family member, and that he or she knows your wishes. You may revoke a durable power of attorney for health care at any time you are competent. For more information on advance directives ask your doctor, or look at the chapter called "Capacity to Make Health Care Decisions and Preparing an Advance Directive."

E. Living Wills

If you wish to give specific instructions about the treatment you would receive if you became incapacitated, you may prepare a living will. This document allows you to give specific instructions about your care, rather than delegating these decisions to someone else. You may also use this type of document to direct the kinds of mental health services you would receive if you become incapacitated. You may revoke a living will at any time when you are competent.

F. If You Do Not Have an Advance Directive

Even if you don't have an advance directive or living will, your doctor will try to contact someone to make medical decisions on your behalf. If you have not made an advance directive, the following people may consent to medical treatment in priority order: (1) a court-appointed guardian, (2) your spouse, (3) an adult child, (4) a parent, (5) an adult sibling, or (6) a friend or other relative who is competent and familiar with your personal wishes.

G. Minors

A minor has the same capacity as an adult to consent to medical treatment if his or her health or life would be harmed by delaying treatment in order to obtain an adult's consent. A minor also has an adult capacity to consent when the minor is married or the parent of a child. An adult's consent is not required when: (1) the minor does not live with the guardian and a reasonable effort to notify the guardian is unsuccessful, (2) notice would lead to physical abuse of the minor, (3) the minor is capable of informed consent because of his or her maturity level, or (4) notification would not be in the best interest of the minor.

A minor has the same capacity as an adult to consent to treatment for or advice about pregnancy, birth control (except sterilization), venereal disease, drug abuse, alcoholism, physical examinations for rape or other sexual assault, and initial screening when being admitted to a detention facility.

Virginia

A. Your Rights

When you are a patient, you have the right to consent, or choose your treatment based on information given to you by your doctor. You also have the right to refuse treatment. Your doctors should tell you in non-technical terms of all treatment alternatives, goals, and the risks of each alternative. The doctor must make this information available even if it is not requested.

B. When Your Consent is Not Needed

There are times, such as a medical emergency, when a physician will not need to receive your consent. When a delay in treatment might adversely affect recovery, a licensed health professional or hospital can provide surgical, medical or dental treatment. A doctor will attempt to get consent from an authorized person and make a reasonable effort to contact a parent or other next of kin.

In certain limited circumstances, consent may be implied. Your consent to HIV and hepatitis B and C testing may be implied when an exposure between bodily fluids occurs in some specific settings. Informed consent for testing for infection with HIV is obtained (1) when you seek the services of a facility offering anonymous testing for HIV; (2) when blood specimens are taken for routine diagnostic purposes; and (3) when you donate or sell your blood.

C. Incapacity

There may be a time when you will be incapable of making an informed medical decision due to a psychological deficiency or physical condition, such as being unconscious. However, in most situations, the doctor will assume that you are competent to make health care decisions. If you are determined to be incapacitated, you will not be able to consent to medical treatment. You will be considered incapacitated if you can't understand the nature, extent or probable consequences of a proposed medical decision, or make a rational evaluation of the risks and benefits of alternatives to that decision. The determination about whether you are incapacitated will be made by two doctors. If you were to become incapacitated or declared incompetent, then your medical decisions can be made by someone close to you.

D. Durable Power of Attorney

In Virginia, you may prepare a durable power of attorney appointing an agent to consent to treatment on your behalf if you are not capable of making a medical decision. Your agent is required to make health care decisions based on what is best for you. It is important that this person be someone you trust, such as a family member, and that he or she knows your wishes. You may revoke a durable power of attorney at any time. For more information on durable powers of attorney, ask your doctor, or look at the chapter called "Capacity to Make Health Care Decisions and Preparing an Advance Directive."

E. Living Wills

If you wish to give specific instructions about the treatment you would receive if you should become incapacitated, you may prepare a living will. This document allows you to give specific instructions about your care, rather than delegating these decisions to someone else. You may revoke this document at any time while you are competent. You may revoke a living will at any time.

F. If You Do Not Have an Advance Directive

Even if you don't have an advance directive, your doctor will try to contact someone to make medical decisions on your behalf. If you have not prepared an advance directive or have not appointed an agent, then there is a list, in order of priority, of people who are empowered to make health care decisions for you. The following persons, in specific order, may grant, refuse or withdraw consent to treatment on your behalf: (1) a guardian or committee for the patient; (2) spouse except where a divorce action has been filed; (3) adult child; (4) parent; (5) adult sibling; or (6) other relatives in descending order of blood relationship. In the event of a disagreement among surrogates of equal authority, majority shall rule.

G. Minors

A minor is considered an adult when consenting to treatment for (1) a sexually transmitted disease, (2) any infectious or contagious disease which must be reported to the State Board of Health, (3) any type of birth control except sterilization, (4) substance abuse, and (5) mental illness. A married minor is capable of consenting to any type of medical treatment other than sexual sterilization. A physician may operate on a minor without consent from a guardian in an emergency situation where a delay would adversely affect the health of the minor. Consent should be obtained from the minor in this situation if the minor is at least fourteen years old and capable of consenting.

Discrimination: Racial and Disability

Racial Discrimination

A. Federal Law

Title VI of the Civil Rights Act of 1964 is a federal law that prohibits recipients of federal funding from discriminating against you based on your race, color, or national origin.

1. Who Are Recipients of Federal Funding Under Title VI?

The United States Department of Health and Human Services, Office for Civil Rights (OCR), lists some of the institutions or programs that may be covered by Title VI, including: extended care facilities, public assistance programs, nursing homes, adoption agencies, hospitals, day care centers, mental health centers, senior citizen centers, the Medicaid and Medicare programs, family health centers and clinics, and alcohol and drug treatment centers.

2. What Constitutes Discrimination Under Title VI?

Title VI prohibits intentional discrimination, as well as policies or practices that have discriminatory effects. In other words, for example, your health care provider can violate Title VI even if he or she (or it) did not intend to discriminate against you. Discriminatory acts prohibited by Title VI include, but are not limited to:

- Denial of services, financial aid, or other benefits based on an individual's race, color, or national origin; and
- Provision of different or segregated services, financial aid, or other benefits merely because of an individual's race, color, or national origin.

3. What Should I Do If I Believe That I Have Been Discriminated Against In Violation of Title VI?

If you believe that you have been discriminated against because of your race, the color of your skin, or your nationality, you can file a written complaint with the Office for Civil Rights within 180 days from the date of the alleged discrimination. This deadline may be extended in certain situations. The written complaint must include:

- your name, address, and telephone number;
- the name and address of the person, institution, or agency you believe discriminated against you;
- how, why, and when you believe you were discriminated against;
- any other information you believe is relevant; and
- your signature.

Important Contact Information

Send your complaint to the OCR Regional Manager in Region III, which covers D.C., Maryland, and Virginia, or to the OCR Headquarters in Washington, D.C.

Office for Civil Rights (Region III)
U.S. Department of Health & Human Services
Public Ledger Building
150 S. Independence Mall West, Suite 372
Philadelphia, PA 19106-3499
(215) 861-4441 / 1(800) 368-1019
TDD (215) 861-4440 / 1(800) 537-7697

Office for Civil Rights (OCR) Headquarters
Director
U.S. Department of Health and Human Services
200 Independence Avenue, SW, Room 506-F
Washington, D.C. 20201
1(800) 368-1019
TDD 1(800) 537-7697
<http://www.hhs.gov/ocr>

B. District of Columbia

The District of Columbia also prohibits racial discrimination in places of "public accommodations." Public accommodations include health clinics and hospitals. Complaints of discrimination should be directed to the D.C. Office of Human Rights at the address provided below, making sure that your complaint:

- is filed within one year of the discrimination;
- states the name and address of the person or institution you believe has committed the discriminatory act; and
- all relevant information about the discrimination.

A representative should contact you within five days of receipt of your complaint.

Important Contact Information

District of Columbia Government
Office of Human Rights
441 4th Street, NW, Suite 570N
Washington, DC 20001
(202) 727-4559
<http://www.ohr.washingtondc.gov>

C. Maryland

Maryland prohibits home health agencies from denying services to individuals based on color, creed, or national origin. It is also illegal in Maryland for a hospital "or related institution" to discriminate against individuals based on race, color, or national origin. If you believe that a Maryland hospital or similar institution has discriminated against you based on your race, color, or national origin, you may file a complaint with the state's Human Relations Commission at the address provided below. Make sure that your complaint:

- is in writing, under oath;
- states the name and address of the hospital or related institution which you believe discriminated against you;
- describes why you believe you were discriminated against; and
- is filed within six months from the date of the discrimination.

Important Contact Information

Maryland Human Relations Commission
William Donald Schaefer Tower
6 St. Paul Street, Suite 900
Baltimore, MD 21201
(410) 467-8600 or (800) 637-6247
<http://www.mchr.state.md.us>

Disability Discrimination

A. Federal Law

Two federal laws – Section 504 of the Rehabilitation Act and the Americans With Disabilities Act (ADA) – prohibit discrimination against qualified individuals with disabilities in the provision of certain benefits or services or in the administration of programs or activities.

1. What Are The Differences Between The Two Laws?

Section 504 of the Rehabilitation Act applies to programs or activities that receive federal financial assistance, including, for example, many hospitals, nursing homes, mental health centers and human service programs. The ADA applies to all activities, services, and programs of a public entity (for example, state and local governments and their departments and agencies), and to places of "public accommodation," which include doctor's and dentist's offices, hospitals, pharmacies, and health insurance offices.

2. What Does It Mean To Be a "Qualified Individual With a Disability"?

You are a "qualified individual with a disability" – and as a result covered by the Section 504 of the Rehabilitation Act and the ADA – if you meet the basic requirements for the receipt of services or benefits of the public entity and/or public accommodation, or for participation in the programs or activities receiving federal money.

3. What Disabilities Are Included Under the Acts?

You have a disability if you have a physical or mental impairment that substantially limits one or more of your major life activities (such as caring for one's self, performing manual tasks, walking, seeing, hearing, speaking, breathing, learning, and working). Examples of covered disabilities include, but are not limited to, the following: visual, speech, orthopedic, and hearing impairments; cerebral palsy; epilepsy; HIV/AIDS; muscular dystrophy; multiple sclerosis; cancer; heart disease; diabetes; mental retardation; emotional illness; and drug addiction and alcoholism.

4. What Constitutes Discrimination Under the Acts?

According to the Office for Civil Rights, entities covered by the laws generally must not:

- establish eligibility criteria for receipt of services or participation in programs or activities that screen out or tend to screen out individuals with disabilities (unless such criteria are necessary to meet the objectives of the program); or
- provide separate or different benefits, services, or programs to individuals with disabilities (unless it is necessary to ensure that the benefits and services are equally effective).

And according to OCR, entities covered by the laws generally must:

- provide services and programs in the most integrated setting appropriate to the needs of qualified individuals with disabilities;
- make reasonable modifications in their policies, practices, and procedures to avoid discrimination on the basis of disability (unless it would result in a fundamental alteration in their program or activity);
- ensure that buildings are accessible; and
- provide auxiliary aids to individuals with disabilities, at no additional cost, where necessary to ensure effective communication with individuals with hearing, vision, or speech impairments. (Auxiliary aids include such services or devices as: qualified interpreters, assistive listening headsets, television captioning and decoders, telecommunications devices for the deaf [TDDs], videotext displays, readers, taped texts, brailled materials, and large print materials.)

5. What Should I Do If I Believe That I Have Been Discriminated Against?

If you believe that you have been discriminated against because of your disability, you should file a written complaint with

OCR within 180 days from the date of the discriminatory act. The written complaint must include:

- your name, address, and telephone number;
- the name and address of the institution or agency you believe discriminated against you;
- how, why, and when you believe you were discriminated against;
- any other relevant information; and
- your signature.

Important Contact Information

Send your complaint to the OCR Regional Manager in Region III, which covers D.C., Maryland, and Virginia, or to the OCR Headquarters in Washington, D.C.

Office for Civil Rights (Region III)
U.S. Department of Health & Human Services
Public Ledger Building
150 S. Independence Mall West, Suite 372
Philadelphia, PA 19106-3499
(215) 861-4441 / 1(800) 368-1019
TDD (215) 861-4440 / 1(800) 537-7697

Office for Civil Rights (OCR) Headquarters
Director
U.S. Department of Health and Human Services
200 Independence Avenue, SW, Room 506-F
Washington, D.C. 20201
1(800) 368-1019
TDD 1(800) 537-7697
<http://www.hhs.gov/ocr>

B. District of Columbia

D.C. prohibits discrimination based on disability in places of public accommodations. Places of public accommodation include health clinics and hospitals. Complaints of discrimination should be directed to the D.C. Office of Human Rights and must:

- be filed within one year of the alleged discriminatory act;
- state the name and address of the person or institution you believe has discriminated against you; and
- include all relevant information about the alleged discrimination.

Important Contact Information

District of Columbia Government
Office of Human Rights
441 4th Street, NW, Suite 570N
Washington, DC 20001
(202) 727-4559

A representative from the Office of Human Rights should contact you within five days the filing of the complaint.

Also, the D.C. Office of Human Rights has a very helpful website: <http://www.ohr.washingtondc.gov/main.shtm>

C. Virginia Law

Virginia prohibits recipients of state funding from discriminating against you based on your disability.

Important Contact Information

Virginia Board for People with Disabilities

202 N. 9th St., 9th Floor or P.O. Box 1157
Richmond, VA 23219 Richmond, VA 23218

(804) 786-0016

TTY 1(800) 846-4464

<http://www.vaboard.org>

Emergency Medical Treatment

Your Rights to Emergency Room Care

Americans are not entitled to receive free health care under our present health care system. As a result, you may not always receive the health care that you need if you do not have health insurance and if you cannot afford to pay for the care. However, a federal law ensures that you will not be turned away from a hospital emergency room without first receiving a medical screening examination and any treatment that is necessary to stabilize an emergency medical condition. Congress enacted this law, the Emergency Medical Treatment and Active Labor Act (EMTALA), out of concern that emergency departments across the country were refusing to treat patients who were unable to pay or were inappropriately transferring patients to other hospitals, a practice known as "patient dumping."

EMTALA, also known as the "Patient Anti-Dumping Act," requires a hospital that participates in the Medicare program to:

- (1) provide you with a medical screening examination that is designed to detect whether you have an emergency medical condition; and, if needed,
- (2) provide treatment to stabilize that condition.

A hospital must provide these services regardless of your insurance status or your ability to pay. If the hospital is unable to stabilize you, then it must provide for an appropriate transfer to another medical facility.

The following are your rights under EMTALA when you go to a hospital for emergency medical care:

A. You Are Entitled to a Medical Screening Exam

- If you go to the emergency room of a hospital and request examination or treatment for a medical condition, the hospital must conduct a medical screening exam.
- The medical screening exam must be thorough enough to identify any emergency medical condition that you may have based upon your physical signs and symptoms.
- The medical screening exam must be performed by a physician or other qualified medical practitioner and must include all available services, such as x-rays, laboratory tests, and other diagnostic services.
- It is important to note, however, that if it is clear to qualified hospital personnel that your request is not of an emergency nature, the hospital is required only to perform the same type of screening that it would for any other patient with similar symptoms, to determine that you do not have an emergency medical condition.
- If the medical screening exam identifies an emergency medical condition, then the hospital must stabilize your medical condition as best it can within its capabilities, transfer you to a more appropriate facility, or obtain your written consent to release you if you refuse treatment or the transfer.
- Importantly, the hospital may not delay the medical screening exam in order to inquire about payment methods or your insurance status.
- However, the hospital is permitted to follow reasonable registration processes, including asking about the patient's insurance, so long as this inquiry does not delay screening or treatment.

B. You Are Entitled to Necessary Stabilizing Treatment

- If the hospital determines that you have an emergency medical condition, it must provide you with stabilizing treatment within the ability of the hospital's staff and its facilities.
- You are considered stabilized if, within a reasonable medical probability, no significant worsening of your condition is likely to result from a transfer or discharge from the hospital.
- The hospital may not call (or ask you to call) your insurance company or employer to request authorization for the treatment before providing the treatment.

a. You Are Entitled to an Appropriate Transfer If Necessary

- The hospital may not transfer you to another facility if you are unstable and if the hospital has the staff and facilities to treat you.

- You may only be transferred to another facility if you are sufficiently stable and the transfer is medically necessary.
- The hospital may not transfer you to another facility because your insurance company requests or requires the transfer.
- If you are transferred, the hospital is required to send copies of your medical records and tests with you.

b. Your Payment Responsibilities

If you go to the emergency room for medical care, then you will have to pay for any health care services that you receive. Most hospitals will talk to you about payment plans and other options if you are unable to pay. Hospitals may even agree to waive some of their fees if you pay a portion of the medical bill. As with any health care services, you have the right to refuse a recommended examination, treatment, or transfer. You also have the right to seek care elsewhere. If you refuse treatment, EMTALA requires the hospital to explain to you the medical risks of your refusing care and to document your decision in writing.

Important Contact Information

If you believe that your rights may have been violated, you should contact the Centers for Medicare & Medicaid Services (CMS), as provided below. If your rights have been violated, you may be entitled to compensation and equitable relief.

Centers for Medicare & Medicaid Services
Region 3
Suite 216, The Public Ledger Building
150 South Independence Mall
Philadelphia, PA 19106
(215) 861-4140
<http://www.cms.hhs.gov>

The Family Medical Leave Act

What is the Family Medical Leave Act and What Does It Do?

The Family Medical Leave Act (FMLA) was created to give you a chance to take the time you need to take care of personal or family medical situations without fear of losing your job.

The FMLA provides eligible employees with up to 12 weeks (or 16 weeks if you work in the District of Columbia) of unpaid, job-protected leave for certain medical conditions and family situations.

How do I know if I am eligible for FMLA protected leave?

Only certain employers have to follow FMLA rules, and even then only certain employees may take protected leave. Even for eligible employees, there are restrictions on what conditions or situations qualify for protected leave. The FMLA is far from perfect, but provides important protection for working families.

Does my employer have to follow FMLA rules?

In order to be eligible for unpaid, job-protected FMLA leave, you must be able to answer "Yes" to one of the following questions about your employer:

- If you work in the District of Columbia, do you work for the DC government, or does your employer have at least 20 employees in the District?
- If you work in Maryland or Virginia, does your employer have 50 or more employees for each working day during 20 or more workweeks during the current (or previous) year?
- Is your employer a public agency? This includes state, local and federal employers.
- Is your employer an educational agency? If so, you may be eligible for FMLA subject to certain additional conditions.

Am I Eligible for Protected Leave?

Making sure your employer is covered by the FMLA is just the first step. The next question is whether you are an "eligible employee."

If you work in the District of Columbia:

In order for you to be eligible to take unpaid, job-protected leave, you must be able to answer "Yes" to all of the following questions:

- Have you been employed by the same covered employer for 1 year without taking off work for anything other than regular holidays, sick days or vacations granted by your employer?
- Have you worked at least 1,000 hours during the 12 month period immediately before your request to take family or medical leave?
- Are you employed in the District of Columbia by an employer who employs more than 20 people who also work in the District?

If you work in Maryland or Virginia:

In order for you to be eligible to take unpaid, job-protected leave you must be able to answer "Yes" to all of the following questions:

- Have you been employed by your covered employer for at least 12 months?
- Have you worked at least 1,250 hours for the employer during the 12 month period?
- Are you employed at a worksite where the employer employs at least 50 or more employees within 75 miles of that worksite?

Will I fall under the Key Employee Exception of the FMLA, making me ineligible for the unpaid, job-protected leave?

Unless you are a "Key Employee," when you return from your unpaid, job-protected leave you are entitled to the same position you held before you took FMLA leave, or an equal position with equal benefits, pay and other terms and conditions of employment.

If you work in the District of Columbia:

An employer in the District can legally keep you from taking back your job only if you are among the 5 highest paid employees of fewer than 50 persons or among the highest paid 10 percent of employees with 50 or more employees and the following is true:

1. Your employer demonstrates that keeping you from taking your job back is necessary to prevent substantial economic injury to its operations and the economic injury is not directly related to the FMLA leave that the employee took.
2. Your employer notifies you that it wants to keep you from taking your job back and tells you why.

If you work in Virginia or Maryland:

A key employee is someone who is among the highest paid 10 percent of all the employees employed by the employer within a 75 mile radius of the employer's worksite.

If you are a key employee, your employer does not have to let you keep your job after you take FMLA leave, if the employer decides that letting you do so will result in a substantial and grievous economic injury to the employer's operations.

When Can I Take Unpaid Job-Protected Leave?

If you work in the District of Columbia:

If you work in the District of Columbia and are an eligible employee for a covered employer, your employer must grant you unpaid, job-protected leave for any of the following reasons:

- The birth of your child, the placement of a child with you for adoption or foster care, or other placement of a child with you, if you will permanently act as the child's parent; or
- When you can no longer work due to a serious health condition.
- When you need to care for a family member with a serious health condition.

Under D.C. law, a serious health condition is any physical or mental illness, injury or impairment that involves:

- Inpatient care in a hospital, hospice or residential care facility; or
- Continuing treatment or supervision at home by a health care provider or other competent individual.

A family member is either:

- A person related to you by blood, legal custody, or marriage;
- A child who lives with you and for whom you permanently act as the parent; or
- A person with whom you share or have shared, within the last year, the same home and with whom you have a committed relationship.

If you work in Virginia or Maryland:

If you work in Virginia or Maryland and are an eligible employee working for a covered employer, your employer must grant you unpaid, job-protected leave for the following reasons:

- The birth of your child, or the placement with you of a child for adoption or foster care;
- To care for your spouse, son, daughter, or parent with a serious health condition; or
- If you have a serious health condition making you unable to perform the functions of your job.

In Virginia or Maryland, a serious health condition is a serious illness, injury, impairment or condition that involves either:

- Inpatient care (includes overnight stays in hospital, hospice or medical care facility and any period of inability to do your everyday activities or later treatment related to inpatient care); or
- Continuing treatment by a health care provider. This includes one or more of the following:

1. A period of inability to do your everyday activities, including the inability to work, attend school, or perform other regular daily activities due to, treatment of or recovery from a serious health condition for more than three days in a row and any later treatment or inability to do your everyday activities that involves: (1) treatment two or more times by a health care provider; or (2) treatment by a health care provider on at least one occasion and continuing treatment under supervision of a health care provider;

2. Any period of inability to do your everyday activities because of pregnancy or prenatal care;

3. Any period of inability to do your everyday activities or treatment for a serious ongoing health condition;

4. Inability to do your everyday activities that is permanent or long term, in which treatment is not effective. The employee or family member must be under the care of a health care provider but does not have to receive active treatment. This category includes Alzheimer's disease, severe stroke, and terminal stages of a disease; or

5. Any period of absence to receive multiple treatments by a health care provider, either for reconstructive surgery after an accident or injury or for a condition that would likely result in a period of inability to do your everyday activities for more than three days in a row without treatment. This category includes treatment for cancer, severe arthritis and kidney disease.

Under the FMLA, a "parent" must have been your parent either biologically or because they took care of you when you were growing up. You can not take FMLA leave to care for a parent in-law.

If you take FMLA leave to care for your child, the child must be biological, adopted, a foster child, a step-child, or a legal ward, or you must be acting in the place of the parent to the child. You must also show: (1) that the child is under 18 years of age, or (2) the child is 18 years old or older but unable to take care of him or herself because of a mental or physical disability.

How Much Unpaid, Job-Protected Leave Am I Allowed?

If you work in the District of Columbia:

You may take up to 16 workweeks of family and medical leave during any 24-month (two-year) period.

If you work in Maryland or Virginia:

You may take up to 12 workweeks of family and medical leave during any 12-month (one-year) period.

Can I Take Intermittent Leave?

In certain circumstances you may be permitted to take intermittent leave. You should contact one of the agencies listed at the end of this manual for more information about eligibility for intermittent leave.

What About Paid Leave?

FMLA leave is unpaid leave. However, if your employer chooses to provide paid leave, you or your employer may opt to substitute the paid leave for FMLA leave. No employer is required by law to give you paid leave.

If you work in the District of Columbia:

Any paid family, vacation, personal leave provided by your employer may be taken for family or medical leave but will count against the total 16 workweeks of allowable protected unpaid family or medical leave provided by D.C. law.

If you work in Virginia or Maryland:

If you decide to use paid leave for FMLA leave, the paid leave you have earned is subtracted from the total 12 workweeks of FMLA leave. Your employer may require you to use up the paid leave you have earned as FMLA leave.

Do I Need to Notify My Employer When I am Planning to Take FMLA Leave?

If possible, you must provide your employer with 30 days advance notice prior to taking FMLA leave. If, however, the need for leave is not foreseeable, you must provide notice as soon as practicable (usually within one or two business days of when you become aware of your need for leave). You do not need to specifically indicate that you are requesting FMLA leave, it is your employers duty to determine whether FMLA leave is appropriate. Moreover, you do not need to provide written notice of your leave request.

If you fail to give notice for foreseeable FMLA leave, and you do not have a reasonable excuse for your delay in providing notice, your employer may delay your requested leave until at least 30 days after you actually provide notice.

What Happens to My Health Benefits While I Am On FMLA Leave?

Your employer must maintain your health coverage under the employer's group health plan, at the same level as if you were still working during the leave period. This includes family coverage, if family coverage was offered prior to your leave. In order to maintain your health coverage, you must continue to pay your group health plan premiums.

Do I Have to Prove the Condition or Situation to be Eligible for Leave?

Yes. Your employer has the right to ask you to give them proof that you need FMLA leave by showing "medical certification." Medical certification means the following:

1. If you need the time off for your health condition, you will need to include:
 - The date when the serious health condition commenced;
 - How long you think the condition will last; and
 - What you know about the condition.
2. If you need the time off to care for a FMLA covered family member, you will need to include:
 - A statement that your help is needed to care for this family member; and
 - How long you think your help will be needed.
3. If you are totally unable to do your job because of your poor health, you will need to include:
 - A statement explaining that you are unable to do your job and why.

What If My Employer Doesn't Believe Me?

If your employer does not believe you, they have the right to require a second medical certification. Although the second medical certification will be at your employer's expense, your employer also has the right to have the certification done by a health care provider of their choice. However, the health care provider for the second certification cannot be employed by your employer. While you are waiting to learn the results of the second opinion, you are allowed to claim your FMLA benefits.

If you and your employer still cannot agree after the second certification, either you or your employer may request a third certification. The third certification also is at the employer's expense, but you and your employer must both agree on which health care provider gives you the third certification. The third certification is final and binding.

Who Can Certify the Condition?

If you work in the District of Columbia:

A health care provider may certify the condition if he or she is licensed under federal, state or District law to provide health care services.

If you work in Maryland or Virginia:

A health care provider who can certify the medical condition may be any of the following:

1. A doctor of medicine or osteopathy who is authorized to practice medicine or surgery by the State in which he or she practices;
2. Others capable of providing health care services, such as: podiatrists, dentists, clinical psychologists, optometrist, and chiropractors (limited to specific treatments), who are authorized to practice in the State and performing within the scope of their practice;
3. Nurse practitioners, midwives, and clinical social workers who are authorized to practice under State law and who are performing within the scope of their practice;
4. Christian Science practitioners listed with the First Church of Christ Scientist Boston;
5. Any health care provider from whom the employer or the employer's group health plan benefit manager will accept certification from; or
6. A health care provider listed above who practices outside the United States who is authorized by the law of that country and who is performing within the scope of their practice.

How Am I Protected?

An employer may not interfere with, restrain, or deny the exercise of (or any attempt to exercise) any of your rights under the FMLA.

Your employer may not discriminate against you for taking FMLA leave or for complaining about your employer's possible violation of the FMLA.

An employer may not take into account your use of FMLA leave in any negative employment actions.

An employer may not contact your health care provider in order to discuss your health condition, but rather may only contact them to verify the certification you obtained from the doctor.

What Do I Do If My Employer Violates My FMLA rights?

The U.S. Department of Labor (for contact information, see the end of the FMLA chapter) handles all employee complaints regarding possible employer violations under the FMLA.

You have two options if you believe your employer has violated the FMLA:

1. You may file or have another person file, on your behalf, a complaint with the Secretary of Labor (or if a DC employer, with the DC Office of Human Rights); or

2. You may file a private civil suit against your employer.

You should do this right away, as there is a limited time period for filing a complaint or suit.

If your employer violated any provision of the FMLA, you may be able to recover lost wages, employment benefits or other compensation that you lost. You may also be entitled to monetary damages as a result of the violation, coverage of your attorney's fees and court costs, and additional damages. You may also receive other benefits such as getting your old job back.

What If I Work For a Local Education Agency?

Special rules apply to you if you are an employee of a local educational agency such as public school boards, and elementary and secondary schools under that agency's jurisdiction; and private elementary and secondary schools. These special rules do not apply to colleges and universities, trade schools and preschools.

There are special rules regarding intermittent leave and reduced leave schedule for instructional employees of local educational agencies. You should contact one of the agencies identified at the end of this chapter for further information.

Where Can I Get More Information?

For more information or questions about your rights under the Family Medical Leave Act check out or contact the following:

United States Department of Labor

(410) 962-2240

<http://www.dol.gov> (FMLA is listed under "Search A-Z" in the upper right hand corner)

District of Columbia Office of Human Rights

441 4th Street, NW – Suite 570N

Washington, DC 20001

(202) 727- 4559

How do I File a Complaint?

If you wish to file a complaint for violations of the FMLA, contact one of the following:

If your employer is in the District of Columbia:

District of Columbia

Office of Human Rights

441 4th Street, NW – Suite 570N

Washington, DC 20001

(202) 727- 4559

<http://www.ohr.washingtondc.gov>

If your employer is in Maryland or in Northern Virginia:

Maryland District Office

US Department of Labor, ESA Wage & Hour Division

Room 207 Appraisers Store Building

103 South Gay Street

Baltimore, Maryland 21202

(410) 962-2240

Family Planning, Abortion, Adoption, and Parenting

This chapter is intended to give you information about the available laws and resources relating to family planning/contraception, abortion, adoption, parenting, and loss of parental rights. At the end of this chapter, we list various government organizations that can provide you with further information on these issues. Many additional organizations are listed in the phone book and on the Internet.

Family Planning: Birth Control / Contraception

Every woman has the right to choose whether or not to use birth control. A woman also has the right to use the type of birth control that best suits her lifestyle. Many organizations in the District of Columbia, Maryland, and Virginia can help women and their partners decide if, when, and what type of birth control to use. Some of these organizations are listed at the end of this chapter.

In the District of Columbia, Maryland, and Virginia, women under the age of 18 (known as "minors") are able to receive contraceptive care without their parents' permission or knowledge. Teens are treated as adults for the purpose of making their own decisions about birth control.

Abortion

A. Adults (18 years and older)

Until a certain point in their pregnancies, women have a legal right to have an abortion. Although it is the woman's choice whether or not to end her pregnancy, state law may limit when and how a woman can obtain an abortion. The abortion laws of Virginia, District of Columbia, and Maryland are described below. Additional information about abortion laws and resources is available from local family planning organizations.

1. District of Columbia

Following an important Supreme Court decision, women may obtain abortions in the District. These abortions must be performed by licensed doctors.

2. Maryland

Maryland law allows a woman to have an abortion until the point in her pregnancy when the fetus has a chance of surviving outside of the mother's body. Maryland law also allows abortions at any time in a woman's pregnancy, if the abortion is necessary to protect the woman's life, or if the fetus has a severe genetic defect or other serious abnormality.

3. Virginia

In Virginia, a woman may have an abortion during her first trimester (first 3 months) of pregnancy if a licensed doctor performs the procedure. Virginia law also allows second trimester abortions (from 3 to 6 months), if a licensed doctor performs the procedure in a hospital. Third trimester abortions (after 6 months) are allowed only when pregnancy complications put the mother's life in danger.

Before a doctor may perform an abortion in Virginia, he or she must first explain the benefits and risks of the procedure and obtain the woman's consent (agreement to have an abortion). The doctor should tell the woman the fetus' age and should offer her written materials describing alternatives to abortion. The doctor also should give the woman an opportunity to ask questions before asking if she agrees to have the abortion.

B. Minors (less than 18 years)

Although young women less than 18 years old do have the right to end their pregnancies, additional laws apply to them.

1. District of Columbia

In the District, a minor may agree to have an abortion without telling her parents. The doctor does not need the parents' permission. The doctor also is not required to notify a minor's parents. The doctor is allowed to tell the minor's parents about the abortion, however, if the doctor believes that informing the minor's parents is necessary to protect the minor's emotional or physical health.

2. Maryland

In Maryland, generally a doctor cannot perform an abortion on an unmarried minor without telling her parents. The doctor does not need the parent's permission, but he or she must notify them about the abortion. The doctor does not have to notify the parents in certain circumstances, such as when the doctor believes that: (a) the minor will be physically or emotionally abused by her parents if they are told; (b) the minor does not live with her parents and the doctor is unable to locate them; or (c) the minor is mature and has made an informed decision.

3. Virginia

In Virginia, a doctor may not perform an abortion on a minor without permission from the minor's parents, guardian, or custodian. If a minor does not want to tell her parents about the abortion, or if her parents will not give their permission, she can ask the court for permission. To do this, she must file a petition in court and go to a hearing. At the hearing, the judge will determine if the minor is able to make the decision to have an abortion and whether or not the abortion is in the minor's best interest. If the minor gets permission from the court, she no longer needs her parents' consent. Depending on the circumstances, the judge may tell the minor's parents about the abortion if he or she believes notification is in the minor's best interest. If the pregnancy has put the minor's life in danger, a doctor may perform an emergency abortion without the minor's parents' permission and without a court order.

Adoption

A. Resources

Many resources are available to help parents through the process of placing their children up for adoption. These resources also can help people who want to adopt a child. Because adoption laws are complicated, parents considering adoption may wish to contact a lawyer to help them through the process.

B. Adoption Law

In D.C., Maryland, and Virginia, anyone, including a parent under the age of 18, may put his or her child up for adoption. If a child has been permanently removed from his or her parent's custody, a licensed child placement agency may put the child up for adoption. Generally, before a child can be adopted, both of the child's birth parents must agree to the adoption. The child's birth parents usually have to wait several days after a child is born before they can give the child up for adoption. Once they have given permission for the child's adoption, the birth parents usually have a short period of time (generally two weeks to a month, depending on where they live) to change their mind. After that time, the birth parents cannot stop the adoption.

Once a child has been adopted, the law treats the child as if he or she had been born to the adoptive parents. After the adoption, the birth parents lose all their rights to the child and are no longer required to pay for the child's support.

The District, Maryland, and Virginia have laws that protect the privacy of everyone involved in an adoption. Adopted children have a right to see the medical history of their birth parents, but generally are not allowed to see any information that tells who their birth parents are. Adoptive parents are allowed to pay some of the birth mother's medical and legal expenses, but they may not give her any additional money as part of the adoption.

Parenting

A. Parenting Resources

Many programs are available to help pregnant women and new mothers. There also are organizations to help men become good fathers.

B. Paternity

Paternity (or identifying a child's father) is often an issue in adoption, child custody, and child support matters. The birth father has certain legal rights. The birth father also has an obligation to pay to support the children he has fathered. If a child's father is known, a court in the District of Columbia, Maryland, or Virginia may order the father to pay child support.

1. District of Columbia

In the District, a man is assumed to be the father of a child if he and the child's mother have been married and the child was born during the marriage or just after it ended. A man also may be identified as a child's father based on genetic tests. A man voluntarily may agree that he is a child's father by signing a written statement under oath.

2. Maryland

In Maryland, a man is considered to be a child's father if he was married to the child's mother at the time of the child's conception or birth, or if he is named as the father on the child's birth certificate, unless he denies that he is the father. A man also may be found to be the child's father after a court hearing.

3. Virginia

In Virginia, a man may declare that he is the father of a child by signing a written statement under oath. If a court is unsure about who the father is, the court may hold a hearing. At the hearing, the judge will consider the relationship between the man and the child's birth mother. The judge also may consider whether the man has treated the child as his own or allowed the child to use his last name. Genetic tests also may be used to determine who a child's father is.

Loss of Parental Rights

In the District of Columbia, Maryland, and Virginia a court may end a parent's rights (terminate parental rights) if it finds that a parent has severely neglected or abused his or her child. Termination ends the legal parent-child relationship, and the child may be placed for adoption. Parents who abuse their children also may face serious criminal charges.

A. Ending Parental Rights

In D.C., Maryland, and Virginia, a court may end a parent's rights when it believes that it is in the child's best interest to be removed from his or her parent(s). The judge will consider the parent-child relationship, whether or not the birth parents have abandoned the child, and any evidence of drug-related activity in the child's home. Generally, the court will end the parent-child relationship when it finds that a parent has abused, intentionally injured, neglected, or caused the death of any child.

B. Criminal Abuse or Neglect

It is a crime in the District of Columbia, Maryland, and Virginia for any parent or guardian to fail to provide necessary food, clothing, and shelter to his or her children. Laws also punish parents who torture, beat, intentionally harm, or sexually abuse children who are less than 18 years old.

Important Contact Information

The following contact information is limited to federal and local government resources dedicated to family planning, abortion, adoption, or parenting issues. Many other resources are listed in the phone book and on the Internet.

District of Columbia

District of Columbia, Child & Family Services – D.C.'s child welfare agency
(202) 671-LOVE or (202) 671-5683
<http://www.cfsa.dc.gov/main.shtm>

District of Columbia, Department of Health Services – provides family planning information and health care, including a list of area clinics and organizations that provide birth control and health care to teenagers
(202) 727-1000
<http://dhs.dc.gov/serv/clinics.shtm>

District of Columbia, Office of Maternal and Family Health Administration – connects mothers with free clinics and health services and also runs a maternity outreach mobile that provides traveling healthcare, birth control and screening to mothers and their children
1(800) MOM-BABY or (800) 666-2229

Healthy Start Initiative – a federally funded project that promotes community based maternal and child health programs
(202) 438-8319 ext. 357
<http://www.healthystartassoc.org>

Maternal and Child Health Administration – administers health services and programs for women and their children
(202) 442-5925

Women, Infants, and Children (WIC) - D.C. – provides pregnant women information on healthy eating and advice on infant nutrition
(202) 645-5663 or 1(800) 345-1942

Maryland

Maryland Department of Health and Mental Hygiene – offers state-funded medical programs to assist mothers and young children
(410) 767-6538
<http://www.dhmh.state.md.us/mma/index>

Maryland Department of Health and Mental Hygiene
Family Health Administration – designed to reduce unintended pregnancy by assuring that comprehensive family planning and reproductive health services are available to Maryland citizens
(410) 767-6713
<http://www.fha.state.md.us>

Maryland Department of Human Resources Adoption Center – Maryland's child welfare agency
(800) 39-ADOPT or (800) 392-3678
<http://www.dhr.state.md.us/how/chldprnt/adoption.htm>

Maryland Family Health Administration, Teen Pregnancy Prevention Program – offers clinic services and counseling regarding sexual decision-making and birth control
(410) 767-5300
<http://www.fha.state.md.us/mch/html/teenpreg.html>

Fatherhoodmd.org – provides a list Maryland resources in to assist fathers and families
(410) 767-4982
<http://www.fatherhoodmd.org>

Women, Infants, and Children (WIC) – Maryland – provides pregnant women information on healthy eating and advice on infant nutrition
(800) 242-4942
<http://www.fha.state.md.us/wic>

Virginia

Virginia Department of Health, Division of Family Planning – offers family planning services for low-income citizens
(804) 786-8663
<http://www.vahealth.org/familyplanning/index.htm>

Virginia Department of Health, Division of Women's and Infant's Health Organization – provides family planning and prenatal health care, as well as education and support for young parents
(804) 371-4106
<http://www.vahealth.org>

Virginia Department of Health, Office of Family Health Services
(804) 371-0478
<http://www.vdh.state.va.us>

Virginia Department of Social Services – Virginia's child welfare agency
1(800) DO-ADOPT or 1(800) 362-3678
<http://www.dss.state.va.us>

The Virginia Fatherhood Campaign – run by the Virginia Department of Health to promote paternal involvement with children and to help improve fathering skills
1(800) 790-DADS or 1(800) 790-3237

Women, Infants and Children (WIC) – Virginia - provides pregnant women information on healthy eating and advice on infant nutrition
1(888) 942-3663
<http://www.vahealth.org/wic>

National

National Women's Health Information Center – a project of the U.S. Department of Health and Human Services providing current, reliable, commercial and cost-free health information to women and their families
1(800) 994-9662
<http://www.4woman.gov>

Maternal and Child Health Information Line – provides information on pregnancy and prenatal care
1(800) 311-2229 (English)
1(800) 504-7081 (Spanish)

Finding a Lawyer

Washington, D.C., Maryland, and Virginia have free or reduced fee legal clinics and lawyer referral services that can either help you with a legal problem or refer you to a lawyer who will. You should contact these organizations even if you are not sure whether you need a lawyer. Someone can help you make this decision and, if necessary, advise you on the best way to handle the problem. This chapter provides a listing of some of the legal clinics and lawyer referrals services in D.C., Maryland, and Virginia.

In addition, the District of Columbia Bar has an excellent website with information to help you find and work with a lawyer in the District of Columbia:

http://www.dcbbar.org/for_the_public/finding_a_lawyer/find.cfm#6

The website includes a glossary of legal terms, an explanation of how lawyers charge for their services, the type of information that you will need to share with your lawyer, and helpful phone numbers.

District of Columbia

District of Columbia Bar
1250 H Street, NW – Sixth Floor
Washington, DC 20005
(202) 626-3499 – 24-hour Legal Information Help Line
http://www.dcbbar.org/for_the_public/finding_a_lawyer/index.cfm

D.C. Bar Pro Bono Program Advice and Referral Clinic – on the second Saturday of every month from 10 a.m. to 12 p.m.
Bread for the City
1525 7th Street, NW
Washington, DC 20001
No direct calls from clients accepted
http://www.dcbbar.org/for_the_public/finding_a_lawyer/advice.cfm

D.C. Bar Pro Bono Program Advice and Referral Clinic – on the second Saturday of every month from 10 a.m. to 12 p.m.
Max Robinson Center
2301 Martin Luther King Jr. Avenue, SE
Washington, DC 20020
No direct calls from clients accepted
http://www.dcbbar.org/for_the_public/finding_a_lawyer/advice.cfm

The Legal Aid Society of the District of Columbia
666 Eleventh Street, NW – Suite 800
Washington, DC 20001-4589
(202) 628-1161
<http://www.legalaiddc.org>

Legal Counsel for the Elderly
601 E Street, NW
Washington, DC 20049
(202) 434-2170

Whitman-Walker Clinic – Elizabeth Taylor Medical Center
1701 14th Street, NW
Washington, DC 20009
(202) 939-7627
<http://www.wwc.org/Legal>

Bar Association of the District of Columbia
1225 19th. Street, NW – Suite 800
Washington, DC 20036
(202) 223-6600 – for information on the BADC Lawyer Referral Service
(202) 296-7845 – for referrals to an attorney
<http://www.badc.org/html/lawref.htm>

Maryland

Legal Aid Bureau (main office)
500 East Lexington Street
Baltimore, MD 21202
(410) 951-7777 or 1(800) 896-4213
TTY: TTY users contact Maryland Relay
<http://www.mdlab.org>

Legal Aid Bureau (Prince George's County)
6811 Kenilworth Avenue, Calvert Bldg.
Suite 500
Riverdale, MD 20737
(301) 927-2101 or 1(888) 215-5316
<http://www.mdlab.org>

Legal Aid Bureau (Montgomery County)
14015 New Hampshire Avenue
Silver Spring, MD 20904
(301) 879-8752
<http://www.mdlab.org>

Tess Legal Clinic, Takoma Park – 1st and 3rd Wednesday of each month from 6 to 7 p.m.
8513 Piney Branch Road
Silver Spring, MD 20901
(301) 565-7675

Charles W. Gilchrist Center for Cultural Diversity – 2nd and 4th Wednesday of each month from 6 to 7 p.m.
11319 Elkin Street
Wheaton, MD 20901
(240) 777-4940
<http://www.gilchristcenter.org>

Bar Association of Montgomery County Lawyer Referral Service
(301) 279-9100 – ask about the reduced fee and "Gray Panel" programs

Virginia

Legal Services of Northern Virginia (main office)
6400 Arlington Blvd., Suite 630
Falls Church, VA 22042
(703) 534-4343
<http://www.lawhelp.org/program/1569/>

Legal Services of Northern Virginia (Arlington office)
1916 Wilson Blvd., Suite 200
Arlington, VA 22201
(703) 532-3733
<http://www.lawhelp.org/program/1569/>

Whitman-Walker Clinic (Northern VA Office)
5232 Lee Highway
Arlington, VA 22207
(703) 237-4900
TDD (703) 237-9340
<http://www.wwc.org/Legal>

Virginia State Bar (Lawyer Referral Service)
(804) 775-0808 or 1(800) 552-7977
<http://www.vsb.org/vlrs.html>

Funerals

Each year, Americans arrange more than two million funerals for family and friends. At a potential cost of more than \$10,000, a funeral may be the third most expensive consumer purchase after a home and a car. Most decisions about purchasing funeral goods and services are made by people when they are grieving and under time constraints. In an effort to allow consumers to get information about funeral arrangements, the Federal Trade Commission (the FTC) developed a trade regulation rule concerning funeral industry practices. The rule went into effect on April 30, 1984, and in general, makes it easier for you to select only those goods and services you want or need and to pay for only those you select. The rule is described in greater detail below.

The Federal Funeral Rule

The FTC's Funeral Rule helps you obtain information about the cost and availability of individual funeral goods and services. The Funeral Rule sets several requirements that funeral directors must follow if you come to them for information on goods and services. These requirements are meant to protect you, as a consumer, from misrepresentation and other harmful practices.

A. Telephone Price Disclosures

By calling different funeral homes you can compare prices among funeral providers which can help you select a funeral home and the arrangements that you want. When you call a funeral provider to ask about terms, conditions or prices of funeral goods and services, the funeral provider must:

- tell you that price information is available over the phone;
- give you prices and any other information from the price lists to reasonably answer your questions; and
- give you any other information about prices or offerings that is helpful in answering your questions.

B. General Price List

If you request information about a funeral service from a funeral provider in person, he or she will give you a general price list. This price list, which you can keep, contains the cost of each individual funeral item and service offered. The price list also contains important information about your legal rights as a consumer about embalming, caskets for cremation, and required purchases, described below.

C. Embalming

Embalming is a temporary preservation of a dead human person, which is accomplished by injecting chemical solutions into the deceased's vascular system. This process slows tissue decomposition and produces a life-like appearance. The Funeral Rule states that the law does not require embalming. According to the Funeral Rule, all funeral homes are required to get permission to embalm. If you select a funeral service that requires embalming, such as a funeral with a viewing, you may have to pay for embalming. Otherwise, if you select arrangements such as cremation, you are not required to have embalming. In some cases, a funeral home may charge you for embalming. If it does, it is required to explain why in writing. Some examples include arranging the body for shipment by a common carrier, or selecting arrangements that require the funeral home to hold the remains for more than 24 hours provided that no refrigeration is available and that embalming does not conflict with religious beliefs or medical examination.

D. Cash Advance Sales

The Funeral Rule requires funeral providers to disclose to you in writing if they charge a fee for buying cash advance items, which include goods or services that were paid for by the funeral provider on your behalf. For example, flowers, obituary notices, pallbearers, and clergy are all considered cash advance items.

E. Caskets for Cremation

In making a decision on what funeral goods and services you want to purchase, you may decide to select direct cremation, which is cremation of the deceased without a viewing or other ceremony at which the body is present. If you choose a direct cremation, the funeral provider will offer you either an inexpensive alternative container (usually made of pressboard, cardboard, or canvas) or an unfinished wood box. Under the Funeral Rule, funeral directors who offer direct cremations:

- may not tell you that state law requires a casket;
- must disclose in writing your right to buy an unfinished wood box (a type of casket) or an alternative container; and
- must make an unfinished wood box or alternative container available.

F. Statement of Funeral Goods and Services Selected

The funeral provider will give you an itemized statement with the total cost of the funeral goods and services you select. This statement will also disclose any legal, cemetery, or crematory requirements that require you to purchase any specific funeral goods or services. You do not have to purchase unwanted goods or services as a condition of obtaining those you do want, unless the law requires you to do so.

G. Other Considerations

The Funeral Rule offers additional protection to you, the consumer, when it comes to purchasing funeral goods and services. For one thing, funeral directors must not tell you that a particular funeral item or service can preserve the body of the deceased in the grave forever. Also, funeral directors cannot make claims that certain funeral goods, such as caskets or vaults, will keep out water and dirt.

Thinking About and Arranging For Your Funeral Ahead of Time

A. The Difference Between Preplanning and Prepaying

Preplanning. In general, people choose to preplan their funeral because of financial reasons and for peace of mind. Many individuals feel that planning their funerals in advance and making most of the related major decisions makes them feel as if they will not be a burden to their spouse or family. Some individuals preplan their own funerals and burials by comparing prices, discussing plans or leaving instructions with family, or making decisions about funeral and burial goods and services that do not require payment in advance. Setting money aside in a bank account for the future purchase of funeral and burial goods and services by the appropriate survivor is another way individuals can preplan.

Prepaying. Individuals prepay for funerals and burials by entering into a preneed contract to pay in advance for goods and services they will receive upon death. Generally, this contract is between the individual and the funeral director, and is funded through a funeral trust, annuity, personal savings, or a certificate of deposit account set aside for funeral expenses; you also have the option of buying a life insurance policy customized for preneed, which directs payment of the death benefit to the funeral home upon death. Keep in mind that when a third party, such as a trustee or insurance company, assumes responsibility of managing your funeral funds, you will lose access to those funds upon signing the preneed agreement. Read the contract carefully and ask the funeral home about your cancellation options. Some individuals may have other types of funeral funding available to them, such as veterans benefits or social security survivor benefits. In most cases, both Social Supplemental Security Income and Medicaid will allow you to exclude prearranged funerals within certain limits. You should contact your local funeral home for more information.

Usually, a preneed contract will include the following items, among others:

- An explanation of the rights and obligations of all parties to the contract.
- The identity of the contract seller, purchaser, and the person for whom the contract is being purchased.
- The kinds of funeral goods and services being selected.
- An explanation of whether the funeral home guarantees the prices of the goods and services you selected.

Nearly every state has a law governing the sale of preneed funeral and burial contracts. Most of these laws address the pro-

professional requirements of sellers of preneed goods and services, requirements of funds in trust (payment is held by the funeral home), contract terms and cancellation requirements, and consumer protection recovery funds. The regulations in the District of Columbia, Maryland, and Virginia concerning funerals and preneed contracts are discussed below.

State Laws Governing the Funeral Industry and Preneed Contracts

The FTC Funeral Rule, discussed above, sets the standards that funeral directors must follow if you come to them for information on funeral goods and services. Each state must follow these federal requirements. Funeral homes in any part of the District of Columbia, Maryland, and Virginia must provide telephone information, a casket price list, an outside receptacle price list, and a general price list.

A. District of Columbia

In the District of Columbia, funeral directors may have their licenses suspended or taken away if they offer, sell, negotiate, or provide funeral services pursuant to a preneed contract that does not fulfill the requirements of the applicable regulations governing funeral establishments. These regulations governing funeral establishments require, among other things, compliance with the requirements of the FTC Funeral Rule regarding the provision of information to consumers.

B. Maryland

In the state of Maryland, a preneed contract must contain the following four items: (1) the name of each party to the contract and, if the beneficiary is an individual other than the buyer, the name of each beneficiary of the contract; (2) a description of any service or merchandise to be provided under the preneed contract; (3) the total price of the services and merchandise agreed on; and (4) the method of payment. The contract must also state the time required for fulfilling the terms and conditions of the contract, the cancellation terms, and the conditions of refunds.

In the case where a preneed contract is cancelled, the seller (a licensed funeral director or a licensed mortician) must refund to the buyer (you) all payments and interest held if (1) you or your legal representative demands in writing a refund of all payments made; (2) the funeral home is discontinued or sold; (3) the funeral director or mortician is unable to perform under the terms of the preneed contract; or (4) you fail to pay the entire contract price before death, in which case the seller considers the preneed contract void. Please note that there are exceptions to these conditions which allow for the creation of irrevocable trusts in some instances.

C. Virginia

A few of the requirements on preneed contracts set forth under Virginia law insist that all preneed contracts: (1) contain a complete description of the supplies or services purchased and state whether the prices of these supplies or services purchased are guaranteed; (2) provide that you may terminate the agreement at any time prior to the delivery of the supplies or services agreed upon in the contract; and (3) include contact information for the Board of Funeral Directors and Embalmers for consumer complaints.

You may cancel payment for supplies or services within 30 days after signing a preneed agreement. Any financial investment made on your part will be refunded 100 percent. As noted in Maryland, the state of Virginia also has exceptions to these cancellation provisions with regard to revocable and irrevocable trusts.

Some Practical Advice

Thinking about and planning your funeral can be a difficult experience for you and your family, but thinking about this important life event will allow you to set aside money to pay for your funeral so that it does not fall on anyone else's shoulders. It will also aid in acknowledging the inevitable and in the end, preplanning will provide you with peace of mind.

In planning your funeral, or the funeral of a loved one, remember that it is your right under federal law that the funeral home you consult about making funeral arrangements provide you with a price list and other types of information meant to protect you in your role as a consumer.

The District of Columbia, Maryland, and Virginia have similar laws governing funeral home operations and the sale of pre-need contracts. For more specific information, contact the offices listed below.

Important Contact Information

District of Columbia

Board of Funeral Directors
Department of Consumer & Regulatory Affairs
941 North Capitol Street, NE
Washington, DC 20002
(202) 442-4461
(202) 442-4400 – DCRA main number
TDD (202) 442-9480
http://dcra.dc.gov/about/index_bpla_funeral.shtm

Maryland

Maryland State Board of Morticians
4201 Patterson Avenue
Baltimore, MD 21215
(410) 764-4792
TDD (800) 542-4964
<http://www.dhmf.state.md.us/bom/>

Virginia

Virginia Board of Funeral Directors and Embalmers
6606 West Broad Street, 5th Floor
Richmond, VA 23230-1712
(804) 662-9907 or 1(800) 533-1560
TDD (804) 662-7197
<http://www.dhp.state.va.us/fun/default.htm>

Additional Information on the Internet:

FTC, About Funeral Planning - The Complete Online Consumer's Guide, available at
<http://www.funeralplan.com/funeralplan/about/index.html>

Funeral Service Foundation,
<http://www.funeralservicefoundation.org>

Private Health Insurance

Understanding the many laws and regulations that control health insurance can be intimidating. There are many different types of insurance products available today. Health insurance is controlled by both federal and state laws, and the laws controlling health insurance may be different from state to state. The laws also may be different depending upon where the company issuing the insurance (the “carrier”) is located, where the individual receiving the insurance (the “insured”) lives, or where the doctor, hospital, pharmacy or other entity providing medical services or supplies (the “provider” or the “supplier”) is located. The laws may also be different depending upon whether or not you receive your health insurance from your employer. Because there are so many factors that may affect health insurance, it is important to understand some basic concepts and terms.

This chapter should give you an overview of important concepts to understand relating to health insurance. This chapter provides information related to common types of insurance carriers and common types of insurance “coverage.” Insurance coverage is the term used to describe payment by a carrier for certain health care costs. This chapter also defines common terms related to health insurance.

Types of Insurance Coverage

A. Traditional Indemnity Coverage

Indemnity coverage is the traditional type of insurance coverage. With indemnity coverage, you receive payment for services based upon the amount of money the doctor, hospital or other provider charges for services provided to you. If you have indemnity coverage, you generally have more flexibility than people with other types of coverage in determining what providers you would like to use. You also have more flexibility in choosing the way in which your services are provided. This is because the carrier does not restrict you in making such choices.

A “premium” must be paid to the carrier in order for you to receive indemnity coverage. A premium is a prepaid payment, or series of payments, such as monthly, semi-annually, or quarterly payments. The amount of the premium is set at the time you enter into your insurance contract. Usually, the “subscriber” pays for the premium. The subscriber is the person who has contracted with the carrier for coverage for him/herself and/or for his or her dependents. If an employer provides the coverage, the premium may be completely or partially paid by the subscriber's employer.

B. Managed Care Coverage

Managed care means health insurance coverage that limits the types of services or providers that you may use. The purpose of the restrictions is to control the cost and/or improve the quality of the health care you receive. Services or supplies provided through managed care are called “covered services.” The person who receives the benefits through managed care is called the “beneficiary.”

There are many different types of managed care. For example, some types of managed care require you to obtain covered services only from certain providers or “networks” of providers. A network of providers is a set of providers with which a carrier contracts to provide covered services to beneficiaries. Under other managed care plans, a carrier must approve a health care service or supply before you receive it. This is called “prior authorization.” Three of the most common types of managed care coverage are health maintenance organization (“HMO”) coverage, preferred provider organization (“PPO”) coverage, and point of service (“POS”) coverage.

1. Health Maintenance Organizations (HMOs)

If you are a member of an HMO, the HMO will provide you with health care benefits through a network of providers. A certain set payment is required no matter how much care you receive during a particular period. Usually this means that the subscriber pays a set amount each month. The subscriber usually does not have to pay a “deductible.” A deductible is an amount that a person pays for health services each year before the person's carrier starts to pay. Also, the subscriber usually pays only a small “copayment” or no “copayment” at all. A copayment is the amount you must pay to the provider at the time you receive a covered service. The downside of HMOs is that usually HMOs only pay for services or supplies provided by or approved by a “network provider.” A network provider is a provider that works for the HMO or that has contracted with the HMO.

There are many different types of HMOs. Some HMOs have doctors that work directly for them. This is called a "staff model HMO." The doctors that work for a staff model HMO usually work at facilities owned and operated by the HMO. Other HMOs enter into contracts with providers and suppliers to provide services to beneficiaries. For example, a "group model HMO" contracts with a medical group. Employees of the medical group provide the covered services. An "IPA model HMO" contracts with an independent practice association ("IPA"). The IPA then enters into contracts with doctors to provide covered services.

2. Preferred Provider Organizations (PPOs)

PPOs combine features of traditional indemnity coverage with features of HMO coverage. If you are a member of a PPO, you must pay for each health care service as you receive the service. You will be charged less if you choose your doctor, hospital or other provider from a network of "preferred providers." Preferred providers are providers that have contracted with the PPO to provide services to the PPO's members at a discount. PPO members usually only pay a copayment for a service at the time the service is received. The network providers then usually charge the PPO for the rest of the cost of the services. Most PPOs allow you to pay a higher price to use a provider that is not preferred or not part of the network of providers. Some PPOs only pay for services received from a network provider. This type of PPO is called an exclusive provider organization, or "EPO."

3. Point of Service Plans (POS)

Some HMOs offer "point of service" coverage. POS coverage combines features of HMO coverage with features of PPO coverage. If you are a POS member you typically will not have to pay a deductible and will only have to pay a small copayment if you receive services from a network provider. But if you receive services from a provider that is not preferred or that is not part of the network of providers, you usually will have to pay a deductible and a larger copayment.

C. Group vs. Individual Coverage

The health insurance you receive is either group or individual. This is the case whether you have managed care coverage or indemnity coverage.

1. Group Coverage

Group coverage is insurance for a group of people under a single master policy. For example, a group policy may be issued to an employer for its employees, or to associations or unions for their members. With group coverage, an insurance carrier agrees to cover all members of the group, regardless of whether individual group members had certain health problems in the past. To receive group coverage, the individual group member need only apply during a specific period of time and pay certain costs.

There are two different types of group coverage. These are "fully-insured" plans and "self-insured" plans. In the case of a fully-insured plan, an insurance carrier or managed care organization must pay all the costs necessary to ensure that payments are made to covered individuals and must pay all the costs necessary to run the plan. In the case of a self-insured plan, an employer or "group sponsor" must pay all the costs necessary to ensure that payments are made to covered individuals and must pay all the costs necessary to run the plan. With a self-insured plan, the employer or group sponsor may contract with an insurance carrier or managed care organization to run the plan, but the employer or group sponsor still will be responsible to ensure that payments are made to covered individuals.

Self-funded plans usually are controlled by a federal law that provides protections for individual group members. For information about your rights under this law, you may wish to visit <http://www.dol.gov/dol/topic/health-plans/erisa.htm>, or contact:

United States Department of Labor
Frances Perkins Building
200 Constitution Avenue, N.W.
Washington, DC 20210
1(866) 487-2365
<http://www.dol.gov>

2. Individual Coverage

Individual coverage provides insurance for a single person or family. If you are interested in individual coverage, you must buy your coverage directly from an insurance carrier through an individual policy. The type or amount of coverage provided by the policy may depend on your particular needs. Individual coverage is usually more expensive than group coverage.

Costs

Most health insurance products require you to pay some combination of out-of-pocket costs. Out-of-pocket costs may include premiums, deductibles, copayments or coinsurance. The costs you are required to pay may be different depending on the type of product or services you receive, your lifestyle, your age, and/or other factors. Also, some out-of-pocket costs have "annual or lifetime limits." An annual or lifetime limit is a limit on the maximum amount that you must pay over a year or over the period that you are covered. The amount you will be required to pay for a particular product should be explained to you in the paperwork you receive from your insurance carrier.

A. Types of Costs

1. Premiums

A "premium" is an amount that is paid to the carrier in order for you to receive insurance coverage. A premium is a prepaid payment, or series of payments, such as monthly, semi-annually, or quarterly payments. The amount of the premium is set at the time you enter into your insurance contract. Usually, the subscriber pays for the premium. The subscriber is the person who has contracted with the carrier for coverage for him/herself and/or for his or her dependents. If an employer provides the coverage, the premium may be completely or partially paid by the subscriber's employer.

2. Deductibles

A deductible is an amount that you or your subscriber may be required to pay toward covered health care costs before the insurance carrier starts paying. For example, if an indemnity contract requires a \$600 deductible, you or your subscriber must pay for the first \$600 of any health expenses received. The carrier only will pay for the rest of the covered costs beyond the \$600 deductible. Usually the deductible paid only applies to a specific period, such as a year. If that is the case, the deductible will start over each period and the amount you or your subscriber pays during one period will not carry over to the next period. For example, if you are required to pay a \$600 annual deductible and the cost of your covered health care in a certain year is only \$500, the carrier will not have to pay anything toward the health care you received during that year. If the next year the cost of your covered health care totals \$900, you will be responsible for paying for the first \$600 and the carrier will have to pay for the remaining \$300 of covered health care you received during that year.

3. Copayments

A copayment is an amount you may be required to pay the provider each time you receive a covered service. The copayment is usually a set fee. For example, you may be required to pay \$25 for each doctor's office visit.

4. Coinsurance

Coinsurance is a percentage of costs you may be required to pay for your medical costs after you have already paid any required deductibles. For example, once you have paid your deductible, if any, you may be required to pay 20% of any hospital services you receive.

B. State Laws Controlling Health Insurance

1. District of Columbia

A health carrier offering group coverage may not charge you a higher premium because of your health status. However, if

you participate in a program of health promotion or disease prevention, your carrier may offer you certain discounts on premiums and copayments.

2. Maryland

Generally, health insurance carriers and HMOs may not charge different copayments, deductibles, or annual or lifetime maximums for services related to certain diseases or diagnoses.

3. Virginia

A health carrier offering group coverage may not charge you a higher premium because of your health status. However, if you participate in a program of health promotion or disease prevention, your carrier may offer you certain discounts on premiums and copayments.

Covered Services / Mandated Benefits

Generally, the benefits offered under your insurance policy or, for managed care beneficiaries, Evidence of Coverage ("EOC") depend on the terms of your policy or EOC. The policy or EOC may exclude benefits for some services altogether, such as cosmetic services, experimental treatments, or services provided by a particular type of provider. The policy or EOC may also limit benefits for certain services. For example, the policy may limit coverage to a certain number of days or treatments. However, state laws often prevent carriers from using such exclusions or limitations by requiring carriers to cover certain kinds of conditions or treatments. When state law requires that a certain condition or treatment be covered, the condition or treatment is called a "mandated benefit."

A. District of Columbia

The District of Columbia requires all group health insurance carriers, including HMOs, to cover medical and psychological treatment for drug abuse, alcohol abuse, and mental illness. In addition, all group and individual health insurance carriers must cover emergency medical services, cancer prevention services, and diabetes treatment.

B. Virginia

Virginia requires all insurance carriers to cover many different kinds of treatments and procedures. These include mammograms, prescription drugs, child health, mental health and substance abuse, bone marrow transplant, certain services provided by chiropractors, clinical social workers, and podiatrists, and minimum inpatient hospital stays for surgery such as a hysterectomy. Virginia also requires carriers to provide a system of referring you to medical specialists when necessary. This means that if your primary care doctor determines that your condition would be best treated by a specialist, then the carrier must have a procedure in place to allow you to receive a referral to a specialist.

C. Maryland

Maryland requires all insurance carriers to cover Alzheimer's treatment, treatment of mental illness and emotional disorders, off-label use of drugs, home health care, hospice care, in vitro fertilization, inpatient hospitalization for childbirth, mammograms and reconstructive breast surgery, and clinical research trials.

Obtaining and Renewing Coverage

There is a federal law and similar state laws that protect your right to obtain and renew health insurance coverage under both group and individual plans. For more information on these laws, you should review the chapter in this book entitled "Pre-Existing Conditions and Your Rights to Obtain and Renew Health Insurance."

Complaints and Appeals Procedures

You usually have the right to appeal a decision by your health insurance carrier that causes your health benefits to be denied, reduced, limited, terminated, or delayed. The processes you must follow to appeal these decisions are controlled by state and, in some cases, federal laws. These processes should be described in the coverage materials you receive from your insurance carrier. Some states have laws that entitle you to "external review" (which is a review by someone other than your insurance carrier) if you are unhappy with the result of the "internal appeal" (which is the appeal conducted by your insurance carrier). You may also file a complaint against your insurance carrier or with the department of insurance in your state.

A. District of Columbia

In the District of Columbia, you are entitled to a three-step "grievance" process when you disagree with a decision by your health insurance carrier. First, you will have an "informal internal review." At the informal internal review you may discuss and appeal your insurance carrier's decision with your insurance carrier's "medical director" or with the health care provider who made the decision. If you request an informal internal appeal relating to urgent or emergency care, your insurance carrier must finish your appeal within 24 hours of receiving your request. If you request an informal internal appeal relating to care that is not urgent or that is not an emergency, your insurance carrier must finish your appeal within 14 business days of receiving your request. Your insurance carrier must give you a written informal review decision, which explains to you the reason for the decision.

You will have the right to appeal your informal review decision. This appeal will be a formal review by a reviewer or by a panel selected by your insurance carrier. Your insurance carrier must notify you that it has received your request for formal review within 10 business days. Your insurance carrier must finish the formal review as soon as possible after it has received all necessary information. If you request a formal appeal relating to urgent or emergency care, your insurance carrier must finish your appeal within 24 hours of receiving your request. If you request a formal appeal relating to care that is not urgent or that is not an emergency, your insurance carrier must finish your appeal within 30 business days of receiving your request, unless you request an extension of time. Your insurance carrier must give you a written formal review decision, which explains to you the reason for the decision.

If you are not happy with the outcome of the formal review, you may ask for external review of the formal review decision by filing a request for external review with the Department of Health. The Department of Health will review your request and then send your request to an independent review organization ("IRO") for a hearing. The IRO will make a recommendation relating to your appeal.

For information on how to appeal a decision by your health insurance carrier in the District of Columbia, go to http://www.dchealth.dc.gov/information/hbp/bill_rightsreview.shtm, or contact:

Grievance and Appeals Coordinator
Office of the General Counsel
District of Columbia Department of Health
825 North Capitol Street, NE, Room 4119
Washington, DC 20002

For help in filing a complaint against a health insurance carrier with the District of Columbia Department of Insurance and Securities Regulation, contact:

Consumer Services Division
Department of Insurance and Securities Regulation
810 First Street, NE, Suite 701
Washington, DC 20002
(202) 727-8000
http://www.disr.washingtondc.gov/services/insurance_complaint/index.shtm

B. Virginia

Virginia requires health insurance carriers to establish both internal and external appeals processes. If you request an internal appeal (which is an appeal by your insurance carrier), your insurance carrier must finish your appeal within 60 working days after receiving all necessary information and materials. However, if your treating doctor or other provider says that the situation is an emergency, your insurance carrier must decide your appeal within 24 hours of receiving it. Also, if your appeal relates to medicine that you need for cancer pain, your insurance carrier must conduct your appeal over the telephone. Your insurance carrier must give you a decision relating to your internal appeal, which explains to you the reason for the decision and your right to request external review of the decision from the Virginia Bureau of Insurance.

If you would like external review of your insurance carrier's internal review decision, you must file a written request with the Bureau of Insurance within 30 days of receiving the internal review decision. You also must provide the Bureau of Insurance with a form called an "Authorization to Release Medical Information" and a \$50 filing fee. After receiving your appeal, the Bureau of Insurance will review your appeal and then send it to an independent review organization ("IRO") for additional review. The IRO must make a decision within 30 working days of receiving all necessary information and materials. If your treating doctor or other provider has said that the appeal is an emergency, the IRO must make a decision within five working days of the date that the Bureau of Insurance accepted the appeal.

If you would like more information on how to appeal a decision by your health insurance carrier in Virginia contact:

Office of the Managed Care Ombudsman
Bureau of Insurance
P.O. Box 1157
Richmond, VA 23218
1(877) 310-6560
ombudsman@scc.state.va.us

To file a complaint against a health insurance carrier in Virginia, contact the Bureau of Insurance at the address or phone number listed above, or go to <http://www.state.va.us/scc/division/boi.index.htm> to submit a complaint electronically.

C. Maryland

Maryland also requires carriers to establish internal review procedures for appeals. Maryland applies different standards depending on whether the decision you are appealing is a decision that a health care service was not medically necessary (called an "adverse utilization review decision") or another type of decision that results in your insurance carrier not paying for your services (called an "adverse coverage decision").

1. Adverse Utilization Review Determinations

If you wish to appeal an adverse utilization review decision, you will have to file a "grievance" with your insurance carrier. If your grievance relates to emergency care, your carrier must make a final written decision within 24 hours of the day you file your grievance. If your grievance relates to care which you have already received, your carrier must make a written decision within 45 working days of the day you file your grievance. In all other situations, your carrier must make a final written decision on your grievance within 30 working days after your grievance is filed.

If you are not happy with the decision made by your carrier, you may ask the Maryland Insurance Administration to review your grievance. You must file your appeal with the Insurance Administration within 30 working days of receiving your internal grievance decision. However, if your carrier has not made a decision in the time required or if you have a compelling reason, you may go immediately to the Maryland Insurance Administration without waiting for a decision from your carrier. If your grievance relates to emergency care, the Insurance Administration must make a final written decision within 24 hours of the day you file your grievance. If your grievance relates to care which you have already received, the Insurance Administration must make a written decision within 45 working days of the day you file your grievance. In all other situations, the Insurance Administration must make a final written decision on your grievance within 30 working days after your grievance is filed.

2. Adverse Coverage Decisions

If you appeal an adverse coverage decision by your carrier, your carrier must make a final written decision within 60 working days of the date you file your appeal. After the carrier makes a decision, you may ask the Maryland Insurance Administration to review the decision. You must file your appeal with the Insurance Administration within 60 working days of receiving your carrier's decision. However, if your appeal is related to a medical condition that requires immediate attention, you may go immediately to the Insurance Administration without waiting for a decision from your carrier.

For help filing an appeal under your carrier's internal grievance process, call the Maryland Attorney General's Health Care Education and Advocacy Unit at 1(877) 261-8807.

If you would like a form for filing an appeal with the Maryland Insurance Administration, you may visit <http://www.mdin-surance.state.md.us/jsp/consumer/Appeals.jsp>10. Your completed form should be mailed or faxed to:

Maryland Insurance Administration
Attn: Consumer Complaint Investigation
Life and Health/Appeals and Grievance
525 St. Paul Place
Baltimore, MD 21202-2272

You also may call the Insurance Administration for help in completing your appeal forms at 1(800) 492-6116.

Other Types of Private Insurance

A. Medicare Supplement/Medigap Coverage

If you receive Medicare, you may wish to buy Medicare supplement coverage. Medicare supplement coverage, which is also called Medigap coverage, will add to your Medicare coverage by paying for certain hospital, medical or surgical costs not covered by original Medicare coverage. Original Medicare coverage is not Medicare+Choice. For more information on Medicare coverage, read the chapter on Medicare coverage in this manual.

B. Workers Compensation Coverage

Workers compensation coverage is coverage that pays certain employees and their dependents benefits for health care costs and lost wages related to work-related disease or injury. If you would like more information on workers compensation, you should read this manual's chapter on Workers Compensation.

C. Long Term Care Coverage

You can buy "long term care insurance" for coverage of certain services that are not covered by your health insurance. Some services that may be covered by long term care insurance are nursing care, home health services and custodial care. Long term care insurance is indemnity coverage and covers you for a set period of time. (See the beginning of this chapter for the meaning of indemnity coverage.) Most states have laws that control long term care coverage.

If you would like a free copy of the Health Insurance Association of America's Guide to Long-Term Care Insurance, contact:

American Association of Health Plans/Health Insurance Association of America
1201 F Street, N.W., Suite 500
Washington, D.C. 20004-1204
(202) 824-1600
<http://membership.hiaa.org/pdfs/2002LTGuide.pdf>

D. Credit Accident and Sickness Coverage

You may wish to buy credit accident and sickness coverage. Credit accident and sickness coverage may protect you if you cannot make payments on a specific loan or credit transaction.

E. Disease-Specific Insurance

You may also buy insurance that covers health benefits only in relation to a specific disease or group of diseases, such as cancer or heart disease. Disease-specific insurance may pay for benefits that are not paid for at all by your regular health insurance or may pay extra for benefits that already are paid for by your regular health insurance.

F. Medical Savings Accounts (MSAs)

Certain employers (generally small or self-insured employers) may set up MSAs for individual employees if the health insurance the employers provide have high deductibles. MSAs are trust accounts that are not taxed. The money within the accounts may be used to pay for pay for health care services and supplies that are not covered by the high-deductible insurance coverage. Money left in an MSA at the end of the year will remain in the MSA and build interest. The money also will be available in later years for future care or may be saved until retirement.

MSAs are controlled by federal law and also may be controlled by state law.

Important Contact Information

District of Columbia

D.C. Department of Insurance and Securities Regulation
810 1st Street NE, Suite 701
Washington, DC 20002
(202) 727-8000
<http://www.disr.dc.gov>

Maryland

Maryland Insurance Administration
Complaints and Investigation Unit/Life and Health
525 St. Paul Place
Baltimore, MD 21202
1(800) 492-6116
<http://www.gacc.com/mia>

Virginia

State Corporation Commission, Bureau of Insurance
Life and Health Division, Consumer Services Section
P.O. Box 1157
Richmond, VA 23218
1(800) 310-6560

Virginia Department of Health
Center for Quality Health Care Services and Consumer Protection
Complaint Unit
3600 West Broad Street, Suite 216
Richmond, VA 23230-4920

Office of the Managed Care Ombudsman
P.O. Box 1157
Richmond, VA 23218
1(800) 310-6560

Medicare

Medicare is the federal health insurance program for people 65 and older, some people with disabilities under 65, and people who have certain kidney diseases. There are three parts to Medicare – Part A, Part B, and Part C (also called "Medicare+Choice" or "M+C"). Part A is also called Hospital Insurance. Most people do not have to pay a fee every month for Part A. Part B is also called Supplemental Medical Insurance. Most people pay a fee every month for Part B. Part C is a program that lets people join a health insurance plan, such as a health maintenance organization (HMO). The amount you pay every month for Medicare+Choice plans vary, but these plans may offer other services not paid by Part A or Part B. All of the fees that you pay each month for Medicare change every year.

Medicare Part A

Medicare Part A pays for hospital and nursing home care. It also pays for hospice and some home health care.

A. Eligibility

If you are 65 and older, you may get Medicare Part A. You may also get Part A if you have been getting Social Security disability checks for at least 24 months or have certain kidney diseases.

B. Benefits

Medicare Part A pays for care in a hospital, nursing home, and hospice. Part A also pays for some home health care. Part A pays for many services in a hospital, such as room and board, drugs, hospital equipment, tests like x-rays, and the doctors and nurses who work for the hospital.

C. Hospital Care

If you are in a hospital, you must pay \$840 (in 2003) for the first 60 days. For the 61st through the 90th day, you must pay \$210 every day (in 2003). You also have a lifetime reserve of 60 days of hospital care which you can use whenever you are in the hospital for more than 90 days. When you use a reserve day, you must pay \$420 per day (in 2003).

D. Nursing Home Care

If you go to a nursing home after you leave the hospital, then Medicare will pay for up to 100 days of nursing home care. You do not pay for the first 20 days, but you do pay \$105 per day (in 2003) for each day after the 20th day. If you need more than 100 days of care, you must pay for all of the care starting on the 101st day. If you have other insurance that pays for nursing home care, such as Medicaid, then the other insurer may help you pay for the care.

E. Home Health Care

Medicare pays for home health visits when you are homebound, such as part-time nursing care, physical and other therapy, medical equipment and supplies, and other services. You do not need to pay for these services. However, you must pay 20% of the cost of medical equipment.

F. Hospice Care

If you are terminally ill, you may choose to get hospice care rather than regular Medicare benefits. If you choose to get hospice care, you will get medical and support services needed for your symptoms and pain. You do not need to pay for these services. For 2003, you only had to pay up to \$5 for drugs and 5% of the cost of respite care.

Medicare Part B

Part B pays for services no matter where they are provided, such as outpatient hospital care, doctors, physical and other

therapy, tests, care for your kidneys, ambulances, and medical equipment.

If you get Social Security checks, you may get Part B when you turn 65. You must pay \$58.70 every month (in 2003), which is usually taken out of your Social Security checks. You must also pay \$100 every year (in 2003), and you must pay 20% of the cost of most Part B services.

Alternative Medicare Plans

Medicare Part A and Part B is a fee-for-service plan. This means that you can get care from any doctor or hospital you want anywhere in the country. However, the regular Medicare program does not pay for all health care. For example, it does not pay for certain drugs, long-term care at home or in a nursing home, eye exams, eyeglasses, hearing aids or dental care. Also, Medicare generally does not pay for care you get outside the United States. So, you may wish to buy supplemental health insurance or get other types of Medicare plans that pay for more health care.

Medigap – Supplemental Medicare Insurance

You may be able to get supplemental insurance from a former employer or union, or Medigap from an insurance company. Insurance from a former employer or union is usually cheaper than Medigap policies.

There are 10 different types of Medigap policies. All offer certain basic services, such as paying the co-pay amounts for hospital care and other medical care, three pints of blood each year, and extra days of hospital care. Some Medigap policies pay for extras, such as check-ups and some drugs. No Medigap policy pays for all of the drugs, long-term care at home or in a nursing home, eye and dental care, hearing aids or private duty nursing.

A. Cost

The amount you pay every month for Medigap plans vary. You can get a "Medigap comparison shopping guide" from your State Health Insurance Assistance Program that lists the costs and benefits of Medigap insurers near your home.

B. How to Join

Once you turn 65, you can join any Medigap plan during a six-month open enrollment period. As long as you pay every month, the insurer must renew your policy for life. The amount you pay per month will change every year. However, once open enrollment ends, insurers can refuse to offer certain Medigap plans because of your health.

C. Helpful Hints in Choosing a Medigap Policy

- Call the insurance department in the state where you live for a list of companies that offer Medigap. Compare the costs and services.
- Know how the monthly payments are calculated. Policies that base their monthly payments on age may seem like a good deal when you are 65, but will cost more when you turn 75.
- Find out if the insurer will file the Medigap claims. This can save you time and stress.
- Check the insurer's reputation with the state insurance department. Generally, companies rated "A" or better are good.

Medicare + Choice Program, Including HMOs

Medicare + Choice or M+C is also known as Medicare Part C or Medicare HMOs. M+C pays for the same doctor and hospital services as the regular Medicare program. The good thing about joining M+C is that it may pay for more services, such as certain drugs and eyeglasses, which are not paid by the regular Medicare program.

M+C members may only use doctors, hospitals, and other providers in their HMO's network. Medicare and the HMO will not pay for care that was not pre-approved, care you get from providers outside the HMO's network, or care you get outside the HMO's service area that is not for an emergency. Some HMOs offer point-of-service (POS) plans that partly pay for care you get outside the network. Also, there are now plans (e.g., "Fee For Service" and "PPO" Plans) that pay for care you get out-

side of the networks, but they may cost more.

You can choose a M+C plan every November. As of 2003, you can choose a M+C plan, change M+C plans, or leave a M+C plan only once in the first three months of every year. You also have some rights if you return to regular Medicare after leaving a Medicare HMO or other M+C plan.

A. Helpful Hints when Choosing a Medicare + Choice Plan

- Getting care from doctors and hospitals – think about whether you can keep seeing your own doctor. Even if the doctor is in an HMO's network, see if you can leave the network at any time.
- Extra Services – be aware that the extra benefits offered by most HMOs vary and may change every year. Make sure the plan you join pays for the drugs you need.
- Cost – know the monthly payment and co-payment amount. Costs change every year.
- Quality and Reputation – speak with other plan members about what they think. For information on plans, go to Medicare's website, at <http://www.medicare.gov>.

Medicare Enrollee Rights

As a Medicare patient, you have certain rights to help protect you.

A. Right to Appeal

No matter what Medicare plan you have, you have the right to appeal. You have the right to a fair and quick process for appealing decisions about health care payment or services. The appeal must be made within six months after you get the unfavorable decision.

You may appeal if:

- you do not agree with the amount that is paid;
- a service is not paid for and you think it should be; or
- a service is stopped before you think it should be.

M+C plans must give you written instructions for filing an appeal. If waiting for a decision about the appeal could seriously harm your health, then you can ask that the plan make a decision within three days. If the plan decides against you, then you can ask that an independent organization that works for Medicare review your appeal.

B. Other Rights

You also have certain rights to:

- information;
- emergency services and information on how to obtain emergency services;
- see doctors, specialists, including women's health specialists and hospitals;
- participate in treatment decisions;
- know your treatment choices;
- culturally competent services;
- file complaints;
- nondiscrimination;
- privacy of health information; and
- privacy of personal (e.g., financial) information.

C. Rights While in a Hospital or Skilled Nursing Facility

You may have other rights if you are in the hospital or a nursing home or if your home health care ends.

Important Contact Information

	State Health Insurance Assistance Program	State Medicaid Agencies	Long-Term Care Ombudsman
D.C.	(202) 676-3900	(202) 724-5506 or (202) 698-4220	(202) 662-4933
Maryland	1(800) 243-3425	1(800) 977-7388 or 1(800) 284-4510	1(800) 243-3425
Virginia	1(800) 552-3402	(804) 786-7933	1(800) 552-3402

1(800) MEDICARE or 1(800) 633-4227 – for Medicare plan and enrollment information
TTY/TDD 1(877) 486-2048
<http://www.medicare.gov>

Elder Care Locator – a nationwide toll-free and on-line service for seniors
1(800) 677-1116
<http://www.eldercare.gov/>

The Social Security Administration
1(800) 772-1213
<http://www.ssa.gov>

Railroad Retirement Board
1(800) 808-0772

BenefitsCheckUp – a comprehensive online service to screen for federal, state and local benefits for older adults
<http://www.benefitscheckup.org>

Medicare Savings Programs (MSPs)

Medicare Savings Programs – Some General Information

As pointed out in the Medicare and Medicaid sections of this manual, persons covered by Medicaid basically do not have to pay for health care services. However, persons with Medicare (beneficiaries) have to pay for costs (such as premiums, deductibles, co-payments and co-insurance). This often leads to concerns and financial troubles, sometimes to the point of avoiding or declining health care in favor of spending on other important needs of life.

In response to this, state Medicaid agencies offer help called, "Medicare Savings Programs" ("MSPs"). MSPs are also referred to as "Medicare Assistance Programs" or "Medicaid Buy-in" Programs. MSPs are offered to help Medicare beneficiaries who have low incomes and who do not own big accounts (assets or resources). Some or all of their Medicare costs can be paid by the MSPs.

MSPs are actually composed of three different programs with different requirements. The three programs are: the Qualified Medicare Beneficiary ("QMB") Program; the Specified Low Income Medicare Beneficiary ("SLMB") Program, and the Qualifying Individual 1 ("QI-1") Program. What is required to get these benefits is briefly explained below.

The thought behind MSPs is that paying for some or all of a person's Medicare costs will "save" that person money. Savings from the programs can range from less than \$10 to several hundred or thousands of dollars a year. These savings can then be used for health care costs that are not covered by Medicare (e.g., outpatient prescription drugs) and/or for other basic needs.

Eligibility to Get Benefits

Persons who are eligible for both Medicare and Medicaid and/or MSPs are often referred to as "dually eligible." Within federal guidelines, the District of Columbia, Maryland, and Virginia (in fact all of America) can set specific requirements for getting benefits.

According to federal law, asset amount (maximum) limits for eligibility for MSPs are \$4,000 for single persons and \$6,000 for couples. These amounts apply in this area. Dual eligible income limits are based on the federal poverty level. The federal government's Department of Health and Human Services informs the public of what these income poverty levels are on a yearly basis. These amounts, just like most Medicare and other health care costs, rise every year.

Note that MSPs do not count \$20 per month of unearned income. For example, the first \$20 of a person's monthly Social Security retirement check is not regarded and does not affect eligibility. States also have the authority to disregard a portion of earned income such as pay wages from work, as well as other sources of income.

The "Qualified Individual" program is available on a limited, temporary basis. Its distribution is on a first come, first serve basis with a March 31, 2004 deadline that may or may not be extended by Congress.

A. The Qualified Medicare Beneficiary ("QMB") Program

Eligibility for the Qualified Medicare Beneficiary (called "kwimbee") Program requires that a person have both Medicare Parts A and B. One's monthly income must be equal to or less than 100 percent of the federal poverty level. Persons who qualify for this program have their Medicare Part B and when applicable, Part A premiums paid, as well as Medicare deductibles, coinsurance and co-payments.

B. The Specified Low-Income Medicare Beneficiary ("SLMB") Program

In order to qualify for the Specified Low-Income Medicare Beneficiary (called "slimbee") Program, monthly income must be between 100 percent and 120 percent of the federal poverty level. Medicare Part B premiums are paid for beneficiaries.

C. The Qualifying Individual 1 ("QI-1") Program

In order to be a beneficiary of the Qualifying Individual 1 ("QI-1") Program, monthly income must be between 120 percent and 135 percent of the federal poverty level. Medicare Part B premiums are covered.

Enrollment/Applying for Benefits

The local Medicaid office accepts and processes applications for MSPs. Basically, the same rules for enrollment for Medicaid also apply to MSPs. However, unlike other dual eligible benefits, QMB benefits can not be retroactively rewarded. QMB coverage begins the first month following the month in which eligibility is determined and not before that.

A simpler, shorter application form and related processing method designed especially for Medicare beneficiaries may be available. (Contact the proper Medicaid office to see if available.) These special applications are designed to point out eligibility for other assistance programs such as Supplemental Security Income (SSI) and Food Stamps.

Unfortunately, MSPs are not well known. Efforts are being made to make them better known, understood and able to obtain. In addition, the law governing MSPs is undergoing changes. At the end of 2003, new Medicare rules were created that will affect "dual eligibles," particularly in 2006. However, all of the "ends and outs" are still in process. The contacts listed below are some of the best ways to find out about upcoming changes.

Important Contact Information

Generally, the same important contact information that applies to Medicare and Medicaid, also applies to MSPs. Additional sources for help are as follows:

<http://www.medicare.gov>

1(800) Medicare - State Health Insurance Assistance and Counseling Programs

AARP

601 E Street, NW

Washington, DC 20049

1(800) 424-3410

<http://www.aarp.org/pbo>

<http://www.benefitscheckup.org>

National Council on the Aging (NCOA)

409 Third Street, SW #200

Washington, DC 20024

(202) 479-6616

Medicaid

Please note – *The Medicaid program has complex rules regarding who is eligible, what services are covered, and what payments, if any, patients must make. Each state (and the District of Columbia) has a great deal of freedom to design its own Medicaid program within certain guidelines set forth in the federal Medicaid law. This outline provides an overview of the Medicaid program. When possible, we have provided phone numbers of government agencies that can provide more detailed information. While this outline describes the basics of the program, you will probably need to contact one of these sources to answer specific questions.*

General Overview

Medicaid is a health care program that provides low-income people with doctor visits, hospital care, lab tests and x-rays, and many other types of health benefits at little or no cost. The program also pays for nursing home care. Medicaid is jointly funded by the federal government and the states (including the District of Columbia).

The Medicaid program is overseen by a federal government agency called the Centers for Medicare and Medicaid Services and operated by the states. Each state has different rules for deciding who is eligible and may offer different benefits to people it covers. As a result, a person who is eligible for Medicaid in one state may not be eligible in another.

A. Eligibility

Three types of people are or may be eligible for Medicaid: (1) low-income people who must be served under federal law (called "categorically needy"); (2) people the states may cover, at their option (called "categorically related"); and (3) people with serious medical problems that states also may choose to cover (called "medically needy"). The specific eligibility rules of the District of Columbia, Maryland, and Virginia are described below.

Legal resident aliens who otherwise meet Medicaid's income guidelines may still be unable to receive Medicaid services until they have lived and worked in the U.S. for a number of years. However, the states have even more flexibility in this area. The specific rules that apply to immigrants in the Washington area are discussed further below.

B. Covered Services

State Medicaid programs must offer certain basic, medically necessary services including: (1) hospital stays and outpatient services; (2) nursing home care; (3) doctor visits; (4) lab and x-ray services; (5) pre-natal and well-child care (including immunizations); (6) family planning services; (7) services at certain community health centers; and (8) nurse-midwife and nurse practitioner services.

States also have the option of covering: (1) prescription drugs; (2) institutional care for people with mental retardation; (3) home and community-based long-term care; (4) personal care and certain other services for people with disabilities; and (5) dental and vision care for adults. States may also provide other services under so-called "demonstration programs."

More information about the federal Medicaid law can be found by calling the Centers for Medicare and Medicaid Services, toll-free at 1(877) 267-2323 or 1(866) 226-1819 (for TTY users), or by looking on their website, at <http://www.cms.hhs.gov>.

District of Columbia

A. Who is Eligible?

To be eligible for Medicaid in the District of Columbia, a person must be a pregnant woman, a child under age 19, a parent or caretaker of a child under 19, or a person who is over 65, blind, or disabled, and must have income that is below a certain level (generally 185 % of the Federal Poverty Level, or FPL). Only D.C. residents who are U.S. citizens or "qualified aliens" are eligible for the D.C. Medicaid program, which is called D.C. Healthy Families.

Families receiving TANF or SSI cash assistance are automatically eligible for Medicaid. People who are on Medicare and have limited income may be able to get help from Medicaid in paying their Medicare premiums, other "out of pocket" costs,

and prescription drug costs. In addition, the District operates special Medicaid "demonstration programs" for people with HIV/AIDS and those who have very low incomes and are between the ages of 50-64.

People who are not eligible for Medicaid because they are not children, parents or caretakers, elderly, blind, or disabled or have too much income may be eligible for D.C.'s SCHIP program or the D.C. Healthcare Alliance program, if they meet the programs' income guidelines (up to 200% of the FPL). The D.C. Alliance Program is available to both U.S. citizens and noncitizens, regardless of how long they have been in the U.S. or their legal status.

For more information, call D.C. Healthy Families at 1(888) 557-1116, or the D.C. Alliance Program at (202) 724-7481. For more information on SCHIP, see this manual's chapter on State Children's Health Insurance Program.

B. How to Enroll

Families, children under 19, and pregnant women must apply by completing an application, available at Department of Health service centers, community health centers, D.C. public libraries, and many D.C. Giant, Safeway, CVS stores, or by calling (888) 557-1116. To find the Department of Health service center in your area, call (202) 724-5506. Elderly, blind and disabled applicants should go to a Department of Health service center to apply.

Applicants will need to present identification (such as a driver's license, passport or birth certificate), proof of Social Security Number, proof of how much you earn and any other income you receive (such as Social Security or Worker's Compensation), insurance cards, and copies of recent medical bills. For help filling out an application, call 1(888) 557-1116 or (202) 526-6266.

Most families who enroll in D.C.'s Medicaid program will be required to enroll in a managed care plan (exceptions include people who receive SSI benefits, women who are at least 26 weeks pregnant, foster children, senior citizens, and persons with HIV/AIDS). Once you are approved, you will receive a package describing the available programs. You will then have thirty days to choose a plan (or primary care doctor) or one will be selected for you.

C. What Services are Covered?

The D.C. Medicaid program covers doctor visits, immunizations, school physicals, emergency care, hospital stays, lab and x-ray services, prescription drugs, prenatal care, labor and delivery, well-child visits, vision care and glasses, some dental care, family planning, home health care, durable medical equipment, health education services, mental health services, drug and alcohol abuse treatment, and transportation to doctor's appointments. Medicaid beneficiaries are not usually responsible for co-payments or premiums.

D. Complaints and Appeals

If you believe that your Medicaid application is wrongfully denied or that your enrollment is wrongfully terminated, you may request reconsideration by calling the Income Maintenance Administration's Customer Service line, at (202) 724-5506, or its Office of Administrative Review, at (202) 698-4650. If the matter is not resolved through this review, you may file an appeal with the District's Office on Fair Hearings (202) 724-5431.

If you have a problem with your primary care physician or managed care plan, you may complain to your health plan or call the District's enrollment broker, Affiliated Computer Services, which operates the District's Medicaid Managed Care Helpline, at (202) 639-4030. Medicaid enrollees also may contact the Legal Aid Society, at (202) 628-1161, or the Alliance for Fairness In Reforms to Medicaid, at (202) 626-0617, for help with appeals.

Maryland

A. Who is Eligible?

Anyone who receives cash assistance through SSI, the state's Temporary Cash Assistance (TCA) program, or the foster care program is automatically covered by Medicaid. People who do not receive SSI or TCA must file an application with the Department

of Social Services office in the city or county where they live to find out if they meet Maryland's income requirements.

To be eligible, you must be 65 or older or under 21, disabled, blind, pregnant, or caring for a related child living in your home and meet state income limits. In addition, you must show that you are a resident of Maryland and a U.S. citizen or qualified legal resident who has lived in the U.S. for five years or more. Refugees and asylees also can receive benefits under certain conditions. Some applicants may be eligible for Medicaid even if they also receive Medicare or have private health insurance. In addition, some children who are not eligible for Medicaid may be eligible for Maryland's SCHIP program. For more information on SCHIP, see this manual's chapter on State Children's Health Insurance Program.

Those who are not eligible for Medicaid because their income exceeds the limits above may still qualify if they have very high medical expenses, or they may be able to "spend down" to the required level, if they spend the money on medical care. To qualify this way, your assets must also be below a certain level, and there are strict rules about disposing of property. If you have questions about eligibility, you should call 1(800) 492-9231.

B. How to Enroll

Medicaid applications are available at local Department of Social Services offices. Applicants must complete an application and answer questions about their income and assets. Local Department of Social Services office phone numbers are as follows: Montgomery County – (240) 777-4600 or (240) 777-3100; Prince George's County – (301) 209-5000.

Most Medicaid beneficiaries are enrolled in Maryland's HealthChoice Program. HealthChoice members choose a primary care provider (who will be the doctor they usually see) and are enrolled in a managed care plan. If the Department of Social Services determines that you are eligible for HealthChoice, you will receive a package in the mail describing available plans. You should complete and return the enrollment form or call 1(800) 977-7388. If you do not choose a plan, you will be assigned to a plan in which your current doctor participates.

People who do not qualify for the HealthChoice Program receive Medicaid coverage through a "fee-for-service" program, which pays for services as they are used instead of through a managed care plan. Medicaid beneficiaries who do not qualify for HealthChoice include people who are on Medicare, people who "spend down" to become eligible for Medicaid, and people in nursing homes, mental hospitals or intermediate care facilities for the mentally retarded. More information about the fee-for-service program is available at (410) 767-1463.

C. What Services are Covered?

Services covered by Maryland's Medicaid program include: hospital care, doctor visits, lab and x-ray expenses, nursing home care, hospice care, family planning services, well-child care for children under age 21, clinic services, prescription drugs, dental and vision care for children (and limited vision care for adults), dialysis, some medical supplies, and transportation to and from doctor's appointments. Depending on income and resources, some Medicaid enrollees over age 18 may be required to make co-payments for some of these services.

D. How Can I Appeal a Decision Against Me?

Medicaid beneficiaries may call the HealthChoice Enrollment Hotline with questions regarding eligibility determinations at 1(800) 492-5231 or (410) 767-5800. People enrolled in managed care plans with grievances may call their health plan or the HealthChoice Enrollee Action Line, at 1(800) 284-4510. Decisions about coverage must be appealed in writing, first to the health plan itself and then to the HealthChoice Program. In addition, the Maryland Legal Aid Bureau may be able to help; it can be reached at (410) 296-6705.

Virginia

A. Who is Eligible?

In Virginia, individuals meeting income and resource limits are eligible for Medicaid. Full benefits are available to certain low-income families with dependent children, pregnant women with income at or below 133% of the Federal Poverty Level,

or FPL, children from birth to age 19 whose family income is at or below 133% of FPL, children under age 21 in foster care or subsidized adoptions, infants born to Medicaid-eligible women, recipients of SSI who are 65 or over, blind or disabled, certain persons who have lost Supplemental Security Income because of a change in conditions, and terminally-ill persons receiving hospice care. Children who don't meet these criteria may be eligible for Virginia's SCHIP program. For more information on SCHIP, see this manual's chapter on State Children's Health Insurance Program.

In addition, people who receive benefits under the federal Medicare program may also receive limited assistance from Virginia's Medicaid program to pay Medicare premiums and other "out of pocket" costs. Others may be eligible for full benefits because they are "medically needy," meaning that they have too much income to qualify for Medicaid but also have very high medical bills. They are allowed to apply these medical bills against their income to "spend down" to the Medicaid limit. Finally, Virginia has complex rules regarding when legal immigrants are eligible for Medicaid; contact the local Department of Social Services office at the number listed below with specific questions about eligibility in these cases.

B. How to Enroll

Applications for Medicaid may be filed with the Department of Social Services in the city or county where you live. The application will require the following information: name, date of birth, Social Security Number, information about property now owned or owned in the past five years, savings and checking account balances, and information about your income from any source (including SSI or other state or federal programs). In addition, you must confirm that you are a Virginia resident and provide evidence of U.S. citizenship or legal alien status.

If the Department of Social Services determines that an individual is eligible for Medicaid, a Medical Assistance Eligibility Card (or Medicaid Card) will be mailed to the enrollee. Most Medicaid beneficiaries will be enrolled in either the Medallion or Medallion II Managed Care programs, which require enrollees to choose a primary care physician who serves as a "gate-keeper" to other doctors or to get their care through an HMO-type network of doctors. Enrollment information can be obtained from the following local Department of Social Services offices: Arlington – (703) 228-1665; Alexandria – (703) 838-0700; Fairfax – (703) 324-7500; Northern Virginia Regional Office – (540) 347-6307.

C. What Services are Covered?

Virginia's Medicaid program covers a variety of services, including: inpatient and outpatient hospital care; physician services; psychiatric services; prescription drugs ordered by a physician; home health services; clinic services; podiatry services; emergency and non-emergency medical transportation; renal dialysis clinic visits; emergency room treatment in emergency situations; durable medical supplies and equipment (such as oxygen and home dialysis equipment); nursing facility care; hospice; and well-child care.

Depending on income and resources, some people may have to make co-payments for Medicaid services. Children under age 21, people in nursing homes, and people in hospice care are never required to make co-payments. In addition, co-payments are never required for emergency services, pregnancy-related services, family planning services, or dialysis. Typical co-payments are as follows: \$1.00 per doctor's office visit, \$1.00 per generic drug prescription; \$2.00 per brand name prescription, \$1.00 per eye examination; and \$100 per hospital stay.

D. How Can I Appeal a Decision Against Me?

Appeals may be made in writing to the Recipient Appeals Division of the Department of Medical Assistance Services at 600 East Broad Street, Suite 1300, Richmond, VA 23219, or by calling (804) 371-8488. Appeals must be mailed no later than 30 days after the denial. Medallion members also may call the Managed Care Helpline at 1(800) 643-2273 with questions about benefits or services. The Department of Social Services' Hotline can be reached at 1(800) 552-3431 for questions about actions of local Department of Social Services employees.

Important Contact Information

District of Columbia

Income Maintenance Administration

645 H Street, NE

Washington, DC 20002

1(800) 666-2229

Medical Assistance Administration

825 North Capitol Street, NE

5th Floor

Washington, DC 20002

(202) 442-5988 or 1(888) 557-1116

http://www.dchealth.dc.gov/information/maa_outline.shtm

AFFIRM

1334 G Street, NW – 2nd Floor

Washington, DC 20005

(202) 626-0617

Maryland

Maryland Department of Health / Medicaid Program

201 West Preston Street

Baltimore, MD 21202-2399

1(800) 492-5231 (in-state only)

(410) 767-5800 or (410) 767-1463 (eligibility)

<http://www.dhmd.state.md.us/mma>

Legal Aid Bureau of Maryland

6811 Kenilworth Avenue, Calvert Bldg. – Suite 500

Riverdale, MD 20737

(301) 927-2101

Virginia

Virginia Department of Medical Assistance Services

600 East Broad Street, Suite 1300

Richmond, VA 23219

In Richmond: (804) 786-7933

(804) 786-4231

<http://www.dmas.state.va.us/downloads/rcp-2003-handbook.doc> (Virginia Medicaid Handbook)

Legal Services of Northern Virginia

110 N. Royal Street

Alexandria, VA 22314

(703) 684-5566

State Children's Health Insurance Program (SCHIP)

Please note – *The State Children's Health Insurance Program (SCHIP) is complex with respect to coverage, eligibility, payments, and other administrative issues. This chapter provides an overview of SCHIP. Whenever possible, we have provided phone numbers of government agencies and links to websites, both official and unofficial, that contain more detailed information. While this chapter summarizes the basics of the program, you will likely need to refer to other sources to address specific questions.*

The State Children's Health Insurance Program (SCHIP) was created to provide health insurance to children not eligible for Medicaid with family incomes up to 200% FPL (2003 – family of 4 making \$36,800 annually). States may choose to provide this coverage by expanding their Medicaid program, creating a combined SCHIP/Medicaid program or by establishing a separate "Health Insurance Program" targeting children ineligible for Medicaid. According to the federal SCHIP law, states may collect insurance or require co-payments for certain services and for particular categories of enrollees, but states may not impose co-payments for pediatric preventative care including immunizations. For specific questions about health insurance for children, call 1(877) 543-7669 toll-free. Useful websites on SCHIP include:

American Academy of Pediatrics: <http://www.aap.org/advocacy/schipsun.htm>

Federal government: <http://www.insurekidsnow.gov/>.

Eligibility

According to the legislation which created SCHIP, states may choose to cover all children with family incomes equal to or less than 200% FPL or may focus on a particular group of uninsured children. Eligibility criteria as established by the federal government suggests that in order to be eligible for SCHIP coverage, a child must be under 19, ineligible for Medicaid and at or below 200% FPL.

A. District of Columbia

The District of Columbia's SCHIP program is called D.C. Healthy Families. It provides free health insurance to children, adolescents under age 19 living alone, pregnant women and parents. The rules and requirements of Medicaid (as discussed in the Medicaid chapter) apply. Participants must meet the income requirements which vary according to size of family and are adjusted each year. In 2003, the following income levels applied:

- Youth and children under age 19 living alone who earn less than \$17,960 are eligible.
- A parent with one child who earns less than \$24,240 is eligible to apply for that child.
- A family of 3 (1 parent with 2 children, or 2 parents with 1 child) earning less than \$30,520 is eligible to apply for the children.
- A family of 4 (2 parents with 2 children or 1 parent with 3 children) earning less than \$36,800 is eligible to apply for the children.
- A family of 5 earning less than \$43,080 is eligible to apply for the children.
- A family of 6 earning less than \$49,360 is eligible to apply for the children.
- A family of 7 earning less than \$55,640 is eligible to apply for the children.
- A family of 8 earning less than \$61,920 is eligible to apply for the children.

DC Healthy Families eligibility continues for one year. Sixty days before the eligibility period terminates, beneficiaries are asked to update information in order to determine eligibility for the next period. While eligible, beneficiaries must report any changes in income or family size within 10 days to DC Healthy Families, 645 H Street, NE, Washington, DC 20002, (202) 698-4200.

B. Maryland

Maryland's State Children's Health Insurance Program is a combination program – made up of an expansion of its Medicaid program and a separate State Children's Health Insurance Program initiative. The Maryland Children's Health Program provides insurance coverage for both uninsured children under age 19 and pregnant women with income at or below

200% FPL. The maximum family income to be eligible in 2003 is listed below:

Family Size	Children	Pregnant Women
1	\$17,960	\$22,450
2	\$24,240	\$30,300
3	\$30,520	\$38,150
4	\$36,800	\$46,000
5	\$43,080	\$53,850
For each additional family member	add \$6,280	add \$7,850

C. Virginia

Virginia maintains a State Children's Health Insurance Program separate from its Medicaid program, called Family Access to Medical Insurance Security Plan (FAMIS). FAMIS provides health insurance to certain uninsured children who are ineligible for Medicaid. Children who are eligible for FAMIS coverage are under 19 years old, residents of Virginia, U.S. citizens (or U.S. Nationals or Qualified Non-Citizens), live in families with gross income less than 200% of Federal Poverty Income Guidelines, are uninsured or without comprehensive health insurance in the last six months, and are not members of a family that is eligible for coverage under a Virginia State Employee Health Insurance Plan. FAMIS eligibility continues for 12 months and must be re-determined at the end of that period. While eligible, any changes in family income, size of family, address, or marital status must be reported to FAMIS immediately. FAMIS income limitations in 2003 for persons below 200% of poverty are the same as the above chart. Virginia allows families with income under 150% of the poverty level to pay a smaller copayment for most medical services.

Enrollment

A. District of Columbia

Applications for DC Healthy Families may be downloaded from the Internet: http://www.dchealth.dc.gov/services/healthy_families/application.shtm. Applications are also available at community health centers and local libraries, as well as at many D.C. Giant, Safeway, Rite Aid, and CVS stores. Applicants may call 1(888) 557-1116 between 8:00 a.m. and 4:30 p.m. for help completing the application form or to have a form mailed to their address. Applications must include proof of DC residency, copies of Social Security cards for applicant children and parents, and proof of one month's income.

Once enrolled, one of four health plans must be chosen to provide benefits: Advantage Health Plan, Amerigroup Corporation, DC Chartered Health Plan, or Health Right.

B. Maryland

Applications for Maryland's Children's Health Program are available at local health departments, school-based health centers, Head Start centers, WIC centers, and Departments of Social Services. Call 1(800) 456-8900 for more information about your local health department or refer to the website <http://dhmh.state.md.us/mma/mchp/pdf/mchpapplcoverltr.PDF>.

The application requires general information such as name, address and telephone number as well as information concerning other health insurance coverage, general information about other family members, Social Security numbers of applicants and information concerning family income and resources. Applicants should mail their completed application or deliver the application to their Local Health Department. An application is available on the Internet at <http://www.dhmh.state.md.us/mma/mchp>.

C. Virginia

Applications for FAMIS may be downloaded from the Internet: http://www.famis.org/English/Materials/New_Application_Form.pdf. FAMIS applicants also may call (866) 87-FAMIS or (866) 873-2647 to request an application. Applications are also available at local Social Service Departments. Applications can be faxed to (888) 221-9402 or mailed to

FAMIS at P.O. Box 1820, Richmond, VA 23218-1820. Applications will request information to determine the family's gross monthly earned and unearned income. Applications mailed to FAMIS will be screened for eligibility for FAMIS as well as Medicaid.

FAMIS coverage begins upon receipt of a FAMIS health benefits card. Once a beneficiary has received the card, he or she may receive services from any provider accepting FAMIS payment until required to choose a Managed Care Entity (a health organization which provides services to members through a network of providers) or a Primary Care Case Manager. FAMIS offers health benefits through two programs, fee-for-service or through a managed care organization (MCO).

Most FAMIS children receive care through a Managed Care Organization, which is a health service organization that provides its members with all health services through a network of primary care providers, specialists, and hospitals. If a family lives in an area where managed care is available, the selected organization will send the child an ID card with the name and phone number of the doctor who will be the primary care provider. The child will see that doctor for care and must always show the ID card to the provider before getting care. The plastic ID card demonstrating enrollment in FAMIS also should be presented to the doctor. Managed care organizations that provide health care include Anthem HealthKeepers Plus, CareNet, Sentara, UniCare and Virginia Premier. Health plan information is available on the FAMIS website:

<http://www.famis.org/English/MCEComparison.htm>. A list of health plans available in each locality is on the website:

<http://www.famis.org/English/MCEInfo/FAMIS MCE and FFS chart.pdf>.

Covered Services

A. District of Columbia

DC Healthy Families coverage is the same benefit package as Medicaid, including the following services: doctor visits, immunizations, school physicals, emergency care, hospital stays, prescription medicines, prenatal care, labor and delivery, well-child visits (EPSDT), vision care and glasses, some dental care, family planning, home health care, durable medical equipment, health education services, mental health services, inpatient substance abuse treatment and transportation to doctor appointments.

B. Maryland

Maryland's Children's Health Program coverage for children includes the following services: inpatient hospital care, substance abuse services, prescription drugs, dental care, vision care, laboratory services, immunizations, sick and well doctor visits, and transportation to medical appointments. Pregnant women receive the same covered services, in addition to prenatal doctor visits and hospital delivery.

C. Virginia

FAMIS covered services include inpatient and outpatient hospital services, prescription drugs, doctor visits, substance abuse services, clinic services, dental care, prenatal care, medical transportation, vision care, and hospice services.

Payment/Cost Reimbursement

A. District of Columbia

Enrollees in D.C. Healthy Families are generally not required to pay for services. See <http://www.aap.org/advocacy/txxisummary.pdf>.

B. Maryland

Enrollees in Maryland's Children's Health Program are generally not required to make pay for services.

C. Virginia

FAMIS coverage: Families who earn less than 150% of the federal poverty level (\$27,600 for a family of four) do not pay

a monthly premium. Families earning above 150% of the federal poverty level must pay a monthly premium. Failure to pay monthly premiums results in disenrollment from the FAMIS program. All families, regardless of income, are required to make co-payments for covered services (such as outpatient hospital and doctor's office visits, prescription medications, inpatient hospital care, and/or non-emergency visit to emergency room) until they reach their yearly co-payment limit. FAMIS can also assist families with eligible children to pay for premiums in employer-sponsored health insurance plans.

Denial of Services and Complaints

A. District of Columbia

If you have specific questions about an eligibility determination, contact the eligibility determination agent, IMA (Income Maintenance Administration) at (202) 724-5506 for customer service. If you had Medicaid coverage and received a letter stating that your benefits have been cut, contact the Office of Fair Hearings at (202) 724-5431. The Office of Fair Hearings can assist you with a host of problems including loss of Medicaid coverage and medical decisions made by your health plan. Contact the Office of Fair Hearings as soon as possible, especially if you don't want your health coverage to stop or if your coverage has already been cut. Depending on the situation, you have anywhere from 10 days to 90 days to request a hearing. In addition to the Office of Fair Hearings, if you have a specific problem with your health plan or MCO, you can contact the Chief of Managed Care for Medicaid, Ms. Maude Holt at (202) 442-9074 for assistance.

D. Maryland

For questions or complaints regarding Maryland's Children's Health Program, call 1(800) 456-8900.

E. Virginia

A complaint about FAMIS may be reported to the FAMIS Central Processing Unit at (866) 87-FAMIS. A complaint about a managed care organization (MCO) in which the child is enrolled must be submitted directly to the organization. More information about filing complaints and requesting a review of managed care decisions (appeals) is provided in the handbook from the selected organization. Complaints about a doctor, pharmacy, or hospital when the child is not enrolled in a managed care organization may be submitted in writing to the Recipient Appeals Unit, FAMIS Review, Department of Medical Assistance Services, 600 East Broad Street, 11th floor, Richmond, VA 23219.

Families have the right to request an appeal or review of any action related to initial or continued eligibility FAMIS. This includes delayed processing of an application, actions to deny a request for medical services, or actions to reduce or terminate coverage after eligibility has been determined. To request an appeal or review, notify the Department of Medical Assistance Services (DMAS) in writing of the action you disagree with within 30 days of receipt of the agency's notice about the action. You may write a letter or complete an Appeal Request Form and send it to: Appeals Division, Department of Medical Assistance Services, 600 E. Broad Street, Richmond, Virginia 23219. Forms are available on the Internet at: <http://www.dmas.state.va.us>.

The Recipient Appeals Unit of Department of Medical Assistance Services may be contacted at (804) 371-8488 for more information.

Important Contact Information

District of Columbia

Department of Health
825 North Capitol Street, NE
Washington, DC 20002
(202) 442-5999

or

DC Healthy Families
645 H Street, NE
Washington, DC 20002
(202) 698-4200 or 1(888) 557-1116

Maryland

Maryland Department of Health and Mental Hygiene / Medicaid Program
201 West Preston Street
Baltimore, MD 21202-2399
1(800) 456-8900 (in-state only)
1(800) 977-7388
(410) 767-5800 – Public Information

Legal Aid Bureau of Maryland
Legal Aid Bureau, Inc.
500 East Lexington Street, Baltimore, MD 21202
(410) 539-5340
1(800) 999-8904
TTY 1(800) 458-5340

Virginia

Virginia Department of Health, Office of Family Health Services
1500 E. Main Street, Room 104
Richmond, VA 23219
(804) 371-0478
<http://www.vahealth.org>

Virginia Poverty Law Center
201 West Broad Street, Suite 302
Richmond, VA 23220
(804) 782-9430

Legal Services of Northern Virginia
6400 Arlington Blvd., Suite 630
Arlington, VA 22042
(703) 534-4343

Additional Information on the Internet:

State Health Facts Online: <http://www.statehealthfacts.kff.org>
National Health Law Program: <http://www.healthlaw.org>
Families USA: <http://www.familiesusa.org>
National Conference of State Legislatures: <http://www.ncsl.org>
Center for Health Care Strategies, Inc.: <http://www.chcs.org>
National Academy for State Health Policy: <http://www.nashp.org>
National Senior Citizens Law Center: <http://www.nslc.org>

Programs of All-Inclusive Care for the Elderly (PACE)

What is PACE?

Programs of All-inclusive Care for the Elderly (known as PACE) help frail elderly people stay out of nursing homes and in the community. These programs provide a broad range of medical and social services (described below) to people who enroll in a PACE plan. PACE services are provided by private non-profit or governmental organizations. Like some managed care plans, for most services (other than emergency and some urgently needed services), the plan must approve of the service before it will be provided.

Who Can Get Services Under the PACE Program?

To get services under the PACE program, a person must live in an area with a PACE plan. PACE plans are not available everywhere.

In addition, to get services under the PACE program a person must:

- be 55 years old or older;
- meet state guidelines for needing nursing home care; and
- at the time of joining, be able to safely live in the community with help from a PACE program.

Are There PACE Plans in My Area?

Currently, there are no PACE plans in the District of Columbia. However, the District of Columbia has a Medicaid waiver program that provides similar services to those available under PACE programs. This program is described at the end of this chapter.

In Virginia, there is a PACE plan called Sentara Senior Community Care. This plan is available to persons who live in Norfolk, Virginia Beach, Chesapeake, and Portsmouth.

In Maryland there is a PACE plan called Hopkins ElderPlus. This plan is available to persons who live in the following zip codes: 22202, 21205, 21206, 21213, 21214, 21218, 21219, 21220, 21221, 21222, 21224, 21227, 21231, 21237, and 21052.

What Services Are Offered Under the PACE Program?

PACE programs offer a broad range of services, including medical care, home health care, physical therapy, dentist and hospital services, surgery, lab tests, prescription drugs and x-rays. PACE programs also provide transportation to appointments, meals, and social services. Finally, if a PACE enrollee can no longer live in the community and needs to go in a nursing home, the PACE program can cover nursing home services. PACE programs can choose to provide additional services.

Many of the services offered under the PACE program are provided in adult day care centers. PACE enrollees may go to an adult day center as often as they need. The average PACE enrollee goes to an adult day center three times a week for services and social activities. Services provided in the adult day center are supplemented by in-home and referral services as needed.

Who Decides What Care PACE Enrollees Need?

In PACE programs, a team that includes a doctor, nurse, social worker, nurse practitioner, therapist, and others will assess the needs of each PACE enrollee and develop a plan of care. The plan of care sets out the services needed to meet the enrollee's medical, physical, emotional and social needs. The team is responsible for carrying out and monitoring the plan of care. The team will review the plan at least twice a year and change it if necessary. If a PACE enrollee has to go to a nursing home, the team will continue to monitor the care of the enrollee.

In order for a service to be covered, it must be authorized by the PACE team, unless it is an emergency service.

What If an Enrollee Disagrees with a PACE Plan's Decision Not to Authorize or Cover a Service?

If an enrollee disagrees with a PACE plan's decision not to authorize or cover a service, the enrollee can appeal the PACE plan's decision. Each PACE plan must have a written appeals process which will explain how to make an appeal. If an enrollee appeals a decision, someone who was not involved in the first decision will review the appeal and make an impartial decision within thirty days of the enrollee's appeal. If the enrollee's health or life is in serious danger, the decision must generally be made within seventy-two hours unless the enrollee asks for a longer time or taking a longer time is in the enrollee's best interest.

What Does It Cost to Enroll in a PACE Program?

PACE programs can charge a premium, or a monthly fee, to receive services. There is no separate charge to enroll. If a person is enrolled in Medicare Parts A and B and is also eligible for benefits under his or her state Medicaid program, Medicare and Medicaid will pay the PACE premium. Most people who enroll in PACE are eligible for Medicaid and enrolled in Medicare.

If a person is not eligible for benefits under his or her state Medicaid program, or is not enrolled under both Medicare Part A and Part B, he or she will have to pay at least some of the monthly premium. The PACE plan in your area can tell you how much it will cost.

How Do I Enroll in a PACE Plan?

To enroll in a PACE plan, contact the plan in your area and ask to enroll. The plan will ask for basic information from you, answer your questions, and explain what forms you need to sign. Your enrollment begins the first day of the month following the date you give the PACE plan the signed enrollment agreement. It is a good idea to keep a copy of this agreement for your records. Once you are enrolled, you are a plan member as long as you like, if you pay the premiums (if any) when they are due and if you continue to live in the plan area, regardless of whether your health changes. If you want to end your enrollment, you should contact the PACE plan.

In Maryland, contact Hopkins ElderPlus at (410) 550-7044 for more information about enrolling in a PACE plan.

In Virginia, contact Sentara Senior Community Care at (757) 456-2700.

What If I live in the District of Columbia Where There Is No PACE Plan?

In the District, many of the services available through the PACE plan are instead available through the D.C. Department of Health's Home-Based and Community-Based Waiver. To qualify for the waiver program, you must reside in the District of Columbia, and have income below \$1,656/month and assets (savings) under \$2,600 (not including your home, or any funeral policy). Income limits may change each year, so call the number below for the most up-to-date information. Only a limited number of people can enroll in the program. To be eligible you must be:

- a District of Columbia resident,
- aged 65 years or older, or
- aged between 18 and 64 years old and diagnosed as having a physical disability,
- with income below \$1,656/month,
- with assets (savings) below \$2,600, and
- require assistance with basic activities of daily living.

Services are arranged through a case management provider who helps to identify which services are needed. Available services include a personal care aide, homemaker services, personal emergency response system, physical changes to a home, respite services, one-time chore services, and assisted living.

For more information and to enroll, call the D.C. Department of Health, Medical Assistance Administration, Office on Disabilities and Aging, at (202) 442-5912 or (202) 442-8994.

For further information about the PACE program, look at the website for the National PACE Association at <http://www.npaonline.org>.

TRICARE: The Government's Health Care Program for Uniformed Services Members

The TRICARE program is a worldwide health care program developed by the United States Department of Defense for active duty and retired uniformed services members, including their families and survivors. TRICARE involves the health care resources of the Army, Navy, and Air Force, and supports them with networks of civilian health care professionals. The goal of the TRICARE program is to provide high quality health care to eligible individuals while maintaining medical support to military operations.

TRICARE Program Options

If you are an active duty or retired member of the uniformed services, you and your family are eligible to be enrolled in TRICARE. Survivors of all uniformed services under age 65 can also qualify for TRICARE.

You generally have three main choices for your TRICARE health care under TRICARE Prime, TRICARE Standard or TRICARE Extra. If you are an active duty service member, you are automatically enrolled in TRICARE Prime because you are not eligible for TRICARE Standard or TRICARE Extra. Both TRICARE Standard and TRICARE Extra are available for non-active duty beneficiaries who do not choose or are not able to enroll in TRICARE Prime. Each option is discussed below:

A. TRICARE Prime

In TRICARE Prime, you are assigned a primary care manager (PCM) who manages your care and provides referrals for specialty care. Enrollees receive most of their care from military providers at a Military Treatment Facility (MTF) or from civilian providers who belong to the plan's network. Active duty members and their families do not pay enrollment fees, annual deductibles or co-payments for care in the TRICARE network. However, retired service members pay an annual enrollment fee of \$230 for an individual or \$460 for a family. Retirees age 65 and older are not eligible to have their PCM at a Military Treatment Facility unless they are enrolled in TRICARE Prime Plus, which is not a health plan but just a primary care access program. If not enrolled in TRICARE Prime Plus, retirees age 65 and older may only get care at an MTF on a space-available basis.

1. TRICARE Prime Remote

TRICARE Prime Remote uses an authorized civilian network of providers to provide TRICARE Prime services and care for active duty personnel and their family members stationed more than 50 miles from a Military Treatment Facility (MTF). Eligible beneficiaries must both live and work more than 50 miles from the nearest MTF. TRICARE Prime Remote is available in the 50 United States only, and requires specific enrollment to participate. Reserve Component members are eligible for TRICARE Prime Remote if activated for more than 30 consecutive days.

B. TRICARE Standard

TRICARE Standard is a fee-for-service option. As a member of this plan, you may see an authorized provider of your choice. Having this flexibility and choice means that care generally costs more than under TRICARE Prime. In addition, although there is no enrollment fee, annual deductions and co-payments are required under TRICARE Standard (20% for active duty family members and 25% for retirees).

C. TRICARE Extra

The TRICARE Extra plan is a preferred provider option (PPO) in which you choose a doctor, hospital, or other health care provider within the TRICARE provider network. No enrollment fee is required and deductibles are the same as with TRICARE Standard, discussed above, but co-payments are 5% lower. You have more choice of providers and more costs than under TRICARE Prime, but less choice and fewer costs than under TRICARE Standard.

TRICARE Pharmacy Benefit

There are three options for TRICARE beneficiaries (who are under age 65) to fill prescriptions:

1. Military Treatment Facility pharmacies provide prescription refills (up to a 90-day supply) at no cost to the beneficiary. Availability of medications is based on the basic core formulary (BCF). Other medications may be available as well based on local MTF determinations.

2. TRICARE Mail Order Pharmacy (TMOP) provides refills through the mail, but also charges a small co-pay (currently the co-pay is \$3 for generic, \$9 for brand name). Information is available at <http://www.tricare.osd.mil/pharmacy/tmop.cfm>.

3. TRICARE Retail Network Pharmacy Program provides refills at participating pharmacies, but also charges a small co-pay (currently \$3 for generic, \$9 for brand name).

OTHER TRICARE OPTIONS

A. TRICARE for Life

If you are a retired member of the uniformed services and are age 65 or over, you and your family are eligible to join the TRICARE for Life program. To join, you must be enrolled in Medicare Part B and you must be registered in the Defense Enrollment Eligibility Reporting System (DEERS). DEERS notifies you within 90 days of your 65th birthday that your medical benefits are about to change. It is necessary that you have up-to-date information in DEERS.

When you turn 65, you can use network and non-network providers under TRICARE Standard and TRICARE Extra when you need medical care. However, once you reach age 65 you can use the Military Treatment Facility (MTF) as your primary care provider only if you are enrolled in TRICARE Prime Plus. Beneficiaries with Medicare Parts A and B are eligible to use TRICARE coverage for physician, hospital, surgical, and pharmaceutical services. There are no enrollment fees or annual premiums for this program.

B. Medicare and TRICARE

TRICARE for Life acts as a secondary payer to Medicare for all eligible Medicare-covered beneficiaries. This means that:

- For services payable by both Medicare and TRICARE, Medicare will pay first and the remaining out-of-pocket expenses will be paid by TRICARE.
- For services payable by TRICARE, but not Medicare, such as overseas care, TRICARE will pay the same as for TRICARE Standard beneficiaries under age 65. You will be responsible for the TRICARE annual deductible and cost shares.
- For services payable by Medicare, but not TRICARE, such as chiropractic services, Medicare will pay as usual, but TRICARE will pay nothing. You will be responsible for Medicare co-pays.
- For services not payable by TRICARE or Medicare, you are entirely responsible for the medical bill.

C. TRICARE Senior Pharmacy

The TRICARE Senior Pharmacy Program is for all Medicare-eligible uniformed services beneficiaries. It allows you to obtain low-cost prescription medications using the "triple option" benefit. You can get the prescription drugs that you need from any one of these three sources: (1) military hospitals and clinic pharmacies, (2) the Department of Defense National Mail Order Pharmacy (NMOP), or (3) the Department of Defense Retail Pharmacy Program (network or non-network civilian pharmacies). Although there are no enrollment fees for this program, there are co-payments or cost shares that vary with each of the three pharmacy options and type of drug (brand name or generic brand).

In order to qualify to receive the benefits of TRICARE Senior Pharmacy, you must be registered in the Defense Enrollment Eligibility Reporting System (DEERS). DEERS notifies you within 90 days of your 65th birthday that your medical benefits are about to change. It is necessary that you have up-to-date information in DEERS.

TRICARE APPEALS

You have the right to appeal decisions related to your benefits made by TRICARE Management Activity (TMA) or by a TRICARE contractor. The appeals process varies depending on whether the denial of benefits involves medical necessity or factual determination.

A. Medical Necessity Determinations

Medical necessity determinations are based solely on medical necessity, that is, whether from a medical point of view, the care is appropriate, reasonable and adequate for your condition. The standard process for an appeal of a medical necessity determination is as follows:

1. The process begins when you send a letter to the managed care support contractor at the address specified in the notice of your right to appeal, which is included in the explanation of benefits (EOB) or other decision. You then have within 90 days of the date on the EOB to submit a letter of appeal, and you must include a copy of the EOB or other decision, and all other supporting documents.
2. The managed care support contractor will review your case and issue a reconsideration decision.
3. If you do not agree with the reconsideration decision, you have the right to appeal at the next level, that is, to the national quality monitoring contractor. The process at the national quality monitoring contractor level follows the steps described in (1) above; the only difference is that at this level, the letter of appeal is sent to the national quality monitoring contractor.
4. In general, if the amount in dispute is less than \$300, the reconsideration decision made by the national quality monitoring contractor is final. If the disputed services are \$300 or more, and you disagree with the national quality monitoring contractor's decision, you can request TMA to schedule an independent hearing.

B. Factual Determinations

Factual determinations involve issues other than medical necessity, such as coverage issues, foreign claims and denial of a provider's request for approval as a TRICARE authorized provider. The following describes the appeals process for factual determinations:

1. The process begins when you send a letter to the managed care support contractor at the address specified in the notice of your right to appeal, which is included in the EOB or other decision. You have within 90 days of the date on the EOB to submit a letter of appeal, and you must include a copy of the EOB or other decision, and all other supporting documents.
2. If the amount in dispute is less than \$50, the reconsideration decision from the managed care support contractor is final. If the amount in dispute exceeds \$50, you can request a formal review from TMA. If you disagree with a reconsideration decision, or with the initial determination from TMA, you can ask TMA to review the case again and issue a formal review decision, provided that the notice of the beneficiary's right to appeal a decision identifies TMA as the next level of appeal.
3. You must send a letter to TMA postmarked and received within 60 days of the date on the initial determination or reconsideration decision, and you must include copies of the determination or reconsideration decision, as well as any supplemental materials not previously submitted.
4. TMA will review the case and issue a formal review decision. In general, if the amount in dispute is less than \$300, the formal review decision made by TMA is final. If the disputed services are \$300 or more, and you disagree with the TMA's decision, you can request it to schedule an independent hearing.

C. Who Can Appeal?

- a TRICARE patient;
- the legal guardian of a TRICARE patient (if the patient is under 18 years of age);
- the guardian of a patient who is not competent to act on his or her behalf;
- a health care provider who participates in TRICARE (providers who do not participate in TRICARE or the TRICARE network cannot file appeals);
- a health care provider who has been denied approval, or who has been suspended, excluded or terminated, as a TRICARE-authorized provider; and
- a representative authorized in writing by a patient or provider (an authorized representative could include a member of

the beneficiary's family as long as the representative obtains the beneficiary's consent). Note, certain individuals may not serve as representatives because of a conflict of interest. For example, an officer or employee of the United States may not serve as a representative. However, an exception could be made for an employee or uniformed services member who represents an immediate family member.

D. Scope of Appeals

You may appeal a decision made in your case only on three conditions:

1. If you disagree with the facts of your case, such as the diagnosis, or the necessity to be an inpatient.
2. If you disagree with a decision to deny pre-authorization for services, including mental health care.
3. If you disagree with a decision to terminate treatment or services that had previously been authorized.

E. Decisions That Cannot Be Appealed

1. You cannot appeal the amount your TRICARE contractor determines to be the allowable charge for a particular medical service. Note, if you disagree with a decision made in this circumstance, you may request an allowable charge review.
2. You cannot appeal the decision made by TRICARE or its contractors to request additional information from you before action is taken on your claim or appeal.
3. You cannot appeal decisions relating to the status of TRICARE providers. Only the provider in question may appeal on his or her behalf.
4. Finally, decisions relating to an individual's eligibility as a TRICARE beneficiary cannot be appealed. A person must appeal decisions regarding eligibility through their branch of service.

Important Contact Information:

- TRICARE Information: 1(877) 363-6337 or <http://www.tricare.osd.mil>
- TRICARE Pharmacy Program:
Registration required: 1(800) 789-7214 or <http://www.express-scripts.com>
- TRICARE Management Activity (TMA)
Appeals, Hearings and Claims Division
16401 E. Centretch Parkway, Aurora, CO 80011-9066
(303) 676-3466

- TRICARE Regional Managed Care Support Contractors

Each TRICARE region has a managed care support contractor (MCSC) except for two – TRICARE Europe and TRICARE Latin America/Canada. The managed care support contractors help combine the services available at military treatment facilities and those offered by a network of civilian hospitals and providers to meet the health care needs of the TRICARE beneficiaries. The TRICARE contracts may change from one company to another depending on the government contracting process. For current telephone numbers and claims information for your region's MCSC, call 1(877) 363-6337 or visit <http://www.tricare.osd.mil>.

- Medicare: For more information about Medicare benefits and Part B insurance, call 1(800) MEDICARE (1(800) 633-4227) or visit <http://www.medicare.gov>.

Viatical Settlements

Patients and families dealing with terminal illness often worry about how they will pay for the terminally ill patient's care. In this situation, there are several options available to you. One of these options is a viatical settlement.

A viatical settlement is the sale of your life insurance policy to a viatical settlement company for a lump sum payment. In a viatical settlement, the terminally ill person transfers his or her life insurance policy to the viatical settlement company in exchange for a percentage of the policy's actual value. The viatical company then becomes the beneficiary of the policy, pays the premiums, and collects on the policy when the original policyholder dies.

A decision to sell your life insurance policy can ease the financial strain a terminal illness can cause, but it is also a major decision that can have profound effects on your family. Remember that if you make a viatical settlement, there will be no life insurance benefits for the person you originally designated as beneficiary. Before you make this decision, you should investigate your options and talk to someone with expertise in financial issues, like a lawyer, accountant, or financial planner.

What Are My Options?

There are other options besides viatical settlements that may be better for your situation. For example, you may consider a loan from the beneficiary of your life insurance policy. However, this is only an option if your beneficiary has the money to loan you. You may also be able to receive accelerated benefits from your life insurance provider. Accelerated benefits are paid by your life insurance provider as an early payment on your life insurance policy. Accelerated benefits are often larger than the viatical settlement you would get on the same policy. Accelerated benefits may be your only option if your life insurance policy has restraints on assignment or transfer of the policy. Accelerated benefits may also be the best option if you require long-term medical care.

If you own a life insurance policy, call your insurance company before you make a viatical settlement. Find out whether accelerated benefits are available and how much they will cost. Costs may include a reduction in the payment to compensate for the interest the company would have earned if it had not paid early on the policy. There may also be a service charge.

If your life insurance company does not offer accelerated benefits, or if the amount it is willing to pay is too low, then a viatical settlement may be a better option. If you have a large life insurance policy, you may also consider the option of selling only a portion of your policy and retaining the balance as a payment to your beneficiaries upon your death.

What Are The Requirements For a Viatical Settlement?

Every viatical settlement company has its own rules for determining which life insurance policies it will purchase. Some common requirements are that:

- You have owned your policy for at least two years.
- Your current beneficiary will sign a release or waiver of his or her benefits under the policy.
- You are terminally ill. Some companies require a life expectancy of two years or less, but some may buy your policy even if your life expectancy is higher. However, you may receive a lower percentage of your policy value the greater your life expectancy.
- You sign a release allowing the settlement company access to your medical records. A doctor will usually have to verify that you are terminally ill.
- The insurance company providing your life insurance policy is financially sound. Viatical settlement companies are less willing to buy a policy if it is possible your life insurance company will be unable to pay.

Will I Have To Pay Taxes On The Settlement?

A. Federal Law

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) makes the proceeds of viatical settlements tax free on the federal level for individuals who are terminally or chronically ill. HIPAA defines terminally ill as being diagnosed

by a certified physician to have a life expectancy of under 24 months. Chronically ill is defined as being permanently and severely disabled by an illness. If you are not terminally or chronically ill as defined under HIPAA, you may have to pay federal taxes. For example, if your life expectancy is five years rather than two, you may have to pay some taxes.

Before you make a viatical settlement, find out whether your state requires viatical settlement providers to be licensed. If your state has this requirement, make sure the settlement provider you use is licensed. Under HIPAA, you are only granted federal tax free status for viatical settlements if the settlement company is properly licensed to operate in your state.

Important Contact Information

Federal Trade Commission
Consumer Protection
CRC-240
Washington, DC 20580
1(877) FTC-HELP
<http://www.ftc.gov> (for a pamphlet on viatical settlements)

B. State Law

In some states, you also have to pay a state tax on your viatical settlement. Maryland, the District of Columbia, and Virginia generally do not tax viatical settlements. However, the criteria for what makes a viatical settlement tax free varies. For example, the settlement may only be tax free if your life expectancy is under two years. Because each case is different, you should always speak to a financial counselor to find out whether your settlement will be free of state taxes. You may also contact the following state offices for more information.

Important Contact Information

District of Columbia

Department of Insurance and Securities Regulation
810 First Street, NE
Suite 701
Washington, DC 20002
(202) 727-8000
<http://disr.dc.gov>

Maryland

Maryland Insurance Administration
525 St. Paul Place
Baltimore, MD 21202-2272
1(800) 492-6116
<http://www.mdinsurance.state.md.us>

Virginia

Virginia Bureau of Insurance
1300 East Main Street
Richmond, VA 23219
(804) 371-9741
<http://www.state.va.us/scc/division/boi/index.htm>

Will Making a Viatical Settlement Affect My Eligibility For Public Assistance?

Making a viatical settlement or collecting accelerated benefits may affect your eligibility for public assistance programs that are based on financial need, such as Medicaid and Supplemental Security Income (SSI). You are not required to make a viatical settlement or choose accelerated benefits before qualifying for public assistance. However, once you make such a settlement, that settlement may be counted as income for purposes of calculating your need. The effect of a viatical settlement will vary greatly depending on the amount of the settlement, your financial need, and other factors. For this reason, you should consult a lawyer or financial planner to determine whether making a viatical settlement will be beneficial in your particular case.

Important Contact Information

Social Security Administration
Office of Public Inquiries
1(800) 772-1213
<http://www.ssa.gov>

Are There Laws Regulating Viatical Settlements?

Of the District of Columbia, Maryland, and Virginia, only Virginia has laws regulating viatical settlements.

Virginia requires that viatical settlement providers be licensed and that viatical settlements be made in a certain way. If you live in Virginia, you should not make a viatical settlement with a company or broker not licensed there. If you do make a settlement with an unlicensed settlement provider, you may be subject to federal taxes.

All viatical settlement contracts in Virginia have an unconditional refund provision of at least 30 days from the start of the contract or 15 days of the receipt of the viatical settlement funds, whichever occurs first.

Virginia also regulates how the settlement provider must pay you. Failure by the settlement provider to pay the settlement by the date promised makes the contract invalid, unless you choose to honor the contract on a later date when the settlement is produced. Payment of the proceeds of a viatical settlement must be in a lump sum, and the viatical provider or the escrow agent may not retain a portion of the settlement. The Virginia Administrative Code requires a minimum percentage of face value of the policy depending on life expectancy. The required percentage may be reduced by 5 percent for a policy provided by an insurance company that is rated poorly. The current Virginia regulations define a reasonable settlement as follows:

Insured's Life Expectancy	Minimum Percentage of Face Value
Less than 6 months	80 percent
At least 6 but less than 12 months	70 percent
At least 12 but less than 18 months	65 percent
At least 18 but less than 24 months	60 percent
Twenty-four months or more	50 percent

In addition, the Virginia law requires that viatical settlement providers explain certain things to you before you make the settlement. This is not a comprehensive list of Virginia's requirements for viatical settlements. For more information, contact Virginia's Bureau of Insurance. Viatical providers must advise you in writing that, among other things:

- There are sometimes alternatives to viatical settlements, and you should talk to your life insurance carrier to find out what your alternatives are;
- The viatical settlement may be taxable;
- The viatical settlement may be subject to the claim of creditors;
- The viatical settlement may affect your eligibility for public assistance; and
- That you have the right to rescind (go back on) the settlement contract within 30 days of the date of the agreement or within 15 days of the receipt of the settlement funds, whichever occurs first.

Important Contact Information

Virginia Bureau of Insurance
1300 East Main Street
Richmond, VA 23219
(804) 371-9741
<http://www.state.va.us/scc/division/boi/index.htm>

What Should I Do If My State Does Not Have Laws Regulating Viatical Settlements?

The District of Columbia and Maryland do not have laws regulating viatical settlements. However, there are certain guidelines that a trustworthy settlement provider should follow. Be suspicious of any provider who:

- Fails to advise you that you may have options other than making a viatical settlement;
- Fails to give you a date when the settlement funds will be available;
- Fails to provide for confidentiality of your medical information;
- Refuses to make an escrow arrangement for your funds to be held while the transaction is being finalized;
- Tells you that you must make a decision now and that you do not need to consult a lawyer or financial planner; and
- Offers you a low percentage of the value of your policy and discourages you from shopping among viatical settlement providers.

Important Contact Information

American Cancer Society
1(800) ACS-2345
<http://www.cancer.org>

The National Association of Insurance Commissioners
120 West 12th Street, Suite 1100
Kansas City, MO 64105
(816) 842-3600
<http://www.naic.org/consumer.htm>

Viatical and Life Settlement Association
800 Mayfair Circle
Orlando, FL 32803
1(800) 842-9811

<http://www.viatical-expert.net/> – Viatical and Life Settlement Consumer Information (lists viatical settlement providers that are licensed as well as providers who are under investigation or have been sanctioned in your state)

Should I Invest In Viatical Settlements?

This section pertains to anyone considering investing in a viatical settlement. Investing in viaticals means that, through a company or broker, an individual supplies the money for the viatical settlement. The idea is that once the insured person dies, the individual investor will receive a return on the investment. Although this seems like a low-risk investment (since the policy holder is terminally ill and, presumably, will die soon), many people have lost thousands of dollars in these investments. Problems arise when the viatical settlement broker is unlicensed or there are problems with the policies. Sometimes, policies are too new to be valid. Another problem is that someone may lie about being terminally ill just to receive the settlement. Then the person does not die so you cannot collect on the policy. Be very careful if you are considering investing in viatical settlements. Be sure that the broker you are dealing with is licensed and is not involved in any lawsuits or investigations.

Important Contact Information

<http://www.viatical-expert.net/> – Viatical and Life Settlement Consumer Information (lists viatical settlement providers that are licensed as well as providers who are under investigation or have been sanctioned in your state)

Conclusion

To be in a position where you need to make a viatical settlement is very stressful. Not only are you dealing with concerns about how you will pay for medical expenses, but also how you will provide for your dependants and how you will deal with a terminal illness. The stress of the situation makes it difficult to make a good decision, and the amount of new information can be overwhelming. For this reason, it is very important that you consult a professional financial planner or lawyer before making a decision to sell your policy. A trustworthy viatical settlement provider will encourage you to do this. Choosing to sell your life insurance policy can be an excellent decision that relieves some of the stress arising from dealing with a terminal illness, but it can also be a poor decision that creates more stress if not done properly. Always speak with several viatical settlement providers to find the best deal, and always speak to a lawyer or financial planner.

Pre-Existing Conditions and Your Rights to Obtain and Renew Health Insurance

In the past, many health insurance plans limited or refused insurance coverage for medical conditions that a person had before or at the time the person joined that health plan. These types of coverage limits are known as "preexisting condition exclusions."

In 1996, a federal law was passed that allows workers to move from one employer to another with less risk of losing coverage for preexisting conditions. In short, the federal law (sometimes referred to as the "HIPAA" law) forbids job-based health plans from refusing to cover preexisting conditions for more than 12 months (or more than 18 months for persons who are "late enrollees" under the law). This time period can be reduced in many cases if a person had health insurance in his or her prior job and did not have a significant gap in insurance coverage. For example, if a person who is not a "late enrollee" had health insurance for at least 12 months and then changes employers within a certain timeframe (63 days), the insurance plan offered by the new job cannot deny coverage for the person's preexisting conditions. If the same person had less than 12 months of insurance at the earlier job, this insurance can be used to reduce the maximum time that the preexisting condition exclusion can apply.

Even if you don't have a preexisting condition, the HIPAA law makes it easier for you to obtain new insurance coverage should you lose your existing coverage and also gives you certain rights to renew your coverage should you want to do so. The rules under HIPAA generally apply to only job-based health plans (often called "group health plans") offered by an employer or union. Some state laws provide stronger rights regarding preexisting condition exclusions for people who are covered by job-based health plans and additional rights for people covered by "individual" health plans. It is also important to note that federal law does not require employers to offer health insurance to their workers and does not limit the cost of insurance premiums.

Obtaining Insurance Coverage for Preexisting Conditions

A. What is a preexisting condition?

Under HIPAA, a preexisting condition is generally a physical or mental condition for which medical advice, diagnosis, care, or treatment was recommended or received by a person in the six-month period before the person joined his or her new health plan. Note that a condition is preexisting if you were diagnosed with it within six months before enrolling in a new plan, even if you did not get treatment for the problem during that time.

The period when you are denied benefits or when your benefits are limited because of a pre-existing condition is called an "exclusion period." During an exclusion period, a health plan will not pay for health care services related to the preexisting condition. However, the plan must pay for all other covered services. Once the exclusion period is over, the plan must pay for all covered services, including those related to the preexisting condition.

B. How Does the Law Work?

Under HIPAA, health insurers and employers may not limit your ability to get coverage based on your medical history, your mental or physical condition, or your past use of health care services. Health insurers and employers also may not charge you a higher premium based solely on these kinds of factors.

If you have a preexisting condition, the HIPAA law limits the ability of most job-based health plans to exclude coverage for these conditions. In general, under HIPAA, a job-based plan can refuse to cover a person's preexisting conditions, but only for a maximum of 12 months or, if the person is a "late enrollee," for a maximum of 18 months. With certain exceptions, a "late enrollee" is a person who joins a health plan after the time when the plan was first available to the person. This maximum time limit can be reduced or even eliminated completely for people who had certain past insurance coverage (called "creditable coverage") and who did not have a significant gap (over 63 days) in coverage.

"Creditable coverage" includes most United States health insurance coverage, such as coverage under a job-based health plan (including COBRA coverage) and coverage through an HMO, individual health insurance policy, Medicare, Medicaid, TRICARE, the Indian Health Service, a state health benefits risk pool, the Federal Employees Health Benefit Plan (FEHBP), or the Peace Corps Act. Coverage under a foreign country's national health plan is not considered to be creditable coverage. You can get a "certificate of creditable coverage" from your insurance plan free of charge to show how much creditable cover-

age you have received under the plan. In addition, you can use other documents, such as insurance cards, bills, etc., to show past creditable coverage.

Under the HIPAA rules, if you have creditable coverage for at least 12 months in a row and then switch to a new group health plan (which usually happens when you change employers) within 63 days, the new plan cannot exclude your preexisting health problems from its coverage. If you are a late enrollee, you would need 18 months of creditable coverage to avoid preexisting condition exclusions. If your creditable coverage is less than 12 (or 18) months, you can still use this past coverage to reduce the time that your health plan can limit or refuse to cover preexisting conditions. For example, if you are not a late enrollee and had eight months of creditable coverage, your new health plan can only limit or refuse to cover your preexisting conditions for four months.

If you do not have any creditable coverage when you enroll in a new group plan, the new health insurer can generally refuse to pay for any of your existing medical problems, but only for a maximum of 12 months (18 months for late enrollees). However, there are special cases in which your new plan cannot refuse to cover preexisting conditions even if you have no creditable coverage. Newborns and adopted children who are covered within 30 days are not subject to the 12-month period. In addition, if the new plan has maternity coverage, the 12-month period does not apply to medical care related to pregnancy.

Please remember that HIPAA's protections generally apply only to job-based health plans. With the exception of a limited group of people called "federally eligible" persons, HIPAA does not apply to individuals covered under "individual" health plans.

C. Special Rules for Certain Government Employees

HIPAA allows state, county, and local governments to choose not to comply with the preexisting condition rules discussed above. As of July 2003, however, all government employers in the District of Columbia, Maryland and Virginia have chosen to follow the HIPAA rules on preexisting condition exclusions. If you work for a government employer, you should check to see if your employer has made a different choice after this guide was written.

Additional Protections Under HIPAA

A. Special Enrollment

HIPAA provides additional protections to help you obtain new insurance in the event you lose your existing insurance coverage. If you have decided not to take coverage under your employer's group health plan because you have other coverage, you will be allowed to enroll in your employer's group health plan within 30 days of losing the other coverage. This also applies if you are a dependent of an employee. For example, if you choose not to enroll in the plan offered by your employer because you are covered under your spouse's plan, and your spouse loses that coverage, you may enroll in your employer's plan within 30 days.

In addition, under HIPAA you have the right to enroll new dependents that you have gained through marriage, birth, adoption or placement for adoption within 30 days of gaining the new dependent.

B. Guaranteed Availability

Insurers who sell individual policies usually are not allowed to deny you coverage, if you are a HIPAA-eligible individual and you would like individual coverage after you have left a group health plan. However, the insurer may deny you coverage if your state offers guaranteed coverage through an alternative program that has been certified by the Secretary of the United States Department of Health and Human Services ("the Secretary"). If your state does not offer an alternative certified program, your insurer generally must allow you to choose to be covered by any insurance policy the insurer sells within the state; or allow you to choose to be covered by one of the insurer's two most popular policies; or allow you to choose between two policies that have different levels of coverage.

C. Guaranteed Renewability

Under HIPAA, if you have individual health insurance coverage, your insurer must allow you to renew or continue your coverage if you so choose. However, your insurer may discontinue your coverage if: (1) you have not paid premiums in a timely

manner; (2) you have committed fraud; (3) your insurer is no longer offering coverage in the individual market; (4) your coverage is offered through a network plan, and you no longer live or work within the service area; or (4) your coverage is offered through an association and you are no longer a member of the association. Your insurer may stop a particular type of coverage if (1) your insurer gives you 90 days notice; (2) your insurer allows you to buy any other type of individual coverage the insurer offers; and (3) the discontinuation is not based on the health of the insurer's enrollees or expected enrollees. In addition, your insurer may stop offering any individual coverage within a state, but only if the insurer gives you at least 180 days' notice.

State Law Protections

The District of Columbia, Maryland, and Virginia all have enacted additional legal protections that may help people who are not protected under HIPAA. These laws may provide stronger protections for people covered under job-based plans and additional rights for people covered under individual plans. Contact your jurisdiction's insurance department for more information on these additional rights.

District of Columbia Department of Insurance and Securities Regulation
810 First Street, NE – Suite 701
Washington, DC 20002
(202) 727-8000, ext. 3018
<http://disr.washingtondc.gov/main.shtm>

Maryland Insurance Administration
525 Saint Paul Place
Baltimore, MD 21202-2272
1(800) 492-6116 or (410) 468-2244
<http://www.mdinsurance.state.md.us/>

Virginia Bureau of Insurance
State Corporation Commission
1300 East Main
Richmond, VA 23219
(804) 371-9944
<http://www.state.va.us/scc/division/boi/>

In addition, the Georgetown Health Policy Institute publishes health insurance guides for the District of Columbia, Maryland, and Virginia. These guides explain additional legal rights and other health insurance rules and can be found at <http://www.healthinsuranceinfo.net/>.

What if I am Denied Coverage?

If you think you have been wrongly denied coverage for a preexisting condition, you should contact the proper agencies to file a complaint. In general, if your problem is with an insurer (including an insurer under a job-based plan), you should contact the insurance department in your state or jurisdiction as listed above. If the insurance department is unable to solve your problem in cases involving HIPAA rights, you should contact the Centers for Medicare and Medicaid Services.

Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244
1(877) 267-2323, ext. 6-1565
<http://www.cms.hhs.gov/hipaa1>

If your problem is not with an insurer but with the job-based plan offered by your employer, you should contact the U.S. Department of Labor.

U.S. Department of Labor
Employee Benefits Security Administration
Washington District Office
S1335 East-West Highway, Suite 200
Silver Spring, MD 20910
(301) 713-2000
1(866) 444-EBSA (2373)

Additional Information on the Internet:

Georgetown University Health Policy Institute:
<http://www.healthinsuranceinfo.net/Insure.com> or <http://www.insure.com/health/hipaa.html>

Continuing Your Health Coverage under COBRA

Overview

A federal law known as "COBRA" requires most employers to offer employees (and their families) the option to continue their health care coverage, at the employee's own expense, for a limited period of time. This option is known as "continuation coverage," and it is only available under certain circumstances. For example, COBRA continuation coverage is offered when an employee no longer has health insurance because he or she has lost their job or is asked to work fewer hours. Additionally, Maryland and the District of Columbia (but not Virginia) have enacted COBRA-like laws that supplement the federal law.

Paying for Continuation Coverage

If you choose to buy continuation coverage, you must pay the entire cost of the health coverage. The monthly premium will probably be high since you will be paying your old share of the costs and the share of the costs formerly paid by your employer, plus an additional 2 percent fee. And, you must pay deductibles and co-payments if your health plan requires them.

Eligibility

A. Who is Eligible for Continuation Coverage?

In general, three groups of people are eligible for COBRA coverage: employees, their spouses, and their dependent children. To get COBRA coverage a "qualifying event" must occur (discussed next).

B. What is a Qualifying Event?

Different qualifying events will trigger eligibility depending on whether you are an employee, a spouse, or a dependent child.

1. Qualifying Events for Covered Employees

If you are an employee covered by your company's group health plan, you can choose continuation coverage if you lose your group health insurance because:

- (1) you leave or lose your job, so long as it is not due to "gross misconduct;" or
- (2) you have reduced work hours.

2. Qualifying Events for Covered Spouses

If you are a covered spouse of an employee, you can choose continuation coverage if you lose your group health insurance because:

- (1) your spouse leaves or loses his/her job, so long as it is not due to "gross misconduct;"
- (2) your spouse has reduced work hours;
- (3) your spouse dies;
- (4) you become divorced or legally separated from your spouse; or
- (5) your spouse becomes entitled to Medicare.

3. Qualifying Events for Covered Dependent Children

If you are a covered dependent child of an employee, you can choose continuation coverage if you lose your group health insurance because:

- (1) your parent leaves or loses his/her job, so long as it is not due to "gross misconduct;"

- (2) your parent has reduced work hours;
- (3) your parent dies;
- (4) your parents become divorced or legally separated; or
- (5) your parent becomes entitled to Medicare; or
- (6) you are no longer considered a "dependent child" under the health plan's rules.

C. Do All Employers Have To Offer Continuation Coverage Under COBRA?

No. First, the federal law generally only applies to employers with 20 or more employees. The law does not apply to those employed by the District of Columbia or the federal government, and it does not cover certain insurance plans offered by church organizations. So, if you work for the D.C. or federal governments (see contact information for government employees below), or your employer has less than 20 people, you are probably not entitled to continuation coverage under COBRA. Note also that Maryland and the District of Columbia have their own laws that supplement the federal law and apply to some businesses with less than 20 people (discussed further below).

Election and Termination of Continuation Coverage

A. How Do I Sign Up for Coverage under COBRA?

Qualified beneficiaries must be given an "election period" of at least 60 days to choose whether to buy continuation coverage. Each person who is eligible for continuation coverage may make their own decision about purchasing coverage (for instance, your spouse may choose continuation coverage even if you do not).

B. How Long Will Coverage under COBRA Last?

If coverage is lost due to job loss or reduced work hours, continuation coverage under COBRA lasts a maximum of 18 months. However, your spouse and dependent children are entitled to 36 months of continuation coverage if: you become eligible for Medicare, you get divorced or legally separated, or you die. In addition, if you are eligible for Social Security disability benefits, you may get additional months of continuation coverage. If you choose continuation coverage you do not have to keep it for the entire coverage period.

C. Can I Lose My COBRA Coverage?

Yes. You can lose your COBRA continuation coverage for a number of different reasons. For instance, if you do not pay your premiums on time, or if your former employer goes out of business or stops offering health insurance, you will lose your coverage. And, if you move out of your health plan's coverage area you may lose your coverage.

District of Columbia Law

The District of Columbia recently enacted a law similar to COBRA that provides continuing coverage to those employed by an employer with fewer than 20 employees. Under this law, employees (and covered dependents) may continue coverage, at the employees' own expense, for a period of three months beyond termination of coverage. Employees must pay the full cost of the policy during the extension, plus an administrative fee not greater than 2 percent. Eligible employees must elect the continuation of coverage benefit and provide payment to the employer within prescribed time frames. Requests for more information or questions can be directed to the D.C. Department of Insurance and Securities Regulation.

Department of Insurance & Securities Regulation
Government of the District of Columbia
810 First Street, NE, Suite 701
Washington, DC 20002

(202) 727-8000

<http://www.disr.washingtondc.gov/main.shtm>

Maryland Law

Maryland has its own law requiring most insurers and health plans to offer continuation coverage to individuals who lose group membership due to three events: loss of the covered person's job (whether voluntary or involuntary, as long as it is not "for cause"), death of the covered participant, or divorce of the participant and the spouse. There are some situations for which continuation coverage may only be available under COBRA, and other situations for which continuation coverage may only be available under Maryland law.

Importantly, Maryland's law requires continuation coverage for an individual whose employer has less than 20 employees. While Maryland's continuation laws and COBRA have many similarities, there are some important differences. Requests for more information or questions can be directed to the Maryland Insurance Administration.

Maryland Insurance Administration
525 St. Paul Place
Baltimore, MD 21202-2272
(410) 468-2090
<http://www.mdinsurance.state.md.us>

Virginia Law

Virginia does not have its own law regarding continuation coverage. However, Virginia has a "guaranteed issue" law that require insurers to cover anyone who applies. This law may be useful to people ineligible for continuation coverage under COBRA. The Virginia Bureau of Insurance may be able to provide additional helpful information.

State Corporation Commission
Bureau of Insurance
Commonwealth of Virginia
PO Box 1157
Richmond, VA 23218
(804) 371-9694
<http://www.state.va.us/scc/division/boi/index.htm>

Who to Contact Generally

If you have questions about COBRA, you can contact the Washington District Office of the U.S. Department of Labor, Employee Benefits Security Administration (formerly called the Pension and Welfare Benefits Administration). Contact information is provided below.

Employee Benefits Security Administration
Washington District Office
S1335 East-West Highway, Suite 200
Silver Spring, MD 20910
Caroline Sullivan – Supervisor
(301) 713-2000

U.S. Department of Labor
Employee Benefits Security Administration
Division of Technical Assistance and Inquiries
200 Constitution Avenue, NW, Suite N-5619
Washington, DC 20210
Employee & Employer Hotline: 1(866) 444-3272
<http://www.dol.gov/ebsa>

Additional helpful information that is available on the Employee Benefits Security Administration's web site includes the publication "Health Benefits Under Cobra" (<http://www.dol.gov/ebsa/pdf/cobra99.pdf>) and the COBRA Fact Sheet (<http://www.dol.gov/ebsa/newsroom/fscobra.html>).

If you are a government employee, the Centers for Medicare and Medicaid Services offers information about COBRA provisions for public-sector employees. Contact information is provided below.

Centers for Medicare and Medicaid Services
7500 Security Boulevard
Mail Stop S3-16-16
Baltimore, MD 21244-1850
(410) 786-3000

Hearing Screenings for Newborn Children

The ability to communicate with others is important for a child's social and brain development. If your baby cannot hear well, he or she may have problems learning to talk. By finding the hearing problem early, your baby will have the best chance to learn. Unfortunately, hearing loss in newborns and infants is not easily detected without the aid of a trained professional. That is why it is very important for all newborn babies to be tested for hearing problems by a trained professional before they leave the hospital. Additional testing should be done if hearing problems are suspected as the baby grows. Trained professionals are generally available through Universal Newborn Hearing Screening programs, which have been established by most states.

This chapter identifies hospitals and resources that participate in hearing screening programs, discusses what programs are there to assist you if your child has a hearing problem, and advises you how to pay for these important screenings.

Initial Hearing Screening at Birth

As a general principle, all newborns should be tested for hearing problems prior to leaving the hospital. Parents should check with their doctor or the hospital to see if their newborn has been tested.

A. District of Columbia

The District of Columbia enacted the Newborn Hearing Screening Act that requires all hospitals and maternity centers in the District to test the hearing of all newborns while they are still in the hospital. If the parents do not consent to the testing because it is against their religious beliefs, then the newborn's hearing will not be tested.

Hospitals in the District that screen a high percentage of newborns (at least 90% of the babies born or admitted to the hospital) can be found at the following website: <http://www.infanthearing.org/unhsprograms/districtofcolumbia.html>.

Important Contact Information

Early Hearing Detection & Intervention Contact
Office of Maternal and Child Health
825 North Capital Street, NE
Third Floor
Washington, DC 20002
(202) 442-5925 or (202) 727-7549

B. Maryland

Maryland has established a Universal Newborn Infant Screening Program. Under the program, hospitals must test every newborn while still in the hospital to see if the baby is likely to have a hearing problem. Hospitals must report the results of such tests to the Maryland Department of Health and to the parents.

A listing of Maryland hospitals that screen a high percentage of newborns is available at the following website: <http://www.infanthearing.org/unhsprograms/maryland.html>.

Important Contact Information

Early Hearing Detection & Intervention Contact
Maryland Universal Newborn Hearing Program
Department of Health and Mental Hygiene
201 West Preston Street, Room 423A
Baltimore, MD 21201
(410) 767-5093

C. Virginia

Virginia law requires all hospitals to test newborns for hearing problems while they are still in the hospital and to report any problems to the parents and to state authorities. Exceptions may be granted for parents who, for religious reasons, object to the testing.

A listing of Virginia hospitals that test a high percentage of newborns is available at the following website:
<http://www.infanthearing.org/unhsprograms/virginia.html>.

Important Contact Information

Early Hearing Detection & Intervention Contact
Speech & Hearing Services
Virginia Department of Health
1500 Main Street, Room 105
Richmond, VA 23219
(804) 786-1964 or 1(866) 493-1090

Virginia Hearing Impairment Identification and Monitoring System
(804) 371-4131
TTY 1(800) 828-1120

Post-Birth Hearing Screening

If your baby's initial hearing test shows a risk of a hearing problem, your baby should receive a follow-up hearing evaluation before three months of age. This evaluation helps determine if the child has a hearing problem and, if so, the nature and severity of the hearing problem. Furthermore, if your child has never received a hearing screening, he or she should be tested as soon as possible. Most of the Early Hearing Detection and Intervention Contacts listed above can also provide assistance with post-birth hearing screenings.

Many studies suggest that a newborn or infant with a significant hearing problem who receives help by six months of age will perform significantly better in language development than an infant whose hearing problem is identified after six months of age. Hearing tests should be performed as early as possible so that the appropriate steps can be taken to help the child.

Early Intervention

Although hearing is an important method of communicating, it is not the only method. Parents of children with hearing loss have several options for communicating with their child, such as sign language. Many types of educational services are available to assist parents and children. Understanding these choices can be confusing and overwhelming. Clearly, there is no best answer for everyone. The following website provides information on some of the alternatives that are available:
<http://www.infanthearing.org/earlyintervention/index.html>.

The Individuals with Disabilities Education Act (IDEA) requires states to provide appropriate educational opportunities for deaf and hard-of-hearing students and provides funding to help states implement various forms of special education for children with hearing problems. Contact the Early Hearing Detection and Intervention Contact for the area in which you live for further information.

Financial and Insurance Implications for Screening

A. District of Columbia

Under the District of Columbia's Newborn Hearing Screening Act, all health plans must include coverage for newborn hearing screening. If the person is on Medicaid, the Early and Periodic Screening, Diagnosis, and Treatment Program (EPSDT) is required and includes hearing screenings. For more information, contact the Early Hearing Detection and Intervention Contact for the District of Columbia listed above.

B. Maryland

Under Maryland's Universal Newborn Hearing Screening Program insurance providers must provide coverage for hearing screenings in every health insurance policy they sell. For more information, or if you are uninsured and would like your child to be tested, contact the Maryland Early Hearing Detection and Intervention Contact listed above.

C. Virginia

Virginia's Universal Newborn Hearing Screening Program requires insurance providers to provide coverage for hearing screenings in every health insurance policy they sell. Virginia has also established a fund to help the uninsured find and pay for hearing screenings. For more information, contact the Virginia Early Hearing Detection and Intervention Contact listed above.

HIV and AIDS

Many resources are available to help people with Human Immunodeficiency Virus (HIV) and Acquired Immunodeficiency Syndrome (AIDS), and to provide information to people who want to learn more about HIV and AIDS. People with HIV/AIDS also have certain rights. This chapter discusses some of the resources and rights.

Overview of HIV and AIDS

AIDS is a disease caused by a virus known as HIV. People who have HIV in their bodies have an HIV infection. People who have an HIV infection are sometimes called "HIV-positive." Almost all people who have an HIV infection will eventually develop (become sick with) AIDS. Often, however, it takes many years for a person to develop AIDS, and there are things people with HIV infections can do to help themselves stay healthier for longer.

People catch HIV by having certain kinds of contact with other people. HIV is in blood, semen, vaginal fluid, and breast milk from people who have HIV. If blood, semen, vaginal fluid, or breast milk from a person who has HIV gets into the body of another person, that other person can catch HIV. HIV usually gets into people's bodies through their veins, anus or rectum, vagina, penis, or mouth. HIV can also get in through people's eyes, the inside of the nose, and through cuts and sores.

For these reasons, it is very unsafe to have any kind of sex with a person who has HIV. It is much safer to have sex with protection (such as a condom or dental dam) than it is to have sex without protection. But, it is safest not to have sex at all with a person who might have HIV. It is also very unsafe to share needles or other drug injection equipment ("works") with other people. It is safer not to share needles or other works with anyone else than it is to share these things. However, it is safest not to inject street drugs at all.

It is important to remember that people who have HIV infections may not look or feel sick, but they can still give HIV to other people.

A woman who has an HIV infection and is pregnant can give HIV to her baby before he or she is born or while he or she is being born. Mothers who have an HIV infection can also give HIV to their babies by breast feeding them.

HIV attacks the body's immune system (the body's way of protecting itself from getting sick) and destroys a particular part of the immune system. HIV kills "CD4+ T cells," which are also called "T-helper cells." The immune system needs to have CD4+ T cells to work. Healthy people have many CD4+ T cells. Over time, a person with HIV infection has fewer and fewer CD4+ T cells because the HIV virus kills these cells. When a person with HIV infection has below a certain number of CD4+ T cells, he or she is considered to have AIDS.

When a person's body has very few CD4+ T cells, the person can get sick very easily. People with very few CD4+ T cells get sicker from common germs than people who have a normal number of CD4+ T cells. Also, people who have very few CD4+ T cells get sick from germs that do not usually cause sickness in people with a normal number of CD4+ T cells. Cancer can also develop more easily in people who have very few CD4+ T cells. The types of sicknesses that people with AIDS get are called "opportunistic infections" because they use the opportunity that AIDS gives them to cause illness.

Certain sicknesses are seen very often in people who have AIDS and are very rare in people who do not have HIV or AIDS. These sicknesses are often called "AIDS-defining conditions." Even if a person does not have a low enough number of CD4+ T cells for a doctor to say that the person has AIDS, a doctor may say that the person has AIDS if he or she has one or more AIDS-defining conditions.

When HIV enters a person's body, the body makes "antibodies" to try to fight the HIV. HIV tests that clinics and doctors use to tell whether a person has an HIV infection work by seeing (detecting) these antibodies. But, a person's body may not make antibodies until up to six months after HIV has gotten into it. So, even if a person has had an HIV test done and the test did not show that the person had HIV (the test was negative), the person still might have HIV and not know it if they have had unsafe contact with someone else who has HIV within six months before having the test done. So, even if a person has tested negative for HIV, they may still be able to give the infection to another person.

For help managing their disease, individuals with HIV/AIDS should see a doctor, other health care provider, or counselor who has experience in helping people with HIV/AIDS. Doctors can prescribe medicines that reduce the amount of HIV in a person's body and can slow down the killing of CD4+ T cells and the development of AIDS. Medicines that reduce the risk of opportunistic infection are also available. A healthy lifestyle (doing things like eating healthy foods and not taking street drugs) can also help to boost the immune system and slow the development of AIDS. Doctors, other health care providers, and counselors can teach people how to live a healthier lifestyle.

Sources: Centers for Disease Control and Prevention Web site, particularly the Divisions of HIV/AIDS Prevention (<http://www.cdc.gov/hiv/dhap.htm>) and CDC links therefrom; U.S. Department of Health and Human Services, HIV/AIDS Treatment Information Service publication "HIV and Its Treatment: What you Should Know," 2nd Edition, September 2002 (can be obtained at <http://www.aidsinfo.nih.gov/other/hivtr.pdf>); National Institute of Allergy and Infectious Diseases, National Institutes of Health, "How HIV Causes AIDS" Factsheet (<http://www.niaid.nih.gov/factsheets/howhiv.htm>).

Important Contact Information

There are many sources of information to learn more about HIV and AIDS generally. The following list includes both governmental and other (for example, private and community-based) sources. However, as with all resource lists in this chapter, the list does not contain all of the resources that are available.

CDC National AIDS Hotline – an anonymous and confidential hotline offering referrals to services and answering questions about HIV/AIDS

1(800) 342-AIDS (2437)

1(800) 344-7432 Español

TTY 1(800) 243-7889

<http://www.cdc.gov/hiv/dhap.htm>

National AIDS Information Clearinghouse – offers information about HIV/AIDS to professionals and the public
P.O. Box 6003

Rockville, MD 20849-6003

1(800) 458-5231 (English/Español)

TTY/TDD 1(800) 243-7012

Whitman-Walker Clinic – D.C. AIDS Information Line

(202) 332-AIDS (2437)

(202) 328-0697 (Español)

TTY (202) 939-7814

Virginia STD/AIDS Hotline

1(800) 533-4148 (in Virginia)

1(800) 344-7432 (in Virginia – Español)

Department of Health and Human Services

HIV/AIDS Treatment Information Service (AIDSinfo) – for information on HIV/AIDS

P.O. Box 6303

Rockville, MD, 20849-6303

1(800) HIV-0440 (0440) (English and Español)

TTY 1(888) 480-3739

<http://www.aidsinfo.nih.gov/>

E-Mail: atis@hivatis.org

The Body – a useful on-line resource about HIV and AIDS

<http://www.thebody.com/>

Testing for HIV Infection, Reporting of Test Results, and Privacy

The only sure way to tell whether a person has an HIV infection is by an oral or blood test. And, as described above, testing can sometimes provide a "false negative" result, leading a person to believe that he or she does not have an HIV infection, when, in fact, he or she does have an HIV infection. Initial testing for HIV infection is performed using a test that looks for antibodies to HIV. This kind of test is called an "HIV antibody test." It can take up to six months from the time of HIV infection before the infection can be detected by HIV antibody tests. Therefore, if a person wants his or her test results to be accurate, it is especially important that he or she not take part in unsafe activities for at least six months before taking the test. The sooner an HIV infection is diagnosed, the greater the possibility that it will respond to treatment.

A. Types of Testing

Anonymous testing means that the person being tested does not tell his or her name to anyone. Instead, the person is given a number that he or she can use to retrieve his or her test results.

In confidential testing, the person being tested does tell his or her name to the people performing the testing. State laws do provide some confidentiality for test results. This means that the doctor or clinic doing the test can't tell just anyone about them. However, if the test indicates that the person tested is infected with HIV, then this information, including the person's name, may be provided to certain state agencies and other people, depending on the state laws.

People who do not want anyone to know about their test results should have the test performed anonymously.

Information of specific interest to people with HIV/AIDS is presented in this section. Additional information on the privacy of your medical information can be found in our chapter on Medical Records.

B. Counseling and the Meaning of Test Results

It is important for people to be tested at a site that provides counseling. Counselors can help people understand the meaning of their test results.

If a person's test is negative, counselors can provide that person with information about how to protect himself or herself from becoming infected.

If the results of the test are positive, counselors can help a person to arrange for a second test to confirm whether he or she is actually infected with HIV. Counselors can also provide information about how to obtain medical assistance, how to protect others from becoming infected, and what behaviors (like eating healthy food and avoiding diseases) can help a person with HIV stay well for longer.

Important Contact Information About Testing

The following groups provide information about testing and can provide referrals to places where people can be tested for HIV infection.

CDC National AIDS Hotline – provides information about testing and referrals

1(800) 342-AIDS (2437)

1(800) 344-7432 (Español)

TTY 1(800) 243-7889

<http://www.hivtest.org/> – provides information and lets you search testing organizations by geographic location

District of Columbia Department of Health

HIV/AIDS Administration

(202) 727-2500

http://www.dchealth.dc.gov/services/administration_offices/hiv_aids/pdf/HIVdctestsites.shtm

The following are government and private organizations that offer HIV antibody testing. Only a few organizations are listed, but many others exist.

Elizabeth Taylor Medical Center
1701 14th Street, NW
Washington, DC 20009
(202) 797-3500
(202) 939-1556 (Español)

Max Robinson Center
2301 Martin Luther King, Jr. Avenue, SE
Washington, DC 20020
(202) 678-8877

Whitman-Walker Clinic of Suburban Maryland
7676 New Hampshire Avenue, Suite 411
Takoma Park, MD 20912
(301) 408-5000
TDD (301) 408-5041

Maryland AIDS Administration
HIV Counseling and Testing Services (CTS)
500 North Calvert Street, 5th Floor
Baltimore, MD 21202
(410) 767-5227
1(800) 358-9001

The Maryland STD and HIV Prevention Program
(240) 777-1760

Alexandria Health Department
517 N. St. Asaph Street
Alexandria, VA
(703) 838-4389 (STD and HIV Clinic)
(703) 838-4400

Arlington Health Department's Edison Center
1800 North Edison Street
Arlington, VA 22207
(703) 228-5175 (AIDS/STD services)
(703) 228-5200 (AIDS/STD information line; English and Español)
(703) 228-4960 (Español)

Medical Screening Services – Nationwide Rapid HIV/STD Screening
1(888) 516-3342
<http://www.AIDS-testing.com>

"Home Access®" Test Kit – a home test approved by the U.S. Food and Drug Administration, available at drug stores or ordered directly from the company, Home Health Testing®
399 Pepper Street NE
Melbourne, Florida 32907-1344
1(800) 211-6636
<http://164.109.56.232/orderinginfo.htm>

Health Care for People With HIV/AIDS

A. Types of Treatments Available

People who are infected with HIV or who have AIDS may be helped by at least two different types of medications. The first type, called "antiretrovirals," are medications that reduce the amount of HIV present in a person's body. These medications may help a person stay healthy for longer. The second type are called "prophylactics" or preventative treatments or medicines. Preventative treatments can help to prevent the occurrence of opportunistic infections.

It is often most helpful for a person with HIV/AIDS to take several kinds of medicine. Usually, it is necessary to take many pills at many different times every day. This may be very complicated, expensive, and inconvenient. Medicines may also have unpleasant side effects. Once a medicine is started, it is usually extremely important not to miss any of the doses of the medicine.

However, medicines can help people stay healthy for longer and to live longer. Doctors and counselors can help a person to decide when it is best for him or her to start taking medicines. Information about specific medicines for HIV/AIDS is available from many sources, including the sources listed above under "Sources of Information About HIV/AIDS Generally."

B. Resources for Medication and Treatment

The Whitman Walker Clinic provides medical care, case management, dental care, eye care, medicines and other services for people with HIV/AIDS at the following locations:

The Fleming-Morgan Access Center
1701 14th Street, NW
Washington, DC 20009
(202) 939-7660

Max Robinson Center
2301 Martin Luther King, Jr. Avenue, SE
Washington, DC 20020
(202) 678-8877

Whitman-Walker of Northern Virginia
5232 Lee Highway
Arlington, VA 22207-1621
(703) 237-4900
(703) 531-4933 (services)
TDD (703) 237-9340

Whitman-Walker of Suburban Maryland
7676 New Hampshire Avenue, Suite 411
Hyattsville, MD 20783
(301) 439-0731
TDD (301) 408-5041

D.C. Department of Health
HIV/AIDS Administration – AIDS Drug Assistance Program
(202) 727-2500

D.C. CARE Consortium – provides services and referrals to people with HIV/AIDS
1436 U Street, NW – Suite 400
Washington, DC 20009
(202) 332-9091
<http://www.dccare.org/>

Maryland AIDS Administration – provides assistance in getting medicines and payment of health insurance premiums
500 North Calvert Street, 5th Floor
Baltimore, MD 21202
(410) 767-6535 or 1(800)205-6308
(410) 767-5227 or 1(800) 358-9001
<http://www.dhmh.state.md.us/AIDS/index.htm>

Maryland Pharmacy Program – helps low-income Maryland residents pay for medicines
P.O. Box 386
Baltimore, MD 21203-0386
1(800) 492-1974
(410) 767-5394
<http://www.dhmh.state.md.us/mma/mpap/>

Alexandria Health Department
Flora K. Casey Clinic – provides medical services
1200 North Howard Street
Alexandria, VA 22304
(703) 519-5979 (English and Español), ext. 211 for intake

Arlington Health Department – Edison Center – provides medical services
1800 North Edison Street
Arlington, VA 22207
(703) 228-5175
(703) 228-5200 (AIDS/STD Services information line)
(703) 228-4960 (Español)

Virginia AIDS Drug Assistance Program (ADAP) – assists in obtaining medication
1(800) 533-4148 Virginia HIV/STD Hotline
1(800) 344-7432 (Español)
<http://www.vdh.state.va.us/std/adap.htm>.

The Inova Juniper Program – provides medical and other services
(703) 204-3780

Other Public Benefits Available to People With HIV/AIDS

Social Security, Medicare, and Medicaid (which are briefly discussed in this section) are only three of the public benefit programs through which people with HIV/AIDS may qualify for assistance. Different forms of assistance are available. Examples of types of assistance that may be available include direct monetary assistance, food stamps, and health insurance.

People who need help in applying for public benefits can contact one of the providers of legal services listed in the section of this chapter called "Legal Assistance."

A. Social Security

People with HIV/AIDS may be entitled to receive benefits (money) from Social Security under two separate programs: (1) Social Security Disability Insurance (SSDI) and (2) Supplemental Security Income (SSI). To be eligible for either program, individuals must have symptomatic HIV infection that inhibits their ability to work. Some children with HIV may be able to qualify for SSI as well.

Whether a person is eligible for SSDI depends on the work that that person, or, in certain cases, that person's parent or deceased spouse, has done in the past. In general, people who earned more qualify for larger benefits. SSI provides benefits to people who have low income and/or limited assets.

The Social Security Administration defines a disability on the inability to work. Only people whose disability is expected to last for more than one year or to result in death qualify for benefits. People with HIV infection whose ability to work is very limited by the infection have a good chance of qualifying for Social Security benefits.

To decide whether a person qualifies for benefits, the Social Security Administration will generally need financial information about a person's income and assets, as well as information about a person's medical condition and how it affects his or her ability to work. Official records, such as tax forms and medical records are needed. However, an application for benefits can be started without all of the needed information, so it is better for a person who thinks he or she might qualify for benefits not to delay in applying.

Important Contact Information

Social Security Administration
1(800) 772-1213 (English and Español)
TTY 1(800) 325-0778
<http://www.ssa.gov>

B. Medicare/ Medicaid

Medicare and Medicaid are health insurance programs for people who meet certain criteria. Medicare is funded and run by the federal government. Medicaid is funded by both the federal and the state governments and is run by the state governments.

People who have been receiving Social Security Disability Insurance (SSDI) for 24 months qualify to receive Medicare benefits. Medicare covers hospital services, skilled nursing care, home health services, hospice care, physician services, outpatient hospital care, medical equipment, and medical supplies. However, Medicare does not cover prescription drugs, does not cover long-term care, has high cost-sharing requirements (deductibles and co-insurance payments), and provides only limited coverage of community-based care, hospice services, home health care. Medicare is administered by the federal government.

People must have income below a specified level to qualify for Medicaid benefits. In Washington, D.C., Maryland, and Virginia, Medicaid helps to pay for prescription drugs. Medicare beneficiaries may qualify for programs such as the Qualified Medicare Beneficiary (QMB) Program or the Specified Low-Income Medicare Beneficiary (SLMB) Program, each of which pays part of the cost-sharing requirements of Medicare.

For additional information, see the chapters of this manual on the Medicare program, the Medicare Savings Program, and the Medicaid program.

Clinical Trials

Researchers (usually doctors and scientists) are continuously looking for new ways to prevent and diagnose HIV infection and AIDS and for new treatments for HIV infection and AIDS. When a treatment or method of diagnosing or preventing HIV infection or AIDS is promising enough, researchers seek to test its safety and performance in people ("human subjects"). These tests are called "clinical trials" or "clinical investigations."

People with HIV/AIDS may be eligible to participate in clinical trials. People who participate in clinical trials may be given medicines, and may receive medical tests and health care related to the clinical trial. Medicines, tests, and medical care related to the clinical trial are usually provided for free to the people participating in the trials. In fact, people may be paid to participate in trials. However, a person should find out a lot of information about a clinical trial before signing up to participate in it.

Additional information on this topic can be found in this manual's chapter on Clinical Trials.

Important Contact Information

HIV/AIDS Treatment Information Service (AIDSinfo) – provides information about clinical trials related to HIV and AIDS
P.O. Box 6303
Rockville, MD 20849-6303
1(800) HIV-0440 (448-0440) (English and Español)
TTY 1(888) 480-3739
<http://www.aidsinfo.nih.gov/>

Whitman-Walker Clinic – offers information on clinical investigations
(202) 745-6137
(202) 745-6111

D.C. CARE Consortium:
1436 U Street, NW – Suite 400
Washington, DC 20009
(202) 332-9091

Marriage and Pregnancy

The nature of HIV infection and its modes of transmission raise issues in certain in the areas of marriage and pregnancy.

A. Marriage

Washington, D.C., Maryland, and Virginia do not require a person applying for a marriage license be tested for HIV. Maryland and Virginia do not require any blood tests to get a marriage license. Washington, D.C. does require a blood test before a marriage license can be obtained, but it is to determine whether a person wanting to get married has syphilis, not HIV. Therefore, a person can't be forced to have an HIV test before he or she gets married in Washington, D.C., Maryland, or Virginia.

B. Pregnancy

The CDC recommends that all pregnant women be tested for HIV infection. HIV can be passed from a woman to her baby before the baby is born, during childbirth, or through breast milk. If a woman knows she has HIV, she can take steps to avoid passing the virus to her child. There are drugs (particularly, zidovudine (zy-DAH-vue-deen), also known as AZT or Retrovir®) that can lower the chance that a woman will pass the virus to her baby before, during, or after birth. Also, women who know that they have HIV can avoid breastfeeding to lower the risk of transmitting HIV to their babies after birth.

Although there are important benefits to HIV testing for pregnant women, and many, many doctors, scientists, and other health care providers think that it is a very good thing to do. Washington, D.C., Maryland, and Virginia do not require pregnant women be tested for HIV. Therefore, if a woman is pregnant, she may want to be tested for HIV to help protect her baby's health. In Maryland and Virginia, doctors are required to provide pregnant women with counseling about the benefits of HIV testing. However, pregnant women can't be forced to have the test in Washington, D.C., Maryland, or Virginia.

More information on pregnancy and HIV can be found by contacting the sources listed above in the section called "Sources of Information About HIV/AIDS Generally."

Discrimination

People with HIV/AIDS may find that they are discriminated against in a variety of areas. However, there are federal and state laws that make this type of discrimination illegal. Specifically, employers, people selling or renting housing, hotels, doctors and dentists, providers of public transportation, and schools can't treat people with HIV/AIDS differently that they treat people without HIV/AIDS.

For example, an employer who is offering a job can't deny a person with HIV/AIDS the job if the person with HIV/AIDS has the skills, education, and other required abilities or characteristics needed to do the job. In other words, an employer cannot deny a person a job just because he or she has HIV/AIDS. Similarly, an apartment house manager can't refuse to rent an apartment to a person with HIV/AIDS if the person can afford the rent and meets any other requirements that apply to everyone renting apartments in the same building. Again, an apartment house manager can't deny a person an apartment just because he or she has HIV/AIDS.

This area of the law is very complicated. For example, an employer cannot refuse to make health insurance available to an employee who has HIV/AIDS. However, the insurance company or HMO can limit the amount it will pay for HIV/AIDS treatment or the specific services it will cover.

The "Discrimination" chapter in this manual provides more information about this topic. Also, there are government and private organizations that help people deal with this area of the law. People who believe they have been discriminated against can contact one of the legal services providers listed below.

Legal Assistance

Many national and local organizations provide free or low-cost legal assistance to people who have low incomes and/or HIV/AIDS. Some of these organizations are described in this section. For information on obtaining legal assistance generally, see this manual's chapter on "Finding a Lawyer."

Lambda Legal – offers assistance with legal matters involving sexual orientation or HIV/AIDS
 (212) 809-8585 – National Headquarters
<http://www.lambdalegal.org/cgi-bin/iowa/index.html>
<http://www.lambdalegal.org> .

Whitman-Walker Clinic Legal Services Program
 1407 S Street, NW
 Washington, DC 20009
 (202) 939-7627 (English and Español)

Whitman-Walker Clinic Legal Services Program
 5232 Lee Highway
 Arlington, VA 22207-1621
 (703) 237-4900 (English and Español)
 (703) 237-9340 (TTY)

Medical Debt Collection

You are responsible for your medical bills and debts. If you do not pay a valid medical bill, your bill may be turned over to a "debt collector." Debt collectors are people or organizations, other than doctors, medical professionals or hospitals, that are paid to collect debts from consumers. These debt collectors can be lawyers, individuals, agencies, or companies that regularly collect past due debts.

The law clearly states that debt collectors must treat you fairly. The Fair Debt Collection Practices Act (the FDCPA) is a federal law that applies to personal, family, and household debts. The FDCPA forbids debt collectors from using unfair, false, misleading, or abusive practices while trying to collect a claimed debt from you or your family. Your rights under the FDCPA include the following:

When and How a Debt Collector Can Contact You and Others

- Debt collectors generally may contact you only between 8 a.m. and 9 p.m., unless you agree otherwise.
- Debt collectors may not contact you at work if they know your employer does not approve of such contacts.
- Debt collectors must truthfully identify themselves and their employer when they call you on the phone.
- Debt collectors generally may not contact other people about a debt they claim you owe, unless you agree to such contacts.
- If you tell a debt collector in writing that you refuse to pay a debt or you want the debt collector to stop contacting you, the debt collector generally must stop contacting you except to tell you that that debt collector or the medical provider will take certain actions allowed by law.

What a Debt Collector Cannot Say or Do to You

- Debt collectors may not harass, oppress, abuse, threaten violence, or use profanity with you.
- Debt collectors may not lie when collecting debts, such as falsely suggesting that you have committed a crime or stating that they represent the government (for example, the police or a court).
- Debt collectors may not give you false or misleading forms.
- Debt collectors must not tell or threaten to tell others that you failed to pay a debt, but may give accurate reports to credit reporting agencies where allowed by law.
- Debt collectors must not threaten to take your property or threaten to take (or "garnish") your wages unless they actually intend to do that under the law.

How You Can Confirm or Dispute a Medical Bill or Debt

- You have the right to know the amount of the debt, the name of the creditor (doctor, hospital, etc.) and the reason for the charges.
- You can dispute whether you owe all or part of a debt if you tell the debt collector of the facts in writing no more than 30 days after your first contact with the debt collector. After that, the debt collector must first give you proof of the debt (such as a copy of a bill) before continuing to try to collect the debt.
- If you have more than one debt, you have the right to decide which debt or debts to which your payments will apply. The debt collector cannot apply your payments to any bill or part of a bill unless you agree.
- The debt collector cannot charge you collection fees, interest, or other extra charges unless such fees or charges are clearly allowed in your original agreement with the medical provider or are allowed by law.

How You Can Learn About and Protect Your Rights

You can learn more about your rights by contacting the Federal Trade Commission (the FTC). You should also contact the FTC if you think your rights are being violated. If your rights are violated, you may be entitled to payment for any actual damages and possibly payment for additional damages of up to \$1,000.

Federal Trade Commission
Consumer Response Center
Federal Trade Commission
600 Pennsylvania Ave, NW
Washington, DC 20580
1(877) FTC-HELP (382-4357)
<http://www.ftc.gov> or www.ftc.gov/ro/eastcentral.htm

How You Can Avoid Debt Problems and Protect Your Credit

If you do not pay a valid medical bill or debt, this may harm your credit history and make it more difficult to buy a house or car in the future.

Taking an active role in managing your medical bills is usually the best way to avoid debt problems. Most medical providers will talk about payment plans and options with you. If you are uninsured, many medical providers may charge you higher rates than the rates they charge insurance companies for the same services. Because of this, if you pay part of a bill, the medical provider might actually agree to write off some of the money it claims you owe. Do not wait for your bill to be turned over to a debt collector. Once a debt is turned over to a debt collector, the debt collector will take a significant part of any money you pay and the medical provider will receive less. Therefore, working out a payment plan or other option with the medical provider before the debt goes to a debt collector can actually help both you and the medical provider.

Debt Counseling Contact Information

If you need further help with debt questions or debt problems, there are many organizations that can help you. The following are some of the organizations that provide debt counseling services in the local area:

Consumer Credit Counseling Service of Greater Washington, Inc.
1275 K Street, N.W.
Suite 885
1(800) 747-4222 or (202) 682-1500
<http://www.debtfreeforme.com>

Myvesta
6 Taft Court
Suite 301
Rockville, MD 20850
1(800) MYVESTA (680-3328) or (301) 762-5270
<http://www.myvesta.org>

Credit Counselors
8136 Old Keene Mill Road
Suite A-304
Springfield, VA 22152
1(888) 737-2933
<http://www.repaydebt.com>

Medical Malpractice

If you believe that you were injured due to the poor quality of care you received from a doctor or other health care provider, you may wish to file a medical malpractice lawsuit against the provider. These lawsuits can ask for compensation for past and future medical costs, lost wages, and other damages. You may especially wish to file such a lawsuit if you have sustained a serious injury that will require costly, long-term care and rehabilitation and you are prevented from working.

Medical malpractice suits must be filed within a set time period or you may forever lose your right to bring the claim. This chapter provides a general overview of medical malpractice claims and some of the things you and your attorney should keep in mind if you are considering filing such a claim.

If you have been injured and have not already obtained medical care or treatment for your injury, you should do so at once. If you do not get care for your injury and the injury gets worse as a result, you may compromise your right to pursue a claim against the provider or to receive compensation for your injury.

Because medical malpractice claims are subject to a lot of rules and restrictions that don't apply to other types of cases, you may wish to contact a qualified medical malpractice attorney who can advise you on your particular case and assist you in coordinating your medical care and treatment. Medical malpractice attorneys usually take cases on a "contingency fee" basis, which means instead of requiring you to pay for the attorney's services upfront, the attorney will collect his or her fee from any damage award that you receive as a result of your malpractice case. Before you hire an attorney to handle your case, you and the attorney should agree in writing what that fee will be. Usually the attorney will ask for a percentage of whatever you receive as a result of your case.

What is Medical Malpractice?

Medical malpractice occurs when a doctor or other healthcare provider is negligent. In other words, he or she fails to properly treat a patient, and the improper treatment causes the patient to suffer a new injury.

To prove a case of malpractice, you must prove that the health care provider made a mistake that another reasonable provider in your community practicing in the same field of medicine would not have made. More than likely, you will need an expert witness to testify to the fact that the provider acted incorrectly. You must also prove that the provider's mistake harmed you. If you were injured, but your injury was not the provider's fault, you will not be able to prove your case. Conversely, even if your doctor was careless, if you are healthy and have suffered no injury or financial loss, your claim will be difficult to prove. If your own actions contributed – even only in part – to your injury (for example, if you didn't do something that a reasonable person would have done to protect themselves), you may not have a case.

What Are Some Examples of Medical Malpractice?

The following are examples of mistakes that providers sometimes make that might be medical malpractice:

- Failing to diagnose a condition because the provider read an x-ray incorrectly or ordered the wrong laboratory tests;
- Giving a patient the wrong medicine, or the wrong amount of the right medicine;
- Performing surgery on the wrong body part; and
- Leaving a surgical sponge or other objects in the patient's body after surgery.

Whether a health care provider has committed malpractice in a given case depends on many things, and may be different in each case. The standard of care expected in one community may differ from the standard in another. For example, the standard of care expected in a city may be higher than that expected in the country, where there may be fewer doctors and less advanced medical equipment.

How Much Time Do I Have To File A Claim?

If you think you have been injured as a result of a provider's negligence, and you want to file a malpractice claim against the provider, state law requires that you file your claim within a certain period of time. This time period is called the "statute of

limitations." These statutes of limitations vary by state, but in this area, can be as short as two years after you were injured. You should contact an attorney immediately if you are concerned about these filing deadlines. For more information on finding a qualified attorney, see the chapter in this manual called "Finding a Lawyer."

The laws governing when you have to file a medical malpractice claim are often confusing and may provide exceptions to extend a particular filing deadline. Generally, however, the rules for this area are as follows:

District of Columbia

- Generally, the statute of limitations is three years from the date that you know or should have known of the injury.
- For minors, the statute of limitation is three years following the minor's 18th birthday.
- For someone who is mentally incompetent or in prison, the statute of limitations is three years from the date the person is no longer mentally incompetent or in prison.
- If your claim is based on malpractice that killed the patient, the claim is called a "wrongful death" action and the statute of limitations is one year from the date the person died.

Maryland

- Generally, the statute of limitations is five years from the date of the injury or three years from the date you first discovered the injury, whichever is earlier.
- For children under age 11, the statute of limitations is five years from the date the child reaches 11. (Additional exceptions may apply if the injury involves a foreign object or the reproductive system.)
- For wrongful death cases, the statute of limitations is three years from the date the person died.

Virginia

- Generally, the statute of limitations is two years from the date of the injury.
- In some cases, such as where a foreign object is left inside of a patient after surgery and the patient is unaware of the injury, the statute of limitations is extended one year from the date the injury is discovered or reasonably should have been discovered, but not more than 10 years after the actual date of injury.
- For children and adolescents between the ages of eight and 18 (if injured after July 1, 1987), the statute of limitations is two years from the date of injury.
- For children under the age of eight, claims must be filed by the child's 10th birthday.
- For patients who are incapacitated, the filing period may be longer, except in cases where a guardian or committee is appointed to represent the patient, in which case a one-year limitation period will apply.
- For wrongful death cases, the statute of limitation is two years from the date of death.

What Is Arbitration?

Sometimes you will be required to arbitrate your claim instead of, or before, trying your case in court. During arbitration, a panel or arbitrator hears the case rather than a judge and jury. They decide whether the provider was negligent and if so, how much you should receive in damages. In many cases, arbitration is faster and cheaper than going to court. However, just as in court, if your case is before an arbitrator, you will need to prove that the provider was negligent and that his or her negligence caused your injury.

There are generally two ways that a medical malpractice claim ends up in arbitration: if state law requires arbitration, or if you have signed an agreement saying that you will arbitrate your claim instead of going to court. In this area, Maryland requires that all medical malpractice claims be filed first with the Maryland Health Claims Arbitration Office, Virginia requires that medical malpractice claims be reviewed by an arbitration panel if one of the party's asks for it, and DC requires medical malpractice claims to be arbitrated at the option of the judge. The rules governing this process in each state are very strict, so you may wish to consult with an attorney before filing a medical malpractice claim with a court or arbitrator.

Agreements that require arbitration generally arise in two ways: you sign an agreement with your health care provider before your treatment begins that says you will arbitrate any claims arising from your treatment, or you sign an agreement

with your HMO, agreeing to arbitrate any claims arising from the health benefits you receive from the HMO. Generally, courts will uphold arbitration provisions so long as the contract between you and the other party was valid. There are different restrictions in each state as to what someone can require you to agree to with respect to arbitration of a medical malpractice claim, however, so you may wish to consult with an attorney before going to arbitration under an arbitration agreement.

Can I Hold My HMO Liable for Medical Malpractice?

Although HMO doctors can be sued individually for negligence, many attempts to hold HMOs themselves accountable for medical malpractice are unsuccessful. HMOs often claim that a federal statute, known as ERISA, prevents the courts from applying state medical malpractice laws to them. Some courts have agreed with that argument and some have not. Many courts have said it depends on exactly how you describe the case that you are bringing. Generally, courts are more likely to let you sue an HMO for medical malpractice if the actions of the HMO underlying your claim concerned your medical treatment rather than whether you had insurance coverage for a particular condition.

Medical Records and Your Privacy Rights

This chapter answers questions you may have about the privacy of your medical records. It discusses your rights to privacy under federal law and in the District of Columbia, Maryland, and Virginia. This chapter also gives you some practical advice on protecting the privacy of your medical information.

Federal Law

A. Are There Any Federal Laws That Would Protect My Medical Information From Being Disclosed?

There are several federal laws that protect your medical information. Generally, the federal laws set a minimal level of protection for your medical records and for your privacy rights. That means a state law can give you even more protection than the federal law, but not less. For example:

- Federal law requires that a provider let you see your information within 30 days. But, Virginia law requires that providers let you see your information within 15 days. (That means the Virginia law is the one the provider has to follow).
- The District of Columbia laws do not require a health maintenance organization (HMO) to let you see your medical information. But, federal law requires HMOs to let you see it within 30 days. (That means the HMO has to follow the federal law).

So as you can see, if a state law gives you more rights than the federal law, then everyone has to follow the state law. And, if a state does not give you a right that the federal law gives you, then the federal law is the one everyone has to follow.

B. What is HIPAA?

There is a federal law called the "Health Insurance Portability and Accountability Act of 1996." Many people call it "HIPAA" for short. This law also has privacy regulations that doctors, health plans, and others have to follow. This is often called the federal "Privacy Rule." These are an important set of federal rules that give people a set of basic protections and rights regarding their medical information. The rules do three important things:

1. Tell the people that handle your information what they can and cannot do with your information,
2. Require those people to:
 - write down certain uses and sharing of your information,
 - be trained on protecting your information, and
 - be punished if they do something wrong with your information.
3. Give you a number of new rights, like
 - the right to receive a "Notice of Privacy Practices" that tells you how the provider uses and shares your information. (Read this carefully and make sure you agree with everything they are doing),
 - the right to see your information,
 - the right to get a listing of how the provider shared your information,
 - the right to fix certain mistakes in your medical record,
 - the right to request certain restrictions on uses and sharing of your information, and
 - the right to agree or not agree to some uses and sharing of your information.

Other federal and state laws may give you more rights and protection than you get just from this federal law.

State Law

A. How Can I Obtain My Own Medical Records?

1. In the District of Columbia

From Your Health Care Provider (e.g., your doctor or hospital): Under federal and District of Columbia law, most providers are required to allow you to see your medical records. Federal law generally requires that you be allowed to see them within 30 days. Mental health professionals and facilities are required by District of Columbia law to let you see your mental health records within 30 days of your written request. A mental health professional or facility may limit what you can see if they believe that seeing it would be harmful to you or another person. If they limit or refuse to let you see it, they will notify you in writing that:

- what you can see is limited or refused,
- the reasons why your access was limited or refused, and
- the options available to you.

For example, one option allows you to ask an independent mental health professional to give a second opinion on whether you should be able to see your information.

From Your Insurer or HMO: The District of Columbia laws do not require Insurers and HMOs to let you see your medical information. But, federal law requires them to let you see your records.

2. In Maryland

From Your Health Care Provider (e.g., your doctor or hospital): Your health care provider must let you see your medical record within a reasonable amount of time after you have submitted a written request (usually 30 days). If your medical record is about a mental illness, your health care provider may refuse to share some information if he or she believes that the sharing may be harmful to your health or the health of another person. But, if your provider denies your access, he or she must do the following upon your written request:

- make a summary of the unshared part available to you,
- place the summary in your medical record,
- permit examination and copying by another provider authorized to treat you for the same condition as your provider, and
- inform you of your right to pick another provider.

From Your Insurer or HMO: Your insurer, including any Blue Cross or Blue Shield Plan, may let you see your information, but Maryland law does not specify the length of time that an insurer has to let you see that information. HMOs, like health care providers, must let you see your medical information within a reasonable time after your written request. Even though Maryland law does not say how long that is, federal law generally requires that you see your information within 30 days. HMOs may limit sharing of medical records about mental illness in the same way as described above for health care providers.

3. In Virginia

From Your Health Care Provider (e.g., your doctor or hospital): To get your medical records from your health care provider (like your doctor, dentist, or hospital), you need to ask them for a copy. Your provider then has 15 days to do one of four things. Your provider may:

- give you a copy,
- tell you that the information does not exist or cannot be found,
- tell you where the information can be found if the provider does not have the information, or
- deny your request if they feel that the information would harm you. They can also deny it if it would not be consistent with your condition and treatment (e.g., mental health records).

If your request is denied, you can pick a doctor or clinical psychologist (who meets certain criteria) to review the denial of your request. That person will then determine if your records should be made available to you.

From Your Insurer or HMO: An insurer or HMO generally must let you see your recorded personal information within 30 days of a receiving your request.

B. Will My Medical Information Be Disclosed To Others?

1. In The District of Columbia

Health Care Providers: District of Columbia laws do not say when a provider may share your general health records. Your provider likely has to follow the federal privacy laws. Those laws talk about using and sharing your general medical records. For example, the federal privacy law permits sharing your information for your treatment. It also permits sharing to help with your provider's operations (like training, licensing, etc.)

District of Columbia laws do talk about your mental health records. A mental health professional or facility may only share your mental health records for special reasons without your permission. They include sharing:

- within a medical facility,
- as required by law (to promote health and safety),
- on an emergency basis,
- for the collection of fees,
- for research, auditing and program evaluation,
- for court-related purposes, and
- with third-party payors (sometimes).

Note that extra protection is provided to personal notes taken by your mental health professional. These notes may only be shared, if needed, for lawsuits brought by you.

Insurers or HMOs: District of Columbia law does not say when insurers may share your medical information. However, under federal law, HMOs generally can only share your medical information under a limited number of circumstances without your consent. For example, an HMO may share your medical records to the extent necessary:

- to conduct its business,
- as required by law or a court order for certain purposes, and
- where the information is necessary in a lawsuit between you and the HMO.

2. In Maryland

Health Care Providers: Your health care provider may share your medical information with others without your consent for:

- treatment,
- payment,
- administrative/business (e.g., accreditation of a hospital), or
- government purposes (e.g., evaluation of a health care service).

For example, your doctor may share your medical records with another provider who is treating you. Also, a hospital may share your information with its office staff to process your insurance claim. Your mental health information is given a higher level of protection and may only be shared under limited circumstances without your consent.

Insurers or HMOs: Your health care insurer (including any Blue Cross or Blue Shield plan) or HMO generally must obtain your consent prior to sharing your information unless it is for:

- treatment,

- payment,
- assisting the insurer with its administrative functions, or
- governmental/regulatory purposes.

3. In Virginia

Health Care Providers: In general, your health care provider may not share your medical information without your written consent. However, there are several exceptions that allow your provider to share your information without your consent. The exceptions include:

- treating you,
- submitting your information to your insurer or HMO, or
- administering of the provider's practice.

For instance, after you visit your doctor, he or she may share your information for treatment or payment.

Insurers or HMOs: Like health care providers, your insurer or HMO generally must obtain your written permission before sharing your medical information. But, an insurer or HMO is allowed to share your medical information if it is reasonably necessary to assist in complying with other laws. For instance, an insurer or HMO may share your information with your physician for the purpose of ensuring your coverage or benefits.

C. Will Information About My Human Immunodeficiency Virus (HIV) Test Results Be Disclosed Without My Permission?

1. The District of Columbia

The District of Columbia severely restricts when an insurer or HMO may share the fact that you were tested for HIV and the results of that test. In fact, an insurer or HMO may only share that identifiable information with:

- you or your legal guardian,
- a court in response to a court order, or
- a person named in a consent form signed by you or your legal guardian.

2. Maryland

Maryland does not have a general law governing the sharing of HIV test results. But, your physician must tell you if your results are positive. He or she must also offer to help you tell your sexual or needle-sharing partners (current and past). If you say no to telling your partners, then your physician can, under certain circumstances, tell them or tell the local health officer. Also, even though Maryland law does not talk about sharing HIV test results, the federal privacy law applies to all health information that can identify you.

3. Virginia

Your HIV test results are given more protection than your other medical information. Usually, you have to sign a permission form before your results are shared with other people. Beyond this, your HIV test results may only be shared with:

- The Virginia Department of Health;
- Health care providers for consultation or care and treatment for you or your child (if you are a mother who is HIV positive at the time of your child's birth);
- Health care facility staff committees which monitor, evaluate, or review programs or services;
- Medical or epidemiological researchers for use as statistical data only;
- Any person pursuant to a court order;
- Any facility involved in procuring/using body fluids, tissues or organs;
- Any person authorized by law;
- Your spouse; and
- Departments of Health outside of Virginia for disease watching and studying.

Some Practical Advice

There are several things you can do to protect your medical record information from being disclosed:

Request and carefully read your health care providers' and insurers' Notice of Privacy Practice. Under federal laws, most health care providers and health insurers are required to provide you with a written description of how they will use and disclose your health information. Also, the Notice will describe how you may access your medical records, request changes to the information if it is not correct, and restrict its disclosure. All providers and health insurers covered by the federal law are required to provide you with this important document.

Carefully read any form that authorizes the release of your information before you sign. As discussed above, most non-regular sharing will require your written consent. You should carefully read any form permitting sharing of your medical information that you get from anyone (like your doctor, insurer, HMO, or other health care provider or entity). Pay attention to the reasons for the sharing and only sign it if you agree to with those reasons. If you do not understand the permission form, ask them to explain it to you.

Request that your information not be shared. Although your doctor, insurer, or HMO is not required to agree to your request that your information not be shared, some may agree to your request. It is best to ask for this in writing and to discuss your reasons for making the request with your health care provider, insurer, or HMO.

Be careful when you provide medical information to persons or entities other than your doctor, HMO, insurer, or other health care provider or entity. Although your health care provider and insurer/HMO are required to protect your medical information, other entities, such as telemarketers or Internet site providers may not have to protect your information. It is important that you ask them:

- how they protect your information, and
- for a written copy of their privacy policies. (This should explain how they protect your information.)

Because others may not be required to protect your medical information, you may want to consider limiting the information that you give about your health to only those who need it for treatment of an illness or payment of a health claim.

Important Contact Information:

U.S. Department of Justice's Office of Information and Privacy
Freedom of Information Act Counselor Service – for FOIA-related inquiries
950 Pennsylvania Ave., NW
Washington, DC 20530
(202) 514-3642 (FOIA)
<http://www.usdoj.gov/foia>

Office for Civil Rights – for information about privacy-related programs
U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, DC 20201
(202) 690-5896
1(866) 627-7748 – Office of Civil Rights
<http://www.dhhs.gov/ocr/hipaa/>

The Health Privacy Project
1120 19th Street, NW -- 8th Floor
Washington DC 20036
(202) 721-5632
<http://www.healthprivacy.org/>

Mental Health

Federal Law

A. Insurance

Federal law (i.e., the Mental Health Parity Act of 1996 or "MHPA") prevents group health plans from placing annual or lifetime dollar limits on mental health benefits that are lower (less favorable) than annual or lifetime dollar limits for medical and surgical benefits offered under the plan. Although the law requires "parity," or equivalence, with regard to dollar limits, MHPA does not require group health plans and their health insurance issuers to include mental health coverage in their benefits package. The federal law only applies to mental health annual or lifetime cost limits, and not to substance abuse, co-payments, deductibles, or inpatient/ outpatient treatment limits.

B. Substance Abuse Records

If a patient has received substance abuse treatment (drug or alcohol abuse), federal law prevents most facilities from releasing records of that treatment without a court order. For more information on the privacy of medical records, see this manual's chapter called "Your Rights to Your Medical Records and Confidentiality." A subpoena alone is not sufficient for release of the records; the subpoena must be accompanied by an order signed by a judge stating that the judge has found "good cause" for release of the records.

Important Contact Information

American Psychiatric Association
1000 Wilson Blvd., Suite 1825
Arlington, VA 22209-3901
1(888) 357-7924
(703) 907-7300
<http://www.psych.org/>

American Psychological Association
750 First Street, NE
Washington, DC 20002-4242
1(800) 374-2721
(202) 336-5510
<http://www.apa.org/>

Bazelon Center for Mental Health Law
1101 15th Street, NW, Suite 1212
Washington, DC 20005-5002
(202) 467-5730
<http://www.bazelon.org/>

Centers for Medicare and Medicaid Services
Region 3 - Philadelphia Regional Office
150 South Independence Mall West, Suite 216
Philadelphia, PA 19106
(215) 861-4140

National Mental Health Association Information Center
2001 N. Beauregard Street, 12th Floor
Alexandria, VA 22311
(703) 684-7722
<http://www.nmha.org>

Mental Health Parity Act (information)

<http://cms.hhs.gov/hipaa/hipaa1/content/sreg.asp#mhpa>

District of Columbia Law

A. Voluntary Treatment

In the District of Columbia, an adult may request admission to a private or public hospital for "observation, diagnosis, and care and treatment" of a mental illness. A spouse, parent or legal guardian may request admission for a person who is under 18.

A voluntarily admitted patient may be released from the hospital at any time by filing a written request with the hospital's "chief of service." (The "chief of service" is the physician or psychologist who is in charge of the unit of the hospital that is treating the patient, or a member of the staff designated by the chief of service.) The chief of service must release the patient within 48 hours of receiving the patient's request for release.

When the chief of service determines that a voluntary patient has recovered or that continued hospitalization is no longer beneficial to him or her – or is inadvisable – the chief of service may release the patient from the hospital.

B. Involuntary Hospitalization, Detention and Treatment

1. Involuntary Detention

Three categories of people may take a person into custody, transport him or her to a public or private hospital, and apply for his or her admission for emergency observation and diagnosis: (1) an accredited officer or agent of the D.C. Department of Human Services; (2) a police officer; and (3) a physician or psychologist. This is permitted if the agent, officer or doctor has reason to believe that the person is mentally ill and, because of the illness, is likely to injure him- or herself, or others, if he or she is not immediately detained. The patient should be admitted to the hospital if a psychiatrist or psychologist on duty at the hospital examines the patient and signs a certificate stating that the patient has symptoms of mental illness and poses a threat to him- or herself or to others because of the illness.

Within 24 hours after a patient's admission to the hospital, the hospital must inform the patient's spouse, parent, or legal guardian that the patient was admitted. If the hospital wants to keep the patient there for more than 48 hours, the hospital must file a request for permission from a judge. The judge may grant permission for the patient to remain at the hospital for emergency observation and diagnosis for no more than seven days.

Within 48 hours after a judge signs an order requiring hospitalization, a physician or qualified psychologist must examine the patient. If the doctors conclude that he or she is not mentally ill to "the extent that he is likely to injure himself or others if not presently detained," the hospital must release the patient.

If a judge has signed an order permitting emergency hospitalization for seven days, and the treating psychiatrist believes a longer hospitalization is needed, the doctor or hospital must file a "Petition for Judicial Hospitalization" (see below).

If a judge has signed an order permitting emergency hospitalization for seven days, and the patient believes there is no legal basis for the hospitalization, the patient's attorney may request a "probable cause" hearing. The hearing must take place within 24 hours of when the request was filed with the court clerk. If the judge or magistrate finds that there is probable cause to believe that the patient is mentally ill and dangerous to himself or others, the patient remains in the hospital. If the judge or magistrate finds that there is not probable cause, the patient is immediately released.

2. Judicial Hospitalization

Involuntary commitment proceedings (which DC law refers to as "judicial hospitalization proceedings") may be initiated by a spouse, parent, or legal guardian, physician or qualified psychologist, or officer if the person has refused to voluntarily submit to examination. The person requesting the hospitalization (the spouse, parent, guardian, etc.) must file a "Petition for Judicial Hospitalization" in the Family Division, Mental Health Branch of D.C. Superior Court. The petition must be accompanied by:

- a certificate of a physician or qualified psychologist stating that he has examined the person and is of the opinion that the person is mentally ill, and because of the illness is likely to injure himself or other persons; or
- a sworn statement by the petitioner that he or she has good reason to believe that the person is mentally ill and, because of the illness, is likely to injure himself or other persons if allowed to remain at liberty.

3. Court Proceedings

a. Commission on Mental Health

If a Petition for Judicial Hospitalization is filed, the patient is entitled to a hearing before the D.C. Commission on Mental Health. In general, people alleged to be mentally ill have a right to have an attorney appointed to represent them at any proceeding before the Commission. A person must be immediately released if, after a hearing, it is found that he or she is not mentally ill (or at least not to the extent that he is likely to injure himself or other persons).

b. Superior Court

If the Commission on Mental Health rules that the patient is mentally ill, and as a result of that illness is likely to injure himself or others if released, the Commission must notify the DC Superior Court. An alleged mentally ill person has the right to demand a jury trial. If the court or a jury finds that the person is mentally ill and, because of that illness, is likely to injure himself or other persons if allowed to remain at liberty, the court may order hospitalization – or any other alternative course of treatment that the court believes will be in the best interest of the person or of the public – for an indeterminate period.

c. Involuntary Medication

A hospital may not medicate a person against his or her will if the person is capable of making a rational decision about medication. If the patient has been declared incapacitated for purposes of making a health care decision, his attorney-in-fact or substitute health care decision-maker may consent to medication, with certain restrictions. If no such person is available or the person does not have sufficient authority to consent, D.C. law provides for an administrative procedure, including a hearing, at which mental health professionals must determine whether medication may be administered against the patient's will. When a patient's objection to the administration of medication is based on religious grounds, the patient's wishes may only be overridden by a judge.

C. Patient Rights

Psychiatric patients in the District of Columbia have the following rights:

Treatment: A person hospitalized in a public hospital for a mental illness is entitled to medical and psychiatric care and treatment during that hospitalization. A hospital must provide to the patient – and his or her spouse, parents, or other nearest known relative – a written statement outlining in simple, non-technical language, all rights accorded to the patient including release procedures.

Reevaluation by the hospital, upon written request, after 90 days and not more than every six months thereafter.

Mail and Visitation: The patient has the right to receive uncensored mail from his attorney, personal physician, or personal qualified psychologist. All other incoming mail or communications may be read before being delivered to the patient.

Records: Medical records shall be made available, upon a hospitalized person's written authorization, to his or her attorney, personal physician, or personal qualified psychologist.

Freedom from Restraints: A mechanical restraint may be applied to a patient if it is prescribed by a physician or a qualified psychologist. If used, the restraint should be removed whenever the condition justifying its use no longer exists.

Maintain Legal Rights: A patient hospitalized for the treatment of mental illness in a public or private hospital may not, by reason of the hospitalization, be denied the right to "dispose of property, execute instruments, make purchases, enter into con-

tractual relationships, vote, and hold a driver's license" unless declared incompetent by a court.

Important Contact Information

District of Columbia Department of Mental Health
77 P Street, NE - 4th Floor
Washington, DC 20002
(202) 673-7440
<http://www.dmh.dc.gov>

University Legal Services, Inc.
300 I Street, NE, Suite 202
Washington, DC 20002
(202) 547-4747
TTY: (202) 547-2657

National Alliance for the Mentally Ill – District of Columbia
422 8th Street, SE
Washington, DC 20003-2832
(202) 546-0646
<http://www.nami.org>
<http://dc.nami.org>

Maryland Law

A. Voluntary Treatment

A person 16 years of age or older may apply for voluntary admission to a public or private clinic, hospital, or other institution – except a Veterans' Administration hospital – that provides treatment or services for mental disorders. A facility may not admit a person unless: (1) the person has a mental disorder; (2) the mental disorder is susceptible to care or treatment; (3) the person understands the nature of a request for admission; (4) he or she is able to give continuous assent to retention by the facility; and (5) the person is able to ask for release. Persons 65 years of age or older must be provided an evaluation by a geriatric evaluation team to determine whether there is an available, less restrictive form of care or treatment that is adequate for the needs of the person.

A parent or guardian of a minor may apply on behalf of that minor to a non-state facility, a regional institute for children and teens, or the child/adolescent unit of a state facility. An admission under this section to a child or adolescent unit of a State facility may not exceed 20 days.

B. Involuntary Detention, Hospitalization and/or Treatment

1. Involuntary Detention for Emergency Evaluation

An emergency evaluation may be made if a petitioner has reason to believe that the person has a mental disorder and that there is clear and imminent danger of the person's doing bodily harm to him- or herself or to another. A petition for emergency evaluation of a person may be made by:

- (1) a physician, psychologist, clinical social worker, health officer, or designee of a health officer who has examined the person;
- (2) a peace officer who personally has observed the person; or
- (3) any other interested person.

The petition must include facts that support the need for an emergency evaluation, a number of which are noted in the statute.

If the petitioner is not a physician, psychologist, clinical social worker, health officer or his or her designee, or a peace officer, the petitioner must present the petition to the court for immediate review. A judge will review of the petition, and "endorse" (approve) it if he or she finds probable cause to believe that:

- (1) the patient has shown the symptoms of a mental disorder, and
- (2) there appears to be clear and imminent danger of the patient's doing bodily harm to him- or herself or to someone else.

2. Involuntary Admission

An application for an "involuntary admission" to a facility may be made by anyone who has a "legitimate interest" in the welfare of the person. The application must be accompanied by the certificates of either one physician and one psychologist or two physicians.

A certificate for involuntary admission must be based on a personal examination of a physician or psychologist and include a diagnosis of a mental disorder, an opinion that the person needs inpatient treatment and an opinion that admission to a facility or Veterans' Administration hospital is necessary to protect the person or another.

A person will be admitted involuntarily only if: (a) the person has a mental disorder; (b) he or she needs inpatient care or treatment; (c) he or she presents a danger to the life or safety of him- or herself or of others; (d) the person is unable or unwilling to be admitted voluntarily; and (e) there is no available, less restrictive form of intervention that is consistent with the welfare and safety of the person. A State facility may not admit a person who is 65 years old or older unless a geriatric evaluation team determines that there is no available, less restrictive form of care or treatment that is adequate for the needs of the person.

A petition for release of a patient from the facility or a Veterans' Administration hospital may be filed at any time by the patient or any person who has a legitimate interest in the welfare of the patient.

Any person proposed for involuntary admission may request a hearing to determine whether he or she is to be admitted to a facility as a involuntary patient or released without being admitted. The patient must be advised of his rights to a hearing within 12 hours of admission. The hearing must be conducted within 10 days of the date of the initial confinement of the patient, but it may be postponed for good cause for no more than 7 days.

3. Involuntary Medication

Medication (i.e., psychiatric medication prescribed for the treatment of a mental disorder) may not be administered to a patient who refuses the medication except:

- (1) in an emergency, on the order of a physician, where the person presents a danger to the life or safety of him/herself or to others; or
- (2) in a non-emergency, when the person is hospitalized involuntarily or committed for treatment by order of a court and the medication is approved by a panel of professionals.

The decision whether to administer medication against a patient's wishes is made by a medical panel. The law sets out duties of the panel, steps for approval of medication (including reasonable bases for its decision) as well as necessary documentation.

C. Patient Rights

1. Treatment, Adjudication and Release

a. Notice

On admission to a facility, a person must be informed of his or her rights in language and terms that he or she can understand. These rights should also be posted. If the patient does not understand the notice of his or her rights, the notice also should be given to the parent, guardian, or next of kin of the patient; the applicant for an involuntary admission of the person; and any other person who has a significant interest in the status of the patient. A facility must have a complaint procedure for patients who believe their rights have been violated.

b. Services and Treatment Plan

Every patient is entitled to receive "appropriate humane treatment and services" with the least possible restrictions on the patient's liberty (consistent with the patient's treatment needs).

Promptly after admission of a patient, a facility must develop a written plan of treatment for the patient in the facility. The patient should:

- (1) participate, in a manner appropriate to his or her condition, in the development and periodic updating of the plan of treatment;
- (2) be told, in appropriate terms and language, of the content and objectives of the plan of treatment, the nature and significant possible adverse effects of recommended treatments, and the name, title and role of personnel directly responsible for carrying out the treatment; and, when appropriate, other available alternative treatments, services, or providers of mental health services.

A patient in a facility has the right to refuse to participate in physically intrusive research conducted at the facility.

2. Correspondence

Each patient in a facility must have access, at all reasonable hours, to writing instruments, stationary, and postage and may use them to write to anyone, "subject to any reasonable limitation that a facility imposes." Patients in a mental health facility should also have reasonable access to a telephone, but a patient may not telephone anyone who has given the facility written notice of not wanting to be telephoned.

3. Visitors

Every patient in a facility is entitled to private visits with a lawyer or clergy during reasonable visiting hours, set by the facility, and from any other visitor if the patient wishes to see the visitor. Visits or private conversations may be restricted for medically justified reasons. The restriction and the reasons must be signed and dated by a physician; made part of the patient's permanent record; and reviewed every 30 days that the restriction remains in effect.

4. Restraints

Each patient in a facility shall be free from restraints or locked door seclusions except for restraints or locked door seclusions that are either:

- (1) used only during an emergency where the patient presents a danger to the life or safety of him/herself or to others or used only to prevent serious disruption to the therapeutic environment; and
- (2) ordered by a physician in writing or directed by a registered nurse if a physician's order is obtained within 2 hours of the action.

5. Other Patient Rights

A mental health facility is required to prepare a written aftercare plan for each patient before the patient is released from the facility.

A person may not be deprived of the right to vote or to receive, hold, and dispose of property, solely because he or she is in a facility or a Veterans' Administration hospital for a mental disorder.

Important Contact Information

Mental Hygiene Administration
Spring Grove Hospital Center
55 Wade Avenue, Dix Building
Catonsville, MD 21228
1(800) 735-2258
(410) 402-8300
TTY: (410) 955-1861
<http://www.dhmd.state.md.us/mha/>

Maryland Disability Law Center
1800 North Charles Street, 4th floor
Baltimore, MD 21201
1(800) 233-7201
(410) 72-6352
TDD: (410) 727-6387
<http://www.mdldlbalto.org>

Centers for Medicare and Medicaid Services
Region 3 – Philadelphia Regional Office
150 South Independence Mall West, Suite 216
Philadelphia, PA 19106
(215) 861-4140
<http://www.cms.gov>

National Alliance for the Mentally Ill – Maryland
711 West 40th Street, Suite 451
Baltimore, MD 21211
(410) 467-7100
Helpline: 1(800) 467-0075
<http://md.nami.org>

On Our Own of Maryland
1521 South Edgewood Street, Suite C
Baltimore, MD 21227
1(800) 704-0262
(410) 646-0262
<http://www.onourownmd.org>

Virginia Law

Any person believed to be mentally ill to a degree that warrants hospitalization may be admitted to and retained as a patient in a hospital in compliance with the State's voluntary or involuntary admission procedures. A hospital generally includes both state and private hospitals devoted to or with facilities for the care and treatment of the mentally ill or mentally retarded.

Under Virginia law, "mentally ill" means "any person afflicted with mental disease to such an extent that for his welfare or the welfare of others, he requires care and treatment. . . ." The law also states that for purposes of hospitalization provisions, the term "mentally ill" includes any person who is a drug addict or alcoholic.

Any person alleged to be mentally ill to a degree that warrants emergency hospitalization may be admitted to and retained as a patient in the state hospital closest to his or her domicile by compliance with the State's voluntary or involuntary admission procedures.

A. Voluntary Admission

Virginia has created "community service boards" that are supposed to participate in mental health hospitalization decisions.

Under Virginia law, any state hospital must admit as a patient any person who requests admission, when he or she "is deemed to be in need of hospitalization." The determination that hospitalization is necessary is made by the community service board or community mental health clinic that serves the political subdivision where the person resides, and by a doctor on the staff of the hospital where the patient is to be admitted. If a person is unable to obtain a prescreening report from the community services board that serves the political subdivision where the patient resides, the patient may be screened by the community services board of the political subdivision where the patient is located.

The Code of Virginia outlines the procedures whereby a parent, guardian or other responsible person may initiate a proceeding to certify a mental retarded person's eligibility for voluntary admission to a facility for the training and treatment of the of the mentally retarded if he or she is not capable of requesting his or her own admission. The certification of eligibility under this process is not to be construed as a judicial commitment of the mentally retarded person "but shall empower the parent or guardian or other responsible person to admit such person to a facility for the training and treatment of the mentally retarded and shall empower the facility to accept the person as a patient."

B. Involuntary

1. Examination and Assessment

A magistrate may order that a mentally ill person be taken into custody to be examined by a competent professional who will "assess the need for hospitalization." The magistrate must find probable cause to believe that: (1) the person is mentally ill and in need of hospitalization and (2) the person presents an imminent danger to himself or others as a result of the mental illness, or is so seriously mentally ill as to be substantially unable to care for himself. The magistrate's order may be based on the sworn petition of any responsible person or upon his or her own motion.

Similarly, if a law-enforcement officer, based upon his observation or the reliable reports of others, has probable cause to believe that a person meets the criteria for emergency custody, he or she may take the person into custody and transport him or her to an appropriate location to assess the need for hospitalization. A court order is not required, and the evaluation must be conducted immediately. The person may not be kept in custody for more than four hours, unless a court issues a temporary detention order. If no detention order is issued, the person must be released. A law-enforcement officer may lawfully go to or be sent beyond the territorial limits of the jurisdiction in which he serves to any place in Virginia for the purpose of executing an order for emergency custody.

2. Involuntary Temporary Detention

The standards for a temporary detention order are similar to the standards for an involuntary assessment. A magistrate may issue a temporary detention order upon the sworn petition of any responsible person or upon his own motion. The order may issue only after an examination by a competent professional (an employee of the local community services board or its designees who is skilled in the assessment and treatment of mental illness and who has completed a certification program approved by the Virginia Department of Mental Health). The magistrate must find, based on available evidence, including any recommendation from a physician or psychologist treating the person, that:

- (1) the person is mentally ill and in need of hospitalization, and

(2) he or she presents an imminent danger to him- or herself or others as a result of mental illness,

or

(1) the person is so seriously mentally ill as to be substantially unable to care for him- or herself, and

(2) he or she is incapable of volunteering or unwilling to volunteer for treatment.

A temporary detention order may include transportation of the person to a facility as may be necessary for emergency medical evaluation or treatment prior to placement.

A magistrate may order a temporary detention without an emergency custody order proceeding or without a prior in-person evaluation if (1) the person has been personally examined within the previous 72 hours by an employee of the local community services board or its designee who is skilled in the assessment and treatment of mental illness and who has completed a certification program approved by the Department, or (2) there is a significant physical, psychological or medical risk, to the person or to others, associated with conducting such evaluation.

If it appears from all evidence readily available that a person detained involuntarily will not pose an imminent danger to himself or others, a judge may release him or her before a detention hearing takes place. The judge may release the patient on his personal recognizance or bond. In the case of a minor, the judge may release the minor to his parent. The director of the hospital in which the patient is detained may release the patient prior to a hearing if it appears, based on an evaluation conducted by the psychiatrist or clinical psychologist treating the patient, that the patient would not present an imminent danger to him/herself or to others if released.

3. Involuntary Admission and Treatment

a. Commitment Hearing

A commitment hearing must be held within 48 hours of the execution of the temporary order.

The judge, in commencing the commitment hearing, must inform the person whose involuntary admission is being sought of his or her right to apply for voluntary admission and treatment and must inform the person of an opportunity for voluntary admission. The judge shall ascertain if such person is then willing and capable of seeking voluntary admission and treatment. If the person is capable and willingly accepts voluntary admission and treatment, the judge will require him or her to accept voluntary admission for a minimum period of treatment and after the minimum period, which may not to exceed 72 hours, to give the hospital 48 hours notice prior to leaving the hospital.

If a person is incapable of accepting or unwilling to accept voluntary admission and treatment, the judge must inform the person of his or her right to a commitment hearing and right to counsel. If the person does not have an attorney, the judge should appoint an attorney to represent the person, unless he or she wants to employ his or her own attorney at his or her own expense.

Before the commitment hearing, the person must be given a written explanation of the involuntary commitment process. In addition, the person's attorney should explain the process to him. The written explanation shall include, at a minimum, an explanation of the person's right to hire his or her own attorney or to be represented by a court-appointed attorney, to present any defenses including independent evaluation and expert testimony or the testimony of other witnesses, to be present during the hearing to testify, to appeal any certification for involuntary admission to the circuit court, and to have a jury trial on appeal.

The judge must require an examination of the person by a psychiatrist or a psychologist who either is licensed in Virginia by either the Board of Medicine or the Board of Psychology and is qualified in the diagnosis of mental illness or, if a qualified psychiatrist or psychologist is not available, any medical health professional who is licensed in Virginia through the Department of Health Professions and is qualified in the diagnosis of mental illness. The examiner shall be able to provide an independent, unbiased examination of the person in private.

The judge must not render any decision on the petition until the examiner has presented his or her report either orally or in

writing. The report must certify that the examiner has probable cause to believe that the person (1) is or is not so seriously mentally ill as to be substantially unable to care for him/herself; or (2) does or does not present an imminent danger to him/herself or to others as a result of mental illness, and (3) requires or does not require involuntary hospitalization or treatment.

b. Outpatient Treatment

After observing the person and obtaining the necessary positive certification and any other relevant evidence that may have been offered, a judge may order outpatient treatment if he or she finds specifically:

- (1) that the person presents an imminent danger to him/herself or to others as a result of mental illness or has been proven to be so seriously mentally ill as to be substantially unable to care for him/herself, and
- (2) that less restrictive alternatives to institutional confinement and treatment have been investigated and are deemed suitable, and
- (3) the patient is capable of understanding the requirements of treatment, and
- (4) the patient expresses an interest in living in the community and agrees to abide by his treatment plan, and
- (5) the patient has the capacity to comply with the treatment plan, and
- (6) the ordered treatment can be delivered on an outpatient basis, and
- (7) the ordered treatment can be monitored by the community services board or designated providers.

If all requirements are met, the judge may order outpatient treatment, day treatment in a hospital, night treatment in a hospital, outpatient involuntary treatment with anti-psychotic medication or any other appropriate course of treatment as may be necessary to meet the needs of the patient. If the patient fails to adhere to the terms of the outpatient treatment, the judge may revoke it and, after notice to the patient and after a commitment hearing, order involuntary commitment for treatment at a hospital.

The community services board has a duty to recommend a specific course of treatment and programs that can provide the treatment. The community board should monitor the person's compliance with the court-ordered treatment plan and report to the court if the patient does not follow the court's orders.

c. Trial and Appeal

A patient has the right to a commitment or certification order under Virginia law. Appeals from such an order must be filed within 30 days from the date of the order. In Virginia, the committed person is entitled to trial by jury; if the patient does not have an attorney, the judge will appoint an attorney to represent him or her.

d. Involuntary Medication

A hospital may not medicate a patient against his or her will without permission from a legally authorized representative (e.g., a family member or guardian), or a court order. If a patient refuses to take medication, and the attending physician believes the medication is necessary for the patient's treatment, and that the patient is not capable of making a rational decision about medication, a hospital should seek permission from a person authorized to make decisions on behalf of the patient. If no one is available, the hospital may seek a court order for involuntary medication.

Under Virginia law, in order to obtain judicial authorization for the involuntary administration of medication, a hospital must demonstrate by clear and convincing evidence that: (1) the patient is unable to make an informed decision about medication, and (2) receipt of the medication is in the patient's best interest. The law defines "incapable of making an informed decision" as "unable to understand the nature, extent or probable consequences of a proposed treatment, or unable to make a

rational evaluation of the risks and benefits of the proposed treatment as compared with the risks and benefits of alternatives to that treatment."

C. Patient Rights

1. Treatment

Within 24 hours after arriving at a hospital, a patient must be examined by one or more of the physicians on the hospital's staff. If the doctors conclude that the patient is mentally ill, he or she must stay at the hospital. If the doctors do not find sufficient cause to keep the patient, he or she must be returned to the place where the petition was initiated or to where the patient resides.

Note that, effective January 1, 2004, the law concerning examinations of persons presented for admission to a hospital is expected to change.

2. Rights

"Each person who is a patient, resident, or consumer in a hospital, other facility, or program operated, funded, or licensed by the Department of Mental Health, Mental Retardation and Substance Abuse Services . . . shall be assured his [or her] legal rights and care consistent with basic human dignity insofar as it is within the reasonable capabilities and limitations of the Department, funded program, or license and is consistent with sound therapeutic treatment."

Each person admitted to a hospital, facility or program operated, funded, or licensed by the Virginia government has the right to:

- (1) retain his or her legal rights as provided by state and federal law;
- (2) receive prompt evaluation and treatment;
- (3) be treated with dignity as a human being and be free from abuse or neglect;
- (4) not be the subject of research without his prior written and informed consent or that of his or her legally authorized representative;
- (5) be afforded an opportunity to consult with a private physician at his or her own expense (and in the case of non-emergency hazardous treatment or surgical procedures, request a second opinion before the procedure;
- (6) be treated under the least restrictive conditions consistent with his or her condition, including not being subjected to unnecessary physical restraint and isolation;
- (7) be allowed to send and receive sealed letter mail;
- (8) have access to his or her medical records and be assured of their confidentiality;
- (9) have the right to an impartial review of violations of his or her rights and the right of access to legal counsel; and
- (10) be afforded the opportunity, consistent with the patient's capabilities and capacity, to participate in the development and implementation of his or her treatment plan.

The state has regulations that further assure a patient's rights, including the right to a nutritionally adequate diet, safe and sanitary housing, participation in non-therapeutic labor, attendance or nonattendance at religious services, participation in treatment and decision-making, including due process procedures to be followed when a patient, resident, or consumer may be unable to make an informed decision, use of telephones, suitable clothing, and possession of money and valuables and related matters.

3. Reevaluation

The director of a state hospital must conduct a review of the progress of each patient admitted to his hospital at intervals of 30, 60 and 90 days after the patient's admission, and every six months thereafter to determine whether such patient should remain at the hospital. The hospital must keep records of these findings.

4. Discharge of Involuntary Committed Patients

The person in charge of a private hospital may discharge any patient involuntarily committed who is recovered, or, if not recovered, whose discharge will not be detrimental to the public welfare, or injurious to the patient. If the guardian, committee or relatives of such patient refuse to provide properly for his/her care and treatment, the person in charge of such institution may (1) apply to the Commission for the transfer of the patient to a state hospital; or (2) apply to the director of the United States Veterans' Administration Medical Center for the transfer of the patient to a veterans' hospital.

5. Judicial Authorization of the Provision, Withholding, or Withdrawal of Treatment and Detention of Certain Persons

Virginia law provides that "[a]n appropriate circuit court or judge . . . may authorize on behalf of an adult person . . . the provision, withholding or withdrawing of a specific treatment or course of treatment for a mental or physical disorder, if it finds upon clear and convincing evidence that (i) the person is either incapable of making an informed decision on his own behalf or is incapable of communicating such a decision due to a physical or mental disorder and (ii) the proposed action is in the best interest of the person." This law is expected to change in January, 2004.

Important Contact Information

Department of Mental Health, Mental Retardation, and Substance Abuse Services
P.O. Box 1797
1220 Bank Street
Richmond, VA 23219-3645
(804) 786-3921
TDD: (804) 371-8977
<http://www.dmhmrzas.state.va.us>

Virginia Board for People with Disabilities
202 North Ninth Street, Ninth Floor
Richmond, VA 23219
1(800) 846-4464
(804) 786-0016
<http://www.vaboard.org>

Centers for Medicare and Medicaid Services
Region 3 – Philadelphia Regional Office
150 South Independence Mall West, Suite 216
Philadelphia, PA 19106
(215) 861-4140
<http://www.cms.gov>

National Alliance for the Mentally Ill Virginia
P.O. Box 1903
Richmond, VA 23218-1903
1(888) 436-VAMI (8264)
(804) 225-8264
<http://www.namivirginia.org>

Federation of Families for Children's Mental Health
1101 King Street, Suite 120
Alexandria, VA 22314
(703) 684-7710
<http://www.ffcmh.org>

Organ and Tissue Donation

Why Would I Want To Donate My Organs or Tissues?

A single donor can help more than 50 people who suffer from injuries, organ failure, and birth defects. Approximately 21,000 organs are transplanted each year, but 5,000 people die waiting for a transplant. Countless others get progressively worse without a needed transplant. Organ and tissue donation is a way to help those in medical need.

Who Can Donate, And How Do I Become a Donor?

Almost any adult can decide to become an organ or tissue donor. The only requirement is that the donor be an adult of sound mind. This means that if you are over the age of 18 and you understand how organ and tissue donation works, you may make an anatomical gift. In Virginia and Maryland, those under 18 can donate with the consent of a parent or guardian.

Most organ donations happen just after the donor dies so the most important aspect of becoming a donor is that you make your desire to donate known before your death. To do this, you need to sign a "document of gift," which can be any signed document, including a will, that clearly says that you want to be a donor. You can even register to be a donor when you renew your driver's license. The current laws guarantee that this process will be quick, easy, and free. It's also a good idea to talk to your friends and family members about your decision if you feel comfortable doing so.

If you decide not to donate after making a document of gift, or choose to change what organs or tissues you are willing to donate, you can change your mind by writing your wishes in a signed statement or by telling two people at the same time.

How Does Donation Work?

There are two types of anatomical gifts: tissue donation and organ donation.

Tissue donation is the easiest and most common donation. Tissues include skin, bone, bone marrow, corneas, and heart valves. After a person dies, the appropriate tissue is removed and used to benefit someone in need.

Organs that can be donated include the heart, liver, pancreas, kidneys, lungs, and small intestine. Kidneys and – less commonly – portions of the liver or a lung can be donated while the donor is alive. For this type of donation, the donor and the person receiving the organ are usually family members. Using a living donor helps to ensure a proper genetic match.

Other organs must be transplanted to the recipient soon after the donor has died. To donate this way, a person must be "brain dead." This term is used to describe a person whose brain has stopped working but whose heart and lungs are still functioning with the help of a ventilator. A person in this condition cannot be revived, and the desire to be an organ donor in no way affects the quality or amount of medical treatment someone receives.

If I Am a Donor, Are Doctors Going To Work As Hard To Save My Life?

Yes. If you are admitted to the hospital, the first priority will be to save your life. Organ donation is only considered after these efforts have failed and there is no longer a chance that you will recover.

Is Donation Expensive?

Organ donation is absolutely free to the donor. All associated costs are covered by the certified agency, such as a hospital, that removes the organs. The donor's family or health insurance company is still responsible for the cost of the donor's medical treatment until death. The family must also pay for funeral costs for the donor.

If I Donate, Can I Still Have a Funeral?

Donation almost never interferes with a funeral. Funeral plans are not usually delayed as a result of organ donation, and

any funeral options are still available, including an open casket service or cremation.

How Are Recipients of Organ And Tissue Donations Selected?

Recipients are classified on an "urgent need" basis. This method means that people who need organs and tissues the most will be at the top of the list. Issues such as income, geographic location, and religion are not considered in determining who receives the organs. If you choose to be a donor, you can specify whether you want your organs or tissues to be used for research and education.

Important Contact Information

Washington Regional Transplant Consortium
8110 Gatehouse Road – Suite 101
West Falls Church, VA 22042
(703) 641-0100
<http://www.wrtc.org>.

Coalition on Donation
700 North 4th Street
Richmond, Virginia 23219
(804) 782-4920
<http://www.shareyourlife.org>

Workers' Compensation: What To Do If You Are Injured On the Job

If you are injured on the job or become sick as a result of something you do as part of your job, you may be eligible for medical benefits and weekly wage-loss payments under the District of Columbia, Maryland, or Virginia workers' compensation laws. These laws require employers to have an insurance program for their employees in case of an on-the-job injury or job-related illness. Employers with only a few employees may be exempt from the law. Also, not all job-related injuries and illnesses are covered by the law. Generally speaking, however, if you qualify for workers' compensation benefits, your employer's insurance company must provide all necessary medical and hospital treatment and some compensation for wage loss resulting from the injury or illness, without any cost to you.

To protect your rights, you should report a job-related injury or illness to your employer right away. In some jurisdictions, and for some types of injuries or illnesses, you must notify your employer of the injury or illness in writing. To obtain workers' compensation benefits, you will also need to file a claim for benefits within a time frame specified by law, in some cases as soon as 30 days after the date of injury. If your injury or illness is covered by workers' compensation, you may be prohibited from suing your employer for medical benefits or compensation related to the injury or illness. It is therefore important to act quickly to avoid losing these important benefits. If your employer disputes your injury and claim for benefits, you should contact the government agency that is responsible for administering the workers' compensation program in the District of Columbia or state where you work.

This chapter briefly describes the workers' compensation benefits that are available in the District, Maryland, and Virginia and, as to each jurisdiction, further describes the following:

- the benefits that you are entitled to receive if you are eligible for workers' compensation and have suffered a job-related injury or illness,
- how to file a claim for benefits, and
- the agency to contact for more information.

Which Law – D.C., Maryland, or Virginia – Applies to Me?

If you are employed and work in the District of Columbia and you suffer a job-related injury or illness, then D.C. law will generally apply and you will need to file a claim with the D.C. Department of Employment Services' Office of Workers' Compensation. Likewise, if you are employed and work in Maryland or in Virginia, you must file your claim with the state workers' compensation office in the state where you work. Contact information for the workers' compensation offices in D.C., Maryland, and Virginia is provided below.

If your injury is serious or you have a question concerning where or how to file a claim, you may want to contact a qualified attorney in addition to the appropriate workers' compensation office. There are many ways of finding an attorney to advise you and help you file a claim. See our chapter on Finding a Lawyer for more information.

Am I Eligible To Receive Benefits?

A. Am I Considered an "Employee"?

If you have an employer and you suffer a job-related injury or illness, you will generally be considered an employee and eligible for workers' compensation, regardless of your age (the laws apply to minors), whether you are lawfully employed, or whether you have a written employment agreement. Some employers may be exempt from the law's requirements if they have only a few employees.

B. Am I Eligible for Workers' Compensation Benefits?

Generally, you will be considered eligible for workers' compensation benefits in either of the following situations:

- you are injured as a result of an accident on the job or related to your job, or
- you become ill from a disease or infection that results from a job-related accident or a natural hazard associated with your job.

The law may also cover non-accidental injuries. If a third person intentionally causes you to suffer injury, you may be eligible for workers' compensation benefits as long as the injury is somehow related to your job.

What Benefits Can I Receive and What Do I Need To Do To Receive Them?

The workers' compensation laws of D.C., Maryland, and Virginia all provide for full medical benefits for the treatment and care of a job-related injury or illness. Depending on whether you are employed and work in D.C., Maryland, or Virginia, you will have different requirements for filing a claim and you may receive different wage-loss benefits. The following is an overview of the laws in D.C., Maryland, and Virginia.

A. District of Columbia

1. What Benefits Will I Get If I Am Injured On the Job?

If you are found to be eligible and to have suffered an injury or illness covered under D.C.'s workers' compensation law, you are entitled to full medical benefits for your disability, as long as you provide written notice to your employer and the D.C. Office of Workers' Compensation within 30 days of the date of your injury or illness, then file a claim for benefits within one year. See "How Do I File a Claim?" below.

Medical benefits to which you are entitled under D.C. law have no time or monetary limit. This means that you will receive these medical benefits for as long as your care and treatment is medically necessary and without regard to the total cost of such care and treatment.

Compensation for lost wages is determined according to the severity of your injury or illness as follows:

- Temporary total disability (TTD) – If you become totally disabled, but only temporarily, you will receive two-thirds (66 2/3 percent) of your average weekly wage for as long as you are disabled. The maximum weekly payment you can receive is either the average weekly wage of all covered employees in the District or \$396.78, whichever is greater.
- Temporary partial disability (TPD) – If you become partially disabled for a temporary period of time, you will receive two-thirds (66 2/3 percent) of your wage loss for as long as you are disabled, but in no case longer than five years. You can determine your wage loss by calculating the difference between the amount you made before the injury and the amount you are able to make while partially disabled. The maximum weekly payment you can receive is either the average weekly wage of all covered employees in the District or \$396.78, whichever is greater.
- Permanent total disability (PTD) – If you are permanently and totally disabled, you will receive two-thirds (66 2/3 percent) of your average weekly wage for as long as you are disabled. The maximum weekly payment you can receive is either the average weekly wage of all covered employees in the District or \$396.78, whichever is greater. Your minimum compensation shall be 25 percent of the maximum compensation.
- Permanent partial disability (PPD) – If you are only partially disabled, but such disability is permanent, you will receive two-thirds (66 2/3 percent) of your average weekly wage for a period of weeks determined by the type of injury you have suffered. The maximum weekly payment you can receive is the average weekly wage of all covered employees in the District or \$396.78, whichever is greater. Compensation for permanent partial disability is generally limited to 500 weeks.

District of Columbia law also provides a benefit of up to \$7,500 for serious disfigurement of the face, head, neck, or other exposed areas.

2. How Do I File a Claim?

In the District of Columbia, you must first report your injury or illness by filing a DCWC Form 7 "Employee's Notice of Accidental Injury or Occupational Disease" with your employer and with the Office of Workers' Compensation within 30 days of the date of your injury or the date on which you discovered that your injury is job related. Within one year of the date of

your injury or illness, you need to file a DCWC Form 7A "Employee's Claim Application" with the Office of Workers' Compensation in order to obtain compensation benefits. For copies of these forms, contact your employer or the District of Columbia Office of Workers' Compensation.

3. Who Can I Contact For More Information?

The District of Columbia's workers' compensation program is administered by the Office of Workers' Compensation. For additional information and for help in filing a claim, contact the following:

DC Department of Employment Services
Labor Standards Bureau
Office of Workers' Compensation
64 New York Ave., 2nd Floor
Washington, DC 20002
(202) 671-1000
http://does.ci.washington.dc.us/services/wkr_comp.shtm

B. Maryland

1. What Benefits Will I Get If I Am Injured On the Job?

In Maryland, if you suffer a job-related injury or illness, you are entitled to full medical benefits and some wage-loss compensation for any disability that prevents you from working, provided that you give notice and file a claim within the required time frame. In general, you must give oral or written notice to your employer within 10 days. Formal claims for benefits must be filed in as short as 60 days from the date of injury. In cases of occupational disease or death, you will have a longer period of time in which to file a claim. See "How Do I File a Claim?" below.

Medical benefits that you receive under Maryland's workers' compensation law have no time or monetary limit. This means that you will receive these medical benefits for as long as your care and treatment is medically necessary and without regard to the total cost of such care and treatment.

Wage-compensation benefits are determined according to the severity of your injury or illness as follows:

- **Temporary total disability (TTD)** – If you become totally disabled, but only temporarily, you will receive two-thirds (66 2/3 percent) of your average weekly wage for as long as your temporary disability persists. The minimum weekly payment you can receive is \$50 (or your actual wage if it is less than \$50); the maximum weekly payment you can receive is the State of Maryland's average weekly wage.
- **Temporary partial disability (TPD)** – If you become partially disabled for a temporary period of time, you will receive one-half (50 percent) of the difference between your average weekly wage before the injury and the amount you are able to earn while you are partially disabled. The maximum weekly payment you can receive is one-half (50 percent) of the State's average weekly wage. Your payments will continue for as long as your partial disability persists.
- **Permanent total disability (PTD)** – If you suffer from permanent and total disability, you will receive two-thirds (66 2/3 percent) of your average weekly wage for the duration of the disability. The minimum weekly payment you can receive is \$25 (or your actual wage if it is less than \$25); the maximum weekly payment you can receive is Maryland's average weekly wage.
- **Permanent partial disability (PPD)** – If you become permanently partially disabled, you will receive from one-third (33 1/3 percent) to two-thirds (66 2/3 percent) of your average weekly wage, depending on the nature and severity of the disability. The minimum weekly payment you can receive is \$50 (or your actual wage if it is less than \$50); the maximum weekly payment you can receive ranges from one-third (33 1/3 percent) to three-fourths (75 percent) of the State's average weekly wage, depending on the nature and severity of the disability. The duration of compensation depends on the nature and severity of the disability.

Maryland's workers' compensation law also provides a benefit of up to 156 weeks' compensation for disfigurement and mutilation.

2. How Do I File a Claim?

In Maryland, you should notify your employer as soon as possible after being injured or becoming ill. You must then formally report your injury or illness by filing an Employee Claim Form with the Maryland Workers' Compensation Commission. If your employer does not have the form, you can obtain one from the Maryland Workers' Compensation Commission free of charge. The following time frames apply.

For accidental injuries:

- 10 days to provide oral or written notice to employer of injury
- 30 days to provide oral or written notice to employer of an employee's death
- 30 days to file claims for all hernia injuries
- 60 days to file claims for all other accidental injuries
- 18 months to file claims relating to an employee's death

For occupational diseases:

- One year to provide written notice to employer of disability caused by occupational disease (the time period is measured from the date on which you have reason to believe that you have an occupational disease)
- One year to provide written notice to employer of an employee's death caused by occupational disease
- Two years to file a claim for illness due to an occupational disease with the exception of illness caused by pulmonary dust disease, for which you have three years to file a claim (the time period is measured from the date on which you have reason to believe that you have an occupational disease)
- Two years to file a claim for an employee's death due to an occupational disease with the exception of death caused by pulmonary dust disease, for which you have three years to file a claim

3. Who Can I Contact for More Information?

The Maryland Workers' Compensation Commission administers the state's workers' compensation program and processes all claims for benefits. For additional information and for help in filing a claim, contact the following:

Maryland Workers' Compensation Commission
10 East Baltimore Street
Baltimore, MD 21202-1641
(410) 864-5100
1(800) 492-0479 (outside the Baltimore metro area)
<http://www.wcc.state.md.us/>

C. Virginia

1. What Benefits Will I Get If I Am Injured On the Job?

Virginia's workers' compensation laws ensure that you will receive full medical benefits and some wage compensation for any disability you suffer caused by a job-related injury or illness. In order to receive benefits under Virginia law, you will generally have 30 days in which to notify your employer of any injury or illness, then two years from the date of injury or illness to file your claim with the Workers' Compensation Commission. See "How Do I File a Claim?" below.

Medical benefits to which you are entitled under Virginia law have no time or monetary limit. This means that you will receive these medical benefits for as long as your care and treatment is medically necessary and without regard to the total cost of such care and treatment.

Compensation for lost wages is determined according to the severity of your injury or illness as follows:

- Temporary total disability (TTD) – If you become totally disabled, but only for a temporary period of time, you will

receive two-thirds (66 2/3 percent) of your average weekly wage. The minimum weekly payment you can receive is 25 percent of the Virginia average weekly wage; the maximum weekly payment you can receive is 100 percent of the Virginia average weekly wage. You will continue to receive these payments for as long as you are disabled, up to a maximum of 500 weeks.

- Temporary partial disability (TPD) – If you suffer an injury or illness that leaves you partially disabled for a temporary period of time, you will receive compensation equal to two-thirds (66 2/3 percent) of the difference between your average weekly wage before you were injured and the average weekly amount that you could earn after your injury. The maximum weekly compensation you can receive is 100 percent of the Virginia average weekly wage.
- Permanent total disability (PTD) – If you are permanently and totally disabled, you will receive two-thirds (66 2/3 percent) of your average weekly wage for as long as you are disabled. Your minimum weekly payment shall be no less than 25 percent, and your maximum weekly payment shall be no more than 100 percent, of the Virginia average weekly wage.
- Permanent partial disability (PPD) – For certain enumerated injuries ("scheduled injuries") that result in a permanent, but only partial, disability, you will receive two-thirds (66 2/3) of your average weekly wage for a duration of weeks that depends on the type of injury. For example, under Virginia law, the loss of a thumb will result in 60 weeks of compensation. Your minimum weekly payment shall be no less than 25 percent, and your maximum weekly payment shall be no more than 100 percent, of the Virginia average weekly wage. For non-scheduled injuries, your compensation shall be two-thirds (66 2/3 percent) of the difference between your average weekly wage before the injury and the average weekly amount that you are able to make after the injury. Such weekly compensation shall be limited to 100 percent of the Virginia average weekly wage. The maximum duration of wage-loss compensation for non-scheduled injuries is 500 weeks.

Virginia law also provides a benefit of two-thirds (66 2/3) of your average weekly wage if you become disfigured. This benefit will be paid to you for up to 60 weeks.

2. How Do I File a Claim?

In Virginia, you must first notify your employer in writing of your injury or illness within 30 days of the accident. Then, you must file a claim with the Virginia Workers' Compensation Commission. For job-related injuries, you must file your claim within two years from the date of your injury. For job-related illnesses, you must file your claim either within two years from the date your doctor diagnoses the illness or within five years from the date on which you were last exposed to the work condition that caused the illness, whichever time period is sooner. Some diseases, especially diseases affecting the lungs, have different time periods for filing a claim. To obtain a copy of the benefits claim form, contact your employer or the Virginia Workers' Compensation Commission.

3. Who Can I Contact For More Information?

In Virginia, the state workers' compensation program is administered by the Virginia Workers' Compensation Commission. For additional information and help in filing a claim, contact the following:

Virginia Workers' Compensation Commission
1000 DMV Drive
Richmond, VA 23220
(804) 367-8600
1(877) 664-2566 (in Virginia only)
<http://www.vwc.state.va.us/>