BREAST CANCER LEGAL RESOURCES GUIDE — WASHINGTON STATE

A COLLABORATIVE EFFORT

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NOTICE: This Guide is not meant to serve as legal advice or as a substitute for working with an attorney.

Dedication

Many of the contributors to this Guide have been personally affected by cancer, in one form or another. To this end, we lovingly dedicate this Guide to breast cancer survivors, their loved ones, caregivers, and most of all to the memory of those who have gone before us.

PREFACE

Every three minutes a woman in the U.S. is diagnosed with breast cancer. In 2006, it was estimated that 212,920 new cases of invasive breast cancer were expected to be diagnosed. Here in Washington state, the incidence of breast cancer is the third highest of all states in the nation.

When a woman is diagnosed with breast cancer, the impact of the illness and medical treatment on the individual, her family and everyday living can be overwhelming. When diagnosed with breast cancer, a woman must face and prepare for some of the most important decisions in her life. Unless a woman is equipped with the knowledge of available resources, including but not limited to information regarding insurance, employment, clinical trials, disability and housing, the ability to maneuver through the various medical and legal issues can be a stressful, painful and lonely one.

In an effort to help alleviate the fear and anxiety often associated with the diagnosis and treatment of breast cancer and to address some of the legal issues that may arise when faced with breast cancer, we introduce the *Breast Cancer Legal Resource Guide—Washington State*. The Guide is an outgrowth of two Breast Cancer Awareness seminars that took place in March and June 2007 in Seattle. The first seminar, held on March 15, 2007 at Seattle University School of Law was co-sponsored by the American Bar Association – Commission on Women in the Profession, Washington Women Lawyers (WWL) Christiansen O'Connor, Johnson and Kindness. The focus of this first seminar was to educate participants about negotiating the best legal outcomes for breast-cancer patients, the right to challenge and appeal health insurance decisions, obtaining and keeping insurance coverage after diagnosis, payment for breast reconstruction mandated by ERISA, managing debt, and keeping current on state and federal legislation. It was the hope of the ABA and WWL that attorneys attending this CLE would use the information both in their practices and in providing pro bono service to breast-cancer patients unable to pay for legal services. Based upon feedback from participants of the first seminar, Breast Cancer Awareness – Part II occurred on June 28, 2007 and was co-sponsored by WWL and the Washington State Bar Association. Topics in Part II included employment, housing, welfare and public benefits and estate planning. It was from these CLEs the concept for the Guide was born.

The purpose of the Guide is to serve as an educational and informational tool for women and their families facing breast cancer. It is meant to be a resource guide to help them identify and acknowledge the important legal and medical issues that may arise. The resource guide will also help identify local, state and national legal resources available to women facing breast cancer.

It is also the intent of the Guide to serve as a resource for attorneys and other professionals who may have the opportunity to provide services to women facing breast cancer.

It is important to note that the Guide is not intended in any way to be a substitute for medical and/or legal advice and counseling. It is not meant to replace the help of medical and/or legal professionals. The editors of the Guide do not endorse, recommend or make any warranties or representations regarding any of the materials, products or information provided by authors or organizations referenced in this resource guide.

Finally, I would like to extend a special thank you to Joan Tierney, President of Washington Women Lawyers, for providing the leadership and guidance in preparing this legal resource guide.

Ellen Conedera Dial
WSBA President, 2006-2007
July 2007

INTRODUCTION

Welcome to the *Breast Cancer Legal Resource Guide—Washington State*. This Guide was written by attorneys and law students for cancer patients, families and caregivers, to address the legal issues that may arise as a result of the diagnosis and treatment of breast cancer or any catastrophic illness. This Guide is not meant to serve as legal advice or as a substitute for consulting an attorney, but is intended to provide useful information regarding employment, housing, estate planning, insurance and privacy issues, among others. Because the law changes frequently and planned updates may not keep up with those changes, we urge readers to seek legal advice from an attorney as the only sure way to receive accurate and up-to-date legal information on these topics.

Attorneys will also find the Guide useful when working with clients grappling with cancer-related issues. It is designed to address questions such as:

What should my client tell an employer about her/his diagnosis?

How do I assist my client in dealing with debt, foreclosure or eviction?

Where does one turn for additional resources?

We also intend that this Guide be used as a training manual for attorneys offering *pro bono* legal services to cancer patients in our state.

I would like to acknowledge and thank Seattle Attorney Lish Whitson, who has a strong commitment to protecting the rights of women with breast cancer and individuals with life threatening illnesses. He, along with the ABA Commission on Women in the Profession, the Breast Cancer Legal Advocacy Initiative, and the ABA Health Law Section, provided the first of two trainings on the legal issues surrounding breast cancer. Their trailblazing efforts inspired us to create this legal resource guide.

I would also like to thank and acknowledge the authors and editors of the guide, particularly our esteemed Editorial Board, as well as the individuals who supported this effort: Dean Kellye Testy, Seattle University School of Law, for her generous support; the Washington State Bar Association and Washington Women Lawyers for hosting this Guide on their websites; and the Susan G. Komen Foundation and K&L Gates for their generosity. To Dana Hess, whose hard work, good sprit and endless hours shared with me editing the final version of this guide, I am eternally grateful. Thanks to Carla Lee for her continued work providing trainings to attorneys throughout the state and beyond, and to Joslyn Donlin for reaching out to bar associations around the state and throughout the country. Most of all, a special thank you to Ellen Dial, WSBA President, whose vision and true leadership spurred us on to complete this valuable project.

Joan Tierney, Editor-in-Chief
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Chapter 1

INFORMED CONSENT

By Joan Tierney

What is Informed Consent?

Informed consent is a person's permission for health care, voluntarily given to a doctor or healthcare provider by a patient (or their representative). Consent is only considered "informed" when information about the risks, benefits, range of available treatments, advantages and disadvantages involved in each course of treatment and the consequences of not accepting treatment has been disclosed, discussed and understood by the patients or their representative.

What is Informed Consent in Washington State?

Under RCW 7.70.60, consent forms signed by legally competent persons or their representative if incompetent, must contain reasonably understandable language, describing the nature, character, and anticipated results of the proposed treatment; recognized alternative treatments, recognized serious risks, complications and anticipated benefits involved in the treatment. Information about alternative treatments and the consequences of declining treatment must also be explained and understood.

What if I do not want to be fully informed about my treatment?

A patient may sign a statement that the patient chooses not to be informed about treatment options and consequences.

When does informed consent not apply?

In situations where emergency treatment is needed or when a patient is unable to voluntarily participate in their own care and there is no named representative.

What is shared decision making?

In Washington, this process involves the doctor or health care provider discussing the risks or seriousness of the disease or condition to be prevented or treated; available

treatment alternatives, including choosing not to have treatment; with the opportunity to ask questions and have them answered to the patient's satisfaction and where the patient shares any relevant personal information that might make one avenue of treatment or likely side effect more or less tolerable than another.

What if I prefer shared decision making over informed consent?

Under RCW 7.70.60, a competent patient or a representative may sign an acknowledgement of shared decision making stating that the patient, or his or her representative, and the health care provider have engaged in shared decision making as an alternative means to meeting the informed consent required by laws, accreditation standards or other mandates; it must also contain a brief description of the services that the patient and the provider jointly agree will be furnished, a description of the decision making aid/s used by the patient and the provider to address the needs for high quality, up-to-date information about the condition, including risks and benefits of available options, and if appropriate, a discussion of the limits of scientific knowledge about outcomes; values clarification where a patient can sort out their values and preferences and guidance or coaching designed to improve the patient's involvement in the decision making process.

What is a Decision Making Aid?

It is a written, audio-visual or online tool, certified by one or more nationally recognized certifying organizations, used to provide a balanced presentation of the condition, treatment options, benefits, harms, including, if appropriate, a discussion of the limits of scientific knowledge about outcomes.

Chapter 2

THE HEALTH INSURANCE PORTABILITY & ACCOUNTABILITY ACT OF 1996 (HIPAA) AND THE WOMEN'S HEALTH AND CANCER RIGHTS ACT OF 1988 (WHCRA)

By Carla C. Lee

The Health Insurance Portability and Accountability Act of 1996 (HIPAA is federal legislation that encourages the development of health information systems through the establishment of standards and requirements for the electronic transmission of certain personal health information. HIPAA requires the Secretary of the U.S. Department of Health and Human Services to publicize standards for the electronic transmission or exchange of private personal health information for the security of health data. Specifically, Title II, Subtitle F, of HIPAA gives the U.S. Department of Health and Human Services the authority:

- To mandate the use of standards for the electronic exchange of health care data;
- To specify what medical and administrative code sets should be used within those standards;
- To require the use of national identification systems for health care patients, providers, payers (or plans), and employers (or sponsors); and
- To specify the types of measures required to protect the security and privacy of personally identifiable health care information.

These standards are commonly known as the Administrative Simplification provisions, which are outlined in the Act, http://www.hhs.gov/ocr/AdminSimpRegText.pdf, or in the Code of Federal Regulations (CFR), 45 CFR 160, 162 and 164.

What types of transactions are regulated by HIPAA?

Generally, HIPAA standards apply to transactions and data elements that enable the exchange of personal health information appropriate for certain types of administrative transactions. These administrative and financial transactions must be consistent with the goals of improving the operation of the health care system and reducing administrative costs. Transactions with respect to the following are covered by the Act:

- Health claims or the equivalent encounter information;
- Enrollment and disenrollment in a health plan;

- Eligibility for a health plan;
- Health care payment and remittance advice;
- Health plan premium payments;
- First report of injury;
- Health claim status;
- Referral certification and authorization.

What types of protections does HIPAA provide?

HIPAA protects millions of working Americans and their families. The following are some important specific HIPAA protections you should know:

- It limits the use of pre-existing condition exclusions;
- It prohibits group health plans from discriminating by denying you coverage or charging you extra for coverage based on your or your family member's past or present poor health;
- It guarantees certain small employers, and certain individuals who lose job-related coverage, the right to purchase health insurance; and
- It guarantees, in most cases, that employers or individuals who purchase health insurance can renew the coverage regardless of any health conditions of individuals covered under the insurance policy.

HIPAA also:

- Increases your ability to get health coverage for yourself and your dependents if you start a new job;
- Lowers your chance of losing existing health care coverage, whether you have that coverage through a job, or through individual health insurance;
- Helps you maintain continuous health coverage for yourself and your dependents when you change jobs; and
- Helps you buy health insurance coverage on your own if you lose coverage under an employer's group health plan and have no other health coverage available

In short, HIPAA may lower your chance of losing existing coverage, ease your ability to switch health plans and/or help you purchase your own individual plan if you lose or change employer's and no longer have other coverage available.

Five steps to understanding HIPAA

To help you better understand HIPAA protections and its limitations, here are five steps to understanding the Act:

1. Understand the different types of health insurance and group health plan coverage that are affected by the Health Insurance Portability & Accountability Act of 1996 (HIPAA.) Generally, HIPAA applies to three types of coverage: group health plans, individual health insurance and comparable coverage through a high-risk pool.
2. Evaluate the impact of a pre-existing condition that you have which may trigger the need for HIPAA's limited protections. Traditionally, many employer-sponsored group health plans and health insurance issuers in both the group and individual markets limit or deny coverage of health conditions in exclusions known as "pre-existing condition" exclusions.
3. Determine how much, if any, creditable coverage you have. Under HIPAA's group market rules, creditable coverage can be used to reduce or eliminate pre-existing condition exclusions that might be applied to you under a future plan or policy.
4. Understand the other HIPAA coverage protections you have. You should obtain general information about special enrollment rights to other coverage, how your health status can affect your access to care, other coverage choices that may help you take advantage of HIPAA protections, and your rights to renew group and individual coverage.
5. Know where to go for more information if you have questions.

Misunderstanding HIPAA

HIPAA does not do the following:

1. It does NOT require employers to offer or pay for health coverage for employees or family coverage for their spouses and dependents;
2. It does NOT guarantee health coverage for all workers;
3. It does NOT control the amount an insurer may charge for coverage;
4. It does NOT require group health plans to offer specific benefits;
5. It does NOT permit people to keep the same health coverage they had in their old job when they move to a new job;
6. It does NOT eliminate all use of pre-existing condition exclusions; and
7. It does NOT replace the State as the primary regulator of health insurance.

Types of Coverage

HIPAA generally applies to the following types of coverage:

Group Plan –A group health plan is health coverage sponsored by an employer or union for a group of employees and possibly for dependents and retirees as well. To understand your rights, you will need to know the following things about your group health plan:

- Does a State or local governmental employer sponsor the plan?
- Does a church or group of churches sponsor the plan?
- Does the plan cover fewer than two current employees?
- Does a small employer or a large employer sponsor the plan?
- Is the plan an insured plan that purchases health insurance coverage from an HMO or group plan?

A group plan is an employee benefit plan maintained by an employer or union that provides medical care to employees and often to their dependents as well.

Health Insurance Issuer—Any company that sells health insurance is a health insurance issuer. Insurance companies and HMOs are both health insurance issuers.

Self-Insured Plan—A self-insured (or self-funded) plan is a group health plan under which the risk or the cost of the benefits provided is borne by the sponsoring employer or union.

Creditable Coverage—Creditable coverage is prior health care coverage that is taken into account to determine the allowable length of pre-existing condition exclusion periods (for individuals entering group health plan coverage) or to determine whether an individual is a HIPAA eligible individual.

Individual Health Insurance

Individual health insurance coverage is insurance coverage that is sold by HMOs or other health insurance issuers to individuals who are not part of a group health plan.
Even though health coverage might be provided through an association or other group, such as groups of college students or self-employed individuals, it is still considered to be "individual" health insurance if it is not provided through a group health plan.

Comparable Coverage through a High-risk Pool

Some States have set up high-risk pools to provide health coverage for people who cannot otherwise obtain health insurance coverage in the individual market. Contact the Washington State Attorney General's Office or the Washington State Department of Health and Human Services for more information.

Eligibility for HIPAA Protections

If you are not currently covered by a particular type of plan or insurance, you need to determine what coverage you may be eligible to receive.

Your eligibility to enroll in a group health plan is determined by the rules of the group health plan and the contract terms of any insurance purchased by an insured plan.

Your eligibility to have HIPAA guarantee you the right to purchase individual health insurance coverage, which in some States will be through a high-risk pool, depends on your ability to meet ALL of the following requirements:

- You have at least 18 months of creditable coverage without a significant break in coverage – a period of 63 or more days during all of which you had no coverage. If you get coverage by midnight of the 63rd day, you have not incurred a significant break;
- Your most recent coverage must have been through a group health plan (through your or a family member's employer or union);
- You are not eligible for coverage under any other group health plan;
- You are not eligible for Medicare or Medicaid;
- You do not have other health insurance;
- You did not lose your insurance for not paying the premiums or for committing fraud; and
- You accepted and used up your COBRA continuation coverage or similar State coverage if it was offered to you.

If you meet these then you become a HIPAA eligible individual.

For more information about the Health Insurance Portability and Accountability Act (HIPAA), you can visit the U.S. Department of Health and Humans Services website at: http://www.hhs.gov/ocr/hipaa/links.html. You can also visit the U.S. Department of Labor website at: http://www.dol.gov/ebsa/publications/yhphipaa.html for more information.

The Women's Health and Cancer Rights Act of 1988 (WHCRA)

The Women's Health and Cancer Rights Act of 1998 (WHCRA) is a federal law that provides protections to patients who choose to have breast reconstruction in connection with a mastectomy. Generally, this law applies to persons covered under group health plans and persons with individual health insurance coverage. But WHCRA does NOT require health plans or issuers to pay for mastectomies. If a group health plan or health insurance issuer chooses to cover mastectomies, then the plan or issuer is generally subject to WHCRA requirements.

What coverage is provided by WHCRA?

If WHCRA applies to you and if you are receiving benefits in connection with a mastectomy and you elect breast reconstruction, coverage must be provided for the following:

- Reconstruction of the breast on which the mastectomy has been performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses (e.g., breast implant); and
- Treatment for physical complications of the mastectomy, including lymphedema.

Generally, WHCRA applies if you are in a self-insured plan. Your State law will determine whether WHCRA will apply to coverage under an insured group plan, or to individual health insurance coverage.

Notification Requirements and WHCRA

The WHCRA also requires group health plans and health insurance issuers, including insurance companies and health maintenance organizations (HMOs), to notify individuals regarding coverage required under the law. These notification requirements are needed during the following three separate times:

1. After enactment of WHCRA;
2. Upon enrollment; and
3. Annually.

Frequently Asked Questions and Answers about WHCRA

Q: Under WHCRA, may group health plans and health insurance issuers impose deductibles or coinsurance for reconstructive surgery in connection with a mastectomy?

A: Yes, but only if the deductibles and coinsurance are consistent with the cost-sharing arrangements that apply to other benefits under the plan or coverage.

Q: Are health plans required to give me notice of WHCRA benefits?

A: Yes. Both group health plans and health insurance issuers are required to provide you notice of WHCRA benefits upon enrollment and annually thereafter.

Q: Does WHCRA affect the amount that my health plan will pay my doctors?

A: No. WHCRA does not prevent a plan or health insurance issuer from negotiating the level and type of payment with attending providers. However, the law prohibits plans and issuers from penalizing attending providers or providing incentives that would induce a provider to provide care that is inconsistent with WHCRA.

For more information about the Women's Health and Cancer Rights Act of 1988 (WHCRA), visit the http://www.dol.gov/ebsa/publications/whcra.html or contact your local U.S. Department of Labor office for more details.

Chapter 3

HEALTH INSURANCE
By Anne van Leynseele

Washington State has a relatively strong consumer advocacy stance on health insurance. Recent laws have initiated an all access insurance plan for those unable to obtain coverage through employment or public assistance. The Washington State Office of the Insurance Commissioner provides consumer counseling and group education on health care issues, enforces insurance law and investigates complaints on behalf of citizens. Health care coverage issues are complex and you must be sure your health care plan will meet your potential needs in order to best manage your breast cancer treatment. It is important to understand your rights and responsibilities after a cancer diagnoses so that you can take full advantage of the services and consumer protections afforded you.

After I am diagnosed with breast cancer, can my health insurance be canceled?

In Washington State you cannot lose you insurance just because you get sick. This is true for both group and individual plans. Most health insurance is guaranteed renewable as long as either you or your employer continues to pay the premiums on the policy; you do not defraud the insurance company, and you meet any conditions of provider use or referrals. However, if you have individual health insurance your premiums may increase as you age or as your health declines. Short Term Major Medical insurance policies will only provide coverage for a limited time, such as six months, and these policies are not guaranteed renewable. When changing or applying for new coverage, always verify that your application form is accurate and complete because any misrepresentation on an application can result in termination of a policy. RCW 48.30.210

If I get breast cancer, do I need to stay in my job to keep my health insurance?

No employee or dependent can be denied group health insurance based on their medical history, including seeking advice, diagnoses or treatment for cancer. If you leave or lose your job, you may be able to retain your group insurance plan for up to eighteen months through COBRA (if your employer has 20+ employees). You may also use COBRA to bridge any potential gap in coverage because of a pre-existing condition or new employee-waiting period. Keep in mind that as a breast cancer patient or survivor it may be

difficult to obtain affordable insurance coverage after this COBRA period ends unless you can join another group plan.

When changing jobs and health plans with a pre-existing condition, you will receive credit for time spent on your prior health plan that was in effect during the three-month period immediately preceding the date of application for the new health plan. For example, if your new employer has a six-month waiting period for insurance enrollment, the employment start date will begin the waiting period for pre-existing conditions, rather than the enrollment start date. Health insurance carriers may apply specific waiting periods for certain treatments, as long as these limits apply to all new enrollees, for instance heart transplants. It is wise to verify the exact waiting period and any exclusion prior to cancelling your previous health insurance coverage.

What can I do if my insurance claim is denied?

Review your policy or coverage benefits booklet and try to determine why the claim was denied. Your denial may have been a clerical error or policy interpretation problem, differences between what your policy is supposed to cover and what it offers to cover. You may not be charged higher rates based on your health or past insurance claims. For, example participating provider agreements prohibit providers from collecting any amount other than the fees contractually agreed upon by the health plan. RCW 48.80.030(5).

When you challenge a claim rejection you will probably be referred to the claims department or customer services. Ask your doctor's office for help in understanding what the charges are and where the problem may have occurred. You should be prepared before you make the initial call with detailed information about the treatment date, doctor, and referral if any. On the call, you should be persistent, write down the details of what you are told and with whom you spoke, and ask for written confirmation of what was discussed. If you do not get satisfactory answers ask to speak to a supervisor.

You are within your rights to ask for a formal review. To best prepare for the formal review you should check if your hospital or cancer center has a patient representative or seek assistance from Consumer Advocacy at the Washington State Office of the Insurance Commission at 1-800-562-6900 or CAD@oic.wa.gov.

If all of these direct efforts fail to help get a reimbursement for a claim that you and your doctor think is justified, a final possibility is to contact a qualified lawyer with experience in health care and health insurance. See the resources at the end of this section.

Will I be able to get health insurance after a breast cancer diagnosis?

It will be difficult to obtain new health insurance coverage after you have been diagnosed or treated for a serious medical condition such as breast cancer. If you currently

have a health insurance plan that is meeting you needs, if at all possible, stay with this coverage. Your policy cannot be cancelled because you get sick.

If you become unemployed or change to a job that does not provide health insurance benefits, your challenge becomes both obtaining coverage and paying for it. It is preferable to extend your previous coverage through COBRA if possible and begin searching for alternative coverage right away. You can look for a group plan through employers, a spouse's plan, professional or political organizations. Some companies offer group plans to the self-employed or small business employers (2-50 employees).

If you are unable to find a group plan, most major providers in Washington State offer an individual plan, but the premiums run for 30 year olds for $120 – $198 through 60+ for $576 – $877 per month. In Washington State, certain individuals are not required to fill out a health-screening questionnaire when applying for individual insurance and no carrier may reject an individual for an individual health benefit plan based upon preexisting conditions of the individual. RCW 48.43.018.

Washington State passed a Health Insurance Coverage Access Act that provides access to health insurance coverage to all residents of Washington who are denied or cannot afford health insurance. RCW 48.41.020. Washington State Health Insurance Pool (WSHIP) is a public-private partnership that covers anyone with a sever and chronic illness who has been denied health insurance in the individual market. In January 2007, WSHIP expanded and restructured its chronic care management program to include breast cancer. RCW 48.41.040.

Chapter 4

PUBLIC BENEFITS
By Liz Ligon

There are a number of state and federal benefits available to individuals who are unable to work as a result of a disability. Cash benefits offered through the state are "needs based" (available to individuals and families with limited income and resources). Federal cash and medical benefits may be needs based (Supplemental Security Income and Medicaid) or earnings based (Social Security Disability Insurance and Medicare).

State Benefits

The Department of Social and Health Services (DSHS) administers needs-based cash and medical assistance programs for low-income individuals who have dependent children or who are unable to work due to a disability.

General Assistance-Unemployable (GA-U) is the state disability benefit available to individuals without dependent children who are afflicted by a short-term disability (3-12 months) which renders them unable to work. GA-U provides a monthly cash grant of $339 and limited medical coverage. **General Assistance-SSI Track** (GA-X) is available to low-income individuals with a long-term disability (more than 12 months or expected to result in death) and provides the same cash grant of $339, but also provides Medicaid coverage, which includes coverage for prescription medications and mental health treatment. Additionally, individuals who are granted GA-X benefits are assigned an SSI Facilitator at DSHS who will assist them in applying for federal disability benefits.

Temporary Assistance for Needy Families (TANF) is a cash grant available to low-income families with dependent children. Parents receiving TANF for their families are required to engage in job search activities or be employed in order to maintain their eligibility. Parents who are unable to work as a result of disability may receive an exemption from the work requirements.

Application for benefits through DSHS may be made online at https://fortress.wa.gov/dshs/f2ws03esaapps/onlineapp/introduction_1.asp, or in person at any DSHS office (locate your local office at https://fortress.wa.gov/dshs/f2ws03esaapps/onlinecso/findservice.asp.

Federal Benefits

Social Security Disability

Social Security administers two cash assistance programs for individuals with disabling health conditions, **Social Security Disability Insurance** (SSDI) and **Supplemental Security Income** (SSI). Individuals who establish eligibility for SSDI become eligible for Medicare 24 months after the onset of their disability, while SSI recipients receive Medicaid throughout the period of their SSI eligibility.

In order to qualify for **SSDI**, a person must have worked at a job where they paid Social Security taxes for a certain number of work quarters (the number of work quarters varies based on the person's age), and they must meet Social Security's definition of disability. Social Security considers a person disabled if they cannot perform any "substantial" work on an ongoing basis, and their disability has lasted or is expected to last for at least twelve months or result in death. In deciding whether an individual is disabled under their rules, Social Security must consider *all* of the person's health problems, including negative side effects of treatment and symptoms such as pain, fatigue and impaired concentration. It is not uncommon for Social Security to deny benefits to applicants who are undergoing treatment such as radiation and chemotherapy based on an assumption that such treatment will be effective and will render the person employable within a year. In such cases, it is important for treating physicians to provide Social Security with a realistic assessment of their patient's prognosis for return to work, taking into consideration the often-prolonged recovery period following treatment, debilitating side effects, and related impairments such as depression. In cases where the patient's condition is considered terminal, this fact should be made known to Social Security as these cases are placed on a fast track in the decision making process.

Individuals who are found eligible for SSDI benefits are provided monthly cash benefits (the amount varies depending on the person's work history), and will usually be able to receive additional cash benefits for any dependent minor children.

Social Security has special rules for SSDI recipients who are trying to return to work that enable them to earn wages for a period of time without immediately losing their cash benefits. The rules are complicated, and it is important for recipients to fully understand the impact of their return to work before starting a job. A failure to fully understand the work rules and reporting requirements often results in significant "overpayment" of benefits by Social Security which often must be paid back. For information about Social Security's rules about returning to work, see http://www.ssa.gov/disabilityresearch/redbook.htm.

Supplemental Security Income (SSI)

In order to qualify for SSI benefits, an individual must be low-income, disabled under Social Security's rules (see above), and have a qualifying immigration status. Eligible individuals are provided with a monthly cash grant and Medicaid. Because this is a needs-based program, individuals who have more than $2000 in available resources ($3000 for couples) are not eligible for benefits. Certain resources, such as a residence and one vehicle, are excluded when determining eligibility.

For individuals on SSI who wish to return to work, Social Security applies a simple formula to reduce their cash grant based on the amount of their earnings. It is extremely important that SSI recipients report all of their earnings to their local Social Security office in a timely manner to avoid being "overpaid" and owing money back to the Social Security Administration.

Medicare

Medicare is a federal health insurance program for people over 65 and those under 65 who are receiving SSDI benefits who have End-Stage Renal disease (permanent kidney failure requiring dialysis or transplant). To be eligible for Medicare, the individual or their spouse must also have worked for at least 10 years in Medicare-covered employment, and must be a citizen or permanent resident of the United States.

Part A

Medicare Part A covers care in (i) hospitals as an inpatient, (ii) critical access hospitals (small facilities that give limited outpatient and inpatient services to people in rural areas), (iii) skilled nursing facilities, (iv) hospice facilities, and (v) some home health companies. Part A coverage is usually free. Individuals who have not paid the requisite Medicare taxes through employment may be able to purchase Part A coverage if they are 65 years of age or older.

Part B

Medicare Part B covers doctors' services, outpatient hospital care, and some other medical services that Part A does not cover, such as the services of physical and occupational therapists, and some home health care. Part B helps pay for these covered services and health care supplies when they are medically necessary. Part B coverage requires payment of a monthly premium, although low-income individuals may be eligible to have their premiums paid by the state's Medicaid program. Application for Medicaid coverage of Medicare premiums can be made through the Department of Social and Health Services.

Part D

Medicare Part D provides coverage for prescription medications, and is available for all Medicare recipients, although enrollment is voluntary. There are a number of different prescription drug plans available through Part D that are administered by private health insurance companies, and plans vary in their coverage, premiums, and co-insurance payments. For help identifying a plan that meets an individual's specific needs, contact SHIBA (State Health Insurance Benefits Advisors) at 1-800-562-6900, or http://www.insurance.wa.gov/consumers/Shiba_HelpLine/dirdefault.asp.

Medigap

Medicare coverage may be supplemented with a Medigap policy. A Medigap policy is health insurance sold by private insurance companies to fill the "gaps" in some of the health care costs that the Medicare plan doesn't cover. For help identifying a Medigap plan that fits your needs, contact SHIBA (above) or Medicare at 1-800-MEDICARE.

Medicaid

Medicaid is a needs-based federal health insurance program that is administered by the states. Eligibility is based on factors including income and resources, age, pregnancy, disability, blindness, and immigration status. Application for benefits may be made online or at your local DSHS office (see above).

Chapter

5

DEALING WITH HOSPITAL MEDICAL DEBT

By Diana Singleton

(Adapted excerpts from "Charity Care: Medical Coverage for Hospital-Based Medical Services" with permission from John Hughes and Joanna Otero)

If you do not have medical insurance or if your medical insurance does not cover all of your medical expenses, dealing with mounting medical debt, particularly in the midst of battling breast cancer, may seem daunting. If you receive care in a hospital, the hospital's financial assistance department should help you identify ways to pay for your medical debt.

If you are low-income, you may qualify for medical coverage from the Department of Social and Health Services (DSHS). You can receive medical coverage for treatment that you received up to three months prior to employing. Those who are eligible for this medical coverage includes children (with incomes below 250% of federal poverty level), pregnant women, disabled adults, aged adults (age 65+), hospitalized people, and families eligible to receive Temporary Aid to Needy Families. If you do not qualify for medical coverage through DSHS, your hospital charges may be reduced or waived through the Charity Care program.

Charity Care is a program established under state law that requires hospitals to provide medical care for free or at a reduced cost for middle-income and low-income patients. If you have medical insurance, but it does not cover all of your medical expenses, Charity Care can cover any expenses that are hospital-based.

Charity Care covers services you receive from a hospital, whether the service is provided on an inpatient or outpatient basis. **However, Charity Care may not cover services that are provided by medical personnel not considered part of the hospital's medical staff; for example, radiologists or anesthesiologists who are not employed by the hospital.** In addition, Charity Care does not cover "extras" you receive while in the hospital, such as telephone or cable television services, unless those services are provided to the public for free.

The legal authority for Charity Care can be found in Revised Code of Washington (RCW) 70.170 and Washington Administrative Code (WAC) 246-453.

Who qualifies for Charity Care?

Your eligibility for Charity Care is based on your income and resources. You must first apply for and use any private health care coverage or government health care coverage (such as Medicare and Medicaid) available to you. Assuming your income and resources make you eligible for Charity Care, and you have exhausted any other available health care coverage, Charity Care coverage should be available to you.

State rules divide eligibility for Charity Care into three categories based on income and resources (the rules of some hospitals are more generous):

1. Any person whose household income is at or below 100% of the Federal Poverty Level, adjusted for family size (see chart below), is entitled to free care. There are no resource limits [WAC 246-453-040(1)].

2. Any person whose household income is more than 100% but not more than 200% of the Federal Poverty Level, adjusted for family size (see chart below), is entitled to reduced cost care based on a sliding scale established by the hospital. The hospital's sliding scale "Charity Care Policy" must be made available to you upon request. The hospital has the discretion to impose a resource limit [WAC 246-453-040(2), 246-453-050(1)].

3. Any person whose household income exceeds 200% of the Federal Poverty Level, adjusted for family size, may be eligible for reduced cost care if their income and resources are not sufficient to enable them to fully pay for the hospital-based services [WAC 246-453-040(3)]. It is up to the hospital to decide whether to reduce charges if your income at this level.

Official 2005 Federal Poverty Level (FPL) (All income amounts rounded up)**

Family Size	Annual 100% FPL	Monthly 100% FPL	Monthly 200% FPL	Monthly 250% FPL
1	$9,570	$798	$1,595	$1,994
2	$12,830	$1,069	$2,138	$2,673
3	$16,090	$1,341	$2,682	$3,352
4	$19,350	$1,613	$3,225	$4,031
5	$22,610	$1,884	$3,768	$4,711
6	$25,870	$2,156	$4,312	$5,390
7	$29,130	$2,428	$4,855	$6,069
8	$32,390	$2,699	$5,398	$6,748
9	$35,650	$2,971	$5,941	$7,472
10	$38,910	$3,243	$6,484	$8,106

** "Income" includes total cash receipts before taxes received from wages and salaries, welfare payments, Social Security payments, unemployment or disability benefits, strike benefits, child support, maintenance (alimony), and net earnings from business and investments. Changes in the income levels are made each April [WAC 246-453-010(17)].

To which hospitals do the Charity Care laws apply?

The charity care laws apply to all hospitals, including psychiatric hospitals, in the state of Washington [RCW 70.170.020(2); WAC 246-453-010(2)]. All hospitals are required to post or prominently display, in public areas of the hospital, information concerning the availability of free and reduced-cost Charity Care [WAC 246-453-010(16); WAC 246-453-020(2)]. Because not all hospitals comply with this notice requirement, you should always request that you be allowed to apply for Charity Care if you think you will need coverage.

How do I apply for Charity Care?

At the time the hospital requests information from you about the availability of insurance, the hospital is required to provide you with information in writing and explain how you may obtain Charity Care. If you are not able to read or do not understand the explanation, the hospital must find someone to make the explanation understandable. This written information and explanation must be made available in any language spoken by more than 10% of the population in the hospital's service area. For those patients who are unable to communicate effectively in English but do not qualify to receive the written information, the hospital must provide a qualified interpreter to explain the availability of free or reduced-cost care [WAC 246-453-010(16); WAC 246-453-020(2)].

You may ask hospital staff for a Charity Care application **at any time**. This means that you can apply for Charity Care even after you received a bill. If you are not properly notified, you should ask hospital staff for a Charity Care application and for their "Charity Care Policy" as soon as you are admitted to the hospital if possible. Hospital staff is required to provide you with an application at any time you request an application.

How does the hospital decide whether I am eligible for Charity Care?

The hospital is required to make two determinations: 1) an **initial determination;** and 2) a **final determination** of your eligibility for Charity Care. The hospital is required to make its initial determination based on any oral information you provide. It is permissible for the hospital to require that you sign a statement that confirms the accuracy of the information you orally provide [WAC 246-453-030(1)]. The initial determination must be completed at the time of admission, or as soon as possible following the initiation of services to the patient [WAC 246-453-020(1)(b)]. If you cooperate with the hospital's efforts to make an initial determination, then no collection actions may be taken against you and no deposits collected from you for hospital services provided. If the initial determination indicates you are eligible, then collection actions and deposits are prohibited [WAC 246-453-020(1)(c)(6)].

Once you are initially determined to be eligible for Charity Care, you are given at least 14 calendar days to obtain documentation which supports the information you provided orally so that the hospital can make a final determination regarding your

eligibility for Charity Care [WAC 246-453-020(3)]. In addition, the hospital is required to make every reasonable effort to determine whether a government agency or private insurance company will cover some or all of the hospital charges to you [WAC 246-453-020(4)].

You may submit any of the following documents as evidence of your eligibility for Charity Care: pay stubs, income tax returns from the previous year, "W-2" statements, unemployment compensation forms approving or denying your claim, forms approving or denying Medicaid and/or state-funded medical assistance, and written statements from employers or welfare agencies [WAC 246-453-030(2)]. This list is not exclusive; if you have other documents that will support your eligibility, you may submit those documents as well.

Hospitals should not require so much information or documents from you that you and others get discouraged and fail to apply [WAC 246-453-030(5)]. Hospitals must take into account language barriers and any physical, mental, intellectual or sensory deficiencies which may make it hard for you to comply with its application requirements [WAC 246-453-020(5)].

Once the hospital has received the requested documentation from you, it must make a final determination and notify you of its decision within 14 calendar days. The notice must include the amount of money you will be required to pay for your hospital services [WAC 246-453-020(7)].

What if my application for Charity Care coverage is denied?

If your application for Charity Care is denied, the notice of denial must provide a reason for the denial [WAC 246-453-020(8)]. If your family income is equal to or less than 200% of Federal Poverty Standards, you must also be provided with a notice of an appeals procedure. The hospital's appeal procedure must include an opportunity for you to correct any deficiencies in the documentation you provided, and to request a review of the decision by the hospital's chief financial officer or equivalent [WAC 246-453-020(9)]. It is also advisable to send a copy of your appeal to the Department of Health, Hospital and Patient Data Systems, P.O. Box 47811, Olympia, WA 98504-7811.

You must also be notified that you have 30 days to appeal. If you appeal within the first 14 days, then no collection action may be started until your appeal has been heard and denied; if you appeal after 14 days but within 30 days, then any collection actions which have been started must be stopped [WAC 246-453-020(9)(a) and (b)].

If your appeal is denied, you must be notified in writing of the decision and the reason for it. The hospital must send a copy of its decision, along with copies of the documentation upon which the decision was based to the Department of Health [WAC 246-453-020(9)(c)].

The Department of Health is required to review denials of Charity Care. If the hospital has inappropriately denied Charity Care, the Department of Health may seek penalties against the hospital and individual staff members [RCW 70.170.070; WAC 243-456-020(9)(d)]. If you are interested in having the Department of Health review your denied application, call (360) 236-4210. *The Department of Health and its contractors are required to maintain the confidentiality of any information that may identify you or any other individual patients [RCW 70.170.090].*

What if the hospital failed to make an initial or final determination of my eligibility for Charity Care in a timely manner?

Hospitals are required to make every reasonable effort to reach initial and final determinations of Charity Care eligibility in a timely manner; however, hospitals are required to make those determinations at any time upon learning of facts or receiving documentation that would support a finding of Charity Care eligibility. If you paid for part or all of the charges made for hospital services received which should have been covered by Charity Care, you are entitled to a refund within thirty days of your being designated eligible for Charity Care [WAC 246-453-020(10) and (11)].

Thus, if a hospital failed to properly process your application for Charity Care, you should immediately contact the hospital and demand that they do so in the manner discussed in these materials.

http://www.lawhelp.org/WA/showdocument.cfm/County/ /City/ /demoMode/=1/Language/1/State/WA/TextOnly/N/ZipCode/ /LoggedIn/0/rpc/1030803/doctype/dynamicdoc/ichannelprofileid/15388/idynamicdocid/1895/iorganizationid/1553/itopicID/864/iProblemCodeID/1030803/iChannelID/7/isubtopicid/2/iproblemcodeid/3

What if I applied for Charity Care coverage but no determination was made by the hospital and the hospital has turned me over to a collection agency?

You should contact both the collection agency and the hospital to inform them in separate letters that the hospital has failed to follow the law and that you are requesting that the hospital immediately process your application for Charity Care and that collection actions be stopped. A sample and blank form letter to a collection agency are provided below. It is advisable to send a copy of the hospital letter to the collection agency, and also send a copy of the collection agency letter to the hospital.

What if I have not yet applied for Charity Coverage but believe I am eligible and the hospital has turned me over to a collection agency?

You should contact both the collection agency and the hospital to inform them that the hospital has failed to follow the law and that you are requesting that the hospital

immediately send you an application for Charity Care. You should also request that collection actions be stopped. A sample and blank form letter to a collection agency are provided below. Again, it is advisable to send a copy of the hospital letter to the collection agency, and also send a copy of the collection agency letter to the hospital.

What if the hospital or a collection agency is suing me?

You should immediately contact an attorney to write to the opposing attorney to inform him/her that the hospital failed to follow the law by not considering you for Charity Care eligibility, and that the lawsuit should be dismissed or suspended pending a determination of your eligibility for Charity Care. If you haven't done so already, you or your attorney should also write the hospital a letter requesting an application for Charity Care Coverage, or demanding they properly process the application you have already submitted. A copy of your letter to the attorney should be sent to the hospital, and a copy of your letter to the hospital should be sent to the attorney. A sample and blank form letter to a collection agency are provided below.

In addition, you should read and use the forms in the publication entitled "How To Present a Charity Care Defense to a Lawsuit for Hospital Debt Collection" which is available for free download on www.washingtonlawhelp.org. This publication includes forms and samples so you can complete an Answer to the Complaint in order to make sure that a default judgment is not entered against you.

If you are unable to convince the attorney to stop your case until a Charity Care determination is made, you should be prepared to go to a hearing and present evidence of your income and resources.

What if the hospital incorrectly determined me to be ineligible for Charity Care coverage and is suing me?

Assuming you were not able to convince the Department of Health to overturn the hospital's decision as described above, you should be prepared to convince a judge that the hospital made an incorrect decision despite the fact that you cooperated appropriately with its application process. You must prepare first by filing an Answer with the court and serving a copy on the opposing counsel. You should log on to www.washingtonlawhelp.org and review the publication, "How To Present a Charity Care Defense to a Lawsuit for Hospital Debt Collection."

The key to winning will be your gathering of documentation that shows that your income and resources make you eligible for Charity Care. Because the hospital or collection agency's attorney may not have been given a complete picture of your case, it is worthwhile to call and write the attorney and provide documentation of your eligibility. A sample and blank form letter to a collection agency are provided below.

What if a judgment has been obtained against me for hospital services that should have been covered by Charity Care?

If proper legal procedures were used in obtaining the judgment (for example, you were properly notified of the lawsuit and failed to answer, or you answered but did not raise the defense that you were not considered for Charity Care), then the judgment will remain in effect and you will be legally responsible for the debt. However, if you can show that the judgment was not obtained properly (for example, you never received notice of the lawsuit), and you can demonstrate that you would have been eligible for Charity Care, then the judgment may be vacated. You should contact an attorney for further assistance with this. If you are low-income and live outside of King County, you may call Northwest Justice Project's CLEAR line at 1-888-201-1014 (TTY: 1-888-201-9737), or 1-888-387-7111 for persons age 60 and over, for information and advice on how to vacate a judgment

Other Legal Hospital-Related Rights

All hospitals must provide **emergency care** to patients who are unable to pay all or part of the costs. A hospital may not transfer a patient with an emergency condition, or who is in active labor, unless the patient gives permission or the transfer is due to the limited medical resources of the transferring hospital [RCW 70.170.060(2)].

No hospital or its medical staff may refuse to admit patients who would be expected to require unusually costly or prolonged treatment unless the care available at the hospital would not be appropriate to the patient's needs [RCW 70.170.060(1)(c)].

No hospital or its medical staff may adopt or maintain admission practices or policies that result in a significant reduction in the proportion of low-income patients admitted who are not able to pay all or part of anticipated charges [RCW 70.170.060(1)(a) and (b)].

It is possible that a hospital may refuse to provide services to an otherwise eligible patient who does not need emergency care services or whose treatment would not be unusually costly or prolonged. If you believe your right to care has been violated, you should contact the Department of Health at (360) 236-4210. If the Department of Health is not willing to assist you and you are not satisfied with its reasons, you should consult with an attorney for legal advice.

It is against the law for a hospital or its staff to engage in unfair and discriminatory practices because of an individual's race, creed, color, national origin, sex, the presence of a disability, or the use of a trained dog guide or service animal by a person with a disability. If you believe that a hospital has unfairly discriminated against you, you should call the Washington State Human Rights Commission at 1-800-233-3247.

Other Charity Care and Billing Voluntary Guidelines

In response to the growing concern that middle-income and low-income uninsured patients were being charged more than insured patients and in response to hospitals' collection practices, the Washington State Hospital Association (WSHA) and its member hospitals have pledged to meet voluntary guidelines that supplement the existing Charity Care law. You can obtain a copy of these voluntary guidelines at WSHA's website, www.wsha.org, and clicking on their publications link.

A summary of the voluntary guidelines includes the following:

- Discounts for uninsured patients;
- Uninsured patients who have a documented income of less than 100% of the Federal Poverty Level will be required to pay for hospital care;
- Uninsured patients who have a documented income of less than 200% of the Federal Poverty Level will be given a discount so that they will not be asked to pay more than the hospital's estimated cost of care;
- Uninsured patients who have a documented income of less than 300% of the Federal Poverty Level will be given a discount which is calculated so that they will not be asked to pay any more than insured patients are charged;
- Hospital boards will increase their oversight of the hospital collection practices and will each set forth policies on when accounts are sent to collections; and
- Hospitals will increase and improve notices to patients about Charity Care.

Resources

If you are low-income and need legal assistance with a DSHS medical coverage or Charity Care problem, you can call Northwest Justice Project's CLEAR legal hotline at 1-888-201-1014, Monday through Friday, from 9:30 a.m. to 12:00 p.m. and on Tuesdays from 3:30 p.m. to 6:15 p.m., for free advice and referral. If you are age 60 and over, you can call Northwest Justice Project's CLEAR Sr* legal hotline at 1-888-387-7111, during the same days and hours. If you are not low-income, you should contact your local bar association for a lawyer referral.

If you encounter a negative experience with Charity Care and/or with a hospital's billing practices, you can contact Washington Community Action Network (Washington CAN!) at 206-389-0050 or the Northwest Health Law Advocates at 206-325-6464.

Sample Letters

You can download and print the sample letters by logging on to www.washingtonlawhelp.org and clicking on the publication entitled "Charity Care: Medical Coverage for Hospital-Based Medical Services."

Chapter

6

VIATICAL SETTLEMENTS
By Joslyn K. N. Donlin

People who are diagnosed with a terminal illness such as cancer, AIDS, other life-threatening illnesses or a "qualified covered condition," oftentimes find themselves in need of cash to pay for mounting hospital and doctor bills, household expenses as well as other bills. In some cases, there may be medical expenses that health insurance does not cover. Life insurance helps surviving beneficiaries meet expenses. To assist those who are facing terminal or life-threatening illnesses, there is another option available, which allows the insured of a life insurance policy to tap into his/her insurance benefits while still alive. This option is a viatical settlement..

What is a Viatical Settlement?

A viatical settlement is the sale of one's life insurance policy at a discount to a third party. The term "viatical" comes from the Latin term "viaticum" which means "provisions for a long journey." The person (owner) selling the life insurance policy is called the "viator." The viator of the life insurance policy sells the policy for an immediate cash benefit. This person gives up ownership of the policy in return for a cash payment, less than the full amount of the death benefit of the life insurance policy. At one time, most viatical settlements involved people with life-threatening illnesses. Today, those not facing a life threatening illness may sell their life insurance policy to get immediate cash.

What is a viatical settlement provider?

A viatical settlement provider is the person or company that buys the life insurance policy. The viatical settlement provider takes on the role of the policy owner, pays the premiums, if any, on the insurance policy and eventually collects the full amount of the death benefit from the insurance company, when the insured dies.

What is a viatical settlement broker?

A viatical settlement broker is the person or company who represents the seller (viator) of the life insurance policy and compares viatical offers for the seller.

Who is eligible for a viatical settlement?

Viatical settlement companies establish their own set of rules and criteria for determining who is eligible for a viatical settlement and which life insurance policies it will purchase. In general, most viatical companies require the following:

- the policy is owned by the insured for at least two years;
- the policy owner is terminally ill. Some companies require a life expectancy of two years or less; others may buy a policy if the life expectancy is four years;
- the current beneficiary must sign a release or a waiver;
- the policy owner must sign a release allowing the viatical settlement provider access to his/her medical records.

What are some financial implications?

The decision to sell one's life insurance policy is a very complex matter. An eligible policyholder should consider all available financial planning options and alternatives. Because of the potential federal and state tax consequences involved in a viatical settlement, the policyholder should consult a tax advisor before deciding to enter into a viatical settlement. In general, if the viator's life expectancy is less than two years, and if he/she sells the policy to a viatical settlement company, the proceeds are tax-free. However, the viator may still owe state tax. However, there are some states that have made these settlements tax-free. In 1997, Congress amended the tax code and made proceeds from viatical settlements tax-exempt. Under federal law, if the viator's life expectancy is less than two years and the viatical settlement company is licensed in the state that requires licensing, then proceeds from viatical settlements are tax-exempt.

Viatical settlements may also affect one's eligibility for public assistance programs that are based upon financial need, such as Medicaid. Once a policyholder cashes in a policy and receives a settlement payment, the money received may be counted as income for Medicaid purposes and may affect eligibility.

Are there model regulations on viatical settlements?

Yes. The National Association of Insurance Commissioners (NAIC) has established model regulations for viatical settlements in the United States. These regulations include guidelines on the amount of money a viator should expect to get fro selling his/her life insurance policy. The NAIC website includes a bibliography of articles on viatical settlements. In some states viatical settlement firms and brokers are required to be licensed and registered with the state insurance commissioner in order to conduct business in that state. See Resources below for contact information on the NAIC and its website.

Does Washington State regulate viatical settlements?

Yes. Washington State, California and New York are the three states with some of the toughest regulations on viatical settlements. The Washington State Insurance Commissioners oversees the regulations of viatical settlements. There are specific state license requirements for viatical settlement providers and brokers. State law also specifies what information must be provided to the viator and that medical information obtained is strictly confidential. The Consumer Protection Act applies to viatical settlements. The applicable statutes and regulations are: Chapters 48.102 RCW and 284-97 WAC. See Resources below for contact information on the Washington State Insurance Commission.

What are some general consumer guidelines on viatical settlements?

The physical, emotional and financial burdens of one facing a terminal or life-threatening illness can be overwhelming and unbearable. For those facing a terminal illness, viatical settlements are one option in accessing needed and immediate cash. However, viatical settlements can be costly and complicated, and should be approached with caution and great care. When considering viatical settlements as an alternative to obtain needed cash, the following are some consumer guidelines that should help avoid potential mistakes and pitfalls:

- check with state insurance offices to determine licensing requirements for viatical settlement companies, providers and brokers and to ensure that requirements are met;
- contact several viatical companies to compare settlement offers and ensure offers are competitive and reasonable;
- inquire about the company's policy for protecting the consumer's privacy;
- verify that the company has the payout money readily available;
- check into the tax consequences and implications for public assistance benefits;
- beware of high pressure sales tactics; and
- seek the help of a financial planner, accountant, tax advisor and/or lawyer well versed on viatical settlements in order to determine its financial, tax and legal implications.

What are some viatical settlement resources?

Washington State Office of the Insurance Commissioner
PO Box 40255
Olympia, WA 98504-0255
http://www.insurance.wa.gov/

National Association of Insurance Commissioners
444 North Capitol Street, N.W.
Washington, DC 20005

American Council on Life Insurance
1001 Pennsylvania Avenue, N.W.
Washington, DC 20004-2599

North American Securities Administrators Association
10 G Street N.E., Suite 710
Washington, DC 20002

National Viatical Association
1200 G. Street, N.W., Suite 760
Washington, DC 20005

Viatical Association of America
1200 19th Street, N.W., Suite 300
Washington, DC 20036

Gloria Grening Wolk, *Cash for the Final Days – A Financial Guide for the Terminally Ill and Their Advisors* (Bialkin Books 1997)

Gloria Grening Wolk, ed., *Viatical Litigation – Principals & Practice* (Bialkin Books, 2002).

Chapter 7

DISABILITY BENEFITS: GENERAL ASSISTANCE UNEMPLOYABLE - RULES AND ELIGIBILITY

By Evonne Zook

GA-U/GA-X is the state cash assistance and medical program for people with disabilities, administered by the Department of Social and Health Services (DSHS). The cash grant is $339. Recipients get GA-U if they have a short-term disability or GA-X if they have a long-term disability and are expected to qualify for SSI.

Who is eligible for GA-U/GA-X?

To get GA-U/GA-X you must apply either at your local DSHS Community Service Office (CSO) or on-line. DSHS will then schedule an interview.

You must:

1. Be a citizen or eligible immigrant.
2. Have income and resources within DSHS rules.
3. Be incapacitated. "Incapacitated" means you are unable to perform gainful employment due to physical or mental conditions (or both) that are expected to last at least 90 days.

If your spouse receives Supplemental Security Income (SSI), and receives a supplemental payment for you, you cannot receive GA, and you will have to meet the stricter Social Security disability standard to receive medical assistance. (Non-Grant Medical)

What is the difference between GA-U and GA-X?

If your disability will improve in less than a year, you will receive GA-U. If your disability will not improve in less than a year (and may worsen), you will be referred to a **Social Security Facilitator** at DSHS. If DSHS believes you will qualify for federal disability benefits (SSI), you will receive GA-X.

The cash grant is $339 for both GA-U and GA-X. However, GA-X recipients receive more medical coverage than GA-U recipients do. If a GA-X recipient is approved for SSI,

the first payment from SSI (lump sum payment) will be used to pay back DSHS for the state cash benefits you received.

What do I need to prove I am incapacitated for at least 90 days?

To prove that you are incapacitated for 90 days and are unable to work (perform gainful employment) you must provide medical evidence supporting your claim. Medical evidence must come from certain medical professionals (doctors for physical disabilities, psychologists for psychological disabilities). DSHS will pay for an evaluation, and provide an evaluation form to give to your doctor. Although DSHS pays for your evaluation, you are not required to go to a doctor chosen by DSHS. You have the right to choose your own doctor as long as that doctor will accept DSHS payment. Your statement that you cannot work is not evidence of your incapacity.

What does DSHS do when my doctor finishes my evaluation?

When DSHS receives your evaluation, a caseworker reviews it to see if you are eligible. Even if your doctor says you will be unable to work for at least 90 days, the caseworker looks at other information including past work experience to decide if you will be approved for GA-U/GA-X. This process is called the Progressive Evaluation Process or PEP. The rules for the PEP process are contained in Washington Administrative Code (WAC) 388-448-0040 through 388-448-0110.

What can I do if I am denied benefits?

If you are denied benefits, you have the right to request a fair hearing. **You must ask for a fair hearing within 90 days of the DSHS notice denying you benefits or you will lose your right to a hearing.** If you believe you are incapacitated even though you have been denied you can give DSHS additional medical evidence that supports your claim that you cannot work. If you originally went to a doctor DSHS sent you to, you may want to consult another doctor and have that doctor give you another evaluation. If the new information supports your claim that you are incapacitated, it is possible that you will be approved for benefits before the hearing. If this happens, you can cancel the hearing. If DSHS does not believe your new evidence helps you, you should give it to the judge at the hearing so the judge can make the decision.

How long do I receive benefits if I am approved?

As long as you follow your doctor's treatment recommendations you will receive your benefits until the time your doctor said you are able to return to work. About a month before that time runs out, DSHS will send you a notice. (If your doctor says you are incapacitated for 90 days (3 months), you will receive a notice from DSHS after 2 months.) The notice will ask you to provide a current medical evaluation. If you believe you are

unable to return to work, make an appointment with your doctor so that s/he can evaluate you. You must provide the current medical information before the date listed on the notice you receive from DSHS. If you do not, you will be terminated and lose your benefits.

Is there anything I can do if DSHS terminates me because the Department believes my condition has improved?

When DSHS reconsiders your case after the initial incapacity period has expired, they will attempt to determine if your condition has improved to the point where you can now perform gainful employment. Recent regulation changes place the burden of proving that there has been NO material improvement on you - the recipient. If you believe the Department has improperly terminated you for "clear improvement," ask for a Fair Hearing and tell the Fair Hearing Coordinator (FHC) that you want to get another evaluation. **If you ask for the fair hearing within 10 days, your benefits will continue while you wait for the outcome of the fair hearing.**

During this time you should get the evidence you need to support your case that you are still unable to work. If you give DSHS information before the hearing date that shows you still are unable to work, DSHS may decide that you cannot work and again find you eligible for GA-U. If DSHS continues to believe you have improved enough to work, take the information to the fair hearing and ask the judge to decide.

Chapter 8

EMPLOYMENT AND CANCER
By Dana C. Hess

One in three persons will be diagnosed with cancer in their lifetime. More than 10 million people in the United States are living with cancer. Additionally, more than 1.3 million persons in the U.S. will be diagnosed with cancer this year. Sixty-five percent (65%) of adults diagnosed with cancer today will be alive five years from now. The large majority of these persons are employed when diagnosed, undergoing treatment, and post-treatment.

As employees, a person with cancer (or had cancer) is in most cases, considered "disabled" under federal and Washington Law and is protected by the Washington Law Against Discrimination (WLAD) and the American with Disabilities Act (ADA) . In addition, if the employee and employer meet the requirements, the employee will be eligible for leave under the Family Medical Leave Act. The following is a very brief overview of each.

I. WLAD – Washington Law Against Discrimination, RCW 49.60

In July 2006, the Washington State Supreme Court in *McClarty v. Totem Electric*, adopted the definition of disability used under the federal Americans with Disabilities Act ("ADA") rejecting the prior broad interpretation of "disability" found under the Washington State Law Against Discrimination ("WLAD").

This bill expanding the definition of disability under the Washington Law Against Discrimination (WLAD), RCW 49.60, was passed by the Legislature during the 2007 legislative session and signed by Governor Christine Gregoire. SB 5340 defines disability more broadly than does the general federal law on disability rights, the Americans with Disabilities Act (ADA). The Washington State Human Rights Commission (WSHRC) enforces the WLAD. The new legislation, which took effect July 21, 2007, includes retroactive coverage of all disability discrimination causes of action through July 6, 2006. This mean cancer is a recognized disability.

General Definition:

According to the new law, a "[d]isability means the presence of a sensory, mental, or physical impairment that:

- is medically cognizable or diagnosable; or
- exists as a record or history; or
- is perceived to exist whether or not it exists in fact."

This definition includes medically diagnosable impairments, regardless of whether they are temporary or permanent, common or uncommon, mitigated or unmitigated, or whether the impairment limits the person's ability to work generally or work at a particular job. Furthermore, most physiological, mental or emotional disorders or conditions are covered.

Reasonable Accommodation Definition:

An employer must accommodate an employee's condition when the impairment is "known or shown through an interactive process to exist in fact," and

- the impairment has a substantially limiting effect on one of the following:
- the individual's ability to perform his or her job;
- the individual's ability to apply or be considered for a job; or
- the individual's access to equal benefits, privileges, or terms or conditions of employment;

or,

the employee puts the employer on notice of the impairment and medical documentation establishes a "reasonable likelihood that engaging in job functions without an accommodation would aggravate the impairment to the extent that it would create a substantially limiting effect."

II. FMLA –Family Medical Leave Act

The Family & Medical Leave Act (FMLA) allows ”eligible” employees to take off up to 12 work weeks in any 12 month period for the birth or adoption of a child, to care for a family member, or if the employee themselves has serious health condition. A spouse means a husband or wife as defined or recognized under your State’s law. A parent is either the biological parent or the person who acted as the parent when the employee was a child. A son or daughter is either biological, adopted, under foster care, a stepchild, a legal ward, or any child that the employee is assuming parenting responsibility. The child must be under the age of 18 or over age 18 if a mental or physical handicap is present. The employer is allowed to ask for documentation, e.g., birth certificate, court documentation or a medical provider's certification.

To be eligible for FMLA, an employee must have a condition that makes him or her unable to perform their essential job function. An “eligible” employee allowed leave under the FMLA is an employee that has been employed with the employer for at least 1,250 hours

during a 12-month period prior to the start of the leave. The 12 months do not need to be consecutive months. The burden is on the employer to show records that the employee has not worked the required 1,250 hours. If the employer cannot show record of work hours, the employee is eligible to use FMLA. (Full-time teachers are eligible for FMLA even though they might not work 1,250 hours in a year.)

The Family & Medical Leave Act (FMLA) applies to the employer if it employs over 50 employees within 75 miles of the worksite, and at least 50 of the employees work 20 or more workweeks in the current or preceding calendar year. If the employer is a public agency, the employer is subject to provide FMLA regardless of the number of employees employed. All schools, private or public, are considered public agencies. The employer is not allowed to terminate FMLA if the employer falls below 50 employees for those employees currently on leave. Once the leave has been granted or the employee provides approval notice, the employer cannot alter the leave.

The eligible employee must provide 30-day advance notice for foreseeable events. The employer is allowed to ask the employee to obtain a certification from a medical provider testifying to the need for the employee to take the leave for herself or for the family member. Upon completion of the leave the employer is allowed to require the employee to obtain a certification of fitness to return to work when the leave was due to the employee's own health concerns. The employer can delay the start of FMLA for 30 days if the employee does not provide advance notice, and/or until the employee can provide certification from a medical provider.

An employer must give an employee requesting FMLA written notice, within two business days, if they are not eligible for FMLA. If the employer does not respond within two business days, the employee will be eligible to take the leave.

The eligible employee is allowed to take 12 weeks of unpaid leave, unless they have paid sick leave, in any 12-month period. The employee's leave can be taken on an intermittent basis; for example, an employee may drop to part-time status until the equivalent of 12 weeks has been obtained. During the 12 weeks of leave the employer must continue the employee's benefits the same as they would if they were not on leave. The employee needs to pay his portion of his benefits the same as if he/she were not on leave. After the 12 weeks have been used, the employee must return to their same position or equivalent position, similar benefits and working conditions, and same pay.

An employer is allowed to periodically ask the employee on leave to report their status and intentions to return to work. If an employee informs the employer that they do not intend to return to work, the employer may terminate the employment relationship and thus end the employee's FMLA.

III. ADA- American with Disabilities Act

Title I of the Americans with Disabilities Act of 1990 (the "ADA") requires an employer to provide reasonable accommodation to qualified individuals with disabilities who are employees or applicants for employment, unless to do so would cause undue hardship. There are three categories of "reasonable accommodations":

(i) modifications or adjustments to a job application process that enable a qualified applicant with a disability to be considered for the position such qualified applicant desires; or

(ii) modifications or adjustments to the work environment, or to the manner or circumstances under which the position held or desired is customarily performed, that enable a qualified individual with a disability to perform the essential functions of that position; or

(iii) modifications or adjustments that enable a covered entity's employee with a disability to enjoy equal benefits and privileges of employment as are enjoyed by its other similarly situated employees without disabilities.

The duty to provide reasonable accommodation is a fundamental statutory requirement because of the nature of discrimination faced by individuals with disabilities. Although many individuals with disabilities can apply for and perform jobs without any reasonable accommodations, there are workplace barriers that keep others from performing jobs that they could do with some form of accommodation. These barriers may be physical obstacles (such as inaccessible facilities or equipment), or they may be procedures or rules (such as rules concerning when work is performed, when breaks are taken, or how essential or marginal functions are performed). Reasonable accommodation removes workplace barriers for individuals with disabilities.

Reasonable accommodation is available to qualified applicants and employees with disabilities. Reasonable accommodations must be provided to qualified employees regardless of whether they work part- time or full-time, or are considered "probationary." Generally, the individual with a disability must inform the employer that an accommodation is needed.

There are a number of possible reasonable accommodations that an employer may have to provide in connection with modifications to the work environment or adjustments in how and when a job is performed. These include:

- making existing facilities accessible;
- job restructuring;
- part-time or modified work schedules;
- acquiring or modifying equipment;

- changing tests, training materials, or policies;
- providing qualified readers or interpreters; and
- reassignment to a vacant position.

A modification or adjustment is "reasonable" if it "seems reasonable on its face. An accommodation also must be effective in meeting the needs of the individual. In the context of job performance, this means that a reasonable accommodation enables the individual to perform the essential functions of the position. Similarly, a reasonable accommodation enables an applicant with a disability to have an equal opportunity to participate in the application process and to be considered for a job. Finally, a reasonable accommodation allows an employee with a disability an equal opportunity to enjoy the benefits and privileges of employment that employees without disabilities enjoy.

However, an employer does not have to eliminate an essential function of the position. Nor is an employer required to lower production standards -- whether qualitative or quantitative-- that are applied uniformly to employees with and without disabilities.

The only statutory limitation on an employer's obligation to provide "reasonable accommodation" is that no such change or modification is required if it would cause "undue hardship" to the employer." Undue hardship" means significant difficulty or expense and focuses on the resources and circumstances of the particular employer in relationship to the cost or difficulty of providing a specific accommodation. Undue hardship refers not only to financial difficulty, but also to reasonable accommodations that are unduly extensive, substantial, or disruptive, or those that would fundamentally alter the nature or operation of the business.

According to the EEOC, there is no specific amount of time that employers have to respond to an accommodation request, but they should respond as quickly as possible. Unnecessary delays in responding or implementing an accommodation can result in a violation of the ADA.

NUTS AND BOLTS:

<u>If you are counsel to an employee currently in or beginning cancer treatment:</u>

1. Notify employer, employer human resources, etc., **in writing,** when first hint of possible diagnosis. (This begins the "interactive process" with employer.)
2. Get a description of the employee's job – check the essential functions of the position.
3. Get a physician's note referencing the medical issue, any medical necessities, and all possible reasonable accommodations that the employees may require during the course of treatment.

4. Request accommodations as necessary – **in writing,** to employer, employer HR, etc. Note any delays in responding to request(s), any substitute accommodation, etc.
5. Check periodically – is employee able to perform essential functions of position with these accommodations? Are accommodations still needed or need revision?

Understanding: Each cancer patient, cancer treatment/treating physician, and employer is different; therefore, each case will be different.

<u>If you are counsel to an employee that has completed treatment or is a survivor:</u>

1. Identify any continuing reasonable accommodations needed and communicate in writing to employer, etc.
2. Do you need a Physician's release to return to work?
3. Want considerations should be made concerning future employment? Will there be limitations or reasonable accommodation needs?

<u>If you are counsel to an employer:</u>

1. Develop company policies regarding the handling of disability notification and accommodation, as well as addressing any disability discrimination procedure.
2. Make them and all their employees/staff aware of the ADA/WLAD and the requirements of reasonable accommodation by suggesting teaching/ training employees on a regular basis.
3. Create an open door environment for employees to discuss any questions they may have regarding disability and reasonable accommodation.

Chapter

9

HOUSING ISSUES
By Merf Ehman

What laws protect tenants in Washington?

The Residential Landlord Tenant Act protects renters who live in a residential dwelling unit like a house, apartment or room. In the City of Seattle tenants have additional protections under the Seattle Just Cause Ordinance. The law does not cover businesses. Certain living situations are not protected by this law. Some examples are:

1. Temporary residents of hotels and motels.
2. Residents of institutions like hospitals, colleges and universities, prisons and jails, nursing homes, and convents and monasteries.
3. Residents who live in the rental unit as part of their employment such as a grounds keeper or property manager.
4. Mobile home park owners who rent only the space in a mobile home park. The Mobile Home Landlord Tenant Act protects those residents. Residents who rent both the space and the mobile home are NOT excluded from the Residential Landlord Tenant Act.

Can a landlord refuse to rent to me because I have bad credit?

Yes.

Can a landlord refuse to rent to me if my bad credit or criminal record is related to my disability?

No, if you meet certain requirements that are explained in Section III.

Can a landlord refuse to rent to me because I have breast cancer?

No, if your breast cancer is a disability and you meet the requirements that are explained in Section III.

Can a landlord ask me to give up rights I have under the law?

No, except in extremely limited circumstances.

What are my duties as a tenant?

1. Pay rent
2. Keep your apartment clean
3. Dispose of your trash properly
4. Use your appliances properly
5. Maintain smoke detectors
6. Do not put anyone in danger
7. Do not cause roaches, rats or other creatures to come into your apartment
8. Do not damage the unit
9. Do not engage in illegal drug or other criminal activity
10. Leave the apartment in the same condition you found it

What are my landlord's duties?

1. Maintain the premises
2. Make sure the roof, floors, walls, and other structures are sound
3. Keep common areas clean and sanitary
4. Control insects, rodents and other pests
5. Provide adequate locks and keys
6. Keep the electric, plumbing, and heating in good working order
7. Provide for garbage removal (except for single family homes)
8. Provide hear and water
9. Give information about fire safety and protection
10. Provide smoke detectors
11. Provide information about the health hazards related to indoor mold

If I am unable to pay my rent, can my landlord take my belongings?

No.

If I am unable to pay my rent, can my landlord shut-off my utilities?

No. This includes water, heat, electricity, or gas.

Can my landlord lock me out of my apartment?

No, unless he or she has a court order to do so.

Will I have to pay penalties if I need to move out early because of my breast cancer?

If you qualify as a person with a disability, you may be able to move out early with no penalties as a reasonable accommodation under the fair housing act. See Section III.

When can my landlord ask me to move?

In most cases your landlord must give you a written notice. This is called an eviction notice. Here are the reasons your landlord can ask you to move:

REASON	**REQUIRED NOTICE**
Your lease term ends	NONE
Not paying rent	Three days notice to pay rent or vacate
Not complying with your rental agreement	10 days notice to comply with your lease or vacate
Running an unlawful business	Three days notice to vacate
Damaging the apartment	Three days notice to vacate
Committing a nuisance	Three days notice to vacate
Not meeting your duties as a tenant	30 days notice to comply
Ending a month-to-month tenancy	20 days notice

Can a landlord give me a 20-day notice to leave even if I did nothing wrong?

Yes, **EXCEPT**:

1. If you live in Seattle your landlord cannot ask you to move unless he or she has "just cause." (Just cause is explained below.)
2. If you have a lease that has not ended.
3. If your landlord gave you the notice because you asserted your rights as a tenant under the RLTA.
4. If your landlord gave you the notice because you complained to a government agency about your landlord's failure to comply with his or her duties and this failure affects your health or safety.
5. If your landlord gave you the notice because of your race, ethnicity, gender, age, disability or other protected class.

AFFORDABLE HOUSING OPTIONS

What is Public Housing?

Public housing is rental housing that is owned by a government entity called a Public Housing Authority. Examples of public housing authorities are the Seattle Housing Authority and King County Housing Authority. Your rent is fixed at 30% of your income.

What is Subsidized Housing?

The federal subsidy is given to the housing and not to the tenant. This is also called a "project based" subsidy. The amount of your rent depends on what type of program in which you are enrolled.

What is Tenant-based Section 8?

The **Section 8** Housing Choice Voucher program gives a subsidy to the **tenant**. The tenant then goes and finds an apartment. The tenant then enters into a rental agreement with the landlord. The landlord has a separate contract with the Section 8 program. Generally, the tenant based Section 8 program is operated by a public housing authority. Your rent is approximately 30% of your income.

What is the Low-Income Housing Tax Credit Program?

This program gives tax credits to developers who invest in affordable housing. You pay a below market rate rent.

Are there any other affordable housing programs?

Yes. There are state and local programs that are not listed here. For more information, go to www.hud.gov, www.wshf.org or www.aptfinder.org.

What are the eligibility requirements for affordable housing programs?

The requirements vary from program to program, but all have some of the same general requirements regarding *income*, *suitability*, what is a "*family*" and what is *citizenship*.

- Income – For most programs, your income must be below 80% of the median income for your area. Generally, you can have assets, but the income from these assets is included as part of your income. There is no minimum income limit.

- Suitability – Most programs want to make sure you will make a "good tenant." The housing provider will review your criminal record, rental history, and credit history. If you do not meet some of these requirements, because of your disability, then you can request a reasonable accommodation.

- Family – Generally, a family can be a single person, one or more adults and dependent children, people who are related by blood, marriage or operation of law or two or more people sharing residency and resources.

- Citizenship – Generally at least one member of the family must be an "eligible citizen" such as:
  - Lawful Permanent Resident
  - Alien granted asylum in the United States
  - Alien admitted to the United States as refugee
  - Alien paroled into the United States for at least one year
  - Alien granted withholding of deportation
  - Alien admitted for temporary residence
  - Victims of Trafficking

Some programs do not have a citizenship requirement.

- Some short-term housing assistance, such as homeless shelters, battered women's shelters, and shelters for runaway, abused or abandoned youth.
- Section 515 rural housing
- Low Income Housing Tax Credit (LIHTC)
- Certain housing administered by HUD. For more information go to www.hud.gov.

If I need a live-in aide to help me, do they need to meet all of the criteria?

To have a live-in aide, you need to show that your live-in aide is qualified, essential and suitable. You can use a letter from your doctor or other health care provider to show this. The live-in aide does not need to meet the income criteria and is not considered part of your family. However, the aide must meet the housing provider's suitability criteria.

Where can I find out more information about affordable housing vacancies?

Go to www.aptfinder.org or www.hud.gov for statewide inquiries.

FAIR HOUSING FOR PEOPLE WITH DISABILITIES

What does the Fair Housing law do?

The Federal Fair Housing Act protects individuals from housing discrimination based on race, color, sex/gender, national origin, religion, familial status, and disability

How does the law protect people with disabilities?

- Prohibits discriminatory practices
- Requires reasonable accommodations
- Requires reasonable modifications

What is the definition of disability in Washington?

1. A physical or mental impairment which substantially limits one or more major life activities;
2. A record of having an impairment; or
3. Being regarded as having an impairment

"Disability" also includes temporary disabilities, and any person in need of a trained guide or service dog. This definition is much broader than the one for Social Security Disability Benefits.

What are some examples of major life activities?

Working, walking, learning, hearing, seeing and breathing are some examples

What does is mean to have a "record of impairment"?

It means having a history of the impairment as documented by an agency, doctor/medical clinic, or other service provider.

What does it mean to be "regarded as having an impairment"?

This means to be perceived and treated as having an impairment that limits a major life activity, regardless of true limitation or record of the impairment. This is to protect people from any fear and stigma related to a disability.

What is an example of housing discrimination based on someone's disability?

An example is a landlord refusing to rent to a person who is disabled because the landlord is afraid that the disabled person cannot take care of himself or herself. Another example is telling a potential renter that an apartment is no longer available, even when it is, just because the potential renter has a disability

Are there any exceptions to Fair Housing Act?

Yes. Fair housing law does not apply if the disability issue is related to:

- Current use of **illegal, controlled** substances
- **Conviction** for illegal manufacture or distribution of a controlled substance
- **Direct threat** to the health or safety of others that no reasonable accommodation can relieve
- A reasonable accommodation that causes the landlord an undue financial or administrative burden

At what point in the rental process can disability discrimination occur?

Discrimination can occur at any point in the rental process:

- admission and screening
- terms and conditions during tenancy
- eviction/termination

When I apply for a rental unit, can a landlord ask me questions about my disability?

Generally, no, but a landlord can ask about a disability if the housing you are moving into is for people with disabilities or you are requesting a reasonable accommodation.

What is a reasonable accommodation?

You can ask a landlord to make changes in the rules, policies, practices, or services, when these changes may be necessary to allow you, a person with a disability, an equal opportunity to use and enjoy the apartment.

What are some examples of a reasonable accommodation?

- Helping a tenant with cognitive disabilities in filling out an application
- Changing a no pets rule to allow a companion dog for someone with a psychiatric disability
- Keeping laundry room door closed so that fumes do not make someone ill who has multiple chemical sensitivity
- Allowing a live-in aide for someone who needs help caring for themselves
- Providing notices to tenants in large print, or calling a blind tenant to read the contents of the notice
- Sending monthly reminder on rent day for someone whose disability causes memory lapses
- Adopting a policy which recognizes that normal wear and tear has a different meaning for a tenant who uses a wheelchair
- Allowing a reasonable extension on rent due for someone who has been hospitalized

Can a landlord force me to ask for a reasonable accommodation?

No. A landlord cannot impose an accommodation on you.

How do I request a reasonable accommodation?

You should make the request in writing. The request must include:

- Information about you disability

- A description of the accommodation you want
- An explanation of why the accommodation will be helpful to you

Do I need to provide all of my medical records?

No. You only need to provide information about your disability that is related to your requested accommodation.

Can the landlord request medical information? ?

Yes. After you make your request, your landlord can ask for proof that you need the accommodation. This could be a letter from you doctor, health care provider or other service agency that describes you disability and the need for the accommodation.

If I already have an accommodation, can I request a new or different one?

Yes. The law does not limit the number of accommodations you may request.

Can a landlord refuse to grant a reasonable accommodation?

Yes, but only for limited reasons. Your landlord can refuse your request if:

- Your request imposes an "undue" financial or administrative burden on the landlord. This means your request requires your landlord to offer services beyond what is reasonable for a landlord to provide or beyond what they normally provide.
- Your request involves excessive cost.
- There is no link between the accommodation you requested and your disability.

What can I do if I need to make physical changes to my apartment such as installing a ramp for a wheel chair or adding grab bars in the bathroom?

You can request a **reasonable modification**. If you are disabled, then a housing provider must permit you to make reasonable physical changes to your rental unit or a rental unit you are going to move into and to common areas. You can make these changes as long as they are necessary for you to fully use and enjoy the premises

Who pays for the modification?

The tenant pays for the modification unless the housing is federally funded. If the housing is federally funded, then the landlord must pay for the modification.

After I make a reasonable modification, can the landlord require me to return the unit to its original condition?

Yes, unless the modification will not affect a future tenant's ability to use and enjoy the premises.

What can the landlord ask me to do if I make a reasonable modification?

- Obtain any necessary building permits
- Condition permission for the modification based on assurance that work will be done properly
- Ask you in writing to agree to restore the unit, but not the common areas, after you leaves unless it is not reasonable to do so
- Ask you to set aside a reasonable amount of money over a reasonable time in an interest bearing escrow account to pay for restoration

What agencies enforce fair housing law?

The following agencies enforce Fair Housing laws, provide assistance to the public, and offer Fair Housing education:

- U.S. Dept. of Housing & Urban Development
- Washington State Human Rights Commission
- King County Office of Civil Rights
- Seattle Office for Civil Rights
- Tacoma Human Rights & Human Services Dept.

Chapter

10

SAVING YOUR HOME: AN OVERVIEW

By Matt Goldberg and Merf Ehman

What is foreclosure?

Foreclosure is the legal means by which a lender can force a sale of an individual's home when the person falls behind on his or her mortgage payments.

How do foreclosures work in Washington?

This depends on the type of financing you obtained when you bought or refinanced your house. There are three types:

1. Mortgage
2. Deed of Trust
3. Real Estate Contract

A mortgage is a written pledge of property by a borrower creating a lien upon the borrower's real estate as security for the lender in the event the borrower is unable to repay the loan on schedule. To foreclose a mortgage, the lender must initiate a court proceeding.

Most homeowners in Washington have a Deed of Trust even though it is often referred to in common parlance as a "mortgage." A Deed of Trust works essentially the same way as a Mortgage, except that it gives lenders the right to conduct what are termed non-judicial foreclosures, which do not involve court action. Unlike mortgage lenders, deed of trust lenders can choose to foreclose in court or nonjudicially.

How does the nonjudicial foreclosure process work for deeds of trust?

If the lender conducts a nonjudicial foreclosure, he must first give you a Notice of Default and then, at least 30 days later, give you a Notice of Trustee's Sale and Notice of Foreclosure.

Can I pay money to save my house?

Yes. This is called redemption. You can avoid foreclosure by making up the delinquent payments at any time until 11 days before the sale. You will also have to pay the lender's expenses in starting the foreclosure process.

How long does the process take?

Your house cannot be sold until at least 190 days have passed from the date you fell behind in your payments. You can continue to live in the house during this period.

How long do I have to move out after my house is sold?

If your house is sold, you must move out within 20 days after the sale or an eviction action may be filed against you. For more on evictions go to the page _ of this section.

Can I get my house back if it is sold?

Once your house is sold you have no right to get it back and the money you have put into the house will be lost.

What happens if my house is sold for less than the amount I owe the lender?

Generally, you do not have to pay the lender. You cannot be required to make up the difference.

What happens if my lender decides to go through a court process to foreclose on my home?

If the lender forecloses on your deed of trust through a court process, he must follow the procedures for foreclosing a mortgage described in the next section. You will have the same rights in the foreclosure action as a person with a mortgage. If your lender uses this type of proceeding, you may have to pay the difference between the amount your house was sold for and the amount you still owe the lender.

How does the foreclosure process work for mortgages?

A mortgage can only be foreclosed by filing a court action in the Superior Court of the county where your house is located. The lender must notify you of the lawsuit by serving you with court papers called a Summons and Complaint. In the lawsuit, the lender will ask for the full unpaid balance of the mortgage. The lender also will ask the court to order the county sheriff to sell your home at public auction (sheriff's sale) to pay the money judgment against you.

What rights do I have if the judge orders my home sold by the county sheriff at the sheriff's sale and can I get my house back after it is sold?

In Washington, there is a one-year right of redemption and a residential owner may remain in possession during the redemption period.

What happens if my house is sold for less than I owe the lender?

If your house is sold for less than the balance you owe on the mortgage, you may be liable to the lender for the difference, which is called a "deficiency."

How does the foreclosure process work for real estate contracts?

If you have a real estate contract and you fall behind in your payments, the seller can end ("forfeit") your contract without going to court. The seller may also foreclose on your contract by going through a court process. This court process is the same as that for a mortgage.

What must the seller do if he does not go through a court process?

If the seller intends to forfeit your real estate contract without going to court, he must give you two notices. He must send you a Notice of Intent to Forfeit, and then send you a Declaration of Forfeiture. Your real estate contract does not end until at least ninety (90) days have passed from the date the seller records the Notice of Intent to Forfeit. A document is recorded when it is taken to your County Recorder's Office.

Can I pay money to save my house?

You can avoid your house being sold in foreclosure by making up the delinquent payments at any time until the date stated in the Notice of Intent to Forfeit. You will also have to pay the seller's expenses in starting the forfeiture action, if payment of these expenses is required by the terms of your contract.

When do I have to move out if the contract is forfeited?

If your real estate contract is forfeited, you must move out within ten (10) days after the day the seller records the Declaration of Forfeiture. If you do not move out, the seller may start a lawsuit to evict you.

What happens if I still owe the seller money?

If your real estate contract is forfeited, the money you have put into the house will be lost. You will not, however, owe the seller any more money.

What happens if my seller decides to go through a court process to forfeit the real estate contract?

If the seller forecloses your real estate contract like a mortgage, he must follow the procedure for foreclosing a mortgage described in an earlier section. You will have the same rights in the foreclosure action as a person with a mortgage.

Can foreclosure be avoided?

Foreclosures can seriously affect your ability to qualify for credit in the future, so you should avoid foreclosure if possible. Do not ignore letters from your lender. If you are having problems making your payments, call or write your mortgage lender immediately and be honest about your financial situation. Be prepared to provide them with financial information, such as your monthly income and expenses. Without this information, they may not be able to help.

Also, stay in your home to make sure you qualify for assistance. You may not qualify for assistance if you abandon your home. Contact a U.S. Department of Housing and Urban Development (HUD) approved housing counseling agency. Call (800) 569-4287 or TDD (800) 877-8339 for the housing counseling agency nearest you. These agencies are valuable resources. They frequently have information on services and programs offered by Government agencies as well as private and community organizations that could help you. The housing counseling agency may also offer credit counseling. These services are usually free of charge.

What are my options during/after foreclosure?

Your lender will determine if you qualify for any of the alternatives. A housing counseling agency can also help you determine which, if any, of these options may meet your needs and also assist you in interacting with your lender. Call (800) 569-4287 or TDD (800) 877-8339.

You may be considered for the following:

Special Forbearance: Your lender may be able to arrange a repayment plan based on your financial situation and may even provide for a temporary reduction or suspension of your payments. You may qualify for this if you have recently experienced a reduction in income or an increase in living expenses. You must furnish information to your lender to show that you would be able to meet the requirements of the new payment plan.

Mortgage Modification: You may be able to refinance the debt and/or extend the term of your mortgage loan. This may help you catch up by reducing the monthly payments to a

more affordable level. You may qualify if you have recovered from a financial problem and can afford the new payment amount.

Partial Claim: Your lender may be able to work with you to obtain a one-time payment from the Federal Housing Administration (FHA) Insurance fund to bring your mortgage current. You may qualify if:

1. Your loan is at least 4 months delinquent but no more than 12 months delinquent; and
2. You are able to begin making full mortgage payments.

When your lender files a Partial Claim, HUD will pay your lender the amount necessary to bring your mortgage current. You must execute a Promissory Note, and a Lien will be placed on your property until the Promissory Note is paid in full.

The Promissory Note is interest-free and is due when you pay off the first mortgage or when you sell the property.

Pre-foreclosure sale: This will allow you to avoid foreclosure by selling your property for an amount less than the amount necessary to pay off your mortgage loan. You may qualify if:

1. The loan is at least 2 months delinquent;
2. You are able to sell your house within 3 to 5 months; and
3. A new appraisal (that your lender will obtain) shows that the value of your home meets HUD program guidelines.

Deed-in-lieu of foreclosure: As a last resort, you may be able to voluntarily "give back" your property to the lender. This won't save your house, but it is not as damaging to your credit rating as a foreclosure. You may qualify if:

1. You are in default and don't qualify for any of the other options;
2. Your attempts at selling the house before foreclosure were unsuccessful; and
3. You don't have another FHA mortgage in default.

Should I be aware of anything else?

Yes. Beware of scams! Solutions that sound too simple or too good to be true usually are. If you're selling your home without professional guidance, beware of buyers who try to rush you through the process. Be especially alert to the following:

Equity skimming: In this type of scam, a buyer approaches you, offering to get you out of financial trouble by promising to pay off your mortgage or give you a sum of money when the property is sold. The buyer may suggest that you move out quickly and deed the

property to him or her. The buyer then collects rent for a time, does not make any mortgage payments, and allows the lender to foreclose. Remember, signing over your deed to someone else does not necessarily relieve you of your obligation on your loan.

Phony counseling agencies: Some groups calling themselves "counseling agencies" may approach you and offer to perform certain services for a fee. These could well be services you could do for yourself for free, such as negotiating a new payment plan with your lender, or pursuing a pre-foreclosure sale. If you have any doubt about paying for such services, call a HUD-approved housing counseling agency at (800) 569-4287 or TDD (800) 877-8339. Do this before you pay anyone or sign anything.

The laws that govern Washington foreclosures are found in Title 61 of the Revised Code Washington (Mortgages, Deeds of Trust and Real Estate Contracts).

Links/References/Resources:
http://apps.leg.wa.gov/rcw/
http://www.hud.gov/foreclosure/index.cfm

Chapter

11

GUARDIANSHIP

By Jenni Frere Volk

This section explains what a guardian is and discusses why you may want to consider nominating a guardian for yourself and for your child.

What is a "guardian"?

A guardian is an adult who aids a minor child or incapacitated adult when they are unable to handle their own affairs. The Court considers an "incapacitated adult" any person who holds a significant risk of personal harm due to inability to provide for nutrition, health, housing, physical safety, or the inability to manage property or financial affairs.

A guardian can be appointed to care for and manage the day-to-day affairs of the person ("guardian of the person"), their financial affairs ("guardian of the estate"), or both.

What is a "guardianship"?

A guardianship represents the legal relationship between the guardian and the person for whom the guardian has been appointed. A guardianship proceeding transfers certain powers to the guardian so that he or she is able to make decisions and act on behalf of the minor child or incapacitated adult.

Who can act as a guardian?

In general, a guardian must be eighteen (18) years of age or older, of sound mind, and a resident of Washington (or a nonresident with an appointed resident agent). A person may not act as a guardian if he or she has been convicted of a felony or of a misdemeanor involving moral turpitude, or if the court determines that the person is unsuitable for the role. The court will allow a professional guardian to be appointed if the person has met the certification requirements.

What are the basic duties and tasks of a guardian?

If you are appointed as guardian "of the person," you will be responsible for making sure that the minor child or incapacitated adult has food, clothing, shelter, medical/dental care, and physical security. You will be responsible for all of their day-to-day affairs, except those directly related to finances. If the person is a minor, you will also be responsible for their educational needs.

If you are appointed as guardian "of the estate," you will be required to care for the minor child or incapacitated adult's financial assets. You will need to make wise investment choices, track bank and savings accounts, reconcile statements, pay bills, and file and pay taxes.

Usually, the same person is appointed as guardian of the person and of the estate.

Can a guardian get paid?

Yes. In Washington, guardians are allowed to compensate themselves in an amount that the Court deems "just and reasonable." The amount of compensation must be approved by the Court. Expenses and costs are also paid or reimbursed to the guardian, when necessary.

GUARDIAN FOR YOUR CHILD

How do I appoint a guardian for my child?

A guardian for your child shall be nominated in your Last Will and Testament ("will") and/or your General Durable Power of Attorney (see chapter discussing General Durable Powers of Attorney). The court will confirm your nomination unless the court finds evidence that the individual is not qualified to serve as guardian.

Whom should I choose as my child's guardian?

Selecting a guardian for your child is a very important and extremely personal decision. There is no formula for determining which friend or family member would be the most qualified guardian. It is wise to choose a person that is responsible, reliable, trustworthy, accessible, financially stable, and of course, willing. Family structure, school district, religion, and politics may also play a role in choosing a guardian. How would your child handle changing schools? Do you want your child to attend church on Sunday mornings? Do you want your child to live a city or rural life? Do you want your child to be raised in a large family? Can your child live with pets? Do you want your child to be held to strict disciplinary rules? Does your nominated guardian have sufficient time to devote to your child?

Once you have made your decision, you will want to discuss the obligations and duties to the person that you have nominated as guardian to be sure that they feel comfortable acting in such a role.

How long will my child's guardian serve?

The guardian of a minor will serve until the minor reaches full and legal age – eighteen (18) years of age.

What if I die and do not name a guardian?

Washington law gives the Court the power to appoint a guardian for your child even if you did not nominate a specific person in your Last Will and Testament. The problem with this scenario is that the Court may or may not appoint the same person that you would have chosen to care for your child.

What can I do to help provide for my child's security in the event of my incapacity or death?

Talk to your child about his or her future. You will need to make sure that your child has age-appropriate information regarding the guardianship procedure, if you are a single parent. Understand that there are resources to help you discuss cancer with your child and teach your child how to find the resources that they may need if something happens to you.

Many parents also choose to involve school counselors, school administrators and teachers in this process, so that they too can act as a support network for the child during these difficult times. Be sure to set aside plenty of time to help your child understand what is going on and who they can turn to for help, or to ask questions. You may want to consult with an expert in child psychology to determine what information is age-appropriate for your child.

If you do not know where to start, contact your local American Cancer Society and/or the counseling center at your child's school.

GUARDIAN FOR YOURSELF

How do I appoint a guardian for myself?

You can nominate a guardian for yourself within your General Durable Power of Attorney document. Court appointment is required in any type of guardianship proceeding.

However, you may not need to involve the Court if you execute a General Durable Power of Attorney in order to appoint an "attorney-in-fact" to act on your behalf in case circumstances change and you are no longer able to handle your own affairs (see chapter discussing General Durable Powers of Attorney). Your attorney-in-fact will be able to act on your behalf without being appointed by the court.

How is a guardianship ended?

The court may modify or terminate a guardianship, or replace a guardian for "good reason." Any person may petition the court to replace a guardian, including the incapacitated person.

Chapter

12

ESTATE PLANNING
By Jenni Frere Volk

The purpose of this section is to help you understand a number of concepts that are important to learn prior to creating your estate plan. You will also gain a general understanding of basic estate planning documents, definitions and strategies.

What is the difference between real property and personal property?

At the most basic level, real property consists of anything that is attached to the land and the land itself. Real property is typically immoveable. For example: house, condo, out buildings and other permanent structures. Personal property is anything that is not real property, and is often thought of as tangible property or personal possessions. For example: books, cars, clothes.

What is a "community property state"?

There are nine community property states and Washington is one of them. In Washington, all property acquired *during* marriage is presumed to be community property. This means that the earnings of one spouse will be the community property of both the husband and the wife. Even if title to an asset is held solely in the name of one spouse alone, the asset is presumed to be community property if it was acquired during marriage.

All property acquired *prior* to marriage is presumed to be separate property. Separate property also includes gifts to one spouse during marriage and inheritance to one spouse during marriage.

Can separate property become community property?

Yes. There are two common ways for separate property to become community property. First, a husband and wife can sign a written agreement that states that they wish to change separate property into community property (or vice versa). Such an agreement can be revoked by either party, at any time, or upon a decree of dissolution or legal separation. Second, if separate property funds are commingled with community property

funds to such an extent that it is nearly impossible to decipher the source of the funds, it is likely that the funds will be deemed community property.

What is a Community Property Agreement?

A Community Property Agreement is an agreement entered into by a husband and wife, which typically states (1) that all separate property is now deemed community property, and (2) that all community property will pass directly to the surviving spouse immediately after the death of the first spouse.

Upon the death of the first spouse, the Community Property Agreement will need to be recorded at the county recorder's office, along with a certified death certificate. This will allow the husband and wife to avoid probate upon the death of the first spouse. However, executing a Community Property Agreement has many legal implications and should only be done only under the guidance of an experienced estate-planning attorney.

WILLS

What is a will?

A Last Will and Testament (commonly referred to as a "will") declares how you would like your assets distributed upon your death. In Washington, married couples are allowed to give away all of their separate property and one-half (1/2) of their community property in a will. The other one-half (1/2) of the community property will pass in accordance with the spouse's will.

Who may make a will?

In Washington, any person who has attained eighteen (18) years of age and is of sound mind can execute a will.

What are the requisites for a will?

Generally, all wills must be written (handwritten or typed) and signed by the person executing the will (known as the "testator"). The will must be attested to by two (2) competent witnesses who are neither related to the testator nor benefiting from the provisions in the will. The will shall be witnessed in the presence of the testator and at the request of the testator. The witnesses shall sign their names to the will and should execute an affidavit or declaration of attestation so that they are not required to appear in court at a later date to prove the will.

Are there different types of wills?

Yes, there are three types of wills in Washington: (1) Self-proving wills; (2) Holographic wills; and (3) Nuncupative wills. The most common type, a self-proving will, is a will that has been attested to, which means that a proper declaration/affidavit of attestation has been signed by both witnesses (see below).

A holographic will is a will that has been entirely handwritten. A holographic will is only valid in Washington if it is signed by the testator and two witnesses. It is common that holographic wills are not witnessed, and thus, they are usually not valid.

A nuncupative will is commonly described as an "oral will" or a "deathbed will." Nuncupative wills are only valid in Washington under very limited and specific circumstances, which are beyond the scope of this chapter.

What is a "self-proving" will?

The court must prove all wills by taking testimony of the witnesses. It is necessary to prove that a will is what it says it is, was signed by the testator, was properly witnessed, and that the witnesses believed the testator was over eighteen (18) and of sound mind at the time the will was signed. A self-proving will is does not require the witnesses to appear in court because an attached affidavit or declaration of attestation states similar facts the witnesses would be required to testify to in court to prove the will. The affidavit or declaration of attestation may be written in the will or attached to the will.

What is an "Executor"?

The executor of your estate, also referred to as the "Personal Representative," will be appointed in your will to manage your estate assets after you die. Your executor will be in charge of finding the original will, notifying your beneficiaries of the pending probate, handling any creditor claims, paying bills, managing bank/investment accounts (and other assets), distributing your assets to the beneficiaries and properly closing the estate, among other duties. Many executors choose to hire an attorney to represent them and help them through the probate process. The executor may be paid a reasonable fee for his/her services. The executor can also be reimbursed for any costs/expenses related to the administration of the estate.

What is a "specific bequest" and what is the "residue" of my estate?

A specific bequest is when you choose to leave a particular asset to a particular beneficiary in your will. For example, "I give and bequeath my truck to my brother" or "I give and bequeath Five Thousand Dollars ($5,000) to the American Cancer Society." The

residue of your estate makes up the balance of your assets, after all of the specific bequests have been satisfied.

Can I change or revoke my will?

Yes, you may change or revoke your will at any time. To make a simple change to your will, you may want to execute a "codicil," which is an amendment to a will. If your change is quite complicated, you may decide to execute a completely new will. To execute a valid codicil, you must satisfy the requisites for executing a will.

The most common way to revoke a will is to destroy the actual document. You can also revoke a will by executing a subsequent will, which specifically revokes any prior will(s) in its language.

Can I disinherit a child or a spouse?

There are many reasons why someone may wish to disinherit a child or a spouse. Many times, it is because the child or spouse is already adequately provided for; however, there are other valid reasons as well. If you plan to disinherit a child or spouse, be sure that the language of your will makes it absolutely clear that you do not intend to leave that person any portion of your estate. Some people wish to include a short statement in the will explaining why the person has been disinherited so that there is no confusion, but this is not required and is a matter of personal choice.

What happens if I leave everything to my spouse in my will and then we later get divorced?

In the event that you have left all, or a portion of, your assets to your spouse in your will, and you subsequently get divorced, the provisions in your will in favor of (or granting an interest or power to) your spouse will be revoked (unless your will states otherwise). The court will proceed to carry out your wishes as if your spouse had predeceased you.

Can someone contest my will?

Yes, Washington law allows people to contest or challenge a will. A common reason why a person may challenge a will is because they do not believe that the testator was competent when he/she signed the will. Sometimes challengers will argue that the testator signed the will under duress or coercion. When dealing with a serious or terminal illness, it is very important to be sure that you sign your will in a physical state when you are alert, competent, free from memory loss, able to understand what you are signing, and able to clearly communicate with those around you. This will significantly reduce the chances of a will contest.

Should I purchase a will template from the internet or should I ask an estate-planning attorney to draft my will?

It is never advisable to purchase a will template from the internet or from an office supply store. Although these will templates are relatively inexpensive, they are rarely written by licensed attorneys and may not be drafted in accordance with the laws of the state of Washington. You can save your family and close friends from headaches and hassle by visiting a licensed Washington attorney and asking him or her to draft your will so that you can be confident that the document meets the legal requirements of our state.

What happens if I die without a will?

If you die without a will, your property will pass in accordance with the intestate laws of the state of Washington. "Intestate" means to die without a will. The laws may not meet with your intentions and wishes, which is why it is always best to execute your own will.

If you are married and die without a will in Washington, your spouse will receive all of your community property. Your separate property will be divided, and one-half (1/2) will go to your spouse and one-half (1/2) will go to your children. If you do not have children, your separate property will be divided and distributed three-quarters (3/4) to your spouse and one-quarter (1/4) to your parents. If you are not married, your children will receive everything.

PROBATE

What is probate?

Probate is a legal procedure that takes place after someone dies. The probate procedure allows us to appoint someone to take control of the decedent's assets and to legally transfer the assets from the decedent (the person who died) to their beneficiaries. Probate will also protect the rights of creditors, the rights of minors, and the heirs of the decedent.

If you execute a will, your estate will likely go through the probate process. However, it is likely that your estate will also go through probate if you die without a will.

The probate laws in Washington are not complicated but it is recommended that you hire an attorney to help with the process. There are many tasks that must be completed in order to execute a proper probate, such as filing the appropriate tax returns, handling creditor claims, providing adequate notice to heirs, beneficiaries and others, transferring assets to the correct beneficiaries and closing the estate, and it is helpful to enlist a professional who is familiar with the probate timeline and Washington law. Furthermore,

the process involves a number of court hearings that an attorney can attend on the executor's behalf.

What is involved in probate in Washington?

Washington is known to have one of the most streamlined and efficient probate systems in the nation. The timeline can be relatively short. It would not be unusual to complete a simple probate in 5-6 months.

Unlike in some states, Washington attorneys cannot charge a percentage of the estate as their fee. Most attorneys will charge an hourly rate for the probate and the court demands that the attorney fees are reasonable.

How can I avoid probate?

As mentioned above, some married couples are able to avoid probate when the first spouse dies by executing a Community Property Agreement.

You may also be able to avoid probate if you have what is considered a "small estate." If you do not own any real property and your personal property assets are less than one hundred thousand dollars ($100,000) in value, you may be able to transfer those assets to your beneficiaries without going through a formal probate procedure. This process is commonly referred to as the "personal property affidavit" procedure.

Another common way to avoid probate is to execute and fund a Revocable Living Trust (see below).

TRUSTS

What is a trust?

A trust is a legal instrument that holds and manages property. There are hundreds of different types of trusts, each with its own purpose. There are trusts for minors, trusts to reduce tax liabilities, and trusts for retirement planning, to just name a few.

Some trusts will require a separate tax identification number (for tax purposes) and some will not. You should meet with a tax advisor if you ever decide to set up a trust.

What is a "revocable living trust"?

A revocable living trust is another type of trust. This type of trust holds and manages assets for the trustor (person who created the trust) while they are living and also

for some period of time after they pass away. A revocable living trust can also be executed by a married couple.

Because the trust is "revocable," it can be amended, altered or revoked at any time.

Similar to a will, a revocable living trust can also control how you would like your assets distributed upon your death. Many people choose to execute a revocable living trust because it allows them to avoid probate and often allows for a speedy transfer of assets from the decedent to the trust beneficiaries. Though you are able to avoid probate (and probate costs & fees), a revocable living trust can be more timely, more expensive and more complicated to set up, maintain and manage. This is a decision that you will need to discuss with an experienced estate-planning attorney.

It is a frequent misconception that you will be able to avoid paying estate taxes simply because you have executed a revocable living trust. This is not true. There are certain tax saving strategies and tools that you may be able to use when setting up your estate plan; however, the mere existence of a revocable living trust will not allow you to avoid paying estate taxes. Furthermore, a revocable living trust does not shield your assets from creditors.

What is a "trustee"?

A trustee is a person named in your trust to manage the trust assets. Typically, the trustor (the person who creates the trust) and the trustee are the same person, at least, initially. A revocable living trust always appoints a successor trustee to manage the trust assets in the event of the primary trustee's incapacity or death.

The trustor is not required to act as the primary trustee though. If the trustor has a serious or terminal illness, it is necessary to determine whether the trustor is healthy enough to act as the primary trustee or whether someone else should be appointed to manage the trust assets.

What does it mean to "fund a trust"?

Once you have executed a revocable living trust, you will immediately need to begin transferring your assets into the trust. This is called "funding the trust." For example, if you own real property such as a single-family residence, you will need to deed the house into the trust. Typically, you will only pay minimal recording fees to do so. Similarly, you will need to change the ownership on your bank accounts, investment accounts, and other assets that are to be placed in the trust, so that they too are titled in the name of the trust rather than your name, individually.

If you fail to properly "fund the trust," the assets left out of the trust may have to go through probate and you may lose many of the benefits of the trust.

Do I need a revocable living trust?

Just as there are hundreds of types of trusts, there are also many different reasons why people choose to set up a trust. Many people execute a revocable living trust to avoid probate. There are other common reasons as well, such as a trustor who owns property in two or more states, a trustor who would like his or her assets to pass to the beneficiaries very quickly after death, or a trustor who would like to transfer assets after death in a very confidential manner.

This being said, it is also important to remember that a revocable living trust is not just for the wealthy. You may have a small to mid-sized estate and still be a good candidate for a revocable living trust based on some of the reasons above, or a different reason all together.

Estate planning is very personal and circumstantial. Please be sure to consult a legal professional regarding your own estate planning needs.

NEW WASHINGTON LEGISLATION

What is the Domestic Partners Registry?

Same-sex couples can register for the Domestic Partners Registry with the Secretary of State for approximately $50. On April 16, 2007, the Governor signed a law (effective July 22, 2007), which gives registered same-sex couples certain legal rights under Washington law. The new law is lengthy and complex, but in part, it allows registered same-sex couples to have the same visitation rights as a spouse at hospitals, to receive certain health care records of their partner, to receive the same inheritance rights as a surviving spouse (if they die without a will), and to have first priority to dispose of the deceased partner's remains.

Chapter

13

END OF LIFE ISSUES: MEDICAL DIRECTIVES AND PHYSICIANS ORDERS FOR LIFE-SUSTAINING TREATMENT

By Joan Tierney

Estate planning is often thought of as preparing for the distribution of property upon death. However, this process should be broadened to include planning for disability, incapacity and end of life care.

How can I legally plan now for my end of life care?

Individuals who wish to direct how they wish to be cared for as they approach the end of their life may issue what are called "advance directives." Washington State recognizes two types of Advance Directives: the Health Care Directive and the Durable Power of Attorney for Health Care. Washington State's Natural Death Act, RCW 70.122, gives an individual the right to make a written directive instructing their physician to withhold or withdraw life-sustaining procedures in the event of a terminal condition. RCW 70.122.030 provides the general language for a directive and RCW 70.122.040 provides the manner for revocation of the directive.

The Patient Self-Determination Act is a federal law that requires health care facilities in all 50 states and the District of Columbia receiving Medicaid and Medicare funds to inform patients of their rights to execute advance directives.

What is a Health Care Directive?

In Washington State, any adult person may execute a directive directing the withholding or withdrawal of life-sustaining treatment in a terminal condition or permanent unconscious condition. This document provides you with the knowledge and comfort that your wishes will be respected and followed when you can no longer participate fully in your own care. Discussions with your physician, care providers, family, friends and spiritual advisors will be helpful as you make decisions about your care. Health Care Directives may also be called a directive to a physician, declaration or medical directive.

Who can serve as a witness to the document?

The directive shall be signed by the declarer in the presence of two witnesses not related to the declarer by blood or marriage and who would not be entitled to any portion of the estate of the declarer under any will of the declarer or codicil then existing or, at the time of the directive, by operation of law then existing. In addition, a witness to a directive shall not be the attending physician, an employee of the attending physician or a health facility in which the declarer is a patient, or any person who has a claim against any portion of the declarer's estate of the declarer at the time of the execution of the directive.

Where should I keep my directive?

The directive should be made part of the patient's medical records retained by the attending physician, a copy of which shall be forwarded by the records custodian to the health facility when the withholding or withdrawal of life-support treatment is contemplated, kept by someone you trust or submitted to Health Care Declarations Registry.

When will the Directive go into effect?

In Washington State, the directive will only go into effect if you have a terminal condition where life-sustaining treatment would only artificially prolong the process of dying; or if you are in an irreversible coma and there is no reasonable hope of recovery.

Who makes the determination regarding my prognosis?

Prior to withholding or withdrawing life-sustaining treatment, the diagnosis of a terminal condition by the attending physician or the diagnosis of a permanent unconscious state by two physicians shall be entered in writing and made a permanent part of the patient's medical records.

May I revoke my Directive?

Per RCW 70.122.040, a directive may be revoked at any time by the declarer, without regard to the declarer's mental state or competency, by any of the following methods:

(a) By being canceled, defaced, obliterated, burned, torn, or otherwise destroyed by the declarer or by some person in the declarer's presence and by the declarer's direction.

(b) By a written revocation of the declarer expressing his or her intent to revoke, signed, and dated by the declarer. Such revocation shall become effective only upon communication to the attending physician by the declarer

or by a person acting on behalf of the declarer. The attending physician shall record in the patient's medical record the time and date when the physician received notification of the written revocation.

(c) By a verbal expression by the declarer of his or her intent to revoke the directive. Such revocation shall become effective only upon communication to the attending physician by the declarer or by a person acting on behalf of the declarer. The attending physician shall record in the patient's medical record the time, date, and place of the revocation and the time, date, and place, if different, of when the physician received notification of the revocation.

(d) In the case of a directive that is stored in the health care declarations registry under RCW 70.122.130, by an online method established by the department of health. Failure to use this method of revocation for a directive that is stored in the registry does not invalidate a revocation that is made by another method described under this section.

There shall be no criminal or civil liability on the part of any person for failure to act upon a revocation made pursuant to this section unless that person has actual or constructive knowledge of the revocation except as provided in RCW 70.122.051(4).

If the declarer becomes comatose or is rendered incapable of communicating with the attending physician, the directive shall remain in effect for the duration of the comatose condition or until such time as the declarer's condition renders the declarer able to communicate with the attending physician.

What if my directive was written in another state?

A directive executed in another political jurisdiction is valid to the extent permitted by Washington state law and federal constitutional law.

Is there specific format for the directive and can I add other provisions to my directive?

The directive may be in the following form, as contained in RCW 70.122.030, directive to withhold or withdraw life-sustaining treatment, but in addition may include other specific directions. Consult an attorney regarding format, content and revocation.

Health Care Directive

Directive made this . . . . day of . . . . . (month, year).

I . . . . . ., having the capacity to make health care decisions, willfully, and voluntarily make known my desire that my dying shall not be artificially prolonged under the circumstances set forth below, and do hereby declare that:

(a) If at any time I should be diagnosed in writing to be in a terminal condition by the attending physician, or in a permanent unconscious condition by two physicians, and where the application of life-sustaining treatment would serve only to artificially prolong the process of my dying, I direct that such treatment be withheld or withdrawn, and that I be permitted to die naturally. I understand by using this form that a terminal condition means an incurable and irreversible condition caused by injury, disease, or illness, that would within reasonable medical judgment cause death within a reasonable period of time in accordance with accepted medical standards, and where the application of life-sustaining treatment would serve only to prolong the process of dying. I further understand in using this form that a permanent unconscious condition means an incurable and irreversible condition in which I am medically assessed within reasonable medical judgment as having no reasonable probability of recovery from an irreversible coma or a persistent vegetative state.

(b) In the absence of my ability to give directions regarding the use of such life-sustaining treatment, it is my intention that this directive shall be honored by my family and physician(s) as the final expression of my legal right to refuse medical or surgical treatment and I accept the consequences of such refusal. If another person is appointed to make these decisions for me, whether through a durable power of attorney or otherwise, I request that the person be guided by this directive and any other clear expressions of my desires.

(c) If I am diagnosed to be in a terminal condition or in a permanent unconscious condition (check one):

I DO want to have artificially provided nutrition and hydration.
I DO NOT want to have artificially provided nutrition and hydration.

(d) If I have been diagnosed as pregnant and that diagnosis is known to my physician, this directive shall have no force or effect during the course of my pregnancy.

(e) I understand the full import of this directive and I am emotionally and mentally capable to make the health care decisions contained in this directive.

(f) I understand that before I sign this directive, I can add to or delete from or otherwise change the wording of this directive and that I may add to or delete from this directive at any time and that any changes shall be consistent with Washington state law or federal constitutional law to be legally valid.

(g) It is my wish that every part of this directive be fully implemented. If for any reason any part is held invalid it is my wish that the remainder of my directive be implemented.

Signed _____

_____
City, County, and State of Residence

The declarer has been personally known to me and I believe him or her to be capable of making health care decisions.

Witness _____
Witness _____

DURABLE POWER OF ATTORNEY FOR HEALTH CARE

What is a durable power of attorney for health care?

A durable power of attorney for health care is a legal document allowing you "the principal" to name a person as your health care "agent" who is then authorized to act for you regarding legal matters. In order to endure incompetency, of the principal, the power contain explicit language to the effect that "this power shall not be affected by disability of the principal" or "this power of attorney shall become effective upon the disability of the principal." See RCW 11.94.010. The durable powers of attorney can be" immediate", permitting the agent to act in the present and to continue to act during incompetency or "postponed" does not become effective until the principal becomes incompetent. The scope of powers and when they go into effect can be tailored to meet the specific needs of principal, and should be designed to give only those powers the principal feels comfortable giving to another.

What does a health care agent do?

The agent, called "attorney in fact" is authorized to consent to, stop or refuse most medical treatment for you if a physician determines that you cannot make those decisions yourself. Your appointed agent can speak on your behalf at any time, not just at the end of your life. This is also referred to as a health care proxy, appointment of health care agent or a medical power of attorney. Powers created to provide for incompetency are broad and enable the agent to give informed medical consent and allow the agent to make decisions about medical and surgical procedures for the principal, per RCW 11.94.010,

How do I choose an agent?

Your agent will be representing you regarding your care and should be someone you trust to respond to any changes in your condition by carrying out your wishes regarding your care.

Who may serve as an agent?

Unless he or she is related to the principal, none of the following persons may act as the agent or attorney-in-fact for an individual: the individual's physician, the physician's employees, owners, administrators or employees of any health care facility where the principal receives health care.

PHYSICIAN ORDERS FOR LIFE-SUSTAINING TREATMENT (POLST)

What is POLST?

POLST is a Physician order sheet describing medical goals and treatments determined by the patient's medical condition and wishes, designed to ensure dignity and respect during treatment. Per protocol, care providers will first follow the orders contained in the document and then contact the physician, nurse practitioner or PA-C, to clarify treatment options. Any section not completed implies full treatment is requested, for that section of the form.

Other than the patient, who can authorize the care wishes contained in POLST?

A POLST may be completed by the parent of a minor, Health Care Representative, Durable Power of Attorney for Health Care attorney-in-fact or Court Appointed Guardian.

Who completes the POLST?

The POLST must be completed by a health care professional based on patient preferences and medical indications and must be signed by a physician, nurse practitioner or PA-C to be valid.

Are there any exceptions to the signature requirement?

Verbal orders are acceptable with follow-up signature by physician or nurse practitioner in accordance with the policy of the facility providing care.

How will my POLST be interpreted by my care providers?

Any section of POLST not completed implies full treatment for that section.

Will a POLST determine where I will receive my medical care and my level of care?

Yes, because an institution's level of care determines the level of intervention administered. Speak with your physician about the differences between "comfort measures only," "limited interventions," and "full treatment." Work with your healthcare provider to determine your care plan.

What if I change my mind about my care plan?

A person with capacity or the surrogate (if patient lacks capacity) can revoke the POLST at any time and request a different course of treatment. One's POLST should be

reviewed and revised upon transfer from one care setting or level of care to another, upon any change in health status or if care option choices change.

How do I revoke my POLST?

To void your form, draw a line through "Physician Orders" and write "VOID" in large letters.

Chapter

14

LIABILITY ISSUES

By Kelly Kenn

While we have some of the finest health care institutions available to us in Washington, positive results cannot be guaranteed. Treatment, even the most aggressive, will not be enough in some situations. Unfortunately, there are times that, the care provided, or lack of care, administered by the professionals treating the patient, furthers harm or results in injury or death. This section briefly explores the rights and possible remedies available to patients and their families who have possibly been injured as a result of medical malpractice.

There are many examples of medical negligence, such as failure to discover the illness; failure to prevent infection after surgery; leaving a medical device in after surgery; surgery without proper consent; late diagnosis or misdiagnosis. The most common breast cancer malpractice involves: primary care physicians ignoring patient complaints or failing to refer to a surgeon; radiologists misreading mammogram images or failing to communicate clearly the results; or surgeons who fail to perform a necessary biopsy.

Medical malpractice occurs when a doctor, hospital, or other medical care provider deviates from the standard of acceptable medical care and acts negligently. The resulting injuries or death can be the basis for a medical malpractice negligence claim. Causation must be proven by the victim showing that the actions or failure to act on the part of the medical provider was the direct cause of the harm. To help you, here are some frequently asked questions:

What if I believe I am not getting the quality of treatment I should be getting?

If you have a question regarding the treatment you are receiving from any health care professional or institution, it is best to consult an attorney who has experience with medical malpractice cases and can assist you in understanding your rights. There are a number of attorneys in Washington State who work extensively in this area.

What kind of damages or compensation could I expect to recover if I am successful bringing a medical malpractice claim?

When a person, or her family, wins a judgment in a medical claim, there are specific types of "damages" that can be awarded by a court. In general, damages fall into two categories, economic and non- economic damages. Economic damages are such items as medical expenses, household expenses (such as house cleaning or yard cleaning service), lost wages, loss of future income, or lost earning capacity.

Non-economic damages are referred to as "pain and suffering." These include compensation for physical pain, metal or emotional anguish (sometimes this can be for family members as well), loss of consortium, disfigurement, impairment (physical or mental), loss of companionship, loss of enjoyment of life. Non-economic damages are more subjective and therefore take on more emotional response.

In Washington State, we do not recognize punitive damages, or those damages meant to punish.

How much time do I have to bring a lawsuit?

In Washington State, medical malpractice actions must be filed within three years of the date of the act or omission giving rise to the injury, or within one year of the date the injury was or reasonably should have been discovered, whichever is later. However, no medical malpractice action may be filed more than eight years after the date of the act or omission giving rise to the injury.

Under Washington law, the statute of limitations begins to run on a minor's eighteenth birthday.

How do I prove the treatment I received was substandard?

With the help of professionals, including "expert witnesses" who are knowledgeable in the area(s) of medical practice applicable to your injuries, you and your attorney prove that, if not for the substandard treatment you received at the hands of the doctor, nurse, facility, or anyone else applicable, you would not have suffered the economic and non-economic damages (injuries) that you are claiming.

It is important to bring your claim as soon as possible after you discover you have been injured. Hopefully, you will never experience negligent medical care. However, if you do, seek legal help with your claim, and learn about your rights.

Chapter

15

WOMEN OF COLOR

By Ling Ly

While the mortality rate for non-Hispanic white women, who have the highest occurrence rate of breast cancer in America, continues to decline, the breast cancer survival rate for many racial/ethnic groups, especially for African American women, remains a significant problem. Although there is not enough research on the reasons for these disparities, some of the contributing factors that can be addressed include access to early detection programs, language barriers, cultural barriers, the urgency created by later-stage diagnosis, and health care coverage.

Early Detection Programs

The importance of routine screening for the early detection of breast cancer cannot be stressed enough. Perhaps the most well-known and widespread free screening program is the National Breast and Cervical Cancer Early Detection Program, which was created by the Breast and Cervical Cancer Mortality Prevention Act of 1990. The Act authorized the Centers for Disease Control and Prevention (CDC) to provide breast and cervical cancer screening services to older women, women with low incomes, and underserved women of racial and ethnic minority groups. Women can receive a free screening even if they do not have Medicare or health insurance.

More information about the National Breast and Cervical Cancer Early Detection Program may be found at: http://www.cdc.gov/cancer/NBCCEDP.

Language Barriers

Language barriers can affect all stages of how women of color experience breast cancer, from detection to survival. Although family members can provide translation, medical terms and the emotional aspects of the topic may prove too much for the translator.

Free translation to individuals in the King and Kitsap Counties is provided by the American Red Cross Language Bank. The organization can provide language services in

over 75 languages and dialects, including Arabic, Cambodian, Hmong, Punjabi, Russian, Somali, Spanish, and Urdu.

A translator can be requested Monday – Friday, 8:30 a.m. – 5:00 p.m. at:

- (206) 726-3554
- (360) 377-3761 ext. 13404, or
- languagebank@seattleredcross.org.
- After-hours emergency assistance can be accessed at (206) 323-2345

Cultural Barriers

Cultural barriers can also how women of color experience breast cancer. Advocacy organizations that advocate on health concerns for ethnic/racial groups can provide resources and support in experiencing breast cancer. Organizations include:

National Asian Women's Health Organization
http://www.nawho.org

Native American Women's Health Education Resource Center
http://www.nativeshop.org

Resources on Breast Cancer for Women of Color
http://health.ivillage.com/breastcancer/topics/0,,8wf9tt91,00.html

BREAST CANCER RESOURCES

NATIONAL:

ABA Commission on Women in the Profession
http://www.abanet.org/women

Advocacy, Inc. (disability rights advocacy)
www.advocacyinc.org
1-800-252-9108

American Cancer Society
http://www.cancer.org

Breast Friends
www.breastfriends.org

CanCare
http://www.cancare.org
(713)461-0028

Cancer Care
http://www.cancercare.org

Cancer.com:
http://www.cancer.com
1-888-227-5624

Cancer Information Network
http://www.cancerlinksusa.com

COBRA insurance
www.dol.gov/ebsa/faqs/faq_consumer_cobra
1-866-444-3272
http://www.dol.gov/ebsa/faqs/faq_consumer_cobra.html

Department of Veterans Affairs
http://www.va.gov

Dr. Susan Love's Website for Women
http://www.susanlovemd.com

Feminist Majority Foundation
http://www.feminist.org

Find Law
http://www.findlaw.com

Gilda's Club
http://www.gildasclub.org/
1-888-GILDA-4-U (1-888-445-3248)

Lance Armstrong Foundation
http://www.livestrong.org
1-866-235-7205

Medicaid
http://www.cms.hhs.gov/home/medicaid.asp
1-800-252-8263

Medicare
http://www.medicare.gov.
1-800-MEDICARE (1-800-633-4227)

National Association of Community Health Centers, Inc.
http://www.nachc.com
(301)347-0400

National Breast Cancer Coalition
http://www.natlbcc.org/

National Cancer Institute
http://www.cancer.gov/

Needy Meds
http://www.needymeds.com/
215-625-9609

Oncolink
http://oncolink.upenn.edu/

Patient Advocate Foundation
http://www.patientadvocate.org/
1-800-532-5274

Pharmaceutical Research and Manufacturers of America (PhRMA)
http://www.phrma.org
1-202-835-3400

Resources on Breast Cancer for Women of Color
http://health.ivillage.com/breastcancer/topics/0,,8wf9tt91,00.html

Sisters Network, Inc.
http://www.sistersnetworkinc.org/
sisnet4@aol.com
(866)781-1808

Social Security
http://www.socialsecurity.gov/
http://www.ssa.gov/disability/
1-800-772-1213

Susan G. Komen for the Cure
http://www.komen.org/

U.S. Department of Labor
http://www.dol.gov/
1-866-487-2365

http://www.womanlinks.com/breastcancerresources.shtml
Women's Cancer Resource Center of Oakland, CA
http://www.wcrc.org/

YME National Breast Cancer Organization
http://www.y-me.org/

EEOC
www.eeoc.gov/facts/cancer.html
http://www.eeoc.gov/types/ada.html
http://www.eeoc.gov/policy/docs/fmlaada.html

Job Accommodation Network
http://www.jan.wvu.edu/

Family Medical Leave Act
http://www.dol.gov/esa/regs/statutes/whd/fmla.htm

U.S. Department of Labor/FMLA

REGIONAL:

Team Survivor Northwest
http://www.teamsurvivornw.org/
info@teamsurvivornw.org
206.732.8350

Susan G. Komen
http://www.komenpugetsound.org/
http://www.komenspokane.org/

STATE:

Washington Breast and Cervical Cancer Health Program
http://www.metrokc.gov/health/bchp/

Breast Cancer Fund
206-524-4405
http://www.breastcancerfund.org

Cancer Lifeline Seattle
http://www.cancerlifeline.org
(206) 297-2100

Seattle Clubhouse
http://www.gildasclubseattle.org/
1400 Broadway
Phone: (206) 709-1400
Fax: (206) 709-9719
info@gildasclubseattle.org

Seattle Cancer Care Alliance
http://www.seattlecca.org/cancerinformation/cancerTreatment.htm

Group Health Breast Center
www.ghc.org
Various Washington locations

Breast Cancer Prevention Fund
http://www.breastcancerpreventionfund.org
(866) 486-4344
PO Box 1508
Everett, WA 98206

Breast Cancer Resource Center
Tacoma, WA
http://www.bcrcwa.org/
253-752-4222

Washington State Human Rights Commission
http://www.hum.wa.gov/

Northwest Women's Law Center - Legal Information and Referral Line
907 Pine St., Suite 500, Seattle, WA 98101
206-621-7691
http://www.nwwlc.org

NORTHWEST JUSTICE PROJECT:

CLEAR Hotline -- Coordinated Legal Education, Advice and Referral system
401 Second Avenue S, Suite 407
Seattle, WA 98104
1-888-201-1014
www.nwjustice.org

SEATTLE - MAIN OFFICE
401 Second Avenue S, Suite 407
Seattle, WA 98104
(206) 464-1519
1-888-201-1012
Fax: (206) 624-7501
1-888-201-9737 (TDD)
E-mail: njp@nwjustice.org

BELLINGHAM OFFICE
Whatcom, San Juan, Island, Skagit Counties
1814 Cornwall Avenue
Bellingham, WA 98225
(360) 734-8680
Fax: (360) 734-0121
1-800-562-8836
1-888-201-1014 (CLEAR - Client Intake)

EVERETT OFFICE
Snohomish County
2731 Wetmore Avenue N., Suite 410
Everett, WA 98201
(425) 252-8515
1-888-201-1017
1-888-201-1014 (CLEAR - Client Intake)
Fax: (425) 252-5945

OLYMPIA OFFICE
711 Capitol Way S., Suite 704
Olympia, WA 98501
(360) 753-3610
1-888- 212-0380
Fax: (360) 753-0174

SPOKANE OFFICE
1702 W. Broadway
Spokane, WA 99201
(509) 324-9128
1-888-201-1019
1-888-201-1014 (CLEAR - Client Intake)
Fax: (509) 324-0065

TACOMA OFFICE
Pierce County
715 Tacoma Avenue South
Tacoma, WA 98402
(253) 272-7879
1-888-201-1015
1-888-201-1014 (CLEAR - Client Intake)
Fax: (253) 272-8226

VANCOUVER OFFICE
Clark, Klickitat, Skamania, Cowlitz, Wahkiakum Counties
500 W. 8th, Suite 275
Vancouver, WA 98660
(360) 693-6130
1-888-201-1020
1-888-201-1014 (CLEAR - Client Intake)
Fax: (360) 693-6352

WENATCHEE OFFICE
Adams, Chelan, Douglas, Grant, Kittitas, Okanogan Counties
300 Okanogan Avenue, Suite 3A
Wenatchee, WA 98801
(509) 664-5101
1-888-201-1021
1-888-201-1014 (CLEAR - Client Intake)
Fax: (509) 665-6557

YAKIMA OFFICE
Yakima and Kittitas Counties
510 Larson Building
6 South Second Street
Yakima, WA 98901
(509) 574-4234
1-888-201-1018
1-888-201-1014 (CLEAR - Client Intake)
Fax: (509) 574-4238

WALLA WALLA OFFICE
Benton, Franklin & Walla Walla Counties
38 E. Main, Suite 207
Walla Walla, WA 99362
(509) 525-9760
1-800-289-0581
1-888-201-1014 (CLEAR - Client Intake)
Fax: (509) 525-9895

COLUMBIA LEGAL SERVICES:

Columbia Legal Services
600 Larson Building
6 South Second Street
Yakima, WA 98901
(509) 575-5593
(800) 631-1323

Columbia Legal Services
300 Okanogan Ave, Suite 2A
Wenatchee, WA 98801
(509) 662-9681
(800) 572-9615

Columbia Legal Services
418 – F North Kellogg
Kennewick, WA 99336
(509) 374-9855
(888) 201-9735

Columbia Legal Services
711 Capitol Way S #304
Olympia, WA 98501
(360) 943-6260
(800) 260-6260

Columbia Legal Services

101 Yesler Way, Suite 300
Seattle, WA 98104
(206) 464-5911

(800) 542-0794
(206) 464-1518 (TDD)

BAR ASSOCIATION REFERRAL SERVICES:

Clark County
Southwest Washington Lawyer Referral Service
(360) 695-0599

King County
King County Lawyer Referral Service
(206) 267-7010

Kitsap County
Kitsap County Lawyer Referral Service
(360) 373-2426

Lewis County
Lewis County Lawyer Referral Program
(360) 748-0430

Pierce County
Tacoma-Pierce County Bar Lawyer Referral
(253) 383-3432

Snohomish County
Snohomish County Bar Referral Service
(425) 388-3018

See also:
http://www.washingtonlawhelp.org/WA/StateDirectory.cfm/County/%20/City/%20/demoMode/%3D%201/Language/1/State/WA/TextOnly/N/ZipCode/%20/LoggedIn/0