Legal Planning for Families with a Dementia Diagnosis

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UW Project ECHO® Dementia

Northwest Justice Project

July 2023

Northwest Justice Project

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Aging and Disability Services
Area Agency on Aging for Seattle and King County

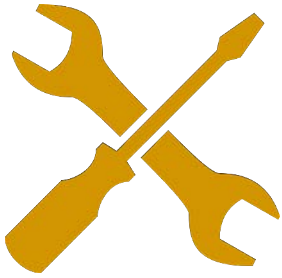
Northwest Justice Project

NJP provides FREE civil legal aid to eligible people with low incomes

Examples of civil (non-criminal) legal Issues	
Family safety and security parenting plans, protection orders	**Housing stability** foreclosure prevention, eviction defense
Protection of income Social Security Disability, TANF, etc.	**Access to medical care or benefits**
Money and Debt issues protection from debt collection abuse, fraud	**Employment issues** lost wages, discrimination, workplace safety
Education rights special education, discrimination	Other basic needs and protections

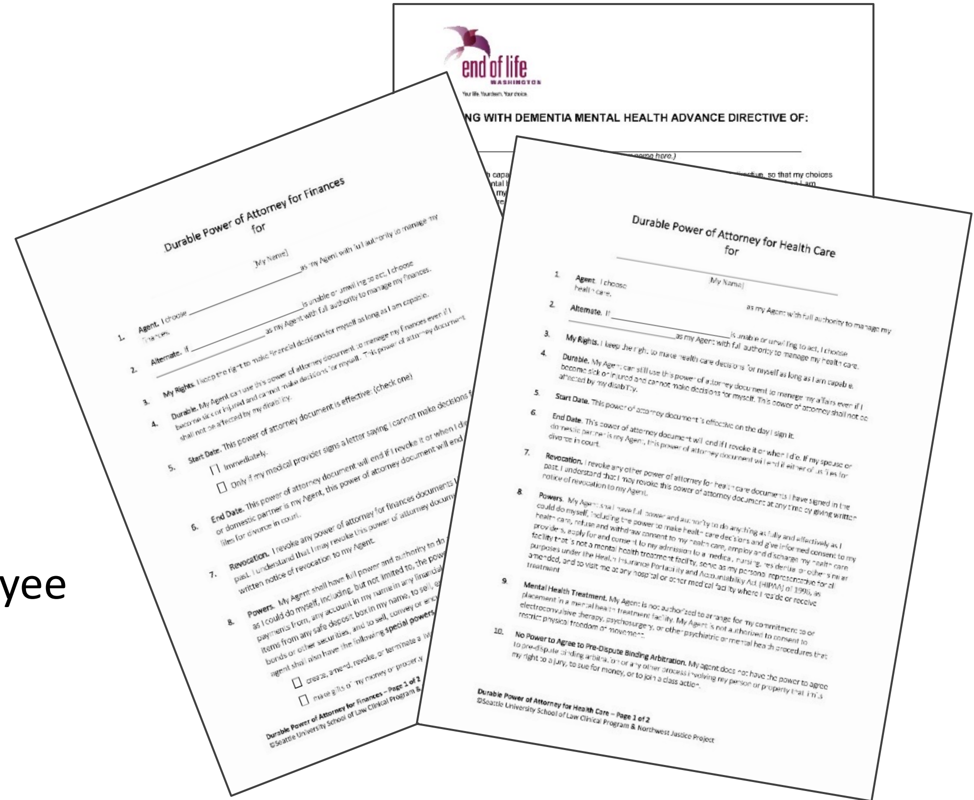
NJP also has specialized units and projects serving:

- **Veterans**
- **Farmworkers**
- **Native Americans**
- **Victims of crime**
- **Survivors of domestic violence**
- **People over 60 years old**
- **Western State Hospital patients**



Decision Support

1. Durable Power of Attorney
2. Health Care Directives
3. POLST
4. Social Security Representative Payee
5. Consent to Health Care Statue
6. Guardianship/Conservatorship



Capacity

- Comprehend legal documents?
- Understand consequences?
- Make rational decisions?

WashingtonLawHelp.org

Dementia Legal Planning Toolkit

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- Estate Planning

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Durable Power of Attorney for Finances
for

____
[My Name]

1. **Agent.** I choose ______________________________ as my Agent with full authority to manage my finances.

2. **Alternate.** If ______________________________ is unable or unwilling to act, I choose ______________________________ as my Agent with full authority to manage my finances.

3. **My Rights.** I keep the right to make financial decisions for myself as long as I am capable.

4. **Durable.** My Agent can use this power of attorney document to manage my finances even if I become sick or injured and cannot make decisions for myself. This power of attorney document shall not be affected by my disability.

5. **Start Date.** This power of attorney document is effective: (check one)

   ☐ Immediately.

   ☐ Only if my medical provider signs a letter saying I cannot make decisions for myself.

6. **End Date.** This power of attorney document will end if I revoke it or when I die. If my spouse or domestic partner is my Agent, this power of attorney document will end if either of us files for divorce in court.

7. **Revocation.** I revoke any power of attorney for finances documents I have signed in the past. I understand that I may revoke this power of attorney document at any time by giving written notice of revocation to my Agent.

8. **Powers.** My Agent shall have full power and authority to do anything as fully and effectively as I could do myself, including, but not limited to, the power to make deposits to, and payments from, any account in my name in any financial institution, to open and remove items from any safe deposit box in my name, to sell, exchange or transfer title to stocks, bonds or other securities, and to sell, convey or encumber any real or personal property. My agent shall also have the following **special powers**: (check all that apply)

   ☐ create, amend, revoke, or terminate a living trust

   ☐ make gifts of my money or property

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Durable Power of Attorney for Health Care
for

____
[My Name]

1. **Agent.** I choose ______________________________ as my Agent with full authority to manage my health care.

2. **Alternate.** If ______________________________ is unable or unwilling to act, I choose ___________________________ as my Agent with full authority to manage my health care.

3. **My Rights.** I keep the right to make health care decisions for myself as long as I am capable.

4. **Durable.** My Agent can still use this power of attorney document to manage my affairs even if I become sick or injured and cannot make decisions for myself. This power of attorney shall not be affected by my disability.

5. **Start Date.** This power of attorney document is effective on the day I sign it.

6. **End Date.** This power of attorney document will end if I revoke it or when I die. If my spouse or domestic partner is my Agent, this power of attorney document will end if either of us files for divorce in court.

7. **Revocation.** I revoke any other power of attorney for health care documents I have signed in the past. I understand that I may revoke this power of attorney document at any time by giving written notice of revocation to my Agent.

8. **Powers.** My Agent shall have full power and authority to do anything as fully and effectively as I could do myself, including the power to make health care decisions and give informed consent to my health care, refuse and withdraw consent to my health care, employ and discharge my health care providers, apply for and consent to my admission to a medical, nursing, residential or other similar facility that is not a mental health treatment facility, serve as my personal representative for all purposes under the Health Insurance Portability and Accountability Act (HIPAA) of 1996, as amended, and to visit me at any hospital or other medical facility where I reside or receive treatment

9. **Mental Health Treatment.** My Agent is not authorized to arrange for my commitment to or placement in a mental health treatment facility. My Agent is not authorized to consent to electroconvulsive therapy, psychosurgery, or other psychiatric or mental health procedures that restrict physical freedom of movement.

10. **No Power to Agree to Pre-Dispute Binding Arbitration.** My agent does not have the power to agree to pre-dispute binding arbitration or any other process involving my person or property that limits my right to a jury, to sue for money, or to join a class action.

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Durable Power of Attorney for Finances
Poder Notarial Duradero para Finanzas
for/*para*

____
[My Name/ (*Mi Nombre*)]

1. **Agent.** I choose ______________________ as my Agent with full authority to manage my finances.
(***Agente.*** *Yo selecciono a ______________________, como mi Agente con plena autoridad para administrar mis finanzas.*)

2. **Alternate.** If ______________________ is unable or unwilling to act, I choose ______________________ as my Agent with full authority to manage my finances.
(***Suplente.*** *Si ______________________ no puede o no está dispuesto a actuar, selecciono a ______________________, como mi Agente con plena autoridad para administrar mis finanzas.*)

3. **My Rights.** I keep the right to make financial decisions for myself as long as I am capable.
(***Mis derechos.*** *Me reservo el derecho de tomar decisiones financieras por mí mismo mientras sea capaz de hacerlo.*)

4. **Durable.** My Agent can use this power of attorney document to manage my finances even if I become sick or injured and cannot make decisions for myself. This power of attorney document shall not be affected by my disability.
(***Duradero.*** *Mi Agente puede usar este documento de poder notarial para administrar mis finanzas aún si yo me enfermo o me lesiono y no puedo tomar decisiones por mí mismo. Este documento de poder notarial no se verá afectado por mi discapacidad.*)

5. **Start Date.** This power of attorney document is effective: (check one)
(***Fecha de Inicio.*** *Este documento de poder notarial entra en vigencia: (marcar uno)*)
   - ☐ Immediately/ (*Inmediatamente*)
   - ☐ Only if my medical provider signs a letter saying I cannot make decisions for myself. (*Solamente si mi proveedor médico firma una carta diciendo que no puedo tomar decisiones por mí mismo.*)

6. **End Date.** This power of attorney document will end if I revoke it or when I die. If my spouse or domestic partner is my Agent, this power of attorney document will end if either of us files for divorce in court.
(***Fecha de Fin.*** *Este documento de poder notarial vence si yo lo revoco o cuando yo muera. Si mi cónyuge o pareja doméstica es mi Agente, este documento de poder notarial vence si cualquiera de nosotros presenta una petición de divorcio en el juzgado.*)

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Read this in:
Arabic / العربية
Spanish / Español
Korean / 한국어
Russian / Русский
Tigrinya / Ge'ez
Vietnamese / Tiếng Việt
Chinese (Traditional) / 中文

Health Care Directive

of

____

[My Name]

I am of sound mind and body, and voluntarily execute this health care directive. If I cannot make decisions for myself, my relatives, friends, agents, and medical providers should fully honor every part of this directive. If any part of this directive is invalid, the rest should be honored. I revoke any health care directives I have signed in the past.

1. **Health Care Values:** The following wishes and preferences should guide all decisions made about my care:

   a. **What makes my life worth living.**

   ☐ Some terminal or serious conditions may stop me from **ever** doing the things that make life worth living for me. In that situation, I want you to stop all treatment except comfort care, pain relief and palliative care if I **cannot ever again**:

   - ☐ Recognize my close friends and family in any meaningful way
   - ☐ exercise,
   - ☐ be outdoors,
   - ☐ read,
   - ☐ watch tv shows/movies
   - ☐ do the following: ___________________________________
   - ☐ Other: ___________________________________

     ____

     ____

   ☐ Life is always worth living. Do everything you can to keep me alive.

   b. **My hopes**. In my last days, I hope to spend my time:

   ☐ With my close friends and family: ___________________________________

   ____

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Mental Health Care Advance Directive

of

____
[My Name]

I, ______________________________, being a person with capacity, willfully and voluntarily execute this mental health advance directive so that my choices regarding my mental health care will be carried out in circumstances when I am unable to express my instructions and preferences regarding my mental health care.

1. My Care Needs - What Works for Me.

In order to assist in carrying out my directive I would like my providers and my agent to know the following information:

☐ I have been diagnosed with the following mental health and/or physical diagnoses:

____

____

☐ I take the following medications for my diagnoses:

____

____

☐ I am also on the following other medications:

____

____

☐ The best treatment method for my illness is the following (give general overview of what works best for you):

____

____

____

☐ I _____have/_____do not have a history of substance abuse. My preferences and treatment options around medication management related to substance abuse are:

____

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Advance Directives

End of Life Washington developed the combined **Durable Power of Attorney for Health Care and Health Care Directive** after years of committed research and development. It has been widely praised by health care professionals, advance planning advocates, and attorneys who specialize in elder law and estate planning. It is also endorsed by Sound Generations.

About Advance Directives

Updated 1-10-2020

Advance Directives Video

See the video

Advance Directives
Tools for Planning
Talking To Your Doctor About Death with Dignity
Living Will
Durable Power of Attorney
Dementia Directives
POLST
Additional Advance Directive Documents
LGBTQ
Wonderfile

LIVING WITH DEMENTIA MENTAL HEALTH ADVANCE DIRECTIVE OF:

____
(Print your name here.)

As a person with capacity, I willfully and voluntarily execute this mental health advance directive, so that my choices regarding my mental health care and Alzheimer's/dementia care will be carried out in circumstances when I am unable to express my instructions and preferences regarding my future care. If I live in a state that has not adopted laws that provide me with the legal right to make this advance directive, then I want this document to be used as a guide for those who make decisions on my behalf when I am no longer capable of making them for myself.

The fact that I may have left blanks in this directive does not affect its validity in any way. I intend that all completed sections be followed.

I understand that nothing in this directive, including any refusal of treatment that I consent to, authorizes any health care provider, professional person, health care facility, or agent appointed in this directive to use or threaten to use abuse, neglect, financial exploitation, or abandonment to carry out my directive.

I intend this Living With Dementia Mental Health Advance Directive to take precedence over any other mental health directives I have previously executed, to the extent that they are inconsistent with this Living With Dementia Mental Health Advance Directive.

I understand that there are some circumstances where my provider may not have to follow my directive, specifically if compliance would be in violation of the law or accepted standards of care.

1. . WHEN AND HOW LONG I WANT THIS DOCUMENT TO APPLY

(*Initial only one – a., b., or c. – and draw a line through the others*)

a. _____ I intend that this directive become effective **immediately** upon signing and that it remains valid and in effect until revoked according to the terms specified in section 16 or until my death.

b. _____ I intend that this directive become effective if I become incapacitated to the extent that I am unable to make informed consent decisions or provide informed consent for my care, as determined by my treating physician, and that it remain valid and in effect until revoked according to the terms specified in section 16 or until my death.

c. _____ I intend that this directive become effective when any of the following circumstances, symptoms, or behaviors occur, and that it remain valid and in effect until revoked according to the terms specified in section 16 or until my death: *(Initial all that apply, and draw a line through the rest.)*

(1) _____ I am no longer able to communicate verbally.

(2) _____ I can no longer feed myself.

(3) _____ I can no longer recognize my partner/spouse.

(4) _____ I put myself or my family or others in danger because of my actions or behaviors.

(5) _____ Other *(describe)*:____

ADVANCE DIRECTIVE FOR DEMENTIA

HOME

A Simple Way to Document the Medical Care You Would Want If You Had Dementia

DOWNLOAD THE DEMENTIA DIRECTIVE FORM

INSTRUCTIONS FAQS RESOURCES IN THE NEWS

An advance directive for dementia as featured in the New York Times.

DOWNLOAD THE DIRECTIVE

What If I Had Dementia?

Planning for the future

Alzheimer's disease is one of the most common problems people face in their 70's and 80's. One of the most important things you can do is tell people who would be taking care of you what medical care you think you would want if you were to develop worsening dementia.

What is dementia? Over many years, people with Alzheimer's (and other forms of dementia) lose the ability to understand what is going on around them. In later stages, people with dementia no longer recognize people they know. They need help from others with their own basic body functions. At times they might still enjoy some experiences. At other times they can become angry and confused.

There is no cure for dementia. Gradually people lose the ability to speak, eat, and walk. Eventually people die from dementia, often from dementia-related pneumonia. This process can take anywhere from 5 years to 20 years.

One of the most important questions to consider is: what kind of medical care do you think you would want if you were to develop worsening dementia?

Why it is important to express your wishes. People with advancing dementia lose the ability to make decisions for themselves. Their families need to make medical decisions for them. Giving family members guidance about what type of care you would want can help ease the burden of their decision making and help you feel more secure that you will receive the care that you would want.

Some people may not want to give this type of guidance, but would rather trust their families to make decisions. For those people, this Directive may not be helpful. However, many people do want to provide some guidance for their family, even if it is hard to know exactly what your future situation might be.

What kinds of guidance can you give? You can say, ahead of time, what you would want the focus of your medical care to be. At what point would you still want everything done to keep you alive longer? At what point might you want only hospice-type care focused mainly on treating your symptoms and keeping you comfortable?

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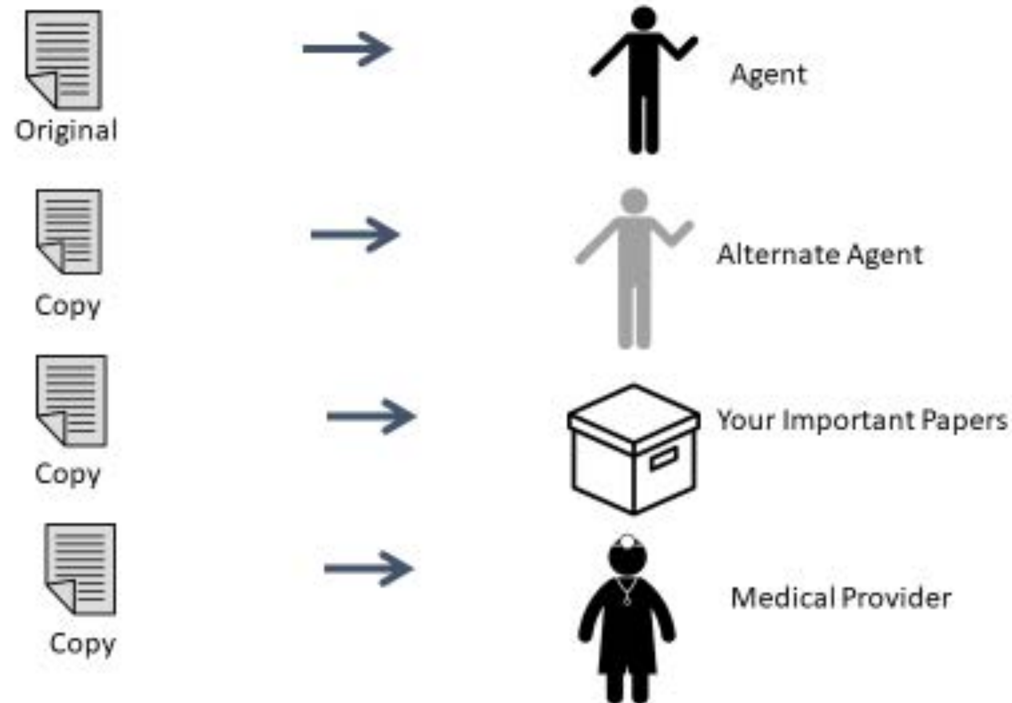
Notarized*



*Documents can be witnessed by 2 people instead, **BUT** witnesses cannot be a health care provider, a relative, or a person entitled to inherit.

POLST: Portable Orders for Life-Sustaining Treatment

HIPAA PERMITS DISCLOSURE OF POLST TO OTHER HEALTH CARE PROVIDERS AS NECESSARY

Washington
POLST
Portable Orders for Life-Sustaining Treatment
A Participating Program of National POLST

LAST NAME / FIRST NAME / MIDDLE NAME/INITIAL

DATE OF BIRTH	GENDER (optional)	PRONOUNS (optional)
/ /		

This is a medical order. It must be completed with a medical professional. Completing a POLST is always voluntary.
IMPORTANT: See page 2 for complete instructions.

MEDICAL CONDITIONS/INDIVIDUAL GOALS:	AGENCY INFO / PHONE (if applicable)

A CHECK ONE

Use of Cardiopulmonary Resuscitation (CPR): **When the individual has NO pulse and is not breathing.**

- ☐ **YES – Attempt Resuscitation / CPR** *(choose FULL TREATMENT in Section B)*
- ☐ **NO – Do Not Attempt Resuscitation (DNAR) / Allow Natural Death**

When not in cardiopulmonary arrest, go to Section B.

B CHECK ONE

Level of Medical Interventions: **When the individual has a pulse and/or is breathing.**

Any of these treatment levels may be paired with DNAR / Allow Natural Death above.

- ☐ **FULL TREATMENT – Primary goal is prolonging life by all medically effective means.** Use intubation, advanced airway interventions, mechanical ventilation, and cardioversion as indicated. Includes care described below. *Transfer to hospital if indicated. Includes intensive care.*
- ☐ **SELECTIVE TREATMENT – Primary goal is treating medical conditions while avoiding invasive measures whenever possible.** Use medical treatment, IV fluids and medications, and cardiac monitor as indicated. ***Do not intubate.*** May use less invasive airway support (e.g., CPAP, BiPAP, high-flow oxygen). Includes care described below. *Transfer to hospital if indicated. Avoid intensive care if possible.*
- ☐ **COMFORT-FOCUSED TREATMENT – Primary goal is maximizing comfort.** Relieve pain and suffering with medication by any route as needed. Use oxygen, oral suction, and manual treatment of airway obstruction as needed for comfort. *Individual prefers no transfer to hospital. EMS: consider contacting medical control to determine if transport is indicated to provide adequate comfort.*

Additional orders (e.g., blood products, dialysis): ____________

C

Signatures: A legal medical decision maker *(see page 2)* may sign on behalf of an adult who is not able to make a choice. An individual who makes their own choice can ask a trusted adult to sign on their behalf, or clinician signature(s) can suffice as witnesses to verbal consent. A guardian or parent must sign for a person under the age of 18. Multiple parent/decision maker signatures are allowed but not required. Virtual, remote, and verbal consents and orders are addressed on page 2.

Discussed with:
- ☐ Individual ☐ Parent(s) of minor
- ☐ Guardian with health care authority
- ☐ Legal health care agent(s) by DPOA-HC
- ☐ Other medical decision maker by 7.70.065 RCW

X **SIGNATURE** – MD/DO/ARNP/PA-C **(mandatory)**	DATE **(mandatory)**
PRINT – NAME OF MD/DO/ARNP/PA-C **(mandatory)**	PHONE

X **SIGNATURE(S)** – INDIVIDUAL OR LEGAL MEDICAL DECISION MAKER(S) **(mandatory)**	RELATIONSHIP	DATE **(mandatory)**
PRINT – NAME OF INDIVIDUAL OR LEGAL MEDICAL DECISION MAKER(S) **(mandatory)**		PHONE

Individual has: ☐ Durable Power of Attorney for Health Care ☐ Health Care Directive (Living Will)
Encourage all advance care planning documents to accompany POLST.

SEND ORIGINAL FORM WITH INDIVIDUAL WHENEVER TRANSFERRED OR DISCHARGED

WSMA Washington State Medical Association

Washington State Department of Health 7-51

All copies, digital images, faxes of signed POLST forms are valid.
See page 2 for preferences regarding medically assisted nutrition.
For more information on POLST, visit **www.wsma.org/POLST**.

REV 04/2021

Page 1

Capacity

- Comprehend legal documents?
- Understand consequences?
- Make rational decisions?

What happens if I don't choose a health care agent?

Washington State law lists who will make health care decisions for you if you cannot

The order for who will decide is:

A guardian appointed by the state

Named health care agent with health care decision-making authority in the advance directive

Your spouse or registered domestic partner (even if separated)

Your adult children *

Your parents *

Your adult siblings *

Your adult grandchildren *

Your adult nieces & nephews *

Your adult aunts & uncles *

A close friend who meets certain criteria *

***Any group that has more than one person: all in the group must agree to the care**

/HonoringChoicesPNW @HCPNW honoringchoicespnw.org

Scan for more information about the Washington State law

Guardianship, Conservatorship, and Protective Arrangements

Resources

Dementia Legal Planning

Get connected to a legal professional

If you are a Washington State resident and need help navigating the completion of dementia legal documents, you may be able to connect with a legal professional who will guide you through them. Attorneys can help talk through:

- Powers of attorney for finances and health care
- Health care directives
- Dementia directive form

This program serves those who are 60 and over, people living with dementia of any age, or those under 60 with a family history of dementia. This free service is subject to capacity. Please note that the Dementia Legal Planning Project does not provide notarization (that part will be up to you).

To get started, you can call the Dementia Legal Planning (DLP) phoneline at **425-780-5589** or fill out the form below. If you call, please leave your name, contact information, and the best time to call you back. Someone from the Pro Bono Council will reach out to you shortly to connect you with services. Normal business hours are Monday through Friday, 9:00 a.m. to 5:00 p.m.

*** COMPLETING THIS FORM IS NOT A GUARANTEE THAT SERVICES WILL BE OFFERED OR PROVIDED***
This service intake form is only for assistance with completing the legal and advance care planning forms mentioned above. Unfortunately, **we do not have enough staff to respond to requests for other services.**

Dementia
Legal
Planning

For free legal help with the documents in this toolkit

Including Power of Attorney for Finance,
Power of Attorney for Health Care,
Health Care Directive, and Dementia Directive

Washington State Residents can contact the Dementia Legal Planning Program at

425-780-5589

https://dementialegalplanning.org/

This program is funded, on behalf of the Dementia Action Collaborative, by the Aging and Long-Term Support Administration/DSHS.

Senior Rights Assistance

Senior Rights Assistance empowers people to utilize their legal rights by providing expert advice free of charge. Topics we help with include Estate Planning, Power of Attorney, Probate, and Guardianship.

If you'd like to speak with an attorney, you may also schedule a free, 30-minute appointment through the Elder Law Clinic — a partnership between Sound Generations and the King County Bar Association. Attorneys at the Elder Law Clinic are available to discuss Power of Attorney, Guardianship, Wills, and Estate Planning. Appointments are available in Seattle or Kent.

To seek advice from one of our highly-trained specialists, set up an appointment with an attorney, or inquire about a free, basic will, call 206.448.5720 or Toll Free 1-888.435.3377, or email **info@soundgenerations.org**.

Our business hours are Monday – Friday, 9 AM – 4 PM.

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- **CLEAR Hotline:** 1-888-201-1014 weekdays 9:15 am-12:15 pm (* **King County call 2-1-1**)
- **Eviction:** 1-855-657-8387
- **Foreclosure:** 1-800-606-4819
- **Deaf, hard of hearing or speech impaired** call using the relay service of their choice.
- Apply Online: www.nwjustice.org/get-legal-help

WashingtonLawHelp.org

Questions and Answers on the COPES Program

Solid Ground – Benefits Legal Assistance July 2023

This pamphlet is accurate as of its date of revision. The rules ch...

1. What is COPES?

COPES is a Home and (
Services (HCBS) waive
for services for people i
These services help peo
otherwise need to be in
"COPES" stands for Co
Program Entry System.

The services offered thr
program are administe
Community Services (H
Washington State Depa
Health Services (DSHS
whether you are eligibl
HCS has 2 other Home
Based Services (HCBS)
Freedom in King and P
Residential Support Wa
eligibility rules for thes
same as COPES. For ar
long term services and
Medicaid and Options for
Adults found at
https://www.dshs.wa
s/publications/docum
The Aging and Long T
Administration website
all long term care servi
https://www.dshs.wa
care-services-informati

Important Note About
COPES are eligible for
Medicare Beneficiary (

Savings Program. QMB pays your Medicare

---

www.WashingtonLawHelp.org

8401EN | January 2021

How do I Sign Documents When I am Physically Unable?

❖ Read this only if you live in the state of Washington.

Should I use this?

Yes, if both of these are tr
- You want to sign a do
re physically un
erstand the doc
es to a physical

notary publ

ary can sign for
ave a disability

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hwest Justice Proj

Questions and Answers on Medicaid for Nursing Home Residents

Solid Ground – Benefits Legal Assistance July 2023

This pamphlet is accurate as of its date of revision. The rules change frequently.

1. What is Medicaid?

Medicaid is a government program that pays for medical services including nursing home care. It is administered by Health Care Authority (HCA). The Washington State Department of Social and Health Services (DSHS) is the designee of HCA in administering the nursing facility program.

To get Medicaid payment for nursing home care, you must be financially eligible. The financial eligibility requirements are described below. Also, you must need the kind of care provided in a nursing home.

Apply for <u>Long Term Care Medicaid</u> for nursing home residents one of threeways: by filing an application online; by submitting a paper application to a local DSHS Home and Community Services (HCS) office; or if calling your local HCS office. The website for filing an on-line application is Washington Connection https://www.washingtonconnection.org/home/

The website for downloading a paper application [form HCA 18-005 (3/14) *Washington Apple Health Application for Long-Term Care/Aged, Blind, Disabled Coverage*] is http://www.hca.wa.gov/medicaid/forms/Documents/18-005.pdf. You may also pick up the application form at a DSHS office.

A paper application may be returned to PO Box 45826 Olympia WA 98504 or to your local Home and Community Service (HCS) office. To find the right HCS office, call 1-800-422-3263 or use the online tool to find the HCS office in your county https://www.dshs.wa.gov/altsa/resources.

Important Note: Individuals under age 65 who are not on or eligible for Medicare may be eligible for health care, known as MAGI Medicaid, through the Health Benefit Exchange (http://wahbexchange.org/). MAGI Medicaid *includes* nursing facility coverage. The information in this publication addressing income, resources, and participation in cost of care *does not* apply to MAGI Medicaid clients requiring nursing facility care. MAGI Medicaid clients requiring nursing facility care do not have to meet resource test requirements and have no participation toward the cost of care. However, the information in this pamphlet addressing estate recovery does apply to MAGI clients 55 and older, depending on the services they receive.

A Note About Names: The Washington State Health Care Authority (HCA) uses the term "Apple Health" to refer to all Medicaid and state medical programs, including long-term

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WashingtonLawHelp.org

5107EN | October 2022

What can I buy and still be eligible for SSI and/or Medicaid?

❖ Please read this *only* if you live in Washington State.

❖ You can find all the fact sheets we link to here at WashingtonLawHelp.org.

Should I read this?

You should read this if you are in any of these situations:

1. You are applying for SSI or Medicaid, but you currently have **too much money** or property to qualify.
2. You already get SSI or Medicaid. You **received extra money** or property from an inheritance, gift, or court settlement.
3. You already get SSI or Medicaid. Someone wants to **give you a gift.**

What is the resource limit?

In most situations, the resource limit for SSI and Medicaid is $2,000 for one person or $3,000 for a couple. Be careful, though. **Being even a little bit over the limit could cause you to lose benefits**.

For example, you might have $2,000 in a bank account. This meets the limit. If that bank account earns just fifty cents in interest, you could become ineligible for benefits.

Not all resources count toward this overall resource limit.

What counts as a resource?

Cash and bank accounts count towards the resource limit. Physical property can also count if you can easily sell it. Some money and property are not counted (they are "exempt"). This can include things you need for everyday life, like a house, a car, clothing, and household goods.

Questions?