PROBLEMS OF THE AGING

HEARINGS

BEFORE THE

SUBCOMMITTEE ON FEDERAL AND STATE ACTIVITIES

OF THE

SPECIAL COMMITTEE ON AGING UNITED STATES SENATE

EIGHTY-SEVENTH CONGRESS

FIRST SESSION

Part 8.—Spokane, Wash.

NOVEMBER 17, 1961

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NOTE.—Thirteen hearings on Federal and State activities in the field of aging were held and they are identified as follows:

Part 1—Washington, D.C.
Part 2—Trenton, N.J.
Part 3—Los Angeles, Calif.
Part 4—Las Vegas, Nev.
Part 5—Eugene, Oreg.
Part 6—Pocatello, Idaho
Part 7—Boise, Idaho.
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PROBLEMS OF THE AGING

FRIDAY, NOVEMBER 17, 1961

U.S. SENATE,
SUBCOMMITTEE ON FEDERAL AND STATE ACTIVITIES
OF THE SPECIAL COMMITTEE ON AGING,
Spokane, Wash.

The subcommittee met at 10 a.m., pursuant to notice, in the ballroom, Spokane Hotel, Senator Frank Church presiding.

Present: Senator Church.

Also present: Walter Horan, a U.S. Congressman from the State of Washington.

Committee staff members present: William G. Reidy, staff director and specialist on health and medical care; Miss Dorothy McCamman, expert on social security; Keith Jaques, representing the minority.

Senator CHURCH (presiding). Ladies and gentlemen, this meeting will come to order.

This is an official hearing of a subcommittee of the U.S. Senate's Special Committee on Aging. It is one of a series of hearings being held by similar subcommittees in some 30 cities throughout the United States before January when Congress reconvenes. Everything that is said here will be recorded, printed, and distributed to all Members of the Congress and to thousands of State legislators and scholars concerned with the problems that confront our older people.

At the outset, I want to mention that the testimony given here today will be brought directly to the attention of your two fine Senators, Warren Magnuson and Henry Jackson. While they are not members of this committee, I know that they are deeply interested in the problems of the aged. Their Washington offices have provided the committee with assistance and cooperation in getting this hearing set up in Spokane, and your Senators will, I know, study the record with great diligence.

This hearing and those which I held in Pocatello on Monday and in Boise on Wednesday are important to all of us. We are making a continuous record to be carried back to Washington, D.C., about what the Northwest believes are the problems of our senior citizens in this part of the country. We have made a real effort to avoid duplicating the record made in Idaho this week and that made in Oregon and Walla Walla, Wash., last week, when Senator Wayne Morse of Oregon held hearings on both nursing homes and Federal-State activities in the field of the aging.

Today, your Washington State experts will give a broader picture of activities on behalf of the aged in your State than was possible in Walla Walla where the subject was specifically that of nursing homes. This does not mean we will avoid the subject of nursing homes, quite

to the contrary. What the hearing today will bring out, I think, is that the problems of the aged are interrelated. We cannot talk of the housing problem for the aged, for example, without also considering nursing homes, homes for the aged, and other places where the aged live.

This afternoon, we will hold a town meeting of senior citizens, where I hope the real experts, the older people, will speak for themselves as to what their problems are and what can be done about them. We want Washington, D.C., to know what the older people in this part of the country are thinking and saying. A statistical picture alone cannot provide the insights we need for legislative action to help meet the needs. There is a wealth of new data concerning the aged in our population from the 1960 census and from recently available economic and health data. The State and local study groups and, finally, the White House Conference held last January have provided a great deal of background material. These extensive considerations of the role of the aged in American society today must be personalized so that we look beyond columns of statistics at the individuals involved. We must recognize that the people in the group whom we sometimes call senior citizens are not alike. Their living circumstances and problems vary widely, and so do the various State and local programs for the aged. They vary widely from State to State. We must get the total picture, and this can be done only by presenting to Washington, D.C., the picture in the Northwest, the East, the South, and the Midwest.

Only when the Committee on Aging has completed its series of hearings will we have that picture of the broad human aspect required to provide the basis for laws made to serve the people of Washington State and those of Idaho, as well as those of other States.

Here with me today are William G. Reidy, our committee staff director and specialist in health and medical care problems, who is sitting on my right; Miss Dorothy McCamman, an expert on social security. With us too is Keith Jaques, legislative assistant to Senator Bennett of Utah, who is substituting for our regular Republican minority staff member. For his information and for that of some few people who apparently misunderstand the nature of this Special Committee on Aging, let me say this: The Congress has committees which handle legislation in specific fields; bills dealing with financing health care go in the Senate to the Finance Committee, and those relating to the building of nonprofit nursing homes to the Committee on Labor and Public Welfare, bills on housing to the Banking and Currency Committee, and so on.

It is because the Senate realized that the problems of our aged citizens are all interrelated, housing, income, job opportunities, health services, all having an effect on one another, that this Special Committee on Aging was created. The committee does not concentrate on any one aspect of the problem. It has prepared and printed excellent reports on housing, on nursing homes, on income maintenance, on guaranteed income bonds, and on half a dozen other subjects that concern elderly people. Each such report was written in terms of the whole of an elderly person's life, and then referred to the appropriate legislative committee for its consideration. That, and that alone, is what we are here for, not to promote any one piece of legislation. We are here to listen and to learn so that we may report to the Congress

on what the people of our Northwest think about any and all problems affecting the aged and the aging.

We shall begin this morning with a panel of witnesses whom we have asked to advise us on what activities your great State of Washington carries on in its attempt to solve the problems of its older citizens. This committee is here in a representative capacity for the Governor of Washington, and, for this purpose, we will ask the committee to be our first witness, Mr. Hegland and his associates, who form this panel, if he would come forward, please, we would be very happy to welcome you today.

Let me say also that your Congressman in this district, Walter Horan, is here, and we will hear his testimony immediately following the Governor's panel, and he will sit with me during the rest of the day. I am happy to welcome you here this morning, Congressman.

Congressman HORAN. Thank you.

Senator CHURCH. We will be looking forward to hearing from you just as soon as the panel has made its presentation.

STATEMENT OF L. L. HEGLAND, CHAIRMAN OF PANEL, REPRESENTING GOV. ALBERT D. ROSELLINI

Mr. HEGLAND. Senator Church, Congressman Horan, committee staff, ladies and gentlemen, before starting the presentation of our panel, I want to bring greetings to you from the Governor. Senator Church very thoughtfully invited the Governor to attend, and he was unable to. So, I am giving his greetings for him.

Governor Rosellini has asked me to bring you his greetings and best wishes for a successful meeting. The Governor regrets very much his inability to be present. However, he felt sure you will understand and accept his reason. As you know, the President of the United States, John F. Kennedy, was in Seattle yesterday, and, among other things, came to do honor to the senior Senator from the State of Washington, Warren G. Magnuson, at a dinner honoring him at the beginning of his 25th year of service in the Congress of the United States.

It is indeed a pleasure, Senator Church, on behalf of Governor Rosellini to welcome you, not only as a representative of the Congress of the United States, but also as a representative of our neighboring State, Idaho. We welcome the opportunity to share some of our problems and some of our successes, which come within the scope of this hearing, to the end that all States may benefit. The people of this State have been particularly conscious of the contributions of its senior citizens to the development and growth of this State. The State, in turn, desires to assist those who have now reached retirement to enjoy a fruitful and satisfactory period of life.

To this end, Governor Rosellini reactivated in February 1958, the Governor's council on aging, to which he has given wholehearted support. At the last legislative session, the Governor submitted a bill to give permanent status to the council. Although no particular opposition was expressed, the bill was caught in the final rush and failed to come to the floor. The council has remained active, however.

In January of this year, a full complement of 28 representatives attended the White House Conference on Aging; having been in

operation as a unified group for a long period of time, it was able to function very effectively in preconference planning.

Since the Conference, the council has been active in putting into effect a number of the recommendations of that Conference. It is not my purpose at this time to detail activities of the various State programs of benefits for senior citizens. There are representatives here of State agencies who will present this information at your convenience.

On behalf of Governor Rosellini and the people of this State, I extend to you and your group very sincere wishes for a successful hearing.

Senator CHURCH. Thank you very much, Mr. Hegland.

Mr. HEGLAND. Now, then, Senator Church and Congressman Horan, I would like to give a brief background report of the department's activities and will then call on other representatives of State departments to present factual data on their area of activity in relation to programs for the aging.

With the adoption of an act relating to the support of the poor in 1854, by the first legislative assembly of Washington Territory, the principle of responsibility of government for those without resources to meet basic needs was established. The superintendency of the poor was placed with the various boards of county commissioners. The first State legislature in 1889 reaffirmed the 1854 act. With the creation of the department of public welfare in 1935, State government was given increasing administrative and financial responsibilities until by act of the 1953 legislature public assistance became fully State administered with all expenditures from the State general fund through legislative appropriation.

Under the law, the public assistance committee, composed of the Governor, the director of the central budget agency, and a lay citizen appointed by the Governor, has full and complete responsibility for programs of assistance. The department is administered by a director appointed by the Governor, with approval of the senate. Recipients are served through 30 branch offices of the department, established on county or multicounty lines.

Legislative adoption of the Old Age Pension Act in 1933, initiative action in 1941 and again in 1948, and legislative action since, indicate quite strongly that the citizens of this State want an adequate program of assistance provided for the needy and have been particularly conscious of the aged within the population. We have no lien law, relative responsibility, or ratable reduction provisions in our old-age assistance program.

Washington normally ranks between fifth and eighth highest among the States in average monthly payments in old-age assistance and stood sixth in September 1961. The average payment in September was $91.43 per case, including vendor payments for medical care. Expenditures for old-age assistance totaled $4,276,000, or 45.2 percent of the total assistance paid that month.

In this State, the cost of medical care, hospitalization, burials, infirmary, and nursing home care, are made directly to vendors. The grant payment therefore averaged but $60 per case in September. Other income, private pensions, OASI benefits, et cetera, available directly to the old-age assistance recipients averages approximately $24 a month. The high point of our old-age assistance caseload was

reached in September 1950, with 74,083 cases, representing 79,416 persons. As of September 1961 there were 46,421 cases and 47,409 persons receiving assistance. This is an average yearly decrease of 2,515 cases over the 11-year period.

Senator CHURCH. May I ask, Mr. Hegland, at that point: What accounts for the decline in the number of cases on old-age assistance? You say that it has dropped from 79,000 to about 47,000.

Mr. HEGLAND. In terms of persons, that is correct.

Senator CHURCH. Well, your population has been going up, and the number of older people within the population has been dramatically increasing; isn't that true?

Mr. HEGLAND. That is right.

Senator CHURCH. Yet the number of the caseload has been going down. Now, what would account for that?

Mr. HEGLAND. Primarily the OASI, old-age and survivors insurance program.

Senator CHURCH. You mean the social security system?

Mr. HEGLAND. Social security system has brought it down. The population of our State 65 years of age and over, on the other hand, increased an average of 67,640 persons per year between April 1950, and April 1960, and this confirms the statement you just made, Senator.

There has been no restrictive legislation since 1950 to account for this decrease. The department may take part of the credit for this decline in maintenance of casework services designed to assist persons to care for themselves to the limit of their ability. The principal reason is found in the extended coverage and increased benefits under amendments of the Social Security Act of 1935.

The proportion of persons receiving benefits under the old-age and survivors disability insurance program, that is, retired workers, wives or widows, increased from 200 beneficiaries per 1,000 in the aged population in April of 1950 to 654 per 1,000 in April of 1960. Average monthly benefit payments more than doubled. There has also been an increase in the proportion of retired workers receiving pensions from industry and government.

While the total population increased during the 10-year period by 19.9 percent, those aged 65 and over showed a 32 percent increase, and among the aged, those 75 years and over had a 52.5 percent jump. As a consequence, our old-age assistance caseload increasingly consists of the older, more infirm of our aged population.

The effects of these changes will be covered by Dr. Hall, who will address his remarks to the medical care program, and at this time I would like to present Dr. Hall, assistant director and head of our medical division of the department. Dr. Hall.

Senator CHURCH. Dr. Hall, we are very happy to have you.

STATEMENT OF DR. ROBERT P. HALL, MEMBER OF THE PANEL, AND DIRECTOR OF MEDICAL CARE, DEPARTMENT OF PUBLIC ASSISTANCE

Dr. HALL. Senator Church, Congressman Horan, members of the committee, ladies and gentlemen, the people of the State of Washington have been providing comprehensive medical programs in the State of Washington for people in need for more than 20 years.

The patients on continuing assistance, that is, those on old-age assistance, aid to dependent children, aid to the blind, the partially or totally disabled, and those on general assistance, who are unemployable, are given a complete medical program, and all their illnesses are cared for.

In the health care, the main factor, of course, would be the physician service, and this is purchased on a prepaid basis from the Washington Physicians Service. The department of public assistance pays $3.31 per person-month for all those on the continuous assistance rolls. For this amount, the physicians in all counties, except King, provide the necessary care for these individuals, and this arrangement has been in progress since 1948.

Senator CHURCH. Doctor, so that I can understand clearly and so that the record is clear on this, this comprehensive medical care program you refer to covers those that are on the old-age assistance rolls?

Dr. HALL. Yes.

Senator CHURCH. And dependent children and others that might be classed as indigents, is that correct? Does it go further than to include only those that are dependent upon public assistance?

Dr. HALL. Yes. Our comprehensive medical care covers all those on continuing assistance; that is, A.D.C., aid to the blind, APTD.

Senator CHURCH. Who else does it cover?

Dr. HALL. This is our medical-only program, which I will cover in just a minute.

Senator CHURCH. That's fine. I just wondered if you could separate the two for purposes of keeping the record clear.

Dr. HALL. Yes. In King County, which, as you know, is the Metropolitan Seattle area, the physicians' services are provided on a fee for service. In other words, we pay the physician for each case.

If you will look at your folders, which I think are on the end of the table there, to give you some idea, without going into a lot of detail, which you can peruse at your leisure, exhibit A is our contract with the Washington Physicians Service. I think it would be of interest to the committee, and I would like to have it entered into the record because I think in many ways it is unique in the United States.

Senator CHURCH. We will do that, Doctor. We will make it a part of the record.

(The document referred to appears on p. 970.)

Senator CHURCH. We provide for the medical indigent a program covering acute and emergent medical conditions. These cases are determined to be indigent by reason of a medical catastrophy. These are referred to as medical-only cases. Our medical-only cases over 65 are our MAA cases in the State of Washington.

Dr. HALL. Now, the other large item is hospital care, and hospital care is provided in nearly all of the hospitals of the State. The rates are determined by reimbursable cost formula, which has been worked out with Washington State Hospital Association, and this is exhibit B, which I would like to have entered in the record without going into detail, which I think also would be of interest to the committee.

Senator CHURCH. We will make it a part of the record.

(The document referred to appears on p. 976.)

Dr. HALL. Four counties, King, Pierce, Whatcom, and Clark, have county hospitals, and in these areas, the patients' care is provided

in these institutions. Drugs are supplied in the hospitals as a part of the hospital cost. This is included in the reimbursable cost formula. Outpatients receive drugs prescribed by their attending physician according to this drug formulary, which is exhibit C (the document referred to appears on p. 986), and it contains the majority of drugs that are used. However, in urgent cases, drugs that are not listed in the formulary may be provided if approved by the screening physician.

Another unique feature of our plan here in the State, we employ in each of the bureau areas a screening physician who is a consultant to evaluate the need of services or drugs, in those cases that are questionable or exceptions to our rules and regulations, which again is exhibit D (the document referred to appears on p. 1006), which we need not go into. These doctors are usually practicing in the local area, well acquainted with the individual doctors, druggists, and so forth. We feel that these men are the key to the successful administration of our program. In other words, when you have a problem arising in a local area, whether or not Mrs. Jones' gallbladder should come out, the question can be decided by consultation in the local town between local doctors. We find that this is quite acceptable to the doctors practicing. I know from personal experience because I practiced under this program for many years.

We also have a prepaid dental program, which is exhibit E (the document referred to appears on p. 1076). The essential dental care, as we define it, is divided into three categories, depending upon the urgency of need, and is provided, insofar as funds will allow, by paying 45 cents per person-month to the Washington Dental Service Corp. Here again, we have a screening dentist, who evaluates the need, the essential need of the particular patient. This is not meant to imply that this is a complete program because it is not. We are trying to take care of the essential dental needs.

Senator CHURCH. Doctor, may I ask there: In connection with your dental program and your medical care or doctor's care program, for those that qualify, where you deal on a contractual basis with the dental association, the hospital association, and the medical association, do these people have the doctors assigned to them or the dentists assigned to them when they are in need of care? How do the mechanics work?

Dr. HALL. For the most part, with the possible exception of the outpatient clinic in the county hospitals, there is free choice of physicians. We have one arrangement here in Spokane where they operate a clinic, but, again, there is choice of physician allowed.

Senator CHURCH. Then the chosen physician bills the joint fund that is maintained for this purpose, is that right, according to a certain schedule of fees?

Dr. HALL. Yes. Each bureau has their own fee schedule. The $3.31 that we pay for a person on the continuing rolls is paid to the Washington Physicians Service. Then this is prorated out to the 23 bureaus, dependent upon the number of people in those counties. We give them a count of those on the continuing rolls, and, for this amount of money, the bureau provides the necessary physician service. Now, this is on the continuing rolls.

Additional goods and services are classes for school-age children, ambulance service, appliances, bandages for nursing home patients where the bandaging is in excess of what would be considered the usual amount, and other ancillary services as required, such as visiting nurse service.

Once a patient is accepted for care, either as a recipient or medical indigent, care is completed without limit to time or expense. In other words, we don't take care of them just for 14 days, or 7 days, or up to $100. The complete illness is cared for.

Nursing home care is almost half of our budget for health care in the State of Washington. We have some 334 licensed private nursing homes in the State, and we have contracts with 312 of these homes, for over 9,000 patients. In fact, I think it is something over 10,000 at the present time. This part of our program was discussed at length last week at Walla Walla. So, we will limit our remarks about nursing homes unless there are questions.

The MAA program, the medical assistance to the aged, in the State of Washington is limited to the medical indigents, those over 65. We have had a medical indigent or medical-only program in this State for many years, but with the recent changes in the Social Security Act, in October 1960, we were able to implement this program and integrate it with our program as it is now operating. We consider the individual's ability to pay and magnitude of medical catastrophe in determining eligibility of the recipient. If it is obvious that the person could never pay for his particular illness, we then declare him eligible and pay part or all of the expenses for that one situation. Should he have another problem the following day, or the following hour, for that matter, after leaving the hospital, he would be eligible again. In other words, there is no limit to the payments per year, or limit on total care required, assuming, of course, that the rules and regulations are followed.

This is, in a very brief sketch, our medical program, and, unless there are some other questions, I will continue on and answer some specific questions which were addressed to me when we were asked to appear on this program.

Senator CHURCH. Very well, Doctor.

Dr. HALL. Standards of assistance and levels of payment: The State department of public assistance is required by law to establish statewide standards of assistance common to all programs, except foster care and noncontinuing general assistance. The standards for requirements are to include reasonable allowances for shelter, fuel, food, clothing, household maintenance, and operation, personal maintenance, and necessary incidentals. The department is also required by law to price the budget items and to alter the allowances for requirements if price changes occur. Grants are to be paid in the amount of requirements less all available income and resources, which can be applied by the recipient toward meeting the need. Thus, average grants in public assistance programs, other than foster care and employable general assistance, depend on five main factors, and they are:

The quantity-quality standards for requirements are a major determinant of average grant. As directed by the legislature, the department has established the quantities and qualities of various budget items considered necessary under specific circumstances for a low cost

but healthful and decent standard of living. These budgets are called the quantity-quality standards for requirements. Whenever possible, the department bases the quantity-quality standards on material prepared by recognized experts in the field of the standard.

The second factor: Since the dollar allowances for requirements depend not only on the items budgeted, but on their cost, the second major factor affecting average grant is the retail price level of the items included in the quantity-quality standards. As required by law, the department conducts annual price studies on a statewide basis and alters the dollar allowances for requirements accordingly.

A third factor affecting average grant is the composition of the caseload. Since the standards for requirements are designed to provide like allowances to persons of like sex, age, and circumstances, changes in the age and sex distributions of persons receiving assistance or changes in the number of persons per case, or in living arrangements, will affect average requirements and hence average grants.

Since, in the absence of a ratable reduction, need is determined by subtracting a recipient's income or resources, other than public assistance, from his requirements, the average income per case is the fourth main factor affecting average grant. If the proportion of the caseload that has little or no income, or income potential increases or decreases, average grant, barring offsetting factors, can also be expected to rise or fall.

Finally, the average grant in a program will depend on whether need is being met in full, or whether a ratable reduction is in effect.

For noncontinuing general assistance cases, budget items, other than food, are allowed only on an emergent basis. In foster care, the rates of payment are based on formulas jointly agreed upon by the State department of public assistance and private child care agencies.

As of June 1961, 46,800 cases were receiving OAA in the State of Washington, or 163 of every 1,000 aged persons in the State. Some 44 percent of these recipients, or approximately 20,500, were also receiving old-age survivors disability insurance. As of February 1960, 11 percent of the aged OASDI beneficiaries in the State of Washington were also receiving OAA. As of June 1961, the estimated recipient rates in the other Federal aid programs were: Aid to the blind, 39 cases per 100,000; aid to dependent children, 33 child recipients per 1,000 children 17 or under; disability assistance, 5 cases per thousand civilian population, 18 through 64. As of June 1, 21 percent of the aid-to-the-blind cases, 5 percent of the ADC cases, and 17 percent of the DA cases were also receiving OASDI.

Senator CHURCH. Thank you, Doctor. I want to say the detail you have given, with respect to the programs in effect in Washington, would certainly indicate that this State has made greater progress toward providing comprehensive programs than many other States in the country. I think this is very much to your credit and to the State of Washington.

Mr. HEGLAND. At the last session, the State legislature gave our department the responsibility for administering a surplus food program. Mr. J. T. Huff, administrator of that program, is here and will tell you about it. Mr. Huff.

STATEMENT OF J. T. HUFF, MEMBER OF THE PANEL, AND MANAGER, SURPLUS FOOD PROGRAM

Mr. HUFF. Thank you very much. Honorable Chairman, Congressman Horan, representatives of the minority, committee members, members of the panel, and ladies and gentlemen, for the first time in State of Washington history, the 1961 session of the legislature passed an act providing for statewide distribution of surplus Federal commodities. This act carried with it an appropriation of $2,492,000, with which to perform the actual act of distribution from the three warehouses located in eastern, central, and western Washington, to our 32 retail outlets located in 30 of the 39 counties of the State, and from these outlets to our customers. We also have satellite distribution from some of our stores into four more of the counties, giving us an almost saturation coverage of the entire State, as far as availability of food is concerned. We operate strictly on a customer clerk approach and give special consideration to our senior citizens.

Since the beginning of statewide distribution of surplus food commodities in June of this year, we have served approximately 106,963 monthly food issues to senior citizens assistance grant recipients, and 9,208 to persons 62 years of age and over, who are not recipients of assistance grants. The monthly average of the above is 22,940 old-age assistance, and 2,050 people 62 years or older. This has resulted in the issuance of 2,323,440 pounds of commodities, having an actual retail value of $929,376. Investigation has shown that the intrinsic value of the commodities distributed is not a true figure because of value of the food that is eliminated by the receipt of our commodities. This is along the line of pastry mixes, pancake flours, and items of similar type that the commodity recipient will not buy because of the fact that they are granted all-purpose flour from our stores. Our findings are that this increases the value of the products from $8 per person per month to $17.50 per person per month.

Senator CHURCH. Do you mean by that, that, if it were necessary for the recipient to buy, it would cost $17.50 a month to buy the mixes and the special prepared flours that they need and buy when they receive the surplus flour?

Mr. HUFF. Right, Senator. These items are eliminated from their purchasing by the fact that they do have other products which will take the place in a food value sense of these products that they normally would purchase, and this, of course, again, is not a true positive figure, but it is to the best of our investigation what we have found.

The commodities distributed are made as easily available to our senior citizens as possible, even to the extent of a very well organized statewide good neighbor program being conducted by many groups in various areas of the State. The groups assisting in this type of activity are furnishing transportation for people finding it difficult to get to the stores and, in some cases, actually include the delivery of the commodities to the recipients' homes. We are pursuing this phase of our program to the fullest extent of our ability and feel that at the present time such service is available to at least 95 percent of the people in this category who are eligible for surplus foods.

Another aid being offered to recipients is the statewide program of demonstration as to the use of some of the commodities, with which the people might not be familiar, particular emphasis being placed on powdered eggs, powdered milk, and cornmeal. This activity is being carried on by the home economics division of the various organizations, namely the county health offices, county agents under the supervision of Washington State Extension Service, power companies, and so forth. The reaction to the program by our elderly citizens has been almost completely one of gratitude. We think that this grant is filling a long time need for nutritional supplements to our low-income diets. Thank you very much, Mr. Chairman.

Senator CHURCH. I just want to add that it seems to me that, with the tremendous quantities of surplus foods that we have accumulated and are maintaining in warehouses at a tremendous cost to the taxpayer, which, as a matter of fact, when you figure interest and transportation, as well as warehouse charges, comes to nearly a billion dollars a year we are paying to store this food, and some of it is deteriorating, that no better use could be made of it than to supplement the food supply of people in need, and I want to congratulate Washington for the vigorous effort it is making to effect the distribution of this surplus food to needy families.

In my State, we are just now in a few of the northern counties getting started with this program, and it is a shame that we haven't had it going in all of our counties for a long, long while, but we are just now getting around to it, and I am glad to know that you have made better progress in the State of Washington on this score.

Mr. HEGLAND. Senator, the next person on our panel is Mrs. Vera McCord, who is the supervisor of nursing, and she represents the department of health and will speak on that program. Mrs. McCord.

STATEMENT OF MRS. VERA McCORD, MEMBER OF THE PANEL, AND COORDINATOR OF INSTITUTIONAL LICENSING PROGRAMS, STATE DEPARTMENT OF HEALTH

Mrs. MCCORD. Senator Church, Congressman Horan, members of the committee. I will confine my statement this morning to the activities of the State department of health as they concern services to the aging in this State.

The Washington State Department of Health is active in the promotion of services to the aged population. These services fall into two general classifications. First is the educational diagnostic evaluation, and, second, is preventive services to the aged. These services have been made possible by active participation of the Federal, State, and local agencies, in cooperation with voluntary agencies and community groups, such as the State department of public assistance, State institution of higher learning, the Governor's council for the aging population, the State medical, heart, and cancer association. Most activities are cosponsored and are agreed upon by the medical advisory committee, composed of medical specialists of the University of Washington, the State medical association and the State heart association, all of whom are closely integrated with the Postgraduate Committee of the University of Washington to insure coordination of all the activities.

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The activities of the State department of health in the heart program are quite extensive and include:

(1) Statewide symposiums for various aspects of heart disease physicians.

(2) Refresher courses to local medical societies, and some nursing associations, by a team of cardiologists and heart surgeons.

(3) Seminars on cardiovascular disabilities, which include public health departments, hospital, private duty nurses.

(4) Promotion of health education programs for personnel of hospitals, nursing homes, and groups dealing with health problems of the aging population.

(5) Cardiac diagnostic evaluation clinics, available to all State residents, operated by the University of Washington School of Medicine in King County, and the University of Washington hospitals. Their primary function is to determine the degree of cardiac disability and outline a program of management. Both are partially subsidized by the State department of health.

(6) As a followup to the White House Conference for the Aging, a nutritional consultant has been assigned to the Nutrition Committee of Washington State Heart Association for the purpose of studying special nutrition needs for the aging, and is available to local health departments and to community programs.

(7) The State department of health contributes toward the operation of the work classification and vocational placement clinic conducted by the State heart association. Nursing followup is planned for persons served by the program.

The department takes an active part in promoting the rehabilitation facilities in the State for all cardiac patients that come to their attention.

(8) A film entitled, "Prevention From the Disability of Stroke," based on the publication, "Strike Back at Strokes," with which many of you are acquainted, has been produced by the department. This has had wide circulation to the local health departments and many copies have been sold to other State agencies.

Another important program is the cancer control program which is carried through the State department of health. The State department not only contributed to this program but cosponsored statewide annual symposiums for physicians which are held at the University of Washington. We plan to cosponsor, with the State medical and cancer associations, such refresher courses or seminars on various aspects of cancer for local medical societies to be conducted by teams of physicians knowledgeable in this field. The department has developed and carries out an orientation program for State and local health departments' personnel through consultation and instruction to public health nurses.

A study is being made and carried out in King County for the detection and treatment of cervical cancer from Federal cancer control funds. Cancer funds have been made available through the State department of health to maintain personnel for tumor registry at the tumor clinic in King County Hospital, which has been approved by the American College of Surgeons.

The department, in cooperation with the State medical and cancer associations, conducted a statewide conference in 1961 to explore the

desirability and feasibility of establishing a Cancer Coordinating Commission for the State of Washington. Special funds to finance this conference were made available from the Federal cancer control program.

The State department is also responsible and has been designated by law as the agency responsible for licensing nursing homes, boarding homes, hospitals, and for giving health approval for the licensing of child-care institutions. The nursing home licensing law, which was passed in 1951, sets forth two purposes. First to provide for the development, the establishment and enforcement of standards for maintenance and operation of nursing homes, which will promote safe and adequate care for patients. The second purpose provides for the improvement of nursing home practices by educational methods so that such practices will exceed the minimums that are required by law and as set forth in our original standards.

I would like to say a word about our rehabilitation education service project that is being conducted in the State of Washington, which comes under our second purpose of educational programs. Beginning in January 1959 the Office of Vocational Rehabilitation made available funds for the State of Washington to conduct a 3-year demonstration and research project for the rehabilitation of chronically ill or disabled patients in nursing homes.

This project was sponsored by three State agencies, the State department of public assistance, the State department of health, and vocational rehabilitation, with the administration of this project delegated to the State department of health. The staff includes a coordinator, two clerical personnel, and a multiple disciplinary team consisting of three nurses, an occupational therapist, physical therapist, vocational counselor, and social workers, serving full time. Serving as consultant to the project on a part-time basis are physiatrists, psychiatrists, hearing aid consultants, speech therapists, project design consultant, and other such specialists as are needed in teaching patient care.

The project was designed with three objectives in mind. The first was to develop within nursing homes and nursing home units of general hospitals an organized program of rehabilitation service, to determine whether a larger number of chronically ill and elderly persons in such facilities could be helped to achieve a greater degree of independence. The second purpose was to develop demonstration and teaching materials to facilitate the expansion of this type of a program into other geographical areas of the State and to other nursing homes. The third and last objective of the project is to evaluate the effectiveness of this program. This is strictly a teaching program for nursing personnel, conducted by members of the project staff and carried out in nursing homes at the request of the nursing home administrators. It consists of a series of classes and demonstrations of various aspects of patient care. In conjunction with the formal presentation, members of the teaching staff work with nursing personnel in the actual care of patients. At the same time, they serve as consultants to the nursing home on nursing practices and assist nursing home administrators on planning construction of new facilities.

A project is being conducted in King County at this time with Federal funds allocated through the State department of health. This is

carried out by the local health department by trained and experienced nurses who go into the nursing homes and teach nursing home staffs how to apply rehabilitation techniques in carrying out patient care and at the same time to understand the value of the licensing program. The health department is interested in preventive services to all aged, while the State department of public assistance carries responsibility for medical care for the indigent aged.

In connection with voluntary professional agencies, the associations have been directing their attention toward establishing facilities for preventive services. With the financial participation of the State department of health by the use of Federal funds, the Kiwanis Club and Council for the Aging sponsor the operation of the Talmadge Hamilton House, a facility established to provide an activity and educational program for the well aged. Many persons have participated in the daily activity, craft, and educational programs.

A similar project is being planned for an area of low-income families within and adjacent to a public housing project. This project, too, is sponsored by the Kiwanis Club and Council for the Aging.

The State of Washington has felt concern about coordinating the activities that are being carried out for the aged. In 1958, the Governor organized an interagency committee, the purpose of which is to make efficient use of the agency resources and related programs, and to improve and strengthen services to people in the area of health, education, and welfare, and to reduce expenses to the taxpayer. Further steps have been taken to coordinate studies and services to various communities in the State. At a recent meeting of State voluntary agencies called to consider community service in relation to Public Law 395, it was recommended and agreed that a committee of representatives from Government and voluntary groups be established to consider statewide needs for service and research in the field of chronic illness. The primary function of this committee would be to develop and maintain a statewide coordinated plan of community health servces to the chronically ill and aging. This committee will serve as a clearinghouse and at the same time insure that areas of need are considered and served. Thank you.

Senator CHURCH. Thank you very much, Mrs. McCord. I think that I might state that we have, owing to the large number of witnesses that want to be heard and the fact that I am told that we must clear the hall by 4 o'clock this afternoon, since the hotel has made some commitment thereafter, that it might be well for those on the panel, who have prepared statements still to give, to present the full statement for the record, and to summarize orally in the interest of saving time.

(The prepared statement of Mrs. McCord follows:)

PREPARED STATEMENT OF MRS. VERA H. MCCORD

FEDERAL-STATE ACTIVITIES IN AGING, STATE OF WASHINGTON

The Washington State Department of Health is active in the promotion of services to the aging population. These services fall into two general classifications: (1) Educational, diagnostic, and evaluation, and (2) preventive services to aged. These services have been made possible by active participation of the Federal, State, and local agencies in cooperation with voluntary agencies and community groups, such as State department of public assistance, State institution of higher learning, Governor's Council for the Aging Population, the State

medical, heart, and cancer associations. Most activities are cosponsored and agreed upon by a medical advisory committee composed of medical specialists of the University of Washington, State medical association, and State heart association, all of whom are closely integrated with the postgraduate committee of the University of Washington to insure coordination of activities.

The activities of the State department of health in the heart program are quite extensive and include:

1. Statewide symposia on various aspects of heart disease for physicians.
2. Refresher courses to local medical societies and some nurses' associations by team cardiologists and heart surgeons.
3. Seminars on cardiovascular nursing programs which include public health, hospital, and private duty nurses.
4. Promotion of health education programs for personnel of hospitals, nursing homes, and groups dealing with health problems of the aged population.
5. Cardiac diagnostic and evaluation clinics available to all State residents, operated by the University of Washington School of Medicine at King County and University of Washington hospitals, are available to all State residents. Their primary function is to determine the degree of cardiac disability and outline appropriate management. Both are partially subsidized by the State department of health.
6. As a followup to the White House Conference for the Aging, a nutritional consultant has been assigned to the nutrition committee of Washington State Heart Association to study special nutritional needs of the aging and is available to local health departments and to community programs.
7. The department contributes toward the operation of a work classification and vocational placement of cardiacs, conducted by the State heart association. Nursing followup is planned. The department takes an active part in promoting rehabilitation facilities in the State for cardiac patients.
8. A film entitled "Prevention of Disability from Stroke," based on the publication "Strike Back at Stroke" has been produced by the department. It has had wide circulation through local health departments and many copies have been sold to other State agencies.

Cancer control program

1. The State Department of Health has contributed to the support of and cosponsored a statewide annual symposium for physicians and dentists held at the University of Washington.
2. Planned to cosponsor with the State medical and cancer associations refresher courses or seminars on various aspects of cancer for local medical societies by teams of physicians competent in this field.
3. Orientation of State and local health department personnel is carried out by the State department of health through consultation and instruction to public health nurses.
4. A study is being carried out in King County for detection and treatment of cervical cancer from Federal cancer control funds.
5. Cancer funds have been made available through State department of health to maintain personnel for the tumor registry at the tumor clinic at King County Hospital which has been approved by the American College of Surgeons.
6. The department, in cooperation with the State medical and cancer association, conducted a statewide conference in 1961 to explore the desirability and feasibility of establishing a cancer coordinating commission for the State of Washington. Special funds to finance this conference are made available from the Federal cancer control program.

Rehabilitation education service project

Beginning January 1, 1959, the Office of Vocational Rehabilitation made available Federal funds to the State of Washington to conduct a 3-year demonstration and research project for the rehabilitation of chronically ill or disabled patients in nursing homes. This project was sponsored by three State agencies: State department of public assistance, State department of health and vocational rehabilitation, with the administration of the program delegated to the State department of health. The staff includes a coordinator, two clerical personnel, and a multidiscipline team consisting of three nurses, occupational therapist, physical therapist, vocational counselor, and social worker serving full time. Serving as consultants on a part-time basis are physiatrists, psychiatrist, hearing aid consultant, speech therapist, project design consultant, and other such specialists as needed.

The project was designed with three objectives:

1. To develop within nursing homes and nursing home units of general hospitals an organized program of rehabilitation services to determine whether a larger number of chronically ill and elderly persons in such facilities can be helped to achieve a greater degree of independence.

2. To develop demonstration and teaching techniques and materials to facilitate expansion of this type of program into other geographical areas of the State.

3. To evaluate the effectiveness of the program.

This is a teaching program for nursing personnel conducted by members of the project staff, and carried out in nursing homes upon the request of nursing home administrators. It consists of a series of classes and demonstrations of various aspects of patient care. In conjunction with the formal presentation, members of the teaching staff work with nursing personnel in care of patients, instructing them in the practical application of what they were taught in class. At the same time they serve as consultants to the nursing home on nursing practices and advise with prospective nursing home administrators on planning construction for rehabilitation facilities. The success of this project is due to many factors, among which are the experience and qualifications of the project team, the acceptance of the nursing home personnel, the involvement of the local health and public assistance staffs, voluntary agencies, associations, and volunteers from the many community groups who give time and energy to service for patients in the demonstration home.

King County nursing home demonstration project

Federal funds allocated through the State department of health to King County Health Department to carry out a 3-year educational program in nursing homes beginning with emphasis on the law, standards, rules, and regulations in meeting requirements for licensing and an acceptable operation.

The staff of one supervising nurse and 3 public health nurses, supervised by the chief of Adult Health Division of King County Health Department, equally share responsibility for the 90 nursing homes in the county.

This program is showing outstanding results in improved patient care, and at the same time the nursing home personnel have come to understand the need for and value of licensing requirements.

Health of the aging

Medical care for the aged, who are recipients of public assistance, is provided by the State department of public assistance through the medical care program. But of major concern is the lack of preventive services for the aged which represents an urgent need of a large portion of the population.

The State and local governments in cooperation with voluntary and professional agencies and associations are directing their attention toward establishing facilities and developing preventive services for the group of aging population within specific geographical locations.

1. With financial participation of the State department of health by use of Federal funds, the Talmadge Hamilton House, a facility established for aging persons, has served the needs of many persons who have participated in its activity, craft, and educational program. As a contributor and cosponsor the Kiwanis Club and Council for Aging, together with regular volunteer service is successfully carrying out a preventive health program.

Because of the demand by the community, Hamilton House is engaged in an expansion program of services and physical facilities. This facility established in 1958 now has a waiting list. It has an average daily attendance of 83 persons; or nearly twice that of the first year. As of September 1, 1961, there were 440 members.

Hamilton House is attempting to meet the need for the well aged persons, many of whom are living on a low income or are retired and desire to make their contribution to society.

2. A second and similar project has been planned for an area of low income residents within and adjacent to a public housing project. This, too, is cosponsored by the Kiwanis Club and Council for Aging with housing facilities provided by the housing project administration. Federal funds have been requested to assist in staffing this program.

Health, education, and welfare programs interagency committee

Positive action has been taken in the State of Washington to coordinate activities of the State agencies. In 1958 the Governor organized an interagency committee on health, education, and welfare, which has three objectives.

1. To make efficient use of agency resources in related programs.
2. Improve and strengthen services to people in the area of health, education, and welfare.
3. Reduce expenses to the taxpayer.

It is the responsibility of this committee to determine what the basic role of each department will be in these related programs by determining what each department is best able to do by reason of philosophy, legal responsibility, organization, and resources. With this determination an attempt will be made to outline a well-rounded statewide program to meet the needs of the State in the areas related to health, education, and the general welfare of individuals and families in the community.

Coordinating committee

Further efforts are being directed to planning for health services to local communities.

At a recent meeting of State and voluntary agencies called to consider community services in relation to Public Law 87-395, it was recommended and agreed that a committee of representatives from governmental and voluntary groups be established to consider statewide needs for services and research in the field of chronic illness. The primary functions of this committee would be to develop and maintain a State coordinated plan of community health services to the chronically ill and aging population. This committee will serve as a clearinghouse and at the same time insure that areas of need are considered and served.

Senator CHURCH. Our next Panel member then is Mr. Ellwood Lease. Am I correct in that?

Mr. LEASE. Correct.

Senator CHURCH. Mr. Lease is Spokane manager of the State Employment Office.

STATEMENT OF C. ELLWOOD LEASE, MANAGER, SPOKANE OFFICE, WASHINGTON STATE EMPLOYMENT SECURITY DEPARTMENT

Mr. LEASE. Senator Church and Congressman Horan, Panel members, ladies, and gentlemen. As the Senator said, I am C. Ellwood Lease, manager of the Spokane local office of the Washington State Employment Security Department. As manager of one of the approximately 1,800 local office units in the Federal-State employment security system, my staff and I have been concerned with the employment problems of workers in the upper age groups for a number of years. It is generally accepted that unemployment in excess of 4 percent is cause for concern.

In the Spokane area, unemployment has been in excess of 4 percent for more than 2 years, ranging from a low of 5.2 percent to a high of 9.7 percent. The most recent economic forecasts for the Spokane area do not indicate a degree of expansion in our local economy which would provide job opportunities for any substantial number of job applicants in the upper age group.

For many years, our agency has recognized the age accented problems of the older jobseeker. In the performance of our functions in counseling and placement, our staff has been trained to take the steps necessary to insure, as far as possible, that the older jobseeker is given full consideration on the basis of his qualifications, and that he is assisted in making whatever changes and adjustments to the labor market as may be needed. While this service is extended to all of

our jobseekers, demands are greatest from the older jobseekers, youth, and other disadvantaged groups.

Certain recent actions, however, at the State and National levels hold promise of making some reductions in the problems of the older jobseeker. The area redevelopment program, with its emphasis on industrial development and revitalization, vocational training and retraining, should benefit the older jobseeker to the degree that it is successful.

The last session of the Washington State Legislature enacted a law prohibiting age discrimination in employment. The law prohibits discrimination against workers between the ages of 40 and 65. The operation of this law will insure that the older jobseeker is considered for hire, and that the reexamination of opinions, which this law will force, will result in better overall community attitudes toward the older jobseeker and to the process of aging itself. This is sincerely to be hoped for because we know that workers as young as 36 have run into the age barrier.

We believe that the recommendations developed by the Employment Security and Retirement Section of the White House Conference on Aging address themselves to the principal areas in which action is needed. As stated earlier, the Public Employment Service is concerned about the ability of the economy to furnish the necessary jobs to approach a minimum level of 96 percent total employment, particularly in view of the forecasted expansion of the labor force in the next 10 years. The entry of 26 million new young workers in this period will add to the employment problems of the upper age group. Retirements will provide many of the needed opportunities to absorb this group. Reluctance to retire, however, is based, in a large measure, on the inadequacy of retirement incomes. All encouragement, therefore, should be given for the improvement and expansion of private pension plans and for timely changes in the social security program as they are needed.

The White House Conference also called for the intensification of study and research to determine the impact of industrial change on the older worker. It is noted that the House Subcommittee on Unemployment and the Impact of Automation has published its report. There is the need, as indicated by both activities, to provide further support for the study and research necessary to identify the problem, take corrective action, and plan for needs of the future.

The question of unemployment of older jobseekers is an inseparable part of the total unemployment problem. We would discourage the belief that long-range solutions to the problems of the older jobseeker could be found outside the context of need for overall economic improvement in terms of available jobs.

Senator CHURCH. Mr. Lease, I think one of the things that has come very often to the attention of this committee is the problem of providing adequate job opportunities for older people, and the need for extending our efforts at the State, local, and National levels to find ways to keep older people profitably employed, but when you said that you in your experience had encountered problems of getting employment for people as young as 36 years of age, that brings it very, very close to home because I just turned 37.

Mr. LEASE. You're lucky.

Senator CHURCH. I think that this is a problem that all of us have to be mindful of. Thank you very much, Mr. Lease. Our next witness on the Panel is Mr. Charles Ross, Executive Director of the Seattle Housing Authority.

STATEMENT OF CHARLES ROSS, EXECUTIVE DIRECTOR, SEATTLE HOUSING AUTHORITY

Mr. Ross. Senator Church, Congressman Horan, Panel members, ladies and gentlemen. I had prepared a speech, but, at the Senator's request and in the interest of brevity, I will make a very brief summary of the remarks I had to make to you and to the committee this morning.

In the State of Washington, there are 17 separate housing authorities. These are so located that 15 counties are represented in programs taking advantage of the opportunities to provide public housing, not only for the low-income families, but, as affecting the aged, most particularly the elderly with low income. This means that less than half of the counties in the State have geared themselves to meet these needs. These 17 housing authorities have a total program of some 8,000 units or apartments. On the basis of the proportion of apartments that we in Seattle are using for the elderly, we can assume that there are some 2,200 elderly families in the State being housed in public housing. At the moment, there are approximately 500 additional units for the elderly in development stage. So that we have now somewhere between 2,700 and 2,800 housing units for elderly low income families, and we can reasonably assume that there is probably a demand or need for such units on the part of some 56,000.

What is the conclusion that we can make? The first one, of course, is that the State, as a whole, is not geared for meeting the needs of the elderly. I do not believe, however, that additional legislation is needed in the State. I think it is a matter of communication. We do have in the State a very fine department of commerce and economic development, and I suggest there is a need for a department of housing development, which will coordinate all the tools and make effective all the tools that are presently available to take care of the housing needs of the elderly.

I am speaking here not necessarily of only the elderly in the low-income level, but of the ones in the next income level and even possibly in the higher income level.

Utilizing the tools of the FHA's (the Federal Housing Administration's) insurance and loan program, public housing, urban renewal, community facilities, among others, is suggested. I am mindful that we do have a very excellent Governor's Council on Aging, about which you will hear further in a moment, which is doing a splendid job in coordinating the facilities that exist, but I believe that we need to pay more particular attention to the housing needs of the very low income elderly and of the group whose income is just too high for public housing, and not high enough for the retirement homes which are being built and sponsored by labor unions, by church organizations, and other nonprofit organizations.

Senator CHURCH. Thank you very much, Mr. Ross. I hope that the changes that the Congress made recently in the FHA program

will prove helpful to expedite housing for the elderly. This has been, I think, a neglected thing.

Mr. Ross. Maybe I missed the mark in making my point, or I didn't bring it out sufficiently. My thought is that there is a lack here of facilities for taking advantage of those things.

(The prepared statement of Mr. Ross follows:)

PREPARED STATEMENT OF CHARLES W. ROSS, EXECUTIVE DIRECTOR, SEATTLE HOUSING AUTHORITY

PUBLIC HOUSING FOR THE AGING IN WASHINGTON AS IT RELATES TO FEDERAL-STATE ACTIVITIES

Public housing programs in the State of Washington are limited to the housing provided by 17 local housing authorities and are related solely to the needs of the particular areas in which these 17 authorities exist.

Eleven of these 17 local authorities are city, or town, housing authorities, and only 6 are county housing authorities. Out of the 17, 3—the Seattle Housing Authority, the Renton Housing Authority, and the King County Housing Authority—are located in the same county. Thus, out of 39 counties in the State, only 15 have some kind of a public housing program in some portion of the county area.

There is no State housing authority, or State housing program, commission, department, or activity of any kind. Thus the local housing authorities, where they exist, are concerned exclusively with programs made possible under aids provided by Federal law.

In a State which has a total population of 2,853,214, including 279,615 elderly citizens aged 65 or over, these 17 local housing authorities operate a combined program of some 8,000 units to meet the needs of all low-income families, including the elderly. On the drawing boards, or in development, are 827 additional units, including some 500 units which will be especially designed as housing for the elderly. Seattle's proposed high-rise apartment for elderly persons of low-income accounts for 300 of these 500 units, with most of the other 200 in the nearby communities of Tacoma, Renton, and King County.

While public housing specifically designed for the aging is thus practically nonexistent in the State of Washington at the present time, it should be recognized that all local housing authorities have been housing elderly people for a long time, and especially so since August 1956, when single elderly persons became eligible under provisions of Federal law. In Seattle, with a total program of 3,400 units as of last September 30, we were housing 931 elderly families consisting of 1 or 2 persons. These elderly families represented 28.5 percent of all our families.

If all the 8,000 public housing units in the State are housing the same proportion of elderly families as Seattle, then at best we are now housing in this State only some 2,280 elderly families in public housing. This out of some 279,000 elderly persons, one-fifth of whom, or some 56,000, we may safely assume have incomes of less than $1,000 annually.

From the foregoing, several conclusions may be drawn:

1. The State as a whole is not geared to meet the housing needs of those aging whose incomes are so limited they must look to public housing, because most communities, including the State's third largest city, do not even have the machinery for initiating public housing or taking advantage of Federal aids which are available in this field.

2. A number of communities, mostly in the heavily populated northwestern section of the State, are alert to the need and are making plans to meet a conservative portion of it.

3. Even if our entire public housing program in the State were to be diverted to meeting the housing needs of low-income elderly persons who are physically able to maintain themselves in independent households, it would be woefully inadequate to meet the needs which can be safely projected over the next 10 to 20 years.

How can we get more realistic and effective action on a statewide basis in this field? Before suggesting an answer, let me comment on another facet of the same problem: housing for the well, elderly person of limited income. Not all such persons have incomes low enough to make them eligible for public hous-

ing; nor do they have incomes high enough to afford a luxury retirement home apartment, or to otherwise buy or rent adequate housing on the private market. Under our Federal laws, we now have aids available where, for example, nonprofit organizations can secure low 3⅛ percent loans to provide moderate cost housing for this inbetween group. But who is to stimulate the formation of such groups where they are needed? And how is the retired person, interested in housing of this type to find out where it is being built, or where it is available?

In the field of Federal-State-local activities, the problem in the State of Washington, it seems to me, is not so much a problem of legislation, as a problem of communication. There are many aids available, not only in the field of public housing, but private housing. But who is to stimulate the local community which does not recognize the need, or its responsibility, in its own community? Who is to stimulate the builder, or the nonprofit citizens group and awaken them to the opportunities already written into the law? Who is to assess what is needed and where in the State, and then take appropriate steps to encourage action?

In meeting the housing needs of the well elderly, whether by public housing or private housing, it seems to me that in this State the gap is too big between Federal law and local community action. I would like to suggest that perhaps the State has a role, and that role need not necessarily be one of a State housing authority to initiate public housing on its own, such as there exist in several States. That role can well be one of communication, stimulation, and coordination.

In this State we have a department of commerce and economic development into which, quite wisely, much time, money, and effort is being put to open up opportunities for business and industrial development, and to encourage business and industry to invest its money here. Why not a department of housing development to provide the mechanics for putting to effective use all the housing tools now available, not only public housing, but the tools provided by FHA, urban renewal, community facilities, etc.?

The State, aware of its growing elderly population, has already taken an important step in this direction through the very effective work of the Governor's Council on aging. The council has undertaken to coordinate all the facilities and services in the State available to the aging and to insure their use. It is doing an excellent job. But perhaps, in this matter of housing, we need to go further and develop a program which will help shape the supply, kind, and location of our housing for the well elderly in terms of the tools available, the needs we know exist today, and the ones which we can reasonably prophesy will exist tomorrow.

Senator CHURCH. Yes, I understand that. Thank you very much. Now, our next witness on the panel had been Mr. Bert Oliver, assistant State superintendent, director of vocational rehabilitation. I understand that Mr. Oliver is not here, but that Dr. Hamilton is here to replace him.

STATEMENT OF DR. ROSS E. HAMILTON, DIRECTOR, EXTENDED SERVICES PROGRAM, DIVISION OF VOCATIONAL REHABILITATION, STATE BOARD FOR VOCATIONAL EDUCATION

Dr. HAMILTON. Senator Church, Congressman Horan, ladies and gentlemen. Your staff, Senator Church, in getting ready for this meeting, apprised Mr. Oliver of the situation that has now developed, and, with your permission, I would like to say that the statement I have prepared is very brief, and it emphasizes only one point. I think some of the remarks already made are germane to what I have to say. I have entitled this brief presentation, "Rehabilitation to Promote the General Welfare With Special Reference to the Aged and Aging."

It is an honor to be invited to present to the committee a statement relating to the role of rehabilitation for the aged and aging. As director of the extended services program, I represent the division of

vocational rehabilitation, an agency of the State board of vocational education in the State of Washington. I speak on behalf of Mr. E. M. Oliver, as the Senator said, who is the assistant superintendent of vocational rehabilitation in charge of the division.

It is appropriate for me to recognize that the division of vocational rehabilitation is the creature of the joint acts of the Legislature of the State of Washington and the Congress of the United States. The funds which are expended by the division in the rehabilitation of handicapped persons come from the appropriations of these two legislative bodies. The committee is obviously interested in what rehabilitation services can now be rendered to the aged or aging under existing Federal and State laws and within currnt appropriations. This interest must also extend to a consideration of the need for further changes in law or appropriations to best meet the needs of each senior citizen and contribute to our national economic and social well-being.

The changes in law relating to rehabilitation services in the State of Washington will be of special interest to the members of the committee and to Congress. These changes have a direct bearing on rehabilitation services for the aged and aging.

Allow me to review briefly the basic changes which have been made since the first Federal law relating to rehabilitation services for civilians.

Congress took a brave step, a very brave new step, some 40 years ago when it passed the Vocational Rehabilitation Act of 1920, a law which promoted a program of services to be provided jointly by the Federal Government and the several States and territories of the Union for vocational rehabilitation of persons disabled in industry and otherwise. It was argued then that it would be good business to rehabilitate physically disabled persons back to self-support.

As the number of physically disabled persons rehabilitated back to self-support increased, new questions were raised by groups of citizens. First, these people were asking, On what basis are these fine productive services justified for the disabled who can be returned to work and denied to those who previously had never been employed? In other words, why not use the same services to habilitate as well as to rehabilitate? Second, the same people were asking, On what basis do we justify rehabilitative services for the physically disabled and deny these services to the mentally disabled?

Some of us can remember when these questions were being asked. We can remember the inquiries by legislative committees and lay leaders. We can remember, too, that these legislative committees and lay leaders saw no valid justification for denying these services to the mentally disabled or other disabled who might profit from them. Congress and the legislatures of the several States and territories thought it would be good business to assist all mentally and physically disabled, and the laws were changed to make this possible.

You are familiar, I am sure, Senator Church, with the changes. At the time of these changes in the law, it became apparent that there was need for the philosophy of rehabilitation to spread beyond the agencies assigned specific responsibility for vocational rehabilitation services. The original Federal Vocational Rehabilitation Act of 1920 provided for working agreements with other agencies rendering other social benefits to disabled persons. This was good, but beyond

these agreements, there was great need for the orientation of professional persons toward a strong supporting attitude in the philosophy of rehabilitation.

The Division of Vocational Rehabilitation in the State of Washington can report that its efforts to spread this philosophy throughout the State has resulted in a steady and constructive expansion of vocational rehabilitation services. Vocational rehabilitation services to the mentally and physically disabled have proved to be good business. When the cost of the services is judged against earnings produced and dependency eliminated, it is very obvious that rehabilitation is good business.

The fact that rehabilitation has proved to be good business has been of great interest to the Legislature of the State of Washington. The cost of dependency in the State has become so great that the legislature has seen fit to authorize vocational rehabilitation services even to nondisabled recipients of public assistance.

Mr. Chairman and members of the committee, the State of Washington receives no Federal support for this phase of its vocational rehabilitation program. With sincerity and humility, I would recommend that this committee might well ask, By what valid justification can the Congress of the United States extend vocational rehabilitation services to the mentally and physically disabled citizens and not to the nondisabled citizens when both are in need?

At this point, I should report that some aged and aging citizens are now receiving the benefits of the Federal-State vocational rehabilitation program for the disabled, and some are also receiving the benefits of the State of Washington program for the nondisabled public assistance recipient, under a joint arrangement with the public assistance department, which Mr. Hegland heads. Fifteen of the workshops in the State are now extending work opportunities to aged persons 60 years of age or more. In these programs, senior citizens are able to augment retirement benefits, personal savings, and other limited income. The result is that the dependency is reduced, usefulness achieved, and happiness produced. Other older citizens, through the rehabilitation services, have been assisted into new jobs compatible with their abilities to produce.

The problems of dependency continue to be heavy in the State of Washington. The pressure for more services for the mentally retarded, the disabled, the aged, and other dependent persons have reached a proportion where the legislature found it necessary to make some decisions. One decision has resulted in a basic and significant change in the laws as related to vocational rehabilitation. It is a change that has had a far-reaching and beneficial effect on the division's services to the aged and aging.

In 1957, the State authorized the division of vocational rehabilitation to render rehabilitation services to persons lacking social competence or mobility, to enable them to obtain or maintain the maximum degree of self-support and/or self-care. Mr. Chairman, these changes in the laws of the State of Washington have embraced premises not yet incorporated as a part of the Federal laws relating to vocational rehabilitation.

Already, the experience of the division had demonstrated the feasibility of such law. Assuming Congress is interested in the economic

and social well-being of our Nation, as well as the economic and social well-being of our aging and aged citizens, it would be appropriate for me to suggest that similar changes in the premises underlying Federal laws relating to rehabilitation would also be good business.

For the aging worker, whose occupational skills become obsolete, or for the aging worker whose productivity becomes limited because of aging, we are now rendering rehabilitative assistance with good results. Under existing Federal law, workers in either category cannot be helped until they have a physical or mental disability. In other words, if a person suffers a stroke, one condition of eligibility under Federal law for service is met. If a person becomes anxious, and anxiety leads to mental illness, again one condition is met. Under the laws of the State of Washington relating to rehabilitation, we no longer have to wait for a mental or physical disability to appear. As a result, the cost of dependency can be prevented or substantially reduced.

In the 87th Congress, the Senate had under consideration S. 1991, the Manpower Development and Training Act of 1961. Your deliberations resulted in all of the original bill, following the enacting clause, being struck. The Senate made major amendments to this manpower bill before the bill was sent to the House of Representatives, and, of course, you realize that's where it is. In view of the experience in the State of Washington under the new law relating to vocational rehabilitation, the Senate may well wish to reconsider its action on S. 1991 and include the services of rehabilitation in this manpower bill.

Recognizing the increased incidence of physical, mental, and social problems of the aging worker, and the successful experience of rehabilitation, it is safe to say that it would be good business indeed. Another feature of the Washington law eliminates the condition of feasibility for vocational placement as a condition for eligibility for rehabilitation. This condition is now reclassified as a desirable objective when applicable. As a result, plans for services can now be based on feasibility for, first, the reduction of their dependency; second, the elimination of dependency; and, third, the prevention of dependency.

The skills and knowledge of the rehabilitation process are now being used in two ways: (1) To improve the self-care ability of persons and (2) to adapt the environment (persons to things) in order to minimize the dependency of the person. As a result of this change, the division is demonstrating that rehabilitation can be effectively used for the aged and the aging to prevent premature dependency and to keep dependency at a minimum.

Preparatory to this statement, I examined many files of aging and aged persons served under this new rehabilitation law. It is possible to quote many cases showing the economic gains.

I would conclude my remarks by quoting from just one letter that stresses the human values involved. All I have to tell you is that age and aging plus technological change caught up with this single woman, and, alone and without the help of existing community services, she could not make a satisfactory adjustment. I would also insert, which I have not done in my prepared material, that our agency worked with her and many of the other agencies involved are represented on

this panel today. This would simply add to what Senator Church implied earlier about the matter of coordinated effort. Through rehabilitation services, this woman was helped out of a mental hospital and back to work.

This is what she said in the final part of her letter:

> Naturally, I often think of my hopeless years in the hospital and earlier in my life when one of my chief difficulties was the lack of opportunity to demonstrate my ability to think and work. It is for this reason that I know that the efforts of vocational rehabilitation are exceedingly important to many patients like myself. Although we may be technically able to handle jobs like the one I now have, it is very unlikely that we would have a chance to do it without first having the opportunity to go to a good college or training school and prove our sincerity. If you can make any use of my experience in order to help others in the same position, please do so. Naturally, the moral support of your teachers and of your department has played a large part in repairing the damage done by years of social disapproval. Please accept my thanks for all of us.

Mr. Chairman, rehabilitation is one of the many community services which can be put to work to serve the aging and the aged. In addition to S. 1991, 87th Congress, you may wish also to reexamine the several "independent living" bills under consideration in the last few sessions. Comparison of these bills with the laws of the State of Washington relating to rehabilitation could, I believe, provide very helpful ideas in the further development and improvement of services for aging and aged persons.

In the few minutes available to me, it is possible to make only a few references to some highlights. I shall be happy to answer any questions anyone may have. Thank you.

(Additional documents submitted by Dr. Hamilton appear in the appendix on p. 1083.)

Senator CHURCH. Thank you very much, Dr. Hamilton. I think you have laid stress upon a very important aspect of the general program for the aging, and that is the rehabilitation phase. This is in accord with the old maxim, "An ounce of prevention is worth a pound of cure," and this is a most important part of any intelligent program.

Now, our next witness on the panel is Miss Margaret Whyte, who is the executive secretary of the Governor's Council on Aging.

STATEMENT OF MISS MARGARET WHYTE, EXECUTIVE SECRETARY, GOVERNOR'S COUNCIL ON AGING

Miss WHYTE. Senator Church, Congressman Horan, committee, panel members, and friends, and I do say friends because I see so many faces of people with whom I have worked throughout the State, and it is a real pleasure to see you here. I want to thank you, Senator, on behalf of our council chairman, Dr. K. K. Sherwood, of Seattle, who could not be with us today, and for other members of the Governor's Council on Aging, who are not here, for calling this hearing here in the State of Washington.

We find that one of the greatest needs is to bring people together and have an opportunity to talk together and realize that it isn't just the older people that need to be concerned with aging, but that it is all of us. In the State of Washington, the Governor's Council on Aging was one of the first 12 in the Nation established back in 1952 without statutory authority. Then Governor Rosellini again in 1958

established the Council on Aging, realizing that it was necessary that we have such a body, and, without statutory authority, that it should be established under executive order. In both instances, the department of public assistance was asked to staff the council and be responsible for the administrative roll. However, the council itself is entirely a citizen body. At the present time, our council consists of 58 citizen members from all parts of the State, each of them serving in a voluntary capacity and appointed by the Governor for a 2-year term.

Beginning as of July of 1961, we also have an interdepartmental committee on aging. This is composed of the members, the director, or a representative of nine of the State departments, including those here, as well as some others. The interdepartmental committee has the responsibility of promoting and coordinating departmental services relating to the aging, while the council is responsible for the general citizen role and promotion of needed services and activities throughout the State. The work of the two groups is very closely coordinated with myself as consultant on aging for the department of public assistance, being assigned the responsibility as executive secretary of the two bodies.

The objective of the council and the interdepartmental committee is to promote a more effective philosophy toward the process of aging, to encourage the expansion or creation of facilities in an environment within the family and the community which will provide opportunity through which each aging person can meet his needs, and to stimulate those persons in middle life to develop positive planning which will give purpose to their later years. We feel the latter is extremely important because those of us in our middle years must be thinking about this.

The council does not operate programs, nor does it actively engage in the promotion of legislation, either State or Federal. However, we do attempt to keep members and other citizens informed on proposed legislation affecting the aging and the aged, and encourage individual decision and contact with appropriate lawmakers. The studies of the council have been directed, first, to the present generation of senior citizens, which in this State has increased from 211,000 in 1950 to approximately 280,000 today.

This means that 9.8 percent of our population are in the 65-and-over age group, as compared to 8.8 percent in 1950, and of our adult population, we now find that 16.2 percent of our adult population are 65 years of age and over. We are extremely concerned with this group, but we are also conscious of the fact that we can't be working in behalf of the older people without also considering those in the middle years. So, our work also includes that of preparing people for retirement and of involving people in middle years in the total program on aging.

The work of the council has been carried on through four major activities. I will give you these very briefly and not go into all that is actually happening; my written report on the latter can be made a part of the record. We made a continuing study of the needs of our aging and the resources available for meeting these needs. We have an extensive educational program to disseminate the information gathered in these studies. We have a statewide information and referral service, and probably our greatest service is that of consultation

to aid local communities, State and local organizations in expansion of existing programs, and the development of new programs, and here we would certainly agree with Mr. Ross on the importance of a housing department within the State to expand that program.

In our concern for the people, the older people, and individual people in middle years, we have found that it is extremely important that there be a local committee on aging comparable to the State council on aging, and to the Federal Committee on Aging. It has been demonstrated that the needs of individual persons are being met much more effectively in those 10 communities where there is a central committee on aging in the community, to coordinate resources that are available, and to stimulate further service as needed. This is one of the major goals of the council for the coming year.

In closing, I want to particularly thank or make special mention of the work of the special staff on aging of the Department of Health, Education, and Welfare, and their regional staff. This has been particularly helpful to us here in the State of Washington. We certainly hope that Congress does see fit to continue this Special Committee on Aging with adequate appropriations for it, and that the role of this committee will be increased to provide a more centralized referral source and technical information on all Federal services for the help of the States.

One other recommendation that I would particularly like to make is that, in line with one made at the White House Conference on Aging, the Congress consider the amendment to the old-age-assistance title of the Social Security Act to permit Federal matching of administrative costs of State personnel serving older people who are not applicants for or recipients of public assistance. This would enable many persons with the aid of the social services to eliminate their potential need for public assistance grants in the future and could provide a central source of leadership for services on aging where needed in each county. Thank you.

Senator CHURCH. Thank you very much, Miss Whyte. Let me say that, in connection with your line of recommendations, the Congress did approve a supplemental appropriation to the Department of Health, Education, and Welfare which will double the special staff on the aging, and we hope that that will be helpful.

(The prepared statement of Miss Whyte follows:)

PREPARED STATEMENT OF MARGARET WHYTE, EXECUTIVE SECRETARY, GOVERNOR'S COUNCIL ON AGING, AND INTERDEPARTMENTAL COMMITTEE ON AGING

Senator Church, I am very grateful for the opportunity to appear here today to tell something of the work of the Governor's council on aging in the State of Washington. In my position as consultant on aging for the State department of public assistance, I was assigned to the council on aging as executive secretary shortly after it was established by executive authority in 1952. I am also now serving as the executive secretary for the newly established interdepartmental committee on aging. Others are here today to report on the assistance programs of the department of public assistance, so I will confine my remarks to the work of the Governor's council on aging.

During the 8 years I have worked with the council, we have found that one of the greatest needs was that of education of the general public and the opportunity for people to discuss the situations which arise in the aging process, and methods for providing new opportunities for the later years of life. I want to thank you, in behalf of our council chairman, Dr. K. K. Sherwood, who could not be with us today, for other council members who are not here, and myself, for

calling this hearing and providing the opportunity for citizens of our State to discuss together, and with our national leaders, the problems facing society and its aging citizens and the solutions to alleviate some of these problems. We hope that this hearing will serve to broaden the concern and promote increased action here in the State of Washington, as well as to aid in the formation and development of Federal programs and services to meet the needs of the aging and aged, not as a segregated group, but as an integral part of our economic, social, and cultural society.

Fifty-eight citizen members from all parts of the State serve in a volunteer capacity as members of the Governor's council on aging, each appointed by Governor Rosellini for a 2-year term. In addition to the council, we now have an interdepartmental committee on aging which has only recently been organized. This committee, composed of the director or his representative from 9 State departments, has a parallel role to that of the council. Thus, the interdepartmental committee has the responsibility for promoting and coordinating departmental services related to the aging, while the council is responsible for general citizen action and promotion of needed services and activities throughout the State. The interdepartmental committee will also provide consultants for committees of the council which are working on assignments specifically related to a certain departmental program. Prior to the new fiscal year, departmental representatives were appointed to the council in an advisory capacity, without a separate interdepartmental committee. The work of the two bodies is now coordinated through the two chairmen and the representative of the department of public assistance who serves on the executive committee of the council and the executive secretary who serves in like capacity to both groups.

The objectives of the council are:

1. To promote a more effective philosophy toward the process of aging.
2. To encourage the expansion or creation of facilities and an environment within the family and the community which will provide opportunities through which each aging person can meet his needs.
3. To stimulate those persons in middle life to develop positive planning which will give purpose to their later years.

The council does not operate programs, nor does it actively engage in the promotion of legislation, either State or Federal. We do attempt to keep members and other citizens informed on proposed legislation affecting the aging and aged, and encourage individual decision and contact with appropriate lawmakers.

The studies and activities of the council have been directed first, to the present generation of senior citizens which has increased in this State from 211,000 in 1950 to approximately 280,000 today. When we look at these figures in relation to our total adult population, we find that 16.2 percent of our adult population is now 65 years of age or over, as compared to 13.6 percent in 1950, and of our total population, the persons 65 years and over make up 9.8 percent as compared to 8.8 percent in 1950.

We are very conscious of the fact that our concern and action on behalf of the aging cannot start or stop with those persons over 65, for what is done today in relation to our senior citizens is going to affect the future of all of us. We therefore believe that a portion of our work must be directed to those persons in their middle years, helping them realize the necessity for their involvement in services and planning with the present generation of senior citizens and in their own preparation for the extended years of life.

The work of the council has been carried on through four major activities: (1) a continuing study of the needs of our aging and the resources available for meeting these needs; (2) an extensive educational program to disseminate the information gathered; (3) a statewide information and referral service; and (4) consultation to aid local communities and State and local organization in the expansion of existing programs, or development of new programs.

Studies have been made by formal surveys, personal interviews, group discussions, demonstrations, review of the findings of other States, and material provided by our Federal Government. The work of the special staff on aging of the U.S. Department of Health, Education, and Welfare, as well as the findings of the Senate Subcommittee on Problems of the Aging and Aged, and the White House Conference on Aging have been very helpful in this study.

As a general educational media and method for reporting many of the findings of the council, we have sponsored two State conferences, eight regional conferences, and institutes on the specific subjects of health, recreation, and education, have assisted in eight local community forums and conferences on aging, and

provided speakers for many service clubs and community and State groups. The council has published directories of resources and services available to senior citizens throughout the State, and publishes a quarterly newsletter which is distributed to approximately 1,500 persons.

In its responsibility for the State's planning for the White House Conference on Aging, the council collected data, held conferences, and community meetings, and incorporated the findings in a report "Aging in the State of Washington." This is a valuable document for students and those organizations and persons working with the aging.

An inquiry and referral service is provided through the council office with all requests which come to any State agency regarding services on aging being directed here for proper clearance and reply. This eliminates much duplication of effort, but also requires extensive research to maintain a current record of available resources and services.

Consultation services are provided by council members, departmental representatives, or the executive secretary upon request to the council office. Through such service, the council has had a part in the development of demonstration programs, extension of the services of existing agencies to include opportunities for the aging and aged, and the establishment of new programs through which these people may find opportunities for needed activities and services. A guide to assist local communities in the establishment of a committee on aging and a handbook to assist in organizing various services and activities has been prepared by the council, and has had wide distribution.

I submit a report of the many services and activities developed in communities throughout the State through direct or indirect consultation from the council for your records, but will not take time to report them verbally.

Although much has been accomplished and many more opportunities for fuller living are now available to our aging and aged citizens than 10 years ago, we realize there is still much to be accomplished. Experience has demonstrated that the needs of individual older persons are being met most effectively in those communities where there is a central committee on aging to serve in the community in a similar manner as that of the State council on aging in the State program; a committee of concerned individuals and agency representatives to study the needs of the aging and aged in the specific community to determine what services are available to meet these needs and actively promote the development of other needed programs and services. Such a committee can be most effective in integrating the aging members into community life if it serves as a central planning and coordinating committee and does not itself operate program, except possibly on a demonstration basis. We now have 10 of such community committees actively engaged in promoting a variety of needed services and developing a new philosophy toward the total process of aging. Six other local committees on aging are in existence, but in each instance these committees have developed one needed program in the community but have not studied other needs or promoted other services. In three communities, committees on aging have become inactive due to lack of leadership and funds for financing.

Recognizing the importance of local committees on aging, the priority goal for the Governor's council on aging for the coming year is to provide leadership and consultation to develop at least double the number of local committees on aging, and eventually have such a committee on aging in each county and large city. We also hope to provide consultation to existing committees where such is needed to strengthen their planning and community action. Where there is an existing community planning organization, the committee on aging should be established as part of a total community plan, but there are few of such community planning organizations in this State.

To realize our goal and still carry on the other work of the council calls for additional consultant service, guides for community surveys, and financial help to support such a community service. Therefore, we need funds which can be allocated to local communities, where requested, to help establish a sound planning committee to coordinate and plan for needed services within the community, and develop activities on a demonstration basis to determine usage and acceptance for community support. Such funds might come from foundation grants, but would be more dependable if allocated to communities on a matching basis from State or Federal appropriations.

Other assistance needed from the Federal Government is a central office with representatives in each regional office through which facts regarding all Federal

programs will be channeled and related to the central agency in the State. This office needs to provide speakers, promotional and general education material, and other technical aids to assist the States in their programs. In my opinion, such an office could be provided through the expansion of the special staff on aging already existing in the U.S. Department of Health, Education, and Welfare.

Other recommendations which the council might make regarding Federal support of specific programs will come from other speakers here today; however, I cannot close without urging that action be taken on the recommendation made at the White House Conference on Aging—to amend the old-age assistance titles of the Social Security Act to permit Federal matching of administrative costs of State personnel serving older people who are not applicants for or recipients of public assistance. This would enable many persons, with the aid of public social services, to eliminate their potential need for public assistance grants in the future, and could provide a central source of leadership for services on aging where needed in a county.

SUPPLEMENT

Programs developed by local committees and organizations as a direct or indirect result of consultation from the Governor's Council on Aging:

(1) Establishment of or progress in 16 local committees or councils on aging to plan for and coordinate local services and activities to meet the needs of the aging, with general community planning councils accepting greater responsibility to incorporate committees on aging as a part of their total community responsibility.

(2) Activity programs in local communities to utilize the time and talents of senior citizens and provide opportunities for association and participation in community life and among contemporaries. Such programs include 9 senior activity centers and 4 others in the planning, over 200 senior recreation and service organizations, 10 senior hobby shows, and several activity programs in nursing homes and retirement homes. City recreation is accepting greater responsibility for programing for the older adult as well as for other age groups, providing recreation personnel to staff senior club programs in community facilities.

(3) Adult education courses to help the senior citizen adjust to retirement living. These are given in five public schools and two junior colleges.

(4) Preretirement courses conducted in three large industries, in the Seattle Post Office, the University of Washington, and two public schools. Other courses are in the process of planning, and the Council on Aging for Seattle and King County has prepared a guide to assist sponsors in conducting a course.

(5) Four new church-operated retirement homes added to the existing homes brings the total retirement homes in the State to 39, with 2 more under construction at this time, and 5 in the planning stages. Two retirement communities are in the planning process at Tacoma and Lacey, in addition to the Ryderwood Retirement Village and a senior residence in a Seattle hotel.

(6) Additional units for the elderly in four public housing programs, and plans underway for a new 300-unit high-rise unit in Seattle public housing.

(7) One small "meals-on-wheels" program, and planning underway for expanded home service programs in several communities.

(8) Observance of October 1961 as Senior Citizens Month, with emphasis upon the contributions of our senior citizens. Over 45 communities participated with the State in this observance, and held special activities calling attention to and honoring the contributions of senior citizens.

Senator CHURCH. Now, our final member of the panel today is Rev. Theodore E. Dorpat, who is the chairman of the eastern regional committee of the Governor's council on aging. We are very happy to welcome you here this morning, Reverend.

STATEMENT OF REV. THEODORE E. DORPAT, CHAIRMAN, EASTERN REGIONAL COMMITTEE OF GOVERNOR'S COUNCIL ON AGING

Reverend DORPAT. Thank you, Senator Church, Congressman Horan, fellow panelists, neighbors and friends. I have submitted a written statement, and I hesitate to accept the suggestion of the chair-

man, the Honorable Senator, that I speak sort of off the cuff from that statement for brevity's sake because, being a professional, when you ask a preacher to do that, you are liable to get a longer rather than a shorter statement.

Senator CHURCH. It might not be shortened.

Reverend DORPAT. It might be lengthened, rather than shortened.

Senator CHURCH. Let me tell you, Reverend, the members of the U.S. Senate have the same occupational hazard.

Reverend DORPAT. In my written statement, I touched on three things because I think they are fundamental, and we need to foremost keep in mind the fundamentals. They have to be kept in mind so that we can recognize the needs and the problems and not go way off base in finding solutions to those needs and problems.

Out of the White House Conference has grown a wonderful bill of rights in brief statements. First, they express the rights of the senior citizens. Then someone got the idea: Why, that is only one side of it because, where there is a right, there is always a related and commensurate responsibility. So, a second listing of responsibilities followed. I will state them briefly and as speedily as I can: (1) The right to be useful; (2) the right to freedom from want in old age; (3) the right to a fair share of the community's recreational and medical resources; (4) the right to obtain decent housing suited to the needs of later years; (5) the right to moral and financial support of one's family so far as is consistent with the best interest of the family; (6) the right to live independently as one chooses; (7) the right to live and to die with dignity; (8) the right of access to all available knowledge on how to improve the later year of life.

Now, the commensurate obligations: (1) The obligation of each citizen to prepare himself to become and resolve to remain active, alert, capable, self-supporting, and useful, so long as health and circumstances permit; (2) the obligation to learn and apply sound principles of physical and mental health; (3) the obligation to seek and develop potential avenues of service after retirement; (4) the obligation to make available the benefits of his experience and knowledge; (5) the obligation to endeavor to make himself adaptable to the changes age will bring; (6) the obligation to attempt to maintain such relationships with family, neighbors, and friends as will make him a respected and valued counselor throughout his later years. To this list I would like the privilege of adding one more: The obligation to maintain a sense of humor all through life.

I would like to now bring the second point of my written report, and that is the area of concentric circles of responsibility. It was felt by all those who participated in and reported at the White House Conference, and we note it even in the areas where there is a cleavage of opinion when minority and majority reports were submitted, yet this basic principle carried through all, namely, that the first area of responsibility for the aging lies with the aging themselves, self-responsibility; second, the family, and that is right in keeping with our whole philosophy of life as American people.

The Ten Commandments are basic to our morals, and the very first one of the second table of the Ten Commandments, pertaining to the duties of man to man, touches on the family, "Honor thy father and thy mother that it may be well with thee and thou mayest live long

on the earth." We must not sidestep this secondary responsibility of the family. Third, the local community with all its developed and also undeveloped potential resources that can be brought into the picture, and, after those three have been applied and used and, let's say, exhausted, then the government, local, county, State, and Federal, and I, for one, and I think many others do view with alarm the tendency that we see in some circles today, of wanting to reverse those circles of responsibility. If we see any need, we want to jump down to Washington, D.C., and have Uncle Sam underwrite the whole thing. Well, he's too far away to even know what we're talking about in many instances.

Finally, a brief report, as chairman of the eastern regional committee of the Governor's council on aging, our State is a large State. It's a matter of wisdom that we have regional committees, and we have been offered to select, as regional groups, goals for the next 2 years, and the two goals that we, the eastern regional committee, have selected, first of all, is the goal of establishing a local committee, a community committee on aging for every community in the eastern part of our State, and the second goal is more adequate housing for elderly, including low rental units, boarding homes, nursing homes with rehabilitation facilities, and services, and special facilities for the care of the poorly oriented, and with that, I will conclude. Thank you very much.

(The report referred to above follows:)

SPOKANE, WASH., *November 16, 1961.*

SUBCOMMITTEE ON AGING OF THE U.S. SENATE,
Spokane, Wash.

GENTLEMEN: It is with deep appreciation of the privilege conferred upon me by your request to appear before this committee with a statement of my philosophy as to the needs and problems of our senior citizens. This philosophy is best expressed in the splendid senior citizens charter, developed in the planning for the White House Conference on Aging of last January. I herewith include a copy of this charter:

SENIOR CITIZENS CHARTER

Rights of senior citizens

Each of our senior citizens, regardless of race, color, or creed, is entitled to:

1. The right to be useful;
2. The right to freedom from want in old age;
3. The right to a fair share of the community's recreational and medical resources;
4. The right to obtain decent housing suited to needs of later years;
5. The right to moral and financial support of one's family so far as is consistent with the best interest of the family;
6. The right to live independently, as one chooses;
7. The right to live and to die with dignity; and
8. The right of access to all available knowledge on how to improve the later years of life.

Obligations of senior citizens

The aging, by availing themselves of educational opportunities, should endeavor to assume the following obligations to the best of their ability;

1. The obligation of each citizen to prepare himself to become and resolve to remain alive, alert, capable, self-supporting, and useful so long as health and circumstances permit;
2. The obligation to learn and apply sound principles of physical and mental health;
3. The obligation to seek and develop potential avenues of service after retirement;

4. The obligation to make available the benefits of his experience and knowledge;

5. The obligation to endeavor to make himself adaptable to the changes ages will bring; and

6. The obligations to attempt to maintain such relationships with family, neighbors, and friends as will make him a respected and valued counselor throughout his later years.

You will note that it consists of two parts; Namely, the rights and obligations of senior citizens. So often, there is a tendency of people to be deeply conscious of their rights and insisting on them but ignoring completely the complimentary obligations. We believe that the two are as closely related as the two sides of the same piece of paper. You simply can't have one without the other.

To round out our philosophy on the needs and problems of aging and their solution, may I add the quite universally accepted areas of responsibility pertaining to the aging: (1) The first responsibility of the aging lies with the aging themselves; (2) with their families—this is certainly implied in the Fourth Commandment of the Decalogue, "Honor thy father and thy mother that it may be well with thee and thou mayest live long on the earth"; (3) the church and other community resources; (4) the local government; (5) State government; (6) Federal Government.

It appears that, until now, this sequence of responsibility has been followed; however, we are somewhat concerned over tendencies to reverse this process of areas of responsibility by putting the Federal Government first and the individual himself and his self-responsibility last. To our mind, this could only lead to disaster.

In conclusion, we hope and pray that some new insights and some worthwhile plans will result from today's hearing by our U.S. Senate Subcommittee on Aging.

Respectfully yours,

T. E. DORPAT,
Hospital Chaplain, Chairman of Eastern Washington Regional Committee of Governor's Council on Aging.

Senator CHURCH. Thank you, Reverend, very much, and thanks to all the members of the panel here for your excellent presentation and, Mr. Hegland, to you for your contribution here this morning.

As I mentioned earlier, and as you, who were not here at the time, have no doubt had occasion to take note, Congressman Walter Horan is here this morning and he has joined me at the table, and I am very pleased to welcome him as a participant, and he would like to make his statement at this time. Congressman Horan.

STATEMENT OF HON. WALTER HORAN, U.S. REPRESENTATIVE FROM THE STATE OF WASHINGTON

Congressman HORAN. Senator Church and members of the committee, wherever they may be at this time, I am very happy to be here and to welcome, not only you, but everyone in this room to this hearing, being held here in the Fifth District, which I have had the honor now going on 20 years to represent in the Congress and the House of Representatives. I am particularly pleased because we here in the State of Washington are aware of the problems and we have been making progress in their solution, as Reverend Dorpat brought it out, in the successful operation of any program such as we here discuss today. There is no substitute for individual, local, and State responsibility. I am happy, Mr. Hegland, that we have had the report from you and your compatriots and the associated related agencies of the State of Washington.

I think your report was comprehensive, and I think it showed what the State of Washington is doing as a sovereign State aware of its

responsibilities to its citizens. I am gratified to notice the large turnout here today, and I believe that the crowd attests to the magnitude of the problems which will be discussed during this hearing. I am also happy, I might say, to see that we have a lot of young people here today, who are also interested in this problem, and you should be, because, as individuals, in the problems of the aging, there is again no substitute for individual responsibility in the solution of those problems.

I don't think any of us can or will deny that many problems do exist when it comes to providing for our Nation's elderly citizens. Over the years, the State and Federal Governments have formulated many programs designed to help provide for a dignified life for those who are in the sunset of their lives. Many of these programs are good. Some of them have been bad.

In our own State of Washington, the senior citizens have available to them many programs, as has been outlined to you, which will allow them to enjoy their declining years. For example, in the field of medical care, our State has made available a program almost identical to the so-called Kerr-Mills plan, which was enacted in the 86th Congress. The fundamentals of this program have been in operation for almost 10 years in our State and have the cooperation of the members of the medical fraternity and the senior citizens themselves. In some counties, may I add, the whole problem has been recognized, and solutions evolved over a decade or more.

Our people are traditionally self-reliant, as they are, I might add, Senator Church, in our neighboring State of Idaho. They enjoy a heritage from their parents, which makes them self-reliant, honest citizens. I believe it is our duty to help them to continue with this heritage, but we cannot do this by simply making them wards of the Government. Rather, I feel we should make more of an attempt to investigate the needs of our senior citizens, both on an individual and collective basis, to determine which of those are truly in need of help. These deserving needy folk should receive our first consideration.

Any program we consider, whether it be in the field of medical care, housing, nursing homes, or whatever, should be based, first of all, on need. This is the key to any successful program. I know that the folks who will appear before you today will all speak from the heart in presenting their views. This is important. It is necessary, according to our American way of life, that we do speak from the hearts when discussing problems involving our aged. They have provided us with the foundations upon which our Nation was built. Now, we must provide sound, constructive programs based on their needs to help them to spend their twilight years in a decent, dignified fashion.

Now, I cannot stress too much the alertness of our own folks here in the State of Washington to the problems of the aging and their solutions. As I have said, both the medical fraternity and the management facilities in this State have been working for solutions over a decade. The advent of the Kerr-Mills approach has made available the very keystone to their efforts and, now that promising beginnings are here, we are happy to have this hearing so that the constructive work can be recorded and we can move on to its improvement, wherever it is deficient. As for myself, you may be certain that I intend to study most carefully the reports resulting from these hearings, and

I am hopeful that sound, constructive legislation will result, which will meet the needs of our deserving senior citizens. You may count on me to do all that I can to help in this regard. Thank you, Mr. Chairman.

Senator CHURCH. Thank you, Congressman Horan. Our next witness is Rev. Erik Madsen of the Central Baptist Church.

STATEMENT OF REV. ERIK MADSEN, CENTRAL BAPTIST CHURCH

Reverend MADSEN. Senator Church, Congressman Horan, I appreciate this opportunity to share for just a few moments an experience which I have had. I am sure that all of us are aware that the many surveys which have been conducted all point to this general conclusion that life expectancy is increasing and that the big advances are in infancy and old age. This, while received joyfully by most of us, cannot be received without an awareness of some very realistic problems.

It is true that many church related persons feel a certain deep responsibility which is directly related to the Christian ethic of "Honor thy father and thy mother." The Apostle Paul goes even further by plainly stating:

> If anyone does not provide for his relatives, and especially his own family, he has disowned the faith and is worse than an unbeliever.

My own denomination at its last annual convention in June struggled with the awareness of some very realistic problems as it sought to arrive at a united witness regarding the endorsement of Federal medical aid to the needy aged. The feeling was strongly evidenced that the church ought to take care of its own folk, but we were quickly made aware of the problem though, for not all of our old folk are related, actively or passively, with any church group. This does not say that the church is not concerned with a person in need simply because he is a nonmember. The church is active in many ways seeking to reach and to do what it can in the face of an exploding population and a highly mobile society. We recognize that there are other problems involved.

Rising costs alone prohibit families, let alone churches, from rising magnanimously to the task with checkbook in hand. Let us take a case in point. I am the pastor of a small church of about 120 members. Our oldest member is 92 years of age.

Recently, I received an urgent call from his household relating that his wife, 83 years of age, had gone to the hospital for an emergency operation. Their income is derived from social security and from a small disability pension which he receives. He has hospitalization coverage; his wife, whom he married about 12 years ago, was not eligible because of her age. I found him extremely concerned and quite a bit upset, not only because of the traumatic experience of having his wife whisked away to a hospital, but also because the unpleasant tidings had reached his ears that doctors and hospitals could attach his income, clean out his small savings, and leave them destitute. He saw, as his only alternative, that of filing bankruptcy. "This is the first time in 92 years I have faced such a situation," he said. I think this points out some of the misinformation and the lack of information which many of our old folk confront. Thanks to Mr. Amborn of our social security department here in Spokane, I was able to set this man's mind at ease.

However, the bill is still a very real obstacle. This man has always earned his own way and is a respected citizen in his own community. By careful handling of his income and by falling back upon his small reserve, I am sure that he will be able to meet this present obligation, but what if it occurs again and again? I doubt seriously if our church could step in and pick up a $1,500 to $2,000 medical tab, and this man in point is only one of the many, many needy aged, who, because of peculiar circumstances, find themselves without the protection of insurance, welfare, reserve funds, or any other means of meeting a medical emergency when it arises.

The situation may not arise for this family again. On the other hand, it may arise tomorrow. What then? I would say further that I called on this man again last night, found that the wife is not feeling well from the operation and may have to return to the hospital again. So, their small reserve will quickly dwindle away.

I believe, and it is the feeling of our denomination, that the answer lies in a carefully thought out program of Federal assistance. Thank you.

Senator CHURCH. Thank you very much, Reverend. I appreciate your statement. I think that it would be well at this point to say that, since the enactment of the Kerr-Mills bill in the Congress last year, we do have an existing program of Federal assistance for meeting some of the medical needs of the elderly. One of the purposes of this committee is to ascertain the experience thus far that the States have had in this program and the extent to which this is or is not an adequate solution. The hearings that are being held throughout the country will be helpful in that connection.

Now, our next witness, and we have just a little time before noon, and I think, if you don't mind, we might move beyond the noon hour a little before we adjourn in order to accommodate a large number of witnesses before that 4 o'clock deadline I mentioned, and so I would like to hear from at least a couple more witnesses this morning before we adjourn for lunch, and the next one scheduled to appear is Robert P. Parker, M.D., who is the chairman of the public relations committee of the Spokane County Medical Society. We are very happy, doctor, to welcome you here this morning.

STATEMENT OF DR. ROBERT P. PARKER, CHAIRMAN, PUBLIC RELATIONS COMMITTEE, SPOKANE COUNTY MEDICAL SOCIETY

Dr. PARKER. Thank you very much. Senator Church, Representative Horan, ladies and gentlemen of the panel, and ladies and gentlemen of the audience, I am speaking to you as a representative of the Spokane County Medical Society. First, may I say that we appreciate the opportunity to present our views before this committee and to this audience.

In considering the many problems which involve people over the age of 65, we, as physicians, are particularly interested in those aspects that have to do with their medical care. We are proud of the fact that, under our system of free enterprise, we have developed and are able to bring to our patients the finest medical care the world has known. It is because there has been so much national concern over the availability and cost of this medical care with so many new

ideas being advanced, particularly along the lines of financing, that I wish to address you today.

The doctors in this area do not feel that all or even a significant part of the people over the age of 65 are unable to care for their medical needs and, therefore, need assistance. The physicians in the State of Washington for years have developed and encouraged private prepaid medical plans, many of which are tailored just for people over the age of 65. Later on in this panel discussion, you will hear from a representative of the private health and accident insurance, who will detail for you the dynamic growth that is occurring in this industry, particularly on plans tailored for people who are entering the 65 and over years. However, for those who feel they cannot afford their medical care costs, several avenues exist in this State.

First, and I would like to heartily second Reverend Dorpat's statement, that there must always be an element of family responsibility in the care for aged people. This is a fundamental concept of society that should be encouraged. Second, there is now available through the Kerr-Mills Act Federal and State matching funds to take care of people who are not on welfare and yet can use financial help when sick. I wonder if a full investigation was made in the case that was detailed to us by the speaker prior to my appearance and whether or not he was aware that these things were available. We feel that one of the fine things to come out of this committee, is that awareness will be made that there is available in this State money on a Federal matching State plan to take care of people not on welfare, but who are in need of help when sick.

Here in the State of Washington, we feel we are in a far better position to know how acute our problem is and to solve it locally. Our medical care system in this State, as Senator Church pointed out after hearing Dr. Hall, is considered one of the finest in the Nation, so much so that we qualified for money under the Kerr-Mills Act under present legislation without having to expand our program one bit. So, today, in this State, we physicians feel there is no need for anyone to be denied medical care because he cannot afford it. In fact, we are convinced that there are not people in this State who are going without medical care, and, if there are, we want to know about it. If an investigation proves that such cases do exist, we will be the first to insist on necessary steps to be taken to correct it.

In conclusion, we feel that the people of this State have adequate medical and nursing home care available to them from either private or locally controlled resources. We do not feel that a Federal Government program, encompassing all people over the age of 65, is necessary—all people whether they can use it, whether need it, or whether they even want it. Thank you very much.

Senator CHURCH. Thank you very much. Our next, and I think perhaps this will be the last we can hear this morning owing to the noon hour having arrived, is Mr. William J. May, who is, as I have it here, a representative of the Spokane Labor Council, AFL–CIO.

Excuse me just 1 minute. I have an announcement here that Mr. Ed Brown, whose address is North 2516 Oak Street, Spokane, and whose telephone number is Fairfax 8–6362, believes that he lost his wrist watch in this hall or en route to the hearing room.

Congressman HORAN. It's found.

Senator CHURCH. That's fine. There is your watch.
Congressman HORAN. This is an honest group.
Mr. BROWN. Here's the owner.
Senator CHURCH. Let's get the owner and the watch back together again. That's fine. We want to welcome you this morning and we are very pleased to hear from you, Mr. May.

STATEMENT OF WILLIAM J. MAY, SECRETARY, SPOKANE LABOR COUNCIL, AFL–CIO

Mr. MAY. Senator Church, Representative Horan, besides being secretary of the labor council, I am the third district Democratic representative from the State legislature, and I was one of the sponsors or cosponsors of the surplus foods bill in the State of Washington. I mention that for your information.

I might open by rebutting what the doctor said about the Kerr-Mills bill. Last year, available figures showed that only 680 senior citizens out of 279,000 in the State received any assistance at all, and this was as of July 1961, figures.

Extending survivors and disability insurance to include adequate health care for the retired and aged people of this country is receiving the same old ballyhoo about socialized medicine. Prepaying costs of burial and prepaying security in your old age by purchasing insurance, endowments, and so forth, has long been a practice. So, why, all of a sudden, should prepaying for hospitalization and medical care for your old age suddenly become such a socialistic monster?

When you figure the cost of medical care for the aging is approximately one-third of their income, of the $72 that most of them receive under social security, two-thirds of this amount, or $48, does not leave the aged person with enough to keep body and soul together. The balance of $24 to be used for medical care or hospitalization will buy very little at today's prices. Perhaps this should be labeled "socialized insecurity."

To say that a relative is legally responsible to pay the medical bills of his aging parents is one thing, but to be able to prove that he is financially able is something else. Many young people would be most happy to have the income to pay medical costs and hospitalization for their parents, but to have a welfare official determine that a son or daughter can assume this additional load does not necessarily make it a fact. A 5- or 10-year siege of medical bills could conceivably place a young family in the same position as their parents were. This would be deferring the medical costs to the next generation, and this maybe should be labeled "socialized injustice."

Private health insurance companies in their programs are unable to meet the cost of medical care for people aged 65. They are in the high cost, high risk, low income group that are dropped out of most plans, or, at least, their benefits are cut down to a point of little value when they retire. This is the group not wanted in the various plans, and it is this same age group that raises the cost of medical services when included in younger groups. So, by what other means can their problems be solved than by extended coverage under social security? No voluntary insurance plan can create resources to provide adequate coverage for this older group.

The Federal plan can be used as a solution to the problem and will not control medical practice. It would make medical practice, as the doctors want to practice it, more available. This plan will enable a patient to go to the doctor or the hospital of his own choice. It will enable American men and women to retire in their old age with more security and, surely, with a great deal more self-respect. It will discourage frivolous or unnecessary use of hospital and other services by requiring the patient himself to pay certain early expenses, and it follows some other practices used in private insurance.

It will be administered by 1 set of laws by the Federal Government, and not by 50 sets of laws by 50 different States. It will enable a person to transfer from job to job, from State to State, and from industry to industry, without losing his vested rights.

This is a bill about the well-being of men and women, retired, those about to retire, and those beginning their working lives. I hope the Anderson-King bill will pass in the next session of the Congress. Thank you very much.

Senator CHURCH. Thank you very much, Mr. May. Now, folks, it's after 12 o'clock, and we had scheduled this hearing to begin again at 2. I think perhaps, because we have to finish by 4 o'clock this afternoon, that it would be wise if we came back and continued with the witnesses who are scheduled to testify and then go into the forum aspect of the meeting for senior citizens themselves at 1:30, rather than at 2 o'clock, here in this hall. Thank you very much for your attendance.

(Whereupon, at 12:10 p.m., the subcommittee recessed until 1:30 p.m., the same day.)

AFTERNOON SESSION

Senator CHURCH. The hearing will come to order again, please, ladies and gentlemen, and the next of our scheduled witnesses was Dr. Douglas Solvie, who is secretary of the Spokane District Dental Society. I understand that he will be represented today by Dr. Todd Schimke of the Spokane District Dental Society. Dr. Schimke comes well recommended. He has a brother in Idaho, in Moscow.

STATEMENT OF DR. TODD SCHIMKE, SPOKANE DISTRICT DENTAL SOCIETY, REPRESENTING DR. DOUGLAS SOLVIE, SECRETARY

Dr. SCHIMKE. Thank you, sir. Senator Church, Congressman Horan, and other distinguished people at the table, and fellow citizens. We, of the dental association, are very grateful for this opportunity to be here today and give you our little worth.

We are desirous that all, including our senior citizens, receive the best possible medical and dental care. Now, this has always been the policy of organized dentistry. We stand ready to cooperate in a proper plan to achieve this end.

When we in this assemblage today—I say "we," and ordinarily when I say "we," I mean the Spokane District Dental Society, but now when I say "we," I mean we people gathered in this assemblage here today to consider medical and dental care for the aged, I am sure that our concern is for the needy senior citizens and definitely not for the ones who are able to pay for their own health care, as well as their other

needs and luxuries. Therefore, we are opposed to any health care program which is not based on need.

Further, such a program as the King-Anderson bill proposes would not care for a considerable segment of those citizens who still are not covered by social security. With the present heavy social security tax burden, it seems to us entirely unnecessary to increase this tax burden to help people who need no help.

Now, we feel that our State of Washington is really outstanding among the States for its program of caring for the needy, both young and old. Some of our senior citizens find themselves in difficulty when medical care can become the straw which breaks the camel's back. They can receive "medical care only." Now, we in dentistry work with the State department of public assistance in furnishing dental care to the aged and feel that this program is adequate.

Let me here call your attention to this very fine study, "Health Care for the Aged in the State of Washington." It is printed and published by the Health Information Foundation, 420 Lexington Avenue, New York 17, N.Y., and may I read a little bit from this introduction:

> The present medical care program for old-age assistance recipients in the State of Washington is the result of a long experience with various methods of providing such care. The present program is of interest both because of the comprehensive care it provides and the unusual administrative mechanism it employs. Among its unusual features are these:
>
> (1) The State contracts with the voluntary health insurance agencies for the physician's care of its assistance recipients. This care is actually provided through a number of local physician-sponsored medical care plans which give recipients free choice of physicians.
>
> (2) The State contracts with the prepaid dental care agencies for dental services for assistance recipients, allowing them essentially free choice of dentists.
>
> (3) The program supports a very extensive use of nursing home facilities by its old-age assistance recipients. About one out of six of these is a nursing home patient.

I thought I didn't have a statistic in the whole thing, but we are certainly statistical minded today, but that one crept in. Then if I may add perhaps, I think the figure is around 60 percent of the whole care program as to the nursing home program. I will quote now the fourth and last of the features referred to:

> (4) It provides recipients with virtually all needed health services, including physician home and office calls, prescribed drugs, appliances, dental care, and dentures.

This study presents the essential features of the Washington program, its development, provisions, utilization, and costs, and for those in other areas, who are concerned with providing health care for the aged and for other groups, I sincerely recommend the study of this for anybody who is interested.

We suggest as an aid or partial solution of these problems that much public money could be saved by making family responsibility a vital factor. We cannot hope through the simple process of legislation to solve all problems concerning health care and bring all things to all people. It simply cannot be done. We welcome change for the better, but do not wish to cast aside a workable plan until we are certain of something definitely better. Congressman Walter H. Judd, who is also an M.D., expressed this rather well in a speech at a session

of the American Dental Association in Philadelphia last month, and I quote:

> We medical people tend to focus our attention on the good. Under our present system, most people have good care. Those who would turn to the Government focus on the bad. They would scrap the present system because the minority does not get the care they need, but where we ought to be is between these two, neither the radical who would abandon what we have because it isn't perfect, nor the reactionary who says it's good enough because it is at least better than anybody else has.

I thank you.

Senator CHURCH. Thank you, Dr. Schimke. Our next witness, folks, is Dr. Hal Wayne, also a dentist, from Kellogg, Idaho.

STATEMENT OF DR. HAL WAYNE, D.D.S., KELLOGG, IDAHO

Dr. WAYNE. Senator Church, Congressman Horan, and Americans. I shall speak for approximately 5 minutes and 7 seconds, give or take a few. The opinions I convey are to be regarded as my own.

Fifty-six nations have workable social security programs; 33 nations have some degree of government-supported medical service, medical care provided as a function of government. We can make medical care available to all through our free enterprise system—which, in fact, embraces social security as a measure of prudence—without "socializing medicine." We cannot properly do this through an inefficient, tax expensive and degrading instrument such as the Kerr-Mills bill. I list 14 objections to the Kerr-Mills bill:

(1) It is not self-supporting. It necessitates higher general taxes, such as sales, income, property and/or corporate taxes.

(2) Such large sums are involved in this welfare program that some States might not be able to support it.

(3) It does little to prevent major medical expense from bankrupting otherwise solvent persons.

(4) The law makes its benefits and execution subject to extreme geographic variations.

(5) Benefits can be subject to local political patronage such as existed before the social security law of 1935 in this welfare field; it would imply some degree of political control over the beneficiary and interfere with the doctor's right to practice according to his skill and judgment within the ethics of his profession.

(6) It places responsible, solvent citizens faced with medical expense in the position of being treated as though on relief.

(7) It is wasteful because it is complex, geographically variable, and difficult to administer. It further requires means tests with consequent staffs of social workers in all areas of the Nation.

(8) It further interferes with the practice of medicine by making benefits uncertain and subject to delay.

(9) The means test discourages a person from seeking early preventive care.

(10) It is just as compulsory as the King bill because taxes are compulsory by nature, and that is how it is supposed to be financed. Further, many who pay for it will receive no benefits.

(11) It interferes directly with the basic doctor-patient relationship. The pauper referred to a public clinic by a social worker has little dignity and little choice.

(12) It does not assure the older adult that medical costs will be met.

(13) It requires an act of degradation—a means test—and such a test to me implies a surrender of one's right to hold his individuality.

(14) It is at best an attempt to circumvent and frustrate efficient and constructive legislation now offered in this field.

By way of perspective, I submit that there is legitimate economic demand for aged medical care. The depression of the 1930's, together with wartime and postwar inflation, crippled our older adults financially in many, many cases. The increased complexity and cost of modern medical care adds a further burden. Secondly, it will improve our perspective in this matter to bear in mind that the Nation's physicians have consistently rejected social security.

Nurses and dentists, like the overwhelming majority of Americans, support that program and participate in it, but the Nation's physicians have consistently expressed a collectivist hostility to social security; this hostility has led to the spectacle of a distinguished and dedicated profession calling "socialism" for lack of better argument.

Two teenagers strolling in the moonlight could by some definition be called socialists; if they kissed, they might be called radical socialists, and I don't mean this facetiously. Nevertheless, the term "socialized medicine" has a definite meaning to me. It means that state of affairs wherein the health professions work for the Government, and I fear this type of thing. I am also fearful of bureaucratic control wherein some office of the Federal or State Government, armed with quasi-legislative authority, regulates and otherwise disturbs the free and independent relationship between patient and doctor. The doctor must be free to treat his patient according to his best judgment. The patient must retain his prerogative to give or withhold consent.

Fear of socialized medicine and Federal control is a legitimate fear, once we articulate what we mean. The King bill, as it stands at present, does not imply socialized medicine or bureaucratic control. It could be expanded to create bureaucratic dominance or a socialist concept, but so could any other act or instrument in this field, if the American people so desire. Neither the people nor the professions desire welfare legislation such as we find in Great Britain and Norway, for example. This is my opinion.

We desire a workable, financial instrument, consistent with our free enterprise system, which will effectively enable our older citizens to obtain medical care after their earning capacity has dwindled. This is mere prudence. The King bill does just that. We in the professions should bend every effort to insure that this legislation is so written that: (1) It will protect the doctor-patient relationship: (2) be difficult to expand into State medicine; and (3) be as free as possible from Federal executive regulation.

Beyond that, it is the voice of the American people, not us doctors, that will say whether this program should be a part of our social security system.

I want to express my gratitude to Senator Church, to the committee, and to you, ladies and gentlemen, for this opportunity. I would add my wish that Almighty God might speed this committee in its deliberations. I regard them as being of paramount importance. Thank you.

Senator CHURCH. Thank you very much, Doctor. As I looked at the list, you were listed as D.D.S. You are, of course, an M.D.?

Dr. WAYNE. No.

Senator CHURCH. You are a D.D.S.?

Dr. WAYNE. Yes.

Senator CHURCH. Well, thank you very much. I wondered if there was confusion here between my list and your statement because your opinion is highly individual. Thank you, Doctor. We appreciate hearing from you. I would like to call next on another Idahoan, from Nez Perce County. I call on him out of order because he has to return to Lewiston, which is some distance, and, therefore, I am sure that you local people will not object if I do that. This is Mr. Otto Brammer, who is the county commissioner for Nez Perce County. We will be glad to hear from you now, and you won't be delayed further for your return trip home.

STATEMENT OF OTTO BRAMMER, COUNTY COMMISSIONER, NEZ PERCE COUNTY, LEWISTON

Mr. BRAMMER. Senator Church, members of the panel, ladies and gentlemen, I am Otto Brammer, chairman of the Board of Commissioners of Nez Perce County, Idaho—of which Lewiston is the county seat. I present this statement on behalf of that board. As an elected official, I feel that I express the views of a large majority of the citizens of Nez Perce County. The plight of our elderly citizens—especially with regard to medical care—is of great concern to me and to other residents of Nez Perce County. It is of special concern to me because of the fact that, year by year, the burden of providing medical care for the elderly has fallen with increasing heaviness upon the counties.

We shall continue to bear this burden as best we can. But I am here to tell you that we do not have the strength or the resources to bear the burden adequately. It is the counties to whom the elderly must turn, in the end, and yet the counties are not even coming close to meeting the full needs of our senior citizens. It is my opinion, based upon long and painful experience, that a new approach must be taken if our elderly residents are to receive the medical care they deserve as senior citizens of the richest nation on earth. In my county, there are an estimated 2,800 men and women aged 65 years or older. More than half of them have income of less than $1,000 a year. Like older men and women everywhere, they are more prone to illness than any other segment of the population. Less than half these men and women haven't any kind of health insurance. The result is that, when major illness strikes, a majority of them are totally unprepared. Either they go without the medical attention which they should receive or they fall back on charity. Sometimes it is the charity of their children, their neighbors, their church, their doctor, or their hospital. Sometimes it is the charity of their State and county.

In my county last month, there were a total of 155 men and women—almost all of them aged 65 or over—who were receiving county assistance as indigents. Our county welfare director estimates there are a great many more who are eligible for such assistance. But they do not apply for it because they cannot bring themselves to sign

away their homes or to sign the pauper's oath which is necessary before they may receive the aid. Nevertheless, despite this hesitation, the number of indigents is growing month by month. It has almost tripled since 1958.

The average monthly population in our county nursing home has risen from 39 to 49 since 1958. Despite the fact that the State now has a medical care program for the elderly, the county bill for medical supplies alone rose from $4,400 in the first 8 months of 1960 to $9,200 in the first 10 months of 1961. These figures suggest what many of us have known for a long time: The demand for medical care for the elderly is fast outstripping the meager resources of the county.

As county officials, we are pretty close to the people. We feel a keen sense of responsibility for the well-being of our elderly neighbors whom circumstances have caused to be indigent. We do not say to them: "We will pay for only 14 days in the hospital and then no more." We do not say: "We will allow only two visits to the doctor each month."

Nor do we believe that the hospitals or the doctors should be left holding the bag because illness may have led an indigent person to exceed an arbitrary allowance of medical care, we try to take care of those who are truly in need, whatever the need may be, because it is our belief that this is a fundamental responsibility of government. However, it is also our belief that this responsibility will never be fully discharged until it is undertaken on a much broader level.

As chairman of the taxation committee of the Idaho State Association of County Commissioners and Clerks, I am painfully aware of the limitation which the tax structure places upon the resources of the counties. In Idaho, the counties rest upon a very narrow tax base, real and personal property. There may have been a time when physical property was an accurate gage of wealth, but today that is far from so. The practical effect of a tax structure based exclusively on real and personal property is to put an almost immovable ceiling on the revenue which can be raised to meet the increasing demand for governmental services. In Nez Perce County, as in many counties of Idaho, we are bumping against that ceiling. In addition to being limited in what it will produce, the property tax is also most unfair in its application. A small businessman and the farmer pays about 70 percent of the cost, while people who are engaged in professions and skilled trades pay a relatively small amount. A prime example of this was shown in a survey we recently conducted in the county. One individual who had a taxable income of over $50,000 paid less than $50 in property tax, while another who had a $10,000 taxable income paid over $2,000 in property tax.

We do not believe that the financing of medical care for our senior citizens should depend upon a system so limited and inequitable as the county property tax. And yet, despite the recent establishment of a State medical care program, that is the base upon which public medical care rests today. We believe that a far sounder and much fairer approach is to be found in the proposal that medical care for the elderly be financed through the social security system. This would place the burden where it belongs and where it can be borne. The burden would be carried by the recipient himself, and his employer

during the wage-earning years. Only through a nationwide, compulsory, prepaid public insurance system such as this can we assure for all Americans the peace of mind to which they are entitled in their golden years. Only through such a system can we banish the indignity upon which our present system is built: the indignity of having to beg for charity where medical treatment can be postponed no longer.

There are many freedoms which men and women are guaranteed by virtue of their American citizenship. But these do not include freedom from the fear which hangs most heavily today over men and women in their later life. This is the fear of illness which could render them destitute, robbing them of their security and perhaps also their self-respect. Surely, it is time that we came to grips with this very real gap in our system of freedom. As medical science improves and lengthens the lives of our people, the inequities and problems that exist under our present system will be compounded over and over. I thank you.

Senator CHURCH. Thank you very much. Our next witness is Mrs. W. H. Frisbie, chairman of the Spokane Council on Aging.

STATEMENT OF MRS. W.H. FRISBIE, CHAIRMAN, SPOKANE COUNCIL ON AGING

Mrs. FRISBIE. The word "gerontology" first became a part of my speaking and working vocabulary in 1952 when gerontology was adopted by my sorority Sigma Kappa as one of its major philanthropies. Since then, the gerontology program has become more and more a part of my life. Working with citizens—senior citizens that is—even in a small way, has been a very rewarding experience.

Senator CHURCH. Is that what gerontology means?

Mrs. FRISBIE. Gerontology means, in a general sense, bringing happiness to elderly people.

Senator CHURCH. Thank you.

Mrs. FRISBIE. During the past few years, the country over, senior citizens and their problems have aroused increased attention of both individuals and organizations, organizations that are fraternal, civic, and religious. Centers of activity for oldsters have been started, and recreational and creative programs have been established, but there is a constantly growing need to extend and enrich these programs, extend them in range of activities, for what interests one individual certainly does not interest all. Take golf, for instance, or art. In extending our programs to include an interest for each individual, these programs should be made available to members of all socio-economic groups.

Leaders in the activity program should be trained to work with senior citizens, not for senior citizens. The activity leaders in some cases could very well be senior citizens themselves. Aging persons need to participate in the planning and execution of their own projects, whether those projects be bazaars, rummage sales, card parties, basket socials, or vesper services. The participating and the giving of voluntary service bring satisfaction that can be gained in no other way.

The senior citizen has time for volunteer services as he never has had before, and his background of experience in the business world and in community affairs should well qualify him to give service to his center. Satisfying service to his own group will undoubtedly promote a desire in some of these senior citizens to offer service in a broader field. Already, right here in Spokane, volunteer service by the aging is assisting the Red Cross and the United Crusade drives, and, certainly, other cities have outstanding examples which would prove the truth of this statement. Also, some oldsters, skilled in crafts, are finding ways to assist the YMCA or the Boy Scouts. Who could better instruct a boy in first aid than a doctor, retired or not? This type of activity keeps the doctor or the oldster in contact with youth groups, and that in itself is a very good thing.

The community must be educated to appreciate and to use the talents and the skills of competent older leaders.

To me, that is a very important factor. Voluntary service by the aged can be and should be real service and accepted as such, not as busy work. Of course, only those volunteers who can do a good job should be used. There should be many such available in every community. It is up to us to make the aging feel our need for them, to feel that they belong. We should remember that the older person needs to participate, he needs to achieve, for from service comes self-satisfaction and the joy of living.

In summing up my remarks, I suggest: (1) Reevaluate and extend and enrich existing programs; (2) utilize senior citizens as leaders in their own recreational activities; (3) utilize retired professional persons and craftsmen in leadership and instructional positions; (4) develop more opportunities for meaningful volunteer community service. Let us all reach out and gain in perspective and understanding so that life may become increasingly meaningful to those citizens who find themselves removed from jobs, left alone through the marriage of sons and daughters and by the death of mates and contemporaries.

Remember, too, every individual, even as you and I, needs to feel that he belongs, that he is wanted. Let not one individual have the epitaph, "He departed without being desired."

Senator CHURCH. Thank you, Mrs. Frisbie.

Mrs. FRISBIE. In my eagerness to speak, I forgot to address you, Senator Church and Congressman Horan. It has been an honor and pleasure to be here.

Senator CHURCH. We appreciate your coming, Mrs. Frisbie. In addition to your excellent testimony, you have taught me a new word that I hadn't understood before, and that is "gerontology."

Mrs. FRISBIE. I wish I had looked it up.

Senator CHURCH. I have one other witness who has expressed a desire to testify, who is not listed on the regular agenda, and Congressman Horan has also asked that he be allowed to testify, and I want to accommodate him. That is Dr. Alfred O. Adams. Dr. Adams, are you here? Would you like to come forward, Doctor?

STATEMENT OF DR. ALFRED O. ADAMS, PHYSICIAN AND SURGEON, MEMBER OF WASHINGTON STATE HOUSE OF REPRESENTATIVES, AND MEMBER OF COMMITTEE ON SOCIAL SECURITY AND PUBLIC ASSISTANCE

Dr. ADAMS. Thank you, Senator Church, for maneuvering your agenda to permit me to appear. Congressman Horan, ladies and gentlemen, I want to confine my remarks, I think, to some things that are very relevant to what you are considering; that is, regarding the medical care of senior citizens in the State of Washington, and I want to place some emphasis on the action that was taken by the last Washington State Legislature.

Now, in order to establish my position here, I want to say that I have practiced medicine and surgery in Spokane for 25 years, have served in the house of representatives of the Washington State Legislature for the past five sessions, and during this entire time have been a member of the committee on social security and public assistance, where programs regarding the medical care of senior citizens were advised. I would digress to say that I had a big hand in writing the present act in 1953. Therefore, I have been in a position to observe our medical aid programs from the time that these programs were initiated down to where they were administered by the counties, and now, as has been testified to, the present program is administered by the State department of public assistance.

The medical program in effect in this State at the present time conforms to the present Federal laws as established in H.R. 4884 in the 86th Congress. That is the Kerr-Mills amendment, as has been testified here. The Washington program has carried out the intent of this present Federal law for several years with the result that this State can be used as an example to show what can be accomplished by the States under the existing Federal laws, and also, I think, shows that the passage of H.R. 4222 in this 87th Congress, that is, King-Anderson bill, is not necessary, at least from the experience we have in this State.

I also wish to call to the attention of the committee then the action taken by the Washington State Legislature in the last session on House Joint Memorial No. 16. This memorial was an executive request measure, requesting the U.S. Congress to incorporate medical care into the social security system. After amendment and after considerable debate, the measure was passed by the house of representatives and referred to the senate. It was never considered on the floor of the senate until it was indefinitely postponed with other measures at the close of the session.

The action of the legislature on this measure in my opinion indicates that the members of the legislature feel that the present medical aid program is among the best in the United States, that it is adequate, and that the problem of medical care for the aging is being handled very well in this State under the present Federal and State laws. Certainly, the present Federal plan should be given a longer period of time to prove its value before making any change.

I would also like to say, Senator Church, that, as I understand the proposed bill, that is, the King-Anderson bill, it only provides for a

very limited period of hospitalization and a very limited period of nursing home care, and if it were in effect, with as many people as we have who have long periods of illnesses, they would be jumping back and forth from a State program into the Federal program, sharing the few weeks each year, and then going back on the State program, because we have many people that have been in our nursing homes for a period of several years. Thank you for this opportunity of appearing before you, and I would like to submit to the committee about six copies of this statement for your record.

Senator CHURCH. Thank you very much, Dr. Adams. We appreciate it. Our next witness is Mr. R. J. Genins, who is administrator of Rockwood Manor.

STATEMENT OF R. J. GENINS, ADMINISTRATOR, ROCKWOOD MANOR, SPOKANE

Mr. GENINS. Thank you, Senator Church. Congressman Horan, members of the committee, ladies and gentlemen, may I begin by expressing my very sincere appreciation for the opportunity of representing a way of life for senior citizens which is relatively new and which is grossly misunderstood. I very much appreciate this opportunity, and I should like to refer back to some of the remarks of the morning made by Pastor Dorpat, and particularly to the comments made by Mrs. Frisbie a few moments ago, because it is in the area of gerontology that I wish to make my comments.

At the invitation of the committee, I have already submitted a statement which is much too long to make here in this gathering. I should like to pick out, however, certain major facets of that for your attention this afternoon.

I have a great concern for the fact that there are problems of the aging, but I do not like to hear people say that the aging are problems, and it is within this area that I would like to stress and make my comments. In the first place, we all recognize the fact that in this modern day social scene there is a great emphasis placed upon personal magnetism. A great deal of individual competition enters into our everyday life. This competition is quite a strain, of course, upon us as we grow older, and, sooner or later, we find ourselves taking the position of sitting back and letting the rest of the world go by, or being forced to assume this position much to our own discomfiture.

It is within the area of these principal emphases, therefore, that I should like to submit to you that the retirement home living makes a very real contribution to the concerns of senior citizens. First of all, it seems to me that the major concern of our senior citizens is in the area of the climate, within which they live. The fact that they must preserve individual dignity, that there must be an opportunity to express one's self, and to know that, when one does so, his opinions are respected, that they are looked upon as being worthwhile and making a very definite contribution.

Secondly, there needs to be for all people of all ages and, certainly, for senior citizens, compatibility of companions. There needs also to be freedom of choice, the right to plan one's daily activities. These things are provided within the environments of a retirement home.

We have heard much said about the concern for health and limited physical energy. This, of course, is a recognized fact of life, that, as we grow older, there is a waning of our reserve of physical energy. We, who represent retirement homes, feel that, therefore, we need to recognize the fact that senior citizens need to be relieved of the chores of housekeeping, of home maintenance, and things of that kind, and to provide an environment in which they can live happily and be relieved of these things is a real service to senior citizens.

We also recognize that infirmary care, such as is provided in a retirement home, is a very important part of the program. I should like to emphasize this, if you please. We can have health protection perhaps through insurance plans, catastrophic illness benefits, and the like. These are important. Not everyone perhaps has them, but these are an important part of our feeling of security. This, however, does not give us the full answer because, certainly, a very real concern of the senior citizen is the fact that, when illness strikes, he will receive care at the hands of someone who knows him and who gives him loving care. Those who live in a retirement home come into contact daily with professionally trained nurses and people who are concerned about their health. When illness strikes, they receive this care at the hands of someone who knows them and who is concerned about them and who gives them loving care.

May I submit to you that this, of its very nature, delays the physical deterioration that very often occurs because of the concern and the fear which senior citizens have for their health.

Now, this last concern, I touch on briefly, but it is important, and this is a matter of concern for financial stability. I do not sit here before you, presuming to say that retirement home living answers all of the problems of senior citizens. It answers a great many of them, and it answers them in a very fine way.

May I submit in this area of financial stability that retirement and senior citizenship are not synonymous, and that this matter of putting our senior citizens on the shelf, where today you are a productive citizen, and tomorrow, because you are 65, you're no longer wanted, and we shunt you off to the sidelines, is a most brutal kind of treatment. This is not only brutal to the individual, but it is foolish on the part of society. How much society has suffered because it has not made use of the know-how of the senior citizens, no one has any way of knowing.

The matter of inflation, of course, is a very great concern for all people, and so, in terms of government, I think we need to be very much concerned about this and what we can do to protect our senior citizens. May I say that in retirement home living, we present to our residents a package set of expenses which they can anticipate and which cares for all of their daily needs. They can plan for this, and provident citizens, before they reach the age of senior citizenship, can look forward to it and become worthwhile citizens of a provident nature as they look toward senior citizenship. Thank you very much.

(The prepared statement of R. J. Genins follows:)

PREPARED STATEMENT OF R. J. GENINS, ADMINISTRATOR, ROCKWOOD MANOR, SPOKANE

Honorable sirs, it is with gratitude that I have accepted the invitation to make a statement before this hearing. May I extend my appreciation for the concern which you here demonstrate in a matter which needs serious study. I appear before you in the capacity of administrator of Rockwood Manor, a retirement home operated by Spokane Methodist Homes, Inc., at 2903 East 25th Avenue, Spokane, Wash. This corporation has been organized for the express purpose of providing a home for senior citizens on a nonprofit basis.

While the type of program represented by Rockwood Manor may not encompass the answers to all of the questions which come before you for consideration, it does present one very good answer to many of them. I urge you to encourage support of this type of program and to assist those who seek to furnish such facilities. Such support should find its expression in information made available to the general public explaining what retirement home living is like.

Undoubtedly, the results of the first White House Conference on Aging and the many subsequent White House Conferences have made available to your committee most of the current thinking about the role of State and Federal Government in meeting the concerns of senior citizens. May I therefore seek to emphasize how the role of retirement homes such as Rockwood Manor assist government in providing for these concerns.

It seems imperative at the outset to plead for the cessation of the unfair categorizing of senior citizenship as a "problem age," to the marked disadvantage of those who make up this segment of society. Whereas it is true that there are peculiar and distinctive characteristics of this particular age segment, it is also true that the same thing could be said for any age bracket one may wish to single out for study. To lift up the 16 million citizens who are 65 years of age or older as "problems" is to admit that society has not planned wisely for a period which is inevitable in its spectrum of experience. Immediately, then, one turns to the agencies of social planning and to educators in the hope that they will take up the challenge and implement programs of public information and education.

A major part of this so-called problem is the fact that these citizens have been, consciously or unconsciously, segregated from the stream of life and therefore have been permitted to become problems. When an individual, through his own maturing processes and with the help of social planning, is fed normally into the ongoing processes of life, he adjusts and takes his rightful place in the scene. When he is forced, for any reason, to assert himself in order to receive recognition as an individual, he becomes a problem to society as well as to himself.

It behooves society to recognize that the present day emphasis upon "personal magnetism" as a coveted characteristic of individual expression makes for keen competition on an individual basis in all walks and phases of life. As one becomes older this pace of competition seems less important and more tiring. Gradually, the individual either elects to let the world pass by or because of inability to keep up with the others, finds himself pushed to the sidelines. In either instance, the individual has lost his status role and immediately the seeds of a problem are sown. Once this process has begun, one is likely to find himself bereft of the kinds of social support which encourage expression as a true citizen in a democracy.

The program of retirement home living seeks recognition on the social scene for its realistic approach to the major concerns of senior citizens. It proposes to meet these concerns in the following ways:

I. CONCERN WHICH SENIOR CITIZENS HAVE ABOUT THE "CLIMATE" WITHIN WHICH THEY LIVE

Dignity of self-expression is highly important and the opportunity to be oneself within a framework of social planning which extends beneficence without the stigma of charity is a major concern of the senior citizen. The cost of housing and maintenance is provided on a nonprofit basis in a retirement home. The program is provided on as a broad a scope as can be supported by the facilities available and every semblance of regimentation or institutionalism is avoided.

Compatibility of companions is highly significant in maintaining personal dignity. Opportunities to associate with others of similar background and experience to feel that when one expresses an opinion it will be respected, becomes increasingly vital in one's life. The very nature of life in a retirement home

provides this important outlet for self-expression among one's peers and under the examination of those who have had years of valuable experience.

Freedom of choices is another significant factor in the well-being of an individual. Planning each day's activities as one can and desires to live them is a privilege no free citizen should be denied. Since the range of activities available in a retirement home is broad and since the home itself is a part of the community, the resident is provided a full spectrum of choices for his day's planning.

II. THE SENIOR CITIZEN'S CONCERN FOR HEALTH AND LIMITED PHYSICAL ENERGY

The waning of reserves of energy is a normal part of aging. Foolish attempts to deny this fact of life only exaggerate their impact upon an individual's personality. With intelligent adjustment to the slowing down of life's processes, comes the need to escape from such responsibilities as home maintenance, housekeeping, and other chores of everyday life. Failing to escape these responsibilities fully, the individual is in need of maximum relief through modern facilities which provide for the specific needs of the aging. The opportunity which retirement home living provides to live cooperatively in a modern building and where one is relieved entirely from the worries of everyday chores, is one of the chief contributions such living makes to meet the concerns of senior citizens.

The fear of health failure lurks constantly in the background thinking of senior citizens. Voluntary health insurance plans and catastrophic illness benefits, while helpful, do not provide any assurance of loving care at the hand of those who are in a position to take anything more than a professional interest in their patients. Infirmary programs under the guidance of professional people who become intimately acquainted with their patients before their confinement, adds to a feeling of security so essential to one's sense of well-being. Physical deterioration may even be slowed and sound mental health encouraged because of the more relaxed attitude made possible by simply knowing that such care is at hand in a retirement home.

III. THE SENIOR CITIZEN'S CONCERN FOR FINANCIAL STABILITY

Before one reaches the age of senior citizenship he must recognize the need for a well planned retirement program. It is fallacy however to identify retirement with senior citizenship. Everyone, by virtue of his democratic heritage is entitled to expression as an individual within the limits of his potential. Arbitrary time limits of productivity imposed by law deny this inherent right of a citizen. Enforced retirement should come about as the result of loss of ability to perform and should be administered on an individual basis. Management and labor must cooperate to provide programs of maximum retirement benefits, to become available when an individual reaches the limits of his productive capacity in a particular position. Even then, recogniton should be given of those possible contributions an individual may make in other pursuits—every effort must be made to capitalize upon the background and experience of these persons. To do this is of significance not only to the individual's sense of worth but constitutes wise conservation of our manpower resources. No one knows how much society has suffered because of its callous disregard for the know-how of its senior citizens who have been "shelved."

Safeguards against inflation must be the vital concern of society for its senior citizens. Adjustments are imperative in whatever plans are implemented so that the benefits can be flexible within reasonable limits of changing costs of living.

A package set of expenses which can be anticipated and which contains no hidden factors, goes far toward giving senior citizens a sense of well-being. Retirement homes such as Rockwood Manor predicate their programs upon the inclusion of charges for all required services in a monthly service charge which is part of the contractual relationship between the corporation and the residents. This enables the residents to plan ahead and assume the dignified status of self-provident citizenship which should be the ultimate goal of all in a democracy.

Senator CHURCH. Thank you. Our next witness is Mr. Robert T. Green, representing the Spokane Life Underwriters Association. We want to welcome you, Mr. Green, to the committee today.

STATEMENT OF ROBERT T. GREEN, REPRESENTING SPOKANE LIFE UNDERWRITERS ASSOCIATION

Mr. GREEN. Senator Church, Congressman Horan, ladies and gentlemen, a good deal has been said this morning and this afternoon by many about people who do not have access to plans or not being able to afford them. I thought it would be interesting to the committee, although it isn't in my written statement, to give you the results of a survey taken in 1957 in the State of Michigan. This survey was of people not covered by prepaid medical care. It says that 15 percent of the people that were not covered said, "We don't think we need it." Another 17.6 percent haven't got around to taking it out, even though it was available; 13.9 percent never gave it a thought; 3.2 percent don't know; still another 7 percent said they don't believe in insurance; 2.1 percent get free treatment. Anyway, the net result was, of this survey, that 60.9 percent appear either to feel that they do not need insurance or do not choose to purchase it.

Now, in addition, one of the previous speakers, Mr. May particularly, indicated that we should have this medical care under social security. For those of you who are in the room perhaps you do not know that social security has been running in the red for the last 3 or 4 years. Someone has to pay for this cost, whether you get it through the Federal Government, or whether you buy private insurance. I should like to call to the attention of Mr. May that the taxes for OASDI in 1969 will reach 9 percent; that is, by the regular schedule.

Now, if you stop to think about it, that is 1 month's pay, and that does not include your income tax and other taxes that you are going to have to pay. For this new social security amendment passed by the recent Congress, the percentage goes up to 9.25 percent by 1968, and if you add the King-Anderson bill, which is proposed, the percentage will run up to 11 percent of employees' earnings. Now, even Secretary Ribicoff has indicated that a 10-percent total social security tax rate appears to be about the maximum that should be imposed.

Now, any committee, whose job it is to be concerned with the welfare of our senior citizens, is necessarily concerned with the health of these citizens. In the few minutes allotted to me, I would like to highlight some of the ways in which private insurance industry is meeting this challenge. Voluntary health insurance has the capacity and is demonstrating its ability to provide the majority of our senior citizens with protection against the more serious costs of health care. For the remaining aged population, there is a portion who do not need or want insurance for health costs because of their financial circumstances or the existence of other private and public programs; health insurance of all types, including Blue Cross-Blue Shield plan, and prepaid group practiced by life insurance companies and other groups, offer plans for the present aged. Insurance companies have developed within the last 5 years several methods to enable such persons to acquire such protection at the lowest possible cost.

Now, here are several examples, and I am sure that some of the speakers this morning, especially the minister, are not aware of some of these: (1) A mass enrollment program whereby insurance is offered to all persons 65 years of age and over, regardless of present or past condition of health, and I hold in my hand here a copy of such ad-

vertisement by a reputable company. Through this method alone, close to 1 million aged persons have become insured in the last 3 years. The coverages, which are guaranteed renewable, include hospital, surgical, nursing home benefits. In addition, catastrophic hospital expense coverage is available, and in amounts up to $5,000.

Senator CHURCH. May I interrupt here to ask you, as it would be very interesting and helpful, if you would furnish for the record information in connection with such proposals as these because I think they have a very real bearing upon one phase of the problem.

Mr. GREEN. I intended to give this to you, Senator Church, this copy I have.

Senator CHURCH. If you could do this for us, we will hold the record open.[1] We would like to know in connection with this plan the number who have joined in it since it was offered, the number among those where the policies have lapsed, and what part of the total medical and hospital bills of the subscribers were actually paid. Do you have that kind of information?

Mr. GREEN. No; I don't have it from this particular company. I could get it for you though.

Senator CHURCH. If you can, it would be helpful to this committee to have that kind of data.

Mr. GREEN. I will attempt to get it for you.

Secondly, more than 30 companies offer policies, guaranteed renewable for life, for issue to persons in Washington over the age of 65; benefits under such policies are available up to amounts of $10,000 and cover all usual and customary in- and out-hospital expenses, including physician visits, prescriptions, drugs, and private duty nursing. Third, the aged can be enrolled through associations or groups of retired persons. One example is the American Association of Retired Persons. This plan includes benefits for hospital and nursing home care, surgery, and physician services in home or office.

Another example, on July 1, 1961, retired employees of the U.S. Government became eligible for health insurance on a group basis. Also a very unique plan has been developed in Connecticut. Connecticut insurance companies, that is, the home offices of the insurance companies in the State of Connceticut, initiated legislation to permit them to join together to provide comprehensive major medical insurance for that State's senior citizens. This plan covers care up to $10,000 and is open to enrollment, regardless of past or present health status. I might add, in addition, they make absolutely no money, which they make public, opening up their costs, and this is done at the net cost of whatever it takes to run the program.

To an increasing extent, group health insurance plans are written to continue after retirement. Senator Church, I think, would be glad to know that the University of Idaho health plan provides for retired employees to continue their health coverage after their retirement. The present aged generally did not have an opportunity during their active working lifetime to obtain either lifetime guaranteed renewable or paid-up insurance. Both of these forms of coverages are now widely offered. We can expect our future aged to have benefits

[1] The material referred to has been filed with the committee.

of substantial magnitude, both individual coverages as well as benefits from retiree group insurance.

The Spokane Life Underwriters Association is convinced that most of our senior citizens, whose numbers are constantly increasing, and whose capabilities of taking care of themselves are likewise increasing, want to and can take care of their own needs. It is our purpose, in appearing before your committee, to point out many new ways that private industry is meeting the problems of the aged in the field of health care. The Spokane Life Underwriters wishes to thank you for allowing us to appear before your committee.

Senator CHURCH. Mr. Green, one statement you made concerns me very much. You said that the social security system is operating in the red. This statement is made from time to time. As a Member of the Congress, either to Congressman Horan or myself, this is a matter of great concern to us because the integrity of the system needs to be safeguarded, and I am wondering on what basis you make this charge because we have had in the Congress repeated studies made by advisory councils on the social security system, and each time we have been assured that the system is actuarially sound, and that such statements, as the one you have made, cannot be borne out on the evidence.

I would like for you, if you have evidence of this, to tell me what it is.

Mr. GREEN. Well, maybe it should be stated this way, that the payments out have exceeded the income in, and I think that is generally conceded. I don't think there is any question about that. You could very well determine that, but the other thing is—I don't wish to get into any argument—that there is not—what was the word that you used just a minute ago—that social security is not on a reserve basis, similar to other funds. It is a combination that would take all afternoon to explain, as you well know, but it is not calculated that way.

Senator CHURCH. I think that, for purposes of our record, I should say that the financing of the social security system has been repeatedly reviewed by advisory councils, and they have been made up of outstanding businessmen, insurance actuaries, and other experts of unimpeachable integrity. The last advisory council included in its membership, for example, such people as Elliott V. Bell, who is chairman of the executive committee of McGraw-Hill Publishing Co., Malcolm Bryan, president of the Federal Reserve Bank of Atlanta, Reinhard A. Hohaus, who is vice president and chief actuary of the Metropolitan Life Insurance Co., and others that are very expert in the field.

This advisory council, after reviewing thoroughly the social security system, made the following statement in its report, and I quote:

> The method of financing the old-age survivors and disability insurance program is sound, and based on the best estimates available, the contribution schedule now in the law makes adequate provision for meeting both short-range and long-range costs.

I think that we ought to be careful because public confidence in this system is a matter of great importance. Congress wants to be sure that it continues to be soundly financed, and that is the statement of the last advisory council who looked into the social security system.

Mr. GREEN. I think that's true. I think the point that I was trying to make on the social security system was to indicate that the payments had exceeded the income, and that, if we are to add an additional amount on there, that there is a danger that it is going to keep on going in that direction.

Senator CHURCH. Thank you, Mr. Green. Now, I have a special request here, and I like to be accommodating to those who have special problems even though I have to deviate from our schedule to do so. I don't believe that there will be objection to this. Mrs. Ivah Deering has advised me that she needs to catch a 3:30 train back to Everett; otherwise, she has to wait until 12 midnight. Mrs. Deering, we don't want you to have to wait until 12 midnight. If you have a statement, won't you please make it now? Mrs. Deering is instructor of the evening division of Everett Junior College.

STATEMENT OF MRS. IVAH DEERING, INSTRUCTOR, EVENING DIVISION, EVERETT JUNIOR COLLEGE

Mrs. DEERING. Senator Church, Congressman Horan, and friends. I have, at the request of the committee, put into their hands copies of a prepared statement in quantity, and in that statement there is a list of recommendations that have been prpared by 11 classes of the Everett Junior College. I am asking that a substitute be made today for those 11, and in place of them, to put into the record 13 that have been passed upon by the current class in the evening division at Everett Junior College, they having now considered the 3 years of experience and coming up with a last considered statement. Today, I shall merely highlight some of the major points in that longer statement in the interest of time.

The Everett Junior College some years ago took positive action to welcome the older adult into the academic halls by the abrogation of fees for those over 60. In the regular classes, the influx of the older adults has not been notable, although we find them in both day and evening classes, particularly in crafts, woodwork, domestic arts, and so forth. In the Challenge of Retirement classes, however, some 200 have met in regular sessions through the 3 years of their existence. I am not here to boast of what we have done. For a bootstrap operation, it takes too much time to get going, but I want to bring to you and to the committee the considered thinking of men and women of 60 to 92 years, who have found it fun to continue learning and rewarding to feel that their long experience of living is not going to waste.

When an instructor in modern problems was pulled in to develop a program of education for retirement, we had no precedents and little down-to-earth material. We started at scratch, decided to turn the class into operational research and, together, to build a curriculum. Even our major goals were developed by the classes themselves of that first year, and they have remained much the same.

(1) To demonstrate the effectiveness of the informal teaching methods, by which the participant learns through study and expression; (2) to do a little mining to discover what was hidden in the experience of older people that could be interpreted and applied to meet social needs; (3) to provide and to test the material available; (4) to keep a record of the findings and place them where they would

do the most good, and here am I today to do just that; (5) to watch closely the emerging programs for the aging and evaluate them as they came out; and, (6) to provide the therapy needed by looking at social problems and relating one's self to them, rather than to air personal complaints.

Now, four of those goals led straight to what they asked me to say to you. Federal-State activities on behalf of the aging will be effective only when understood and accepted by those who are retired. On the one hand, there are many dedicated and trained individuals, who have the professional skills which the aging lack; on the other hand, there are the 17 million over 65, who have become, through no fault of theirs, second-class citizens. Their status, income and health are not what they used to be. Is it surprising that they are supersensitive, overaggressive to shield their hurts? That they lack group skills, technical and social, to meet their own needs, they do not always know; yet they have lived through a period of overwhelming change and they have survived, even if they have not gotten away with the adjustments necessary. Yet at this moment, these two groups, strong, able, speak to each other in terms completely misunderstood each by the other. As one person put it this morning, they are so far away from each other many times that they cannot hear what each other is saying. The rift has grown steadily greater. Is it not a matter of communication?

As one of our speakers said this morning, perhaps since the workers in the field of aging tend to be mostly those who are still employed, the rift is the result of their reluctant recognition that "here in a very short time go I." American society is still under the shock of the increased life span and expanding numbers of the old and have not as yet decided what attitude to take toward the aging and toward the whole situation.

The slight tone of patronage, the exaggerated care of the aged, which brings the inevitable response of the modern independent elderly, "I want to climb that roof; I want to walk that slippery street; I want to do as I darn please." The aged today are merely acting like human beings under stress and uncertainty. They react either by flight or fight. It is possible, however, when they are challenged to think deeper and ever deeper into the problems of which they are a part, to turn their energy into consideration of this very rift. That is what we have tried to do, with these results. May I say that in all the consideration, seldom has there been anger, not often has there been a personal complaint. They are not always in agreement with their leader, but seeing their own plight in the light of the greater problem, they come up with these definite recommendations:

The first is general. The surplus food distribution and the aging programs, based in welfare departments, are open to question. The retired individual, though without a job, is still a person. He doesn't want to embarrass his family. Social status is still important to him. He has pride and independence, which are his rights, and recognizing that there are always some that accept and sell for personal benefit, we believe that the majority are honest. To be forced to go to the welfare office, to declare indigency, in order to establish eligibility, creates an antagonism to public assistance and prevents many from getting what they need.

Wholly aware that here is an agency that has its machinery all set up to function efficiently in giving aid or setting up a program, we believe that any program routed through an agency whose primary purpose is to handle public assistance, automatically labels the program and builds barriers between the professionaly trained worker and the lay retired, which are very difficult to surmount. Such a program, they say, cannot be acceptable to the rank-and-file of the 17 million over 65. "We feel that a new plan should be devised to distribute surplus foods and to spark effective programs for the aged in our several States." In this space age, they told me, this should not be too difficult, nor too creative a task.

Second, the continuance of a State council on aging under the direction of the highest political office of the State inevitably implies political influence, which invites reluctance on the part of the retired to fully accept that council.

Third, since only a small percentage of those over 65 have incomes comfortably over the subsistence level, it would be well if, in setting up State or Federal conferences, that greater care be used to insure representation from this economic level. It is difficult, they said, to interpret the problems of the lowest income group unless it be one of them who also possesses a high degree of skill, observation, analysis and interpretation.

In the field of health, there as been 100 percent agreement in our classes that the private insurance agencies have not met the medical and hospital needs of those over 65, and there is a very large proportion of them whose policies have been canceled, whose rates have been raised beyond their ability to pay, and who are prevented from benefiting from their policies by the diagnostic clauses almost always included. An uncomfortable number of the retired now have no health or hospital insurance. There is a unified belief that, although the bills now before Congress are not fully satisfactory and will need improvement, that there is need for immediate legislation, placing medical and hospital care under the social security system, which is based on a prepayment plan. May I say that these groups have had representation from senior social clubs of the county, some of whom have several hundred members in their groups. This is the only recommendation on which all agreed throughout all of the sessions.

It would be well, they said, if Federal agencies, which handle loans for the building of private nursing homes, make a condition of acceptance that the management develop a continuing program of physical and occupational therapy and rehabilitation of patients, that high standards be established for the conduct of nursing homes with adequate inspection.

Now, in the field of education, there should be full-time directors, they said, of adult education in every sizable school system, whose immediate service will be to coordinate all efforts in adult education and develop more programs applicable to the older adults.

Seventh, that schools starting retirement programs should make arrangements for regular school transportation, as is done for people of other ages who attend school. In the interim, it may be necessary to hold school classes in a central offcampus situation.

Eighth, that the discussion method serves best in the education of older adults, since, from the expression of ideas, we learn. Because

this technique implies faith in man and his potential, it is worth the effort to find and to train teachers with the necessary personalities and skills to stimulate and guide discussion into channels of learning. No school building should be built which does not provide adequate conference rooms where informal discussion may be carried on without disturbance of other classes by voices necessarily raised to compensate for the frequent loss of hearing.

The biological facts of aging in all forms of life, including man, should be a part of the curriculums of high schools and colleges now, and when research points the way, in the lower grades. As a part of the social sciences, community responsibility for the welfare of the retired should reach the young, rather than the old. Here is one place, they told me, where sound social attitudes can be developed.

In the last field of housing—housing for the elderly is almost universally inadequate for the low income group. Some assistance from Federal housing agencies through local councils and authorities is needed to cover the cost of studies of population concentration and the location of the retired. The initial cost of such studies often prevents the small community from discovering the crucial needs until too late. However, a study that is not followed by community action is worthless.

The last one—duplication of facilities today is a waste. It will be essential for schools to begin making provisions for community activity centers for the older people on ground level and in pleasant surroundings. New housing for the elderly might well be placed near school buildings which already have such facilities or provide for creative activity within their own walls.

Thank you, Senator Church, for the opportunity to be here, and to present my statement.

(The prepared statement of Mrs. Deering follows:)

PREPARED STATEMENT OF IVAH DEERING, INSTRUCTOR, EVENING AND PART-TIME EDUCATION, EVERETT JUNIOR COLLEGE, EVERETT, WASH.

Federal and State activities on behalf of the aging will be effective only when understood and accepted by those who are retired. There are truckloads of facts, but the bridges are not always in repair. The result is all too often a waste of money, time, and manpower. Now that we are recovering from the shock of discovery of the explosion of the aging population, it may be well to recognize the aging—not as a special people apart (for every human being is aging) but as a part of the total effort to solve a major social problem. Sitting recently in a well publicized and well planned meeting for the retired, we noted a very small number of those who were to be served among the many professional workers. The program was practical and meaty, and the speakers honest and dedicated, but there was no contact. A puzzled voice came over my phone that night, "Wasn't I tuned in to the right wavelength? They were fine speakers and fine people, but someway there was no sympathy." "Do you not mean empathy?" I asked. "Yes, only that word has not gotten into my everyday vocabulary yet." Sometimes this lack appears in the form of a certain unmeant condescension, a hint of patronizing, or failure to recognize the conditioning which takes place when a man has been compelled to declare himself indigent, incompetent, in order to receive the help he needs. Could it be that the middle aged who make up the employed engaged in serving the aged, are hindered by their own resistance to the idea that "here, too, go I"? We do not know yet what attitude to take toward the retired and the responsibility for determining what that attitude may be lies upon the retired themselves as well as the local, State, and Federal agencies who, like your committee, are trying to solve the problems involved.

A certain sense of unreality surrounds the firm pronouncements we hear at every conference. There is (or was) a shadow of the old "every day in every

way, the world is better and better" philosophy. Was it whistling in the dark? Was it a deliberate attempt to keep the patient immune to the bitter facts of life? In any case, with the best intent in the world on the part of those who have become interested in gerontology and geriatrics, the rift has grown wider between those who are past 65, with the experience of living through and surviving, if not totally adjusting to the great technological changes, and those who have trained minds and skills in group work with which to tackle the problem with intelligence.

GOALS

We felt these things dimly in August 1958, when Everett Junior College initiated the first retirement class. We have not gone far in the kind of total education which can make of the latter years the high peak of life, for that process should begin at or before birth, but some of the things learned may help in a united attack on some of the major problems. We approached the job from the angle of research, rather than instruction. We started out in a new college setup, with no precedents to guide us, to learn together what it was all about. True, we had some goal in mind, perfected as we went along.

1. To demonstrate the effectiveness of the informal teaching method, under which the participant is introduced to dependable information and is led to seek his own development.
2. To discover the hidden and lost human resources, by listening to the experienced and recording his analysis of the period in which he lived.
3. To lead the group to think honestly of their place in today's world and to bring about an "expanded vision" which comes from seeing an individual experience in a larger framework. To demand deeper thought than the members realized they could do.
4. To record and make any findings available for us in development of programs for and with the aging.
5. To provide and to test the best material available in the field and together evaluate it.
6. To watch closely the emerging patterns in programs for the aging and when possible to evaluate them.

And inherent in these goals was a final one: to offer that therapy which comes from consideration of common problems, social rather than intimately personal, with the confidence that the retired can be useful in their solution.

SETUP OF CLASSES

We are just completing the 12th class:

One was an experiment with preretired, made up of professional women between 40 and 60.

One combined caseworkers and clients.

One dealt with programing for senior social clubs.

One was a forum on living conditions and their effect on the elderly.

The remainder were made up of those over 65, dealing with all phases of the problem.

HOW WE WORKED

We needed all that had been written and all that has been learned from hearings and conferences, not for textbooks, but for reference. We were not inclined to turn the class into a testimony meeting for personal complaints, but we kept the friendly, informal atmosphere by a rearrangement of the classroom chairs, and the serving of coffee in the midst of a 3-hour session. The men and women who came, at first so timidly, were challenged to think deeply and more deeply, to express their own ideas regarding the phenomena of the added years, and to see the social framework for their own living situations. In no time at all the students were engaged in fascinating research. It was early recognized that to listen intelligently is as much a part of informal discussion as to talk, so each member takes a turn at recording the ideas, agreements, and disagreements. Although some are prevented from participation in this activity by accident or defective eyesight, the recording has become a vital part of the experiment.

It takes courage for him who never went to school to enter a college classroom. He thinks of lectures and exams. He has braved the amusement of his family. He knows that he has experience, judgment, perhaps, a knowledge

of the relationship of cause and effect, but he must be led to value his own very real education, to be respected, to be freed to express himself clearly, and to seek new facts.

So we met as informally as was possible, read and checked the record of the preceding session, but kept the mechanics of registration and records to a minimum; used what we had in the way of material and in carefully planned, but wholly free and informal discussion; we searched for truths. Wheelchairs and canes became a natural sight, for the ages climbed as the word spread. "It is my legs that refuse to work, not my head," one woman put it. We found 3 hours of daylight brought the most satisfactory results, for it gave time for the slower minds to add their bit to the consideration.

But a method so different from what colleges and other institutions understand, caused eyebrows to lift and questions to be asked as to the validity of the process. The Everett Junior College, geared to youth, was aware of the existence of a great and stirring problem, and was ready to open the door, but for some time did not understand what we were about. A few would drop in for too short a time to see the pattern. Members of the classes were plied with questions. We had little time for explanations. Though we knew that with the older adult the method was the only one which could possibly succeed, we were in the experimental stage. Results would show later.

HURDLES

Everett Junior College was like every other college. It was totally unprepared for a program of education of the older adult. To accept the cradle-to-grave concept of education is to provide fewer formal classrooms and more informal conference rooms, where those who want to come early and get their breath, may rest quietly before class begins. There would be a full use of school buses for the old as well as for the young, since colleges are built out where the land begins and cars disappear at 70, and buses run infrequently and cost more than the diminished income will allow.

AIDS

Very early the Everett Junior College eliminated fees for all students over 60. Sometimes we found members insisting on paying the $7 fee required for all community service classes. I have never been totally sure of the validity of this abrogation of fees. One questions every form of discrimination. But it worked. As one student put it, "When one is forced to retire from employment at 65, he is already segregated and cannot meet his needs." These people know that though 4 percent of the 17 million over 65 have incomes above subsistence level, that more than half are under $2,000 for 2 people. And inflation to them means meat and potatoes. So they have accepted the elimination of fees with gratitude and have responded in increased numbers.

We have a library at Everett Junior College which never fails us. Any film for which we asked was available with operator. Booklists were prepared with their help. The newest written material was put on the shelves at our request for use of those who were still able and eager to read. The never failing courtesy of a canteen staff who brought the coffee to our distant room, the staff services department who met our deadline for mimeographed material when overwhelmed with work, a domestic science department who willingly demonstrated the nutritional value of certain food. And that indefatigable voluntary transportation pool, built by the daughter of a class member, who brought many of the members to and from classes in lieu of other transportation. All these helped to carry the experiment through to some results, which we will offer here.

RESULTS TO THE MEMBERS

A semester has 10 or 12 weekly sessions. After a little the fears of an academic atmosphere gave way to pride in being students at a college, with attendant privileges. There was a growing interest in retirement plans which would affect their children, in ways of adding to income, in community transportation problems, in the dangers of colesterol and in founder's fee homes. What they knew about nursing homes would surprise many managers. They were not easily fooled and they called spades by their correct names. They began to see the larger problems of their own and other communities and worked out some suggested solutions. They tested information with intelligence, if with skepticism.

They began to demand a higher level of entertainment and slowly built programs for the benefit of future classes.

They began to be proud of their years. When a frail little woman of 92 spoke of the "fun of learning," a check was made to discover the median age of those represented. For one class it would be 67 plus; again 70 plus; once it was 76.8, and the current class is 71.2, with the oldest 87. Attendance can never be regular for these older ones, but when 12 members arrived from an old-age home, we discovered that what was talked about in class was rediscussed in the halls and rooms of Bethany.

WHY ONE CLASS FAILED

During the first year the college announced a class for those between 40 and 60 in preretirement planning. Though there was much learned from the few who responded, we failed for several reasons:

1. We were not yet ready for the all-out, time-consuming promotion it takes. An instructor on an hourly basis of salary needs a great deal of assistance to initiate such a community venture.
2. There was not yet sufficient dependable material available to make such a class practical and appealing.
3. The eternal resistance of the middle aged to a personal acceptance of the fact of one's own aging is still functioning as a deterrent.
4. Industry and business were still reluctant to face their responsibility for cooperation in such a program either in or out of their plants. In this past year at least two general plans for a preretirement educational program have been prepared, one by the U.S. Post Office Department and one by the King County Council on Aging, in the State of Washington.

RESULTS SPECIALLY PERTINENT TO THESE HEARINGS

It is expected that the findings from the 12 classes already held will be included in a book later. From the first 11 classes came the following ideas, which will be presented for full discussion to the 12th class at their next session, with conclusions to be offered in our oral statement. These suggestions do not represent the results of a quick "either-or questionnaire; not a spot check nor a poll, but have been thought out together under an instructor who believes it to be entirely proper that her conclusions may not always agree with those of the group, and who refuses to dominate their thinking. They reflect the thinking of the first 11 sessions, without benefit of the final consideration. They may not always be palatable to dedicated agencies and councils. They are the honest and prolonged effort of some 200 men and women of mature years. We submit them with pride in their sincerity and strength and with appreciation and confidence in the desire of this committee to get the considered opinion of the older mature themselves.

GENERAL

1. Surplus food distribution and aging programs based in welfare departments are open to question. The retired individual though without a job, is still a person. He does not like to embarrass his family; social status is important to him. He has pride and independence, which are his right. Recognizing that there are always some who will accept and sell for personal benefit, we believe that the majority are honest. To be forced to go to the welfare office and to declare their indigency in order to establish eligibility creates antagonism to the public assistance and prevents many from getting what they need. Wholly aware that here is an agency with machinery set up to function efficiently in giving aid or setting up a program, we believe that any program routed through an agency whose primary purpose is to handle public assistance, automatically labels the program and builds barriers between the professionally trained worker and the lay retired, which are difficult to surmount. Such a program will not be acceptable to the rank and file of the 17 million over 65. We feel that a new plan should be devised to distribute surplus foods and to spark effective programs for the aged in our several States. In this space age, this should not be too difficult or too creative a task.

2. The continuance of State councils on aging under the direction of the highest political office of the State inevitably implies political influence, which invites reluctance on the part of the retired to fully accept that council.

3. Since only a small percentage of those over 65 have incomes comfortably over the subsistence level, it would be well in setting up State or Federal conferences, that greater care be used to insure representation from this economic level. It is difficult to interpret the problems of the lowest income group unless it be one of them who also possesses a high degree of skill in observation, analysis, and interpretation.

HEALTH

4. There has been 100 percent agreement in our classes that the private insurance agencies have not met the medical and hospital needs of those over 65 and there is a very large proportion of them whose policies have been canceled, whose rates have been raised beyond their ability to pay, and who are prevented from benefiting from their policies by the diagnostic clauses almost always included. An uncomfortable number of the retired now have no health and hospital insurance. There is a unified belief that although the bills now before Congress are not wholly satisfactory and will need improvement, there is need for immediate legislation placing medical and hospital care under the social security system, which is based on the prepayment plan.

5. It will be well if Federal agencies which handle loans for the building of private nursing homes make a condition of acceptance that the management develop a continuing program of physical and occupational therapy and rehabilitation of patients. That high standards be established for the conduct of nursing homes, with adequate inspection.

EDUCATION

6. There should be full-time directors of adult education in every sizable school system, whose immediate service will be to coordinate all efforts in adult education and develop more programs applicable to the older adult.

7. That schools starting retirement programs should make arrangements for regular school transportation as is done for other ages who attend school. In the interim it may be necessary to hold classes in a central off-campus situation.

8. That the discussion method serves best in education of older adults, since from the expression of ideas we learn. Because this technique implies faith in man and his potentials, it is worth the effort to find and to train teachers with the necessary personalities and skills to stimulate and guide discussion into channels of learning.

9. That no school buildings should be built which do not provide adequate conference rooms, where informal discussions may be carried on without disturbance of other classes by voices necessarily raised to compensate for the frequent loss of hearing.

10. The biological facts of aging in all forms of life, including man, should be a part of the curriculums of high schools and colleges now, and when research points the way, in the lower grades.

11. As a part of the social sciences, community responsibility for the welfare of the retired should reach the young, rather than the old. Here is one place where sound social attitudes can be developed.

HOUSING

12. Housing for the elderly is almost universally inadequate for the low-income groups. Some assistance from Federal housing agencies to local councils of authorities is needed to cover the cost of the studies of population concentration and the location of the retired. The initial cost of such studies often prevents the small community from discovering the crucial needs until too late. However a study that is not followed by community action is worthless.

13. Duplication of facilities today is a waste. It will be essential for schools to make provision for community activity centers for the older people on a ground level and in pleasant surroundings. New housing for the elderly might well be placed near school buildings which already have such facilities, or provide for creative activity within their own walls.

Senator CHURCH. Thank you very much, Mrs. Deering. We have had a request. Some of the people here in this crowded room have objected to the smoking, and I want to pass that on because I do think the room is quite crowded, and we have been in here going on some

time now. If we can keep that in mind for those who do find it objectionable, I think that everyone will appreciate it. We will be through here in a little while. One member of the committee, when this request came forward, said that he would age a little prematurely if he had to do without his cigarettes, but he is willing, and I think others will be, too.

All right, our next witness is Mr. John Ardner, executive secretary of the Spokane Welfare Council.

STATEMENT OF JOHN ARDNER, EXECUTIVE SECRETARY, SPOKANE WELFARE COUNCIL

Mr. ARDNER. Senator Church, Member of the House, Mr. Horan, ladies, and gentlemen, the points that I wish to make here are my personal comments. Although this program shows that I have an official position here in this community, these statements do not represent anything else but my own personal views.

During the course of this inquiry, you are considering many ideas on how to resolve the problems of the aging. May I submit that an old and universally respected precept can be taken from the annals of another profession. It is the fourth commandment, "Honor thy father and thy mother." Some of us translate this precept into belief that our parents belong in our own homes and not in small apartments and nursing homes, some of the men in dormitory rooms in downtown flophouses, and some of the women in shabby downtown roominghouses, or boarding homes, quite frequently, at public expense. They belong in our homes where the so-called affluent society with "discretionary income" has more and more of the conveniences that make living easy. They belong in our homes where responsibilities to them can be discharged personally and with affection. They make the best babysitters in the world.

Those who have been concerned about how effectively we are transmitting our true American heritage to our own children would have less to be concerned about when the grandparents and the grandchildren live together in one home. The Orientals make us look rather shabby by comparison. This should be public social policy. We ought to understand clearly that the solid U.S. citizen is the one who discharges personally and fully his responsibilities to his parents, as well as to his children.

It seems pertinent to me to add that our own children at the recent White House Conference on Children and Youth urged us to strengthen family life. This is one of the elements, and this leads me to my first point.

Everything we do that relates to the family should be an integral part of a national design to strengthen family life. This is urgent. Those of you who are familiar with the data on social breakdown or family breakdown know why I say this. However, in our State, it is possible and legal for children, regardless of their economic position, to have their parents supported by public assistance, in nursing homes, in our hospitals, at State and Federal expense. Our ideals and our current practices appear to be poles apart.

My second point concerns medical care. In our State, as you already know, we have one of the most advanced medical care programs

for those on public assistance, and for those who are medically indigent only. It is financed by appropriations of around $50 million every 2 years. It has prepaid medical and dental features.

Medical care is provided under contract between the State department of public assistance and nonprofit medical service bureaus located in several key counties of our State. This system, like everything else devised by man, is not perfect, but I submit that it is sound, it is working, it is meeting the acute and emergent needs of our citizens, young as well as old. It has the support of our doctors, dentists, nursing home operators, and of our hospitals. We are proud to say that it appears superior to any other proposals for medical care or for hospital care that we have seen. It has been in operation for a number of years and merits a careful examination by you, Senator, as chairman of this important Senate committee.

With respect to adding medical care provisions to social security, it is my opinion that social security should for the present remain an insurance plan for regular income payments to employees upon retirement and to their dependents. My reasons are two: (1) The medical care plan of this State is much broader than social security. It covers youngsters as well as oldsters, those on social security, as well as those ineligible for social security. The other 49 States of the Union would do well to follow our lead; (2) it seems more logical to use social security as a base for developing a new and more imaginative approach to income maintenance based on the insurance principle; and this brings me to my third point.

It is my opinion that it is high time for us to give serious consideration to junking the entire categorical assistance program. It is obsolete. The categories were born under adverse conditions during the great depression. They are, per se, a form of discrimination. They were sold on the basis that everybody was for helping the aged, the blind, widows, and their children, and the disabled. I would suggest that the social security program gives us a base for developing an income maintenance insurance plan that is scaled to family needs, that is financed jointly by the employees and employers, including Government, that is applicable to all citizens equally in all 50 States, that is geared to the financial support as documented by income tax records. Such a prepaid insurance system should apply, Mr. Horan, to the farmer, to the banker, to the seaman, to the veteran, to industrial workers, to clerks in stores, and to railroad employees. I have named these groups for specific reasons.

The coverage rate, based on actuarial requirements, should be adjusted to blanket in those now assisted by categories and those out of work. This to many of you may seem visionary. So were the Dallas schoolteachers who in 1929 paid $6 a year to the administrator of Baylor University Hospital to start Blue Cross on the road to becoming the largest single insurance plan in the world.

Special grants to special interests groups, including the entire program of unemployment compensation, should be gradually modified and eventually terminated in favor of one source of income maintenance for the U.S. family. It is my opinion that our modern industrial democracy should set its sights on developing such a program of coverage for all of our citizens. Thank you.

Congressman HORAN. Mr. Chairman, I would like to ask Mr. Ardner some questions.

Senator CHURCH. Go right ahead.

Congressman HORAN. Although I am a Member of the House of Representatives and not properly a member of this subcommittee, Senator Church has very kindly consented. How long have you been in welfare work, Mr. Ardner?

Mr. ARDNER. Thirty years.

Congressman HORAN. I am very much impressed, and I am sure that all right thinking Americans are, that we cannot build a nation unless we recognize individual responsibility, and that should carry with it not only a responsibility to ourselves to be good citizens, but it should carry with it the sanctity of the marriage vow. It should carry with it the sanctity of the family, and all of the concurrent responsibilities that go with it. You agree with those, I assume?

Mr. ARDNER. Yes, sir. I go further. In our society today, the sacred contracts that we have are between management and labor, or between taxpayer and the Treasury Department, not between man and wife. I think we need to look at this very, very seriously.

Congressman HORAN. Well, I certainly agree. I think we have been a little bit lax in recognizing those contracts of the social and moral nature. We have enough of the others without being delinquent in our welfare laws and the way that we regulate and administer them. As a social worker, if we had that attitude, it would make the work of those who are laboring in this vineyard a lot easier, wouldn't it?

Mr. ARDNER. I think so; yes, sir.

Congressman HORAN. Thank you, Mr. Chairman.

Senator CHURCH. Thank you, Congressman.

Mr. CRAVEN (from audience). Why don't you let some of these other people testify? This is a one-sided proposition, so far.

Senator CHURCH. That is what we are trying to do.

Mr. CRAVEN. You ain't doing it.

Senator CHURCH. Would you like to come up and testify, sir?

Mr. CRAVEN. Can I talk from here?

Senator CHURCH. We have microphones up here. If you would like to come up and testify, you are certainly welcome to.

Mr. CRAVEN. I'll testify pretty soon.

Senator CHURCH. All right, fine. The next witness who has asked to testify is Prof. Harry O. Harmsworth, chairman of sociology, University of Idaho at Moscow.

STATEMENT OF PROF. HARRY O. HARMSWORTH, CHAIRMAN OF SOCIOLOGY, UNIVERSITY OF IDAHO, MOSCOW

Professor HARMSWORTH. Senator Church, Representative Horan, ladies and gentlemen, I might say here at the outset that I am speaking as a private citizen, and not necessarily as a representative of the University of Idaho, although I am quite sure that I won't say anything that would keep me from fully representing the University of Idaho. I shall speak as a sociologist, however.

In that respect then, I wish to dwell a little while on the role of the college and the university in not only this problem at hand, but in all

social problems. Colleges and universities have a threefold function, that of teaching, research, and service to the citizens of the State. With respect to teaching, we, in colleges and universities, come in contact with not only hundreds, but thousands of students, and it is our function to interpret a lot of these social problems that you people are dealing with every day.

From the standpoint of research, we also have a very responsible function. Numerous organizations are calling upon us day by day to carry on research in particular phases of social problems within our individual States. That is one way in which I think the university can perform a very worthwhile service to the State and the Nation because the colleges and universities have for years been studying research methods, and they feel that they have built up a set of methods that can be relied upon. I want to call your attention to a type of research that should be avoided at all costs. This is some research that was made by a team of sociologists, and I should say quote "sociologists" unquote, headed by Dr. J. W. Wiggins and Helmut Schoeck of Emory University located at Atlanta, Ga., which purported to show that the vast majority of older people have no unfilled medical needs. In fact, it was reported 9 of every 10 persons report that they have no unfilled medical needs, and the remainder list lack of money as one of the least important reasons for failure to relieve the needs.

Well, there isn't any reputable sociologist in the United States that I know of that will subscribe to and support this research project. Here are some of the ways in which such a project has been condemned. They deliberately did not interview anyone over 65 who was receiving old-age assistance.

Yet this group represents 16 percent of all the aged. And they deliberately, because they said they lacked funds, omitted nonwhite people over 65, who represent about 7 percent of the aged. In other words, ladies and gentlemen, these people, who carried on this research, did not have a representative sample of aging people and their needs.

Now my overall thesis is that social and economic trends in the United States during the present century point to a continuous decrease in the volume of economic services supplied to those in need, by the family and other primary groups, and a steady increase in those performed by governmental agencies, especially on the Federal level. These trends apply particularly to older citizens. The bases for this situation seem to be located in a complex of demographic, ecological, economic, and sociopyschological factors.

It is a well-known fact, that for more than a century, the population of the United States has become older as measured by the proportion of men and women 65 years of age or more. This age category grew from 3 million in 1900 to 15.8 million in 1960, more than a fivefold increase. As a consequence, the proportion of older people in the population more than doubled, going from 4 to 8.7 percent, over the same period. Prof. Philip M. Hauser, eminent demographer at the University of Chicago predicts: "by 1980, the number of persons 65 to 69 will probably exceed 8.5 million, while those 70 or over will number almost 16 million. This would be nearly a 50 percent increase in the older population over the next 20 years."

Moreover, ecological conditions and trends do not appear favorable to the social adjustment of senior citizens. About 30 percent of our 190 million people live in cities of 100,000 and over. Those in the productive period of life—20 to 50 years of age—are much more adaptable to the stresses and strains of the city than are the dependent elements in the population. Older people in cities generally find it more difficult to maintain an independent household during their retirement years than do people of comparable ages in villages and on farms. Likewise in cities, family heads, especially in the lower and middle income brackets find it much harder to support and care for an aging parent in their households.

With the mounting cost of living, including the high cost of housing, every additional person in the home becomes an extra burden on the wage earner's salary. Taking an elderly parent into the household may mean that the wife must give up her job, thereby further reducing the family income. Should the older person be afflicted by a chronic disease and without adequate medical and hospital insurance, the financial burden often becomes more than the wage earner can bear.

One large study showed that the median money income of men 65 years of age and older, was $1,575, compared with the median of $4,190 for men 55–64 years old, who were still employed. The National Opinion Research Center found that three out of four older people believe that one cannot save enough during his working life to take care of him during retirement.

In times past, the problem of the aging was not acute. The proportion of older people in the population was relatively small due to high death rates at younger age levels. And a large percentage of those who remained could look forward to living out their lives on their own farmstead. Today that is all changed. An ever-increasing proportion of aging persons in the population face steadily increasing life expectancy without farmsteads and in many cases without homes of their own.

I wish to make it emphatic that I personally support the idea of individual planning for retirement during the productive years of life through careful saving and private investment. And I certainly honor those millions of men and women in the United States who often at great sacrifice, care for an elderly parent in their home. Nevertheless, for the masses of elderly people in this country who arrive at the end of their working career without adequate savings, and no close relatives who can or will provide for them, there just does not seem to be any other dependable way of caring for them than through some universal social insurance program, which includes in addition to necessities of life, adequate medical care.

Senator CHURCH. Thank you, Professor, for coming. We know the very effective work the universities do in their research programs. Our next witness is Mrs. Annalee Carhart of the Communications Workers of America.

STATEMENT OF MRS. ANNALEE CARHART, COMMUNICATIONS WORKERS OF AMERICA, LOCAL 9118

Mrs. CARHART. Senator Church, Congressman Horan, members of the committee, I believe my speech will be one of the shortest ones on record. At least, I sincerely hope so, that it will be real short. My name is Annalee Carhart, and I am appearing here today as a representative of the Communications Workers of America. My present office is secretary-treasurer of local 9118 in Spokane, which I have held for almost 13 years, and have been an active member of this local and the national CWA.

I feel most confident that my views are not only those of our local's members, but they also are the concern of the thousands of members which belong in CWA across the Nation, because we have a newspaper and in this newspaper, we have a section called "social security," and members write questions in and they get answers and advice every month on social security problems.

I would also like to say that I am a member of the Spokane Welfare Council, of which Mr. Ardner is the secretary, and, as you heard, he has been in social work for 30 years and he is doing a wonderful job here in Spokane, and he gives diligently of his time every day and even in the evening.

In the area of the disability test under the present social security law, I would like to present for your consideration what I believe to be a typical case, and we do have quite a few. With your permission, I will not use this person's name but, instead, will use Miss X. Miss X was employed by a large corporation for a period of 29 years. She became ill and went out on disability. At the end of 6 months, her personal physician released her as cured and able to return to her employment to work. The corporation, when told about it, asked her to make an appointment with the company doctor; that she would have to have a complete physical checkup before she could return. She did this three times, and three times she was turned down due to the fact that they figured her blood pressure was too high, and that she could not return to normal duties. By this time, her disability had run out. So the corporation then put her on a disability pension. She then applied for social security, and the administration sent her yet to another physician for special examination. After this examination, the benefit eligibility board advised that she had been disqualified for social security wage benefits, as the medical evidence was to the effect that she was able to work on a full-time basis where moderate activity was required.

It has been established that opportunities for men and women, or opportunities especially for women, are extremely limited for workers without clerical skills, and due to the fact that for 29 years she did only one type of work, she feels mentally incapable and too old to now start a new vocation in life. It is a known fact that there is very little demand on the labor market today for men and women over the age of 50, and I heard the age of 36 mentioned here today, and I know, also, that they say, unless you are under 36, well, you're not so good any more, but, after hearing the doctor talk on the vocational rehabilitation this morning, it seems that we have made some progress along these lines, but we still have a long way to go to replace these people in the labor market.

I am sure you will agree that a remedy in the law is sorely needed, and we prevail upon your good judgment in this matter. May I thank you, Senator Church, and your committee for this opportunity to appear before you, and I am most grateful.

Senator CHURCH. Thank you, Mrs. Carhart. The next witness is Mr. Richard McTighe, the community services representative of the AFL–CIO.

STATEMENT OF RICHARD B. McTIGHE, SECRETARY, SPOKANE LABOR COUNCIL'S COMMUNITY SERVICE COMMITTEE

Mr. McTIGHE. Senator Church, Congressman Horan, ladies and gentlemen, committee members, I might explain that I am the secretary of the Spokane Labor Council's Community Service Committee. One of our primary functions is to conduct a referral service for people with social problems, and those especially who are unable to meet these problems through their own resources. The referrals are made to social agencies in our community. Most of the people require financial assistance for a variety of reasons, but the most frequently heard reasons involve medical expense due to disease or accident. In most of these cases, the individuals are over 50 years old. They are not yet 62. They would be retired because of disability if they were working under the Railroad Retirement Act, or employed by a large corporation, or they were a veteran, or they had had a productive life in order to enable them to purchase retirement insurance against disability. Even if they, in many instances, didn't have what little they had, the Department of Public Assistance recognizes them as disabled. Yet, under the present social security law, they are not recognized as disabled.

Now, the severity of the disability test under the present social security law works an extreme hardship and injustice upon many who are actually disabled. These people are past their prime and with considerable disability. Who is going to hire them? Yet, according to the law, they are able to engage in substantial, gainful activity. Now, we have talked a lot here about facts, figures, statistics. I would like to talk about some people. These are people who are here today. They don't explain their own cases too well.

The first one that I would like to talk about is Carl Northcutt. He is sitting with you now. He is 62 years old. He applied for social security disability after an industrial accident in 1958. He has been examined by five different physicians. Their reports vary in admitting what degree of disability he is suffering. The injury affects his spine. He is not able to work at his trade of bricklaying, which is all he has done during his life. One physician in June of 1959 stated that the claimant was totally disabled from productive work because of severe and advanced degenerative disk disease with definite nerve damage. Surgery was recommended and it was believed he could return to physical activity after surgery. Then in later examinations by different physicians, it was believed that surgery would not restore his ability to pursue his trade, but they believed it would be possible for him to remain active in any occupation not involving heavy lifting or maintaining a continuing bent-forward position. This man has an eighth-grade education. He is 62 years old. His memory is failing him.

We do not believe this man can be employed in any gainful activity. Who is going to hire him in his condition? Yet, he has just received word on the hearing examiner's decision, that he is again being denied disability benefits. He has suffered here these last few years with much pain and discomfort. He now takes vinegar for his arthritic condition because he cannot afford the prescription given him by his physician. He is about to lose his home because of debt incurred during the time of his illness. I predict he will lose it the first of next month.

In order to keep up some of the payments and allow for some of the other basic necessities of life, he has had to rent his home and to take up quarters in a converted chicken coop on the back of his property. Now, this fellow's wife was alive up until about a year ago. When he became disabled, she worked. They were very proud people, and she provided for them. She since has died of cancer. They have received some State aid and they feel very grateful for it, but somehow or another our so-called wonderful social plans have not met this person's needs. He is suffering.

The second case has to do with Madeline Scher. She is a widow. I don't know if she is still here or not. She is 54 years old, and she has arthritis of the nerves and muscles. She has chronic bursitis in her shoulders. She has been examined by four different physicians since September 1959. Apparently, they do not find her disabled according to the law. Her occupation, for many years, has been that of a waitress. She can no longer carry a cup of coffee without spilling it. At her reconsideration hearing on Tuesday of this week, it was suggested that she could seek employment as a cashier. Well, now, I'm from the catering industry, and I know that cashiers have a great deal more to do than to accept customers' checks and ring that money up in the till. In fact, most of them are a little older and they have to compete with the waitresses for their very jobs. Most of them are required to do a great deal of cleaning, et cetera. I may not know too much about disability, but, believe me, I know what it's like to work for a living, and I know how it is to go out and look for work, especially when you are past that so-called prime, because I see these people and we work with them.

Besides this physical pain, and this seems to be common in many, many instances for these people, she is suffering an emotional disturbance. She's bothered. We submit that no employer is going to hire her. Now, we heard some talk this morning about vocational rehabilitation. We have a good vocational rehabilitation department. The only thing is that it's about 10 percent of the size it should be to work with these people. Now, perhaps in the State of Washington, we should make some changes. According to the social security law, as I understand it, when a person applies for disability, he is screened by the department of vocational rehabilitation, but in the State of Washington this is not true. He is screened by the department of public assistance, and that's it. Here again, we need some regulations so that things are done the same every place.

Well, in the last case, and I don't think this woman is here, her name is Myrtle Moore. She has an arthritic condition. She was employed as a maid for many years by a local hotel. She was successful in establishing her disability after taking it to court, and I forget

just how many hearings she had to establish disability. She finally took the case to court. Now, after she won the case, it was 8 months before she started receiving benefits. I understand, in talking to the social security people yesterday, that part of this was due to her lawyer's fault for not getting the work that the judge suggested he do, in fast enough. Of course, according to the law, he is allowed a fee of $25, and you know how much service you get from a lawyer for $25. No reflection on the lawyers. They have to eat, too.

So it's our feeling that if a person should have to take a case to court, and he should win, that the Government attorney should not be allowed to sit on his case, but that there should be a reasonable time limit so the individual can have what is coming to him. In other words, the Government could appeal it within 60 days; if not, let them pay the claimant.

On behalf of the Spokane Labor Council's Community Services Committee, I would like to thank you very much for the time and for possibly consideration on lessening the severity of the disability test under the present social security law.

Senator CHURCH. Thank you very much, Mr. McTighe. The next witness is the Honorable Bernard Gallagher, who is an attorney and former State senator from Spokane. As soon as Mr. Gallagher's testimony has been received, we will then move to the open forum phase of this meeting, and anyone who hasn't been called upon and wants to talk will have a chance to do so.

STATEMENT OF HON. BERNARD GALLAGHER, ATTORNEY AND FORMER STATE REPRESENTATIVE, SPOKANE

Mr. GALLAGHER. Senator Church, distinguished guests, ladies and gentlemen, I want to thank you first, Senator, for the opportunity you have given me to present my views on problems of the aging. I want to thank your committee, too, for coming to the city of Spokane to give our people an opportunity to present their views. To the ladies and gentlemen in the audience who are scheduled to testify, I will say that I will make this just as short as I can so that you will have an opportunity to present your own views.

As the Senator said, I was a former member of the Washington State Legislature for 14 years, during which time and all of which time I was a member of the social security committee dealing with problems of the aging and other social problems. As such, I have a few ideas. I have always believed that the best place to get your ideas about the problems is from the people themselves. As you see, I am getting a few gray hairs myself and am getting a little closer to that problem myself, where I am going to be more and more personally interested.

Before I go into the group over 65, I wish to also point to the difficulties that people, men over the age of 40 particularly, have in getting new jobs once they are discharged from present positions. I would suggest that industry and labor work out—together with the Government—work out some program whereby workers can be retrained for newer jobs, for different jobs, also that some provisions be made for flexibility of retirement plans which wouldn't penalize a man who has to jump from job to job, or has to make a job change

after he has spent the major portion of his life in one particular employment.

As one of my particular tasks as a former member of the legislature, I, on occasion, conducted some public hearings relative to problems of the aging and the treatment of older people. At one time, I had before me eight screening doctors of the State, and I found, to my surprise, that only one out of those eight had any idea of the advanced techniques that were available for the retraining and rehabilitating of aged people who were stricken down by disease and relegated to nursing homes but who, with advanced techniques, the newer techniques, could be brought back to some degree of self-care.

I would suggest, therefore, that the Federal Government give serious consideration to helping in the field of geriatrics to see that there is more opportunity for the training of medical men in the field of geriatrics, more training for social workers, psychologists, in the field of geriatrics. I suggest that support and encouragement be given to hospitals, social agencies, medical societies, public health agencies, to use the team approach for the handling of problems of aging and sick people.

It has been my experience with a great number of older people that they like, as far as possible, to live in their own homes and not to be put into a nursing home or into a hospital unless absolutely necessary. I would suggest, therefore, the team approach, the use of physician, nurse, homemaker, housekeeper, and social worker, be used in home visits to persons who can be cared for in their own homes. This would have a very fine effect on the morale of the older persons. To those of you in public life who are responsible for the appropriations to take care of people in hospitals and nursing homes, this would offer one way of cutting that cost and providing more care for those who need it most desperately.

I would suggest, too, that more consideration be given to the establishment of community centers where older residents may join in interesting and productive work. I have in mind something in the nature of what are called day centers in New York, where men and women may come and where they have work to do, which isn't just "make work," but actual tasks that they can perform for themselves and for their fellows.

In some cases, an actual employment service is run. The statistics, as I recall them, would indicate the use of this type of center in a controlled group has shown that medical costs, hospital costs, are much, much lower for groups who make use of such centers as compared to those who don't.

In the field of housing, I would suggest that more consideration be given in the plans and financing, to the special problems and needs of the aging population. Now, in all of this, I speak of the aging population, but I don't like to set them out as a special group. The aging people have to be considered as a part of the whole community. They can't be considered just as a group and set off to the side like a bunch of lepers. Although people don't use this type of language, I think we should be very frank with ourselves because some people do have that tendency. They just give our old people very, very short shrift. This is not what should be done at all.

Housing establishments and housing plans should take into consideration the fact that older people are and want to be and can be very active and valuable members of the community practically till the time they die. It has been my own personal experience in the practice of law, for example, to notice that some of my older colleagues, who have practiced law past the age of 80, and who have remained, while not as physically fit as some of the younger men, but mentally alert up until the very, very late retirement time.

Believe me, if they hadn't been keeping active, mentally and physically, they wouldn't be in that shape today. I am not suggesting that everybody can do this, but I am suggesting that if you have something to do, and you do it, that you are far better off than just being relegated to a nursing home or a hospital.

I cannot agree with my distinguished friend, who preceded me, that medical care coverage today is adequate. I don't think that's a fact at all. I know it isn't a fact from my one personal observation, and I know it isn't a fact from the observations of the people and the many men who have had to deal with the problem. I do think, however, that any solution to this problem that is worked out must maintain the traditional personal relationship between doctor and patient.

I believe that every effort should be made to work out a plan that meets the approval of the medical profession and the needs of our aging population and the needs of our population generally. However, should this fail, then I think it is time that the Government step in and set up a program which will take care of the problem. I also feel that every effort should be made to return the patient, who is in a nursing home, to his highest potential of physical self-care and employability. I suggest that grants be made by public bodies for the development of rehabilitation services for the aging in local hospitals and nursing homes, as it has been in this State, and I think we probably have the best hospital and best nursing home care in the country.

Time was in the past when we sort of penalized the hospitals and we penalized the nursing homes for rehabilitative efforts; that is, we penalized them financially. In other words, generally speaking our hospital and nursing home care and the payment for it was made on and based on the amount and quality of care needed. If you had a bedridden patient who couldn't do anything for himself, you pay so much; if you had a man who was ambulatory and could get around, you didn't pay as much. There is no financial incentive for the nursing home operator to really go in and do a job of rehabilitation of a patient.

I think that every means should be used to encourage nursing home and hospital operators to rehabilitate their patients and get them in the best possible physical condition and, if possible, to return them to their own homes, and I think the people that do this work should be paid well for it.

Bluntly speaking and materialistically speaking, and speaking as a former member of the Appropriations Committee, you not only would be better off spiritually, you'd be a heck of a lot better off financially if you did this.

Now, as I say, I think the way a public official can best get his ideas is not from some of us who are so-called experts, but the really smart ones try to get the ideas from the people themselves. Senator Church,

I again want to thank you for giving me this opportunity to present what ideas I have and get them to you. I want to thank you on behalf of the city of Spokane and the surrounding area for the opportunity you have given them to present their ideas. Thank you.

Senator CHURCH. Thank you, Mr. Gallagher. Now, we have set up here a microphone in the front of the room and another microphone will be set up in the back of the room, and we are going to open this up now to the senior citizens who are here, who have not had prepared testimony and who want to relate to the committee their own views or their own problems. This testimony will be taken down and made part of the record, just as the prepared testimony, and we only ask that those of you who want to avail yourself of this opportunity and take the microphone, please identify yourself, your name and your address, for purposes of the record.

Mr. CRAVEN (from the audience). Can I talk now?

Senator CHURCH. Yes. Take that microphone back there right next to you, sir. There is also Albert Manley and Mr. and Mrs. Leavitt that we will want to hear from too, who have asked to be heard.

STATEMENT OF CHARLES B. CRAVEN, SPOKANE

Mr. CRAVEN. My name is Charles B. Craven. I am a citizen of the State of Washington, and I was 72 or 73 years old when I applied for social security, and I got the magnificent sum of $13 a month, and it has cost me over $2,000, that little bit of money they granted me. The welfare state said I didn't report it, and they have taken it out of me, and they've been taking it off me ever since, and they take $10 a month now. They've taken over $2,000 from me, notwithstanding a judge in Yakima ruled that they couldn't take my pension, but they didn't care for that because they had their rules, and that's my trouble, and that is all I've got to say, I think, and I thank you very much.

Senator CHURCH. Thank you very much. I'm sorry you have had this kind of trouble. If you leave your name with the committee—well, we have it in the record, and we will look into your case and see if anything can be done to help you.

Mr. CRAVEN. We ought to take the case and sue them with some lawyer, but I can't pay him. I can't do that because I would have to pay him, and I can't stand that.

Senator CHURCH. All right. Mr. Manley has asked to speak. Is Mr. Albert Manley here?

(No response.)

Senator CHURCH. Mr. Leavitt. Won't you come up and take this microphone?

STATEMENT OF MR. AND MRS. C. C. LEAVITT, PRESENTED BY MR. LEAVITT, COEDUCATIONAL DIRECTORS, IDAHO AFFILIATE OF NATIONAL LEAGUE OF SENIOR CITIZENS

Mr. LEAVITT. Senator Church, Congressman Horan, ladies and gentlemen, I used to be an itinerant preacher in the Methodist Church, or perhaps irritant would be better. I don't know about this microphone, but I saw the gentlemen on the program today, who have been

using this, had their hands down. I couldn't say an intelligent word unless I could use my hands. So, I don't know how we'll get along.

It is indeed gratifying that the Senate Committee on the Problems of the Aged is holding a hearing in Spokane. We believe it will help to promote better days for our senior citizens. In behalf of our organization, we salute you. As a representative of the National League of Senior Citizens, permit us to present the following paper on the problems of the aged.

First, our goals: Federal social security payments of $173 per month; lower the eligibility age for women to 55 and men at 60; hospitalization and health care within the framework of the Social Security Act; permit earnings up to $2,400 a year after age 60, no limit after 70; $100 million direct Federal loan at 3½ percent and other provisions to develop low rent housing for elderly; elimination of all local welfare office investigators, visitors, and other assorted snoopers; Federal laws prohibiting States from imposing lien laws, responsible relative laws, and pauper's oath.

To bring the attention of your committee to the problems of the elderly in Idaho, may we present a concrete example, which came under our observation, and which shows the indignities imposed by Idaho law upon the recipients of public assistance. The case was that of an elderly widow. She was very industrious, resourceful, and of an independent nature. She never asked anyone to do anything for her that she could do for herself, and she was quite capable. However, the time came when her health seemed to be failing, and no one knew of her condition as the department of public assistance had not called on her for a long time. In her distress, she sent a request to some friends to call on her.

They found her alone with no one to prepare food for her, and her drinking water was dipped out of the river which flowed near her little boat house. The friend then kept her supplied with city water and ice, as it was the hot time in the summer, and proper food. It was not long until she revealed to them that she had over a period of years saved out of her monthly check until she had several hundred dollars put away in a secret place. When asked why she had deprived herself of the things she needed, she replied that it was for her burial expenses. Her independent spirit could not bear the thought of a pauper's burial.

In a short time, she had to be taken to the hospital, and when she was placed in a clean, comfortable bed in a lovely room, she exclaimed in genuine appreciation, "Oh, this is heaven." Well, she had the care which she needed but soon passed away. The same friends, to whom she had entrusted her savings and to whom she had given instructions, paid the doctor, the hospital, and the funeral expenses, and she was given a decent burial with a headstone at her grave, without any expense to the county or to anyone else.

Later, the ones who had done all they could to carry out her wishes were informed by an attorney that they had acted unlawfully and could be subject to a suit, since, according to law, she was supposed to spend her entire check each month, and they had no right to take any part in disposing of any of her belongings. These people, however, were and are happy in knowing that she had the care to which she was entitled, and that she passed away knowing that she had left no

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burden upon anyone. Documents filed in the office of the probate court verify the accuracy of this report.

These elderly people who are being so sadly neglected are not dependent by choice, but are the victims of circumstances over which they have no control. Many were the victims of continued crop failures, grasshoppers, and drought in the Prairie States. Many had their life savings in banks and loan associations and insurance companies, and so forth, at the period when wheat was 10 cents a bushel. If the guaranteed bank deposit law had been in effect 20 years earlier, this problem might not be with us today. Many of us remember the abuse which was heaped upon the heads of those who advocated such a law 40 years ago.

Many valid reasons could be cited why the problems of the aged are the obligation of the Federal Government. The lack of support by the States for the Kerr-Mills bill is a case in point. Only 12 States cooperated. The attitude of too many States is that legislation in the interest of the aged is the State's business, and that there should be no Federal program.

On September 5 of this year, in a speech on the floor of the Senate by the Senator from Vermont, Mr. Aiken, he pointed to the futility of the Senate program and said this:

> Sooner or later, the Federal Government will do it. When the States will not provide what is needed, I do not know what else can be done. I can visualize the same thing occurring in regard to medical care for the aged. The States apparently are not going to put themselves in a position to care for their own aged people, even with the cooperation of the Federal Government. [Congressional Record, Sept. 5, 1961, p. 16930.]

We believe that Senator Aiken's views are supported by the majority of his colleagues and doubtless will be saluted by the people as heralding the dawn of a brighter day for our worthy senior citizens.

This is signed by the coeducational director of the Idaho affiliate of the National League of Senior Citizens. Committee, I thank you.

Senator CHURCH. Thank you very much, Mr. Leavitt. There is a gentleman right here. Would you like to come up?

STATEMENT OF CLARENCE ANDERSON, SPOKANE GOLDEN AGE CLUB

Mr. ANDERSON. My name is Clarence Anderson. I am a member of the Spokane Golden Age Club, and my wife and I are living on social security of about $62 apiece per month. Now, that's barely enough to pay ordinary expenses, and if medical expenses come up, why, that's got to come out of our very meager reserves.

The President has promised that health care for the elderly under social security, H.R. 4222, will be one of the first bills brought up when Congress meets in January. We have about 1,200 overlapping expensive health plans, and they pay off millions of dollars for advertising and agents' commissions, and it is all collected from the policyholders. You can buy two or three of these expensive policies and still you don't have the coverage you need. We pay the Spokane Medical Service Corp. $150 a year. Every week, my wife has a shot for pernicious anemia, and every month we have a big bill for office calls and medicine. None of this is covered by our medical service

plan. We need H.R. 4222, medical care for the elderly under social security.

Now, this medical plan that we have, it doesn't have a level premium. They can change the premium and change the coverage and kick it out any time they like, and the coverage, we're covered for hospitalization, partly covered for operations, laboratory tests, and maternity care.

Senator CHURCH. Thank you. All right, this gentleman.

STATEMENT OF MRS. DONALD GUMPRECHT, COEUR D'ALENE, IDAHO

Mrs. DONALD GUMPRECHT. Senator Church, I have something to say.

Senator CHURCH. I promised this gentleman first.

Mrs. GUMPRECHT. It's pertinent to his testimony, too. I'm from Coeur d'Alene. I am Mrs. Donald Gumprecht. I am also a physisian, and I would like to protest the testimony of Mr. Manley and also Mr. Leavitt, and I assume Tom Wood. I would just like to put in the record that the Idaho National League of Senior Citizens of Coeur d'Alene, Idaho, is the old Idaho Pension League. They dissolved and have reformed, and the membership is the same. The Idaho Pension League is listed as subversive by the Attorney General of the United States. I would just like to have that put in the record.

UNIDENTIFIED MEMBER OF AUDIENCE. Thank you for those very kind side remarks. I would like to have a word about our doctors now.

Mrs. GUMPRECHT. I would like to say that they were allowed to testify, whereas our own Kootenai County Medical Society was not allowed to put in their testimony here.

Senator CHURCH. Just a moment now. We want you to know that this hearing is open to everyone. My clerk here on the committee tells me that your association has filed a statement.

Mrs. GUMPRECHT. Yes. We were told that we could not give——

Senator CHURCH. I have told you now that you have full access to this committee, and you may speak, and everyone may speak. You have made a statement, and I will say that nobody is being excluded for any purpose. Let's make that perfectly clear now.

Mrs. GUMPRECHT. Senator Church, I just want to make clear the nature of the organization.

Senator CHURCH. You made your statement. Mr. Wood.

STATEMENT OF TOM WOOD, COEUR d'ALENE

Mr. WOOD. Senator Church, the lady very kindly made some very charitable remarks. The lady—I don't want to say too much about the lady, but——

Senator CHURCH. Let's confine our testimony to the point at issue, which has to do with problems facing the aged, because that is the purpose of our hearing.

Mr. WOOD. I stand corrected. I do not speak for any medical, any doctors, or any insurance company, but I speak for the 17 million senior citizens of America, most of whom need hospital and financial

care. We senior citizens are getting pretty cynical, and we have good reason to be cynical. We really doubt that hearings of this kind are really necessary, because, after all, anybody in this audience or anybody in the United States can get a copy of Senator McNamara's report of the Subcommittee on Problems of the Aged and Aging, which goes into this thing far more fully than we can go into it today.

What we need, ladies and gentlemen, is action, not words. What we need is some action. What we need is more Congressmen who vote in Washington the way they talk at home. This is no reflection on any of these gentlemen present, but there are many who do not vote in Washington the way they talk at home.

Now, like I say, we have problems, many problems. We in America are the richest country in the world, but the fact of the matter is in the matter of social legislation, we are behind most of the civilized nations in the world today. That is a fact. Even poor, little insignificant nations like Norway, Denmark, Sweden, they are miles ahead of us. They have their old-age pensions as a matter of right, and their medical and social security needs met and they had this generations ago. Even Canada, to the north of us, once poorer than we are, and much poorer now than we are, has adopted a system of health control.

Here, they talk about socialized medicine. The same doctors here, who talk about socialized medicine, are perfectly willing to let the Nation run our public schools.

It's all right for our Nation to run our public schools, it's all right for our Nation to provide the national defense through taxation, it's all right for our Nation to build our public highways, it's all right for our Nation and our communities to provide police protection and parks and libraries, and what have you, but, oh, these doctors, when you mention medical aid as a matter of right, socialism, socialism. Don't look under the bed tonight. You might find a Socialist goblin under there.

UNIDENTIFIED MEMBER OF AUDIENCE. We're able to take care of you any time, only you won't let us.

Senator CHURCH. Now, we're going to have to have some order here because everyone has a right in this country to speak, regardless. Let's remember that.

Mr. WOOD. We here in Idaho have a lien law on the books where every senior citizen claiming or applying for public assistance, if he has a home, a little home that maybe he and his wife worked all the years of their life for, he must give a lien on that home before he can get a penny of public assistance. Now, what does that mean? It means that the State refuses to recognize that it has a responsibility to those senior citizens. By forcing those people to apply for what is in effect a loan, they deny them the right, and they have a right. I know many of those people and have worked with them, and I know they have paid taxes in Idaho all their life, and many times, through no fault of their own, they're compelled to seek public assistance when they get old enough.

We want to divorce this whole program of medical and financial aid. We want to divorce it completely from the province of need and put it in the realm of right. We want a program that will permit Federal pensions as a matter of right. We want to do away with the

pauper's oath, and we want the old people at age 60 to get medical attention as a matter of right also, not as a matter of need, but as a matter of right. We want these things to be taken away. We don't like this humiliation. We don't believe that 17 million senior citizens should be humiliated and forgotten and degraded and insulted. We don't believe in it.

We believe that they are entitled to rights as American citizens. Other countries have done it. Other countries, as I said before, are miles ahead of us in this respect, and we want those people placed in a category of right. We want the senior citizens of America, of whom I am one, we want them to become first-class citizens and not to be humiliated and insulted by an infamous lien law over there in Idaho. We want to abolish all of those things. What is the lien law for? It isn't because the State intends or expects that they can get money out of it. They'd never make any money out of it. Whatever is coming, the lawyers generally get it all. That lien law is put on the books to humiliate the old people so they will not apply for public assistance and some of those people are proud. They're proud and they are reasonably proud. They're Americans, and they work. They are not parasites. They work all their lives, and when they get old, the States owes them and the Nation owes them medical care and financial care as a matter of right, and we will always hold that. So, we want to remove that humiliating lien law.

Senator CHURCH. I am obliged at this point to take note of the fact that the hour of 4 o'clock has arrived, and I think that the hotel is not putting us out yet, but since we have a little more time, I want to allow some of the other people, who want to be heard, to be heard. We do have that commitment of about 4 o'clock and we do have that limit. I notice there are some others who want to be heard.

Mr. WOOD. I don't want to exclude anyone.

Senator CHURCH. I want to hear from people who have not yet been heard. The gentleman back there now.

FURTHER STATEMENT OF C. C. LEAVITT, IDAHO AFFILIATE OF NATIONAL LEAGUE OF SENIOR CITIZENS

Mr. LEAVITT. Mr. Chairman, I would like to make a further observation. I ask that our remarks by our former president of the Idaho program, who was present for a long period, I ask that that be made a part of the record today.

Senator CHURCH. All the remarks are part of the record. That is taken care of.

Mr. LEAVITT. All right.

Senator CHURCH. Will this gentleman come forward now? Incidentally, before you start, may I say that anyone here who wants to use the paper and the envelopes that the committee provides here and elsewhere in the room to make a written statement of your own particular problem and your own particular viewpoint, please feel free to do that, and we will take those written statements and give them the same consideration that any oral statement would be given and made here. I mention that in case anybody doesn't have a chance to use the microphone and wants to leave a statement with the committee. All right, sir.

STATEMENT OF B. A. READ, SPOKANE

Mr. READ. My talk is going to be in the nature of a question. The Honorable Mr. Horan made the statement this morning that the American people relied on self-help, that we desire self-help. Now, I desire self-help myself. Now, then, before he sat down, he also extolled what a great medical aid the Government had recently given us, and this is strictly a giveaway tax proposition.

Now, I would like to know why it is branded not self-help, if during a citizen's productive years, if he sees fit to lay away a portion of his income to take care of himself after retirement and for his medical aid. Now, I would like to know why, and I would like to have the answer explained to me, why that would be considered creeping socialism or communism, or whatever you want to brand it. It sounds so silly to me. I think that, if I want to take out of my wages during my productive years and turn it over to my Government, I have confidence in my Government that it will always be there. I heard statements made here by the insurance people that the insurance could beat our Government. Now, I know he backed up on that when he was cornered on the social security.

Now, insurance is good. I have insurance. I carry insurance, but insurance can be wiped off. I lost two policies in the time of the depression. I lost two policies that I paid a lot of money into, and I lost those policies so completely that I didn't get a thing out of them. Insurance is good, but insurance is not the answer.

Our answer is the Government, and we're not asking the Government to give us a thing. We're asking the Government to administer the funds that we take out of our earnings, or the people do that are working. I've quit work. We want the Government to administer those funds to become effective at retirement age. I can't see where that can be branded as socialism or communism, or any dirty remark like that.

Senator CHURCH. Let me remind you folks that we have just a few more minutes. All right, sir.

STATEMENT OF LESLIE PLUMMER, SPOKANE

Mr. PLUMMER. My name is Leslie Plummer. I live at 1606 East First Avenue, Spokane. I am supposed to be a retired citizen. What I would like to say—I haven't heard it mentioned here today—the money that is turned over to the State that is supposed to be for social security, or from that fund, it is turned over to people to help people here who draw some social security, and they get some State assistance, and through the source of that, through the State assistance part of it, usually whatever is turned over from the raise from the Federal Government into the social security that they're supposed to get, they don't get it. It's taken off on the other end by the State, and I presume it's put into the general fund or used for some other purpose.

Now, I would think there would be some preparation through your Congress to find out whether the people who were supposed to get it, really got it, or if they didn't send it to the State for the simple reason to balance the budget, or raise the salary of somebody that's al-

ready getting considerable money. That looks like a good simple way of doing it.

I would like to also state that they have come out, different people, and they stay about 1 day average and see what people get. I personally know of people here, a man and wife, with a six-room house that they don't need, they draw $1,568.72, and that covers everything imaginable that comes up in their lives. Well, that's not very much money.

Another thing I would like to scatter around, if you don't mind, would be this insurance business. Now, this has gone along, and I've noticed it for a considerable time. A few years ago, it was so high that the ordinary person couldn't have it, not only that but their age limit was out. It was written off after you became a certain age. Now, it's a good deal like betting on a poor horse with somebody that doesn't want it. There's more companies bidding for it, naturally with a little better conditions on the thing. You know that. All of you know that. I mention it for the simple reason that it might kind of renew this thing in your own mind.

Another thing, we speak of doctors and dentists. Maybe you don't like what I'm saying, but this is true. I know a few years ago that I knew personally people, two women that worked for technicians, and I knew a man that was in the business of making teeth for doctors, and he was a technician. He told me personally that at first he got $6 for a set of teeth, upper and lower, and he finally got it up to $8, and that's the most that he ever got, and you can go by there at 9 o'clock in the morning, and he will take your impression, and he will give them to you at 5 o'clock in the evening for $350. Think it over.

All right, they don't want socialized medicine. Under the plan we have, it isn't socialized medicine. It's money that is paid in, and on that I would like to make another point. This proposition of holding out, say 2½ percent for social security on the employee and on the employer, if it isn't enough to keep it going, why not keep it at 2½ percent on the employer and raise the other on 5 or 6 or 7 or 8, or whatever it should be, on the worker, and place it on that basis to start with, and build up a fund, because he's already being held out on with the withholding tax, and he doesn't get any benefit out of that, that is, any more in a government way. In this way, they could build a tremendous fund which could go and help finance the thing for himself.

Speaking of doctors then, when we go, they speak of socialized medicine. It isn't socialized medicine. Did you ever hear of a doctor refusing to go into a big Government hospital at a big salary? Did you ever? No. They like to do that, but they don't want it around home that way. I believe, gentlemen, that's about all I have to say, and thank you.

Senator CHURCH. Thank you very much. Is there anyone else now?

STATEMENT OF MRS. MINNIE SELLMER, HERON, MONT.

Mrs. SELLMER. My name is Mrs. Minnie Sellmer, and we just came in from Heron, Mont. My husband and I are both on social security, and we're drawing $100 a month, for which we are very, very thankful, and it has helped us along. I raise a garden and I have my place there, and I do everything I can.

My husband goes prune picking every year, and last year I went along with him, and I helped him with that and we got a little money for it. Now, the reason I went and helped him was that I needed some extra money because I have to have a breast operation. We still haven't got enough money for that, and I can't seem to get any from the social security on account of that.

So, I wonder if there is a way for the aged to receive any aid because most hospitals where we live want half cash. I know that because I've needed this breast operation for years, and I've put it off, and my children don't even know much about it and, anyway, they couldn't help to pay it, and I wonder if there is any way the aged can get help. I am 66, and I will be 67 years old.

Senator CHURCH. I would say to you that one of the purposes for which we passed the Kerr-Mills bill last year was to help out in cases just like yours. You are not on public assistance?

Mrs. SELLMER. No.

Senator CHURCH. You are independent and living in your own small home?

Mrs. SELLMER. Yes.

Senator CHURCH. Your social security does bring in a little retirement income?

Mrs. SELLMER. Yes.

Senator CHURCH. You can't meet the large medical bills because the medical bills and hospital costs are too high?

Mrs. SELLMER. No other income but the social security.

Senator CHURCH. In this kind of case, I would suggest that you check in your own State with your own department. In most States, it is being handled through the public assistance department. If you will, you might check with that department to see if they will implement it with this Kerr-Mills bill and are in a position to give you assistance on this kind of case. I cannot tell you since I am not familiar with their kind of law in Montana and the extent to which that State is taking advantage of the Kerr-Mills bill, but if you check with the department of public assistance in the State of Montana, they will be able to give you the correct information.

Mrs. SELLMER. Thank you very much.

Senator CHURCH. Anyone else?

STATEMENT OF MRS. HARRY WEBSTER, OPPORTUNITY, WASH.

Mrs. WEBSTER. I am Mrs. Harry Webster, and I live at 2622 East Broadway, Opportunity. I would say that my husband and I are on social security, and I feel that the Kerr-Mills bill should be given a fair chance before any other legislation is introduced because I think we already are overburdened with too much giveaway, and I'm sick and tired of it, and if anybody wants to read something that will make their hair stand on end, let them read "Children Without Fathers" in the last Reader's Digest.

Senator CHURCH. Now, the purpose of this meeting has been to hear from the senior citizens in the open forum. It is now a quarter past 4, and we promised to close this meeting at 4 o'clock. Would those who have not yet been heard please be good enough to give us written statements for the committee so that we can read them?

I see we have one more here.

STATEMENT OF HARVEY BURGETT, SPOKANE

Mr. BURGETT. Mr. Chairman, may I say one word, please, in behalf of the disabled veterans? Just wait 1 minute, ladies and gentlemen, while I make this important announcement. This is an announcement if you will just sit down for 1 minute.

We have a film that we would like to show to any group in the city of Spokane and the immediate area. It's free. It is an educational, history film, based on the history of America. We will gladly bring this and show it to you free of charge to any senior citizens or any group in the Spokane area.

My name is Harvey Burgett, a disabled American veteran, and I might say I saw my good friend Walter get pretty mad the other night, but he's the only friend I have. He is also a veteran from Wenatchee, from one of the greatest States in the Union, but God bless him for that too. I'm an alcoholic myself.

Senator CHURCH. Thank you very much. We will adjourn the hearing for today.

(Whereupon, at 4:15 p.m., the subcommittee adjourned.)

APPENDIX

Comprehensive Medical Program of the State of Washington

The State of Washington has a comprehensive medical program which provides services to recipients of public assistance and the medical indigent. Those patients on continuing assistance, i.e., OAA, ADC, AB, APTD, and GA–U, are given complete medical care for all illnesses.

Physician service is purchased on a prepaid basis from the Washington Physicians Service. The department of public assistance pays $3.31 per person per month for all continuing assistance recipients. For this amount the physicians in all counties, except King, provide the necessary care for these individuals.

In King County (Seattle area) and for those patients on noncontinuing assistance, i.e., GA–E, MO or MAA, the physician service is provided on a fee-for-service. The contract with Washington Physicians Service is exhibit A.

Hospital care is provided in nearly all hospitals of the State. The rates are determined by a reimbursable cost formula which has been worked out with the Washington State Hospital Association. This is exhibit B. In four counties, King, Pierce, Whatcom and Clark, we have county hospitals. In those areas the hospital care is provided in these institutions.

Drugs are supplied in the hospitals as a part of hospital cost. Outpatients receive drug when prescribed by their attending physician. Exhibit C, the drug formulary, is used for the majority of the drugs. However, in urgent cases drugs not listed in the formulary can be provided if approved by the screening physician.

Screening physicians are employed as consultants in evaluating the need for services or drugs in those cases that are questionable or exceptions to our rules and regulations, which is exhibit D. These doctors are usually in practice in the local area and well acquainted with the individual doctors, druggists, etc. We feel that these men are the key to successful administration of our program.

The dental program, exhibit E, is a prepaid plan with the Washington Dental Service. They provide essential dental care for recipients of continuing assistance at a cost of 45 cents per person per month.

Additional goods and services are: Glasses for school-age children, ambulance service, appliances, bandages for nursing home patients, and other ancillary services as required. Once a patient is accepted for care either as a recipient or a medical indigent, the care is completed without any limit to time or expense.

Nursing home care is almost half of our budget for health care in the State of Washington. We have some 334 licensed private nursing homes in the State. We have contracts with 312 of these homes for over 9,000 patients. This part of our program was discussed at length last week in Walla Walla, so we will limit our remarks about nursing homes unles there are questions.

The MAA program in the State of Washington is limited to the medical indigent over 65. We consider the individual's ability to pay and the magnitude of the medical catastrophe. If it is obvious that the person could never pay for his particular illness, we then declare him eligible and pay part or all of the expenses of that one situation. Should he have another problem the following day, or hour for that matter, after leaving the hospital, he would be eligible again. In other words, there is no limit to frequency per year nor limit on total care required.

STANDARDS OF ASSISTANCE AND LEVELS OF PAYMENT

The State department of public assistance is required by law to establish statewide standards of assistance common to all programs except foster care and noncontinuing general assistance. The standards for requirements are to "include reasonable allowances for shelter, fuel, food, clothing, household mainte-

nance and operation, personal maintenance, and necessary incidentals."[1] The department is also required by law to price the budget items yearly and to alter the allowances for requirements if price changes occur. Grants are to be "paid in the amount of requirements less all available income and resources which can be applied by the recipient toward meeting need."[1] Thus average grants in public assistance programs other than foster care and employable general assistance depend on five main factors:

(1) The quantity-quality standards for requirements are a major determinant of average grant. As directed by the legislature, the department has established the quantities and qualities of various budget items considered necessary under specified circumstances for a low-cost but healthful and decent standard of living. These budgets are called the quantity-quality standards for requirements. Whenever possible the department bases the quantity-quality standards on material prepared by recognized experts in the field of standards.

(2) Since the dollar allowances for requirements depend not only on the items budgeted but on their cost, the second major factor affecting average grant is the retail price level of the items included in the quantity-quality standards. As required by law the department conducts annual price studies on a statewide basis and alters the dollar allowances for requirements accordingly.

(3) A third factor affecting average grant is the composition of the caseload. Since the standards for requirements are designed to provide like allowances to persons of like sex, age, and circumstances, changes in the age and sex distributions of persons receiving assistance or changes in the number of persons per case or in living arrangements (including geographical shifts in caseloads) will affect average requirements and hence average grant.

(4) Since, in the absence of a ratable reduction, need is determined by subtracting a recipient's income or resources other than public assistance from his requirements, the average income per case is the fourth main factor affecting average grant. Average OAA grants, for example, would have been higher in recent years without the increases that have occurred in average OASDI income. If the proportion of the caseload that has little or no income or income potential increases or decreases, average grant, barring offsetting factors, can also be expected to rise or fall.

(5) Finally, the average grant in a program will depend on whether need is being met in full or whether a ratable reduction is in effect.

For noncontinuing general assistance cases, budget items other than food are allowed only on an emergent basis. In foster care the rates of payment are based on formulas jointly agreed upon by the State department of public assistance and private child care agencies.

As of April 1961, average money grant in the old-age assistance program was $61.06 per case and $59.61 per person. Since these figures include the low money grants (for clothing and personal incidentals only) paid to hospital and nursing home cases, the average grants paid to cases in their own homes are higher. As of April 1, the average OAA case maintaining a household had requirements (other than medical) of $91.24, income other than public assistance of $24.54, and a money grant of $66.70. Average April money grants in other programs were $144.93 in aid to dependent children, $75.12 in aid to blind, $70.47 in disability assistance, and $73.04 in general assistance. The average April foster care payment was $62.35.

As of June 1961, 46,800 cases were receiving OAA in the State of Washington or 163 of every 1,000 aged persons in the State. Some 44 percent of these recipients or approximately 20,500 were also receiving OASDI. As of February 1960, 11 percent of the aged OASDI beneficiaries in the State of Washington were also receiving OAA.

As of June 1961 the estimated recipient rates in the other Federal-aid programs were:

Aid to blind: 39 cases per 100,000 civilian population 18 or over.

Aid to dependent children: 33 child recipients per 1,000 children 17 or under.

Disability assistance: 5 cases per 1,000 civilian population 18 through 64.

As of June 1, 21 percent of the AB cases, 5 percent of the ADC cases, and 17 percent of the DA cases were also receiving OASDI.

[1] RCW 74.08.040.

History of the Medical Care Program

The medical care program, as it now exists in this State, is a result of many years of effort, varied philosophies, and much trial and error. The provision of public assistance, including very limited medical care, was recognized in Washington as early as the year of 1854, when Washington was still a Territory. In 1889, the new State of Washington placed the administration and financial responsibilities for public assistance in the hands of the counties and until the depression in 1933, this function remained a county responsibility.

In 1933, with the passing of the State Emergency Relief Act, the responsibility for public assistance was assumed by the State, and the State was assisted financially by the Federal Emergency Relief Act. This participation by the Federal Government has continued until the present. Not only did the Federal Government participate financially in our medical care program, but in 1935, the State department of public welfare, in its plan to provide medical care to recipients of OAA and ADC, divided the responsibility for medical care between the State and the counties resulting in a three-way split of the financial burden. Then in 1937, again by legislation, full responsibility for administration was given the counties with a provision for statewide financing. At this time, medical and dental boards were established to advise and assist in the administration of the medical program. This plan proved unsatisfactory and again changes were made giving responsibility for financing, as well as administration, to the counties. Under this system, most counties reverted to the old system of county doctors with the result that the amount of medical service provided continually decreased. This method of providing public assistance, including medical care, continued to 1939, at which time the law was again amended giving the State authority to assume operation of the public assistance program in any county not complying with the rules and regulations established by the department, then called the department of social security.

The history of the program to this point established that many counties were financially unable to support an adequate medical program without assistance from the State and, as a result, the people approved Initiative 141 in November 1940. This initiative established a medical care program under the administrative responsibility of the State department of social security and resulted in a sudden expansion in medical care services without adequate means of supervision and control. While the department was responsible for financing, advising, and gathering statistical data, it permitted the administration of the program to be borne by county welfare offices. Under this system, the department found the continued control of services extremely difficult. Therefore, the entire medical program was characterized by liberality with little or no control. During this period medical and dental advisory committees were brought into play to assist the department in establishing administrative procedures.

Operation of the program continued as a State responsibility until 1947, when the legislature again gave control of all assistance programs, including medical care, to the counties. This action resulted in a variety of different programs lacking any degree of uniformity among the counties.

Insurance to provide physician care was introduced in Washington in the early 1930's. In 1945 some preliminary steps toward a prepaid medical program for welfare recipients were taken by the State medical association and the department, but negotiations failed. Interest in a prepaid program continued, however, until 1947, when an agreement with the Washington Physicians' Service was reached which provided physicians' services and certain other stipulated services such as physical examinations. This contract became effective January 1, 1948, and was originally for a trial period of 3 months. Many difficulties were encountered during the early periods of the prepaid program, nearly all of which centered around the need for control.

In 1949, under initiative 172, full responsibility for the program was returned to the State and was administered by the State department of social security through its county offices. Costs of all services continued to rise. In 1951, the program was transferred to the State department of health and, by legislative action, a division of medical care was created to administer the medical care program.

With the creation within a department for a separate division to administer the medical care program, the first sound steps were taken toward the establishment of a statewide medical program which could be administered to the satisfaction and benefit of eligible recipient and taxpayer alike. The creation of a division of medical care required the employment of personnel whose sole responsibilities were the administration of the medical program. Such a staff made possible much closer working relationships with the medical and dental professions and all other vendor groups who render services under the program. Closer relationships have also resulted in greater understanding of the many complex problems existing in a program of medical care.

While progress in many areas was made during the period to 1955, the proper position in State organization had not been found. With administration by the health department, it was not possible to claim Federal funds to assist in the ever-rising cost of the medical program. Therefore, in 1955, responsibility for the medical care program was transferred again to the department of public assistance. From 1955 to the present, the medical program has remained a division of the State department of public assistance, and as such is considered a basic part of public assistance and has allowed the claiming of additional Federal funds amounting to several millions of dollars.

Since those early years in 1948 the administrative problems have been gradually resolved through the cooperative efforts of the doctors, dentists, and the State of Washington. Today there is a prepaid medical contract with the Washington Physicians' Service to provide welfare recipients necessary physician service throughout the State except in King County. The doctors of King County, in 1948, chose to provide their services on a fee-for-service basis rather than use the per capita method. In addition, dental care is provided in cooperation with the Washington Dental Service Corp. in what is perhaps the first statewide prepaid dental care plan in the United States.

Hospital care is provided when needed in county hospitals or private hospitals. Cost of private hospital care is paid on a per diem basis as determined by a reimbursable cost formula.

Nursing home care is furnished in accordance with an individual contract with 320 private nursing homes throughout the State.

Necessary drugs are available when prescribed by the recipient's doctor. The majority of the drugs are limited to a formulary; however, any drug may be provided if deemed necessary.

Other medical services provided are physical therapy, visiting nurse service, X-ray, laboratory, blood, oxygen, glasses, hearing aids, ambulance service, and miscellaneous appliances. In other words, the program has become a very comprehensive one. The medical program in the State of Washington is considered one of the best in the United States.

Attached to this information is a condensation of additional historical data with quotations from the applicable laws which may provide additional detailed background.

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MEDICAL CARE

In 1951 provisions in law relative to medical care for recipients of assistance were summarized by the Department as follows: 1/

Cost Recip. No.		
	1935-1937	OAP - No provision in the law AB - County responsibility ADC - No provision in the law GA - County responsibility
	1937-1939	OAA, AB, ADC, GA - County responsibility
$ 2.61 5.13 7.16	1939-1941 '41-'43 '43-'45	OAA, AB, ADC, GA - County responsibility with some financing by state. Primarily available through county physicians' offices and/or clinics.
	1941-1945 (Initiative 141)	OAA - Full health services provided by statute. AB, ADC, GA - Responsibility for health care delegated to respective counties using state and county funds.
7.72	1945-1947	OAA, AB - Full health care provided by statute. ADC, GA - Principal health care responsibility delegated to respective counties using state and county funds.
5.72	1947-1949	OAA, AB, ADC, GA - Health services delegated to counties financed by state and county funds. Bureau operation, statewide contract.
8.91	1949-1951 (Initiative 172)	Full health care provided by SDSS.
8.96	1951-1953 (Initiative 178)	OAA, AB, ADC, GA - Health care at a standard prescribed and administered by the State Department of Health. Care shall be equivalent to accepted standards in the community.
9.51 10.36	1953-1955 '55-'57	Provisions of Initiative 178 were repealed by Chapter 5, Laws, Extraordinary Session, 1953. A Welfare Medical Care Committee was created. Section 2 stated,"....Eligible persons shall be entitled to medical services as defined by the Welfare Medical Care Committee."

1/ Comparison of Public Assistance Legislation in Washington from 1935 to 1951. Department of Social Security.

1953-1955 cont'd.

Paragraph (2) of Sec. 4 stated, "The Department of Health shall provide for necessary physicians' services and hospital care as defined by the Welfare Medical Care Committee, and may provide such allied services as dental services, ambulance services, drugs, medical supplies, nursing service in the home, nursing home care, (except subsistence which shall be the responsibility of the Department of Social Security) and other appliances as determined by the Welfare Medical Care Committee, who shall take into consideration the appropriations available."

1955-1957

Under Chapter 273, Session Laws of 1955, administration of the medical care program was returned to the Department of Public Assistance as of July 1, 1955. Provisions relative to recipient care were as follows: "Recipients of public assistance shall be entitled to such medical services as are defined by the assistant director, who shall consider the recommendations thereon of the Welfare Medical Care Committee."

"The Division of Medical Care shall provide for necessary physicians' services and hospital care, considering the recommendations of the Welfare Medical Care Committee, and may provide such allied service as dental services, nursing home care, ambulance services, drugs, medical supplies, nursing services in the home, and other appliances, considering recommendations of the Welfare Medical Care Committee, who shall take into consideration the appropriations available."

Text of the initiatives relative to medical care is as follows:

Initiative 141:

"Additional Care. In addition, the Department shall provide for those eligible for medical, dental, surgical, optical, hospital and nursing care by a doctor of recipient's own choosing; and shall also provide artificial limbs, eyes, hearing aids and other needed appliances."

Initiative 172:

"Section 15. Additional Care. In addition to Senior Citizen grants, each recipient who is in need of medical and dental and other care to restore his health shall receive:

"(a) Medical and dental care by a practitioner of any of the healing arts licensed by the State of Washington of recipient's own choice.

"(b) Nursing care in applicant's home and hospital care as prescribed by applicant's doctor, and ambulance service.

"(c) Medicine, drugs, optical supplies, glasses, medical and pharmaceutical supplies, artificial limbs, hearing aids, and other appliances prescribed as necessary: PROVIDED that when Federal matching funds become available for this program, it shall be the duty of the state to accept such matching funds; until such time this section shall be financed from state and county funds."

EXHIBIT A

AGREEMENT BETWEEN

WASHINGTON PHYSICIANS SERVICE, INC., AND DEPARTMENT OF PUBLIC ASSISTANCE, STATE OF WASHINGTON

1. THIS IS AN AGREEMENT between the WASHINGTON PHYSICIANS SERVICE, INC., a Washington Corporation and the DEPARTMENT OF PUBLIC ASSISTANCE of the State of Washington, entered into pursuant to Title 74 R.C.W. Chapter 74.09 and the Appropriations Act, Chapter 26 Laws of the Extraordinary Session, 1961. By this Agreement, the Washington Physicians Service undertakes to provide for payment for medical services to the recipients of public assistance as defined in said Title. The Washington Physicians Service, Inc., is acting for and on behalf of the several County Medical Service Corporations or Bureaus throughout the State of Washington who are members of the Washington Physicians Service, Inc., and who have signed agreements to participate, and for and on behalf of the individual physicians who, by contract with a County Medical Bureau, have offered to perform services under this Agreement.

2. A list of participating county bureaus and the areas served is attached to this Agreement.

3. IT IS AGREED by the parties hereto as follows:

For the purposes of this Agreement, unless the context indicates otherwise, the following definitions shall apply:

"Department" shall mean the State Department of Public Assistance.

"Recipient" shall mean a person eligible for continuing public assistance as determined by the Department of Public Assistance under the provisions of the Act and so certified by the Department, excepting those who are eligible as Recipients of Non-continuing General Assistance, Medical Assistance for the Aged, and Medical Indigents as defined by the Department.

"Medical Indigent" shall mean persons without income or resources sufficient to secure necessary medical services, as set forth in Chapter 74.09.010 (6) R.C.W.

"Screening Physician" shall mean a physician employed by the State, as a professional screener by authority as set forth in Chapter 74.09.110 R.C.W.

"Bureau" shall mean the local County Medical Service Corporations which are component units of the Washington Physicians Service and which, by Agreement with the Washington Physicians Service will service this Agreement.

"Participating Physicians" shall mean those physicians who are currently licensed in the State of Washington and who have agreed in writing with both the Department and the local Bureau, to participate in this program.

"Necessary Medical Service" shall mean general and special medical and surgical services, as set forth in Chapter 74.09.130 R.C.W. and as defined by the Rules and Regulations of the Department. These services include all diagnostic X-ray and laboratory procedures but do not include:

(1) X-ray and radiation therapy or isotopes

(2) Diagnostic X-ray and laboratory procedures for a patient who is a bed patient in any private or county hospital, and

(3) Services of a physical therapist

(4) Administration of anesthesis.

4. The Bureaus agree to pay all participating physicians, osteopaths, and optometrists for all necessary services rendered, and neither the Washington Physicians Service, the Bureaus, nor any participating physician shall seek or accept any additional compensation for such services over and above that provided for in paragraph three of this Agreement. In view of the fact that Public Funds are being expended for the care of Welfare recipients, it is not possible to exclude any licensed participating Washington State physician, osteopath, or optometrist from the program, and it is, therefore, specifically understood and agreed that all licensed practising physicians, osteopaths, and optometrists in the State of Washington who have agreed, in writing, with first, the Department and then the local Bureau, to participate in this Program shall be eligible to render service under the Act.

5. The Bureau shall maintain all necessary facilities for authorization of medical and ancillary services and for processing and pre-auditing invoices for these services as provided by Chapter 74.09.110 R.C.W. and the Rules and Regulations of the Department.

6. The Bureaus shall maintain an individual posting record of each person served. Such records are the property of the local Bureau, subject to the provisions of Paragraph 27. (Drugs excluded)

7. The Bureau shall furnish the Department upon request, if a reasonable need is shown, any and all information available from bureau records in connection with professional services furnished to an individual providing the same is not in violation of the patient's rights and privileges given him by law.

8. The Bureau agrees to furnish the Department, monthly, a copy of physicians Report of Services made to the Bureau showing: (1) nature of service(s) rendered including diagnosis, (2) category, name and number of the recipient, (3) number and type of services as to office, home or hospital calls. The Bureau agrees to maintain necessary precautions to assure the completeness and legibility of the information outlined above. With the prior concurrence of the Washington Physicians Service, the Department reserves the right to reasonably revise the method of submitting the above information when the Department considers such revision necessary. The furnishing of this information shall constitute full and complete compliance as relates to statistical information that may be required of the Bureaus. The Bureau will not be required to account for the disbursement of monies that have been received on a per-capitation basis.

9. The Bureaus may make necessary rules and regulations not inconsistent with the Act, this Agreement, or the Rules and Regulations of the Department.

10. Each Bureau shall provide for the screening physician or physicians, classification nurses, and the medical caseworker or workers adequate and reasonable office space, desk space, office equipment, telephone, postage, and miscellaneous office supplies sufficient to enable them to carry out their duties as outlined by the Act, this Agreement and the Rules and Regulations of the Department, and further provided the Bureau will specifically assign required necessary clerical and stenographic assistance commensurate with Bureau practice in maintaining clerical assistance for general Bureau operation to Department personnel stationed at the Bureau to insure regular and orderly recording and handling of documentations required by the Department in the processing of medical indigent applications and related matters. It is further specifically agreed and understood that the Department reserves the exclusive right to supervise and control administrative functions of screening physicians, classification nurses, and the various medical caseworkers at the several Bureaus under this Agreement.

11. The Bureau shall receive and process all vouchers and supporting invoices, authorizations, and statements covering services and such appliances as artificial limbs, trusses, eyeglasses, prosthetic and other devices, which have been authorized by the screener and rendered hereunder including services rendered to Medical Indigent cases and fee-for-service cases including recipients of Non-continuing Assistance. Bureaus shall check and pre-audit these invoices and no voucher shall be transmitted to the Department until it has been checked and certified as to the patient's eligibility and the screener's approval and the correctness of physician and hospital charges and, when possible, the correctness of other vendor charges processed through Bureau Offices. The pre-audit and certification of vouchers and supporting invoices and authorizations includes hospital care, drugs, glasses, optical devices, prosthetic appliances, therapy bills, as the Department may require, but does not include pre-audit of nursing home and dental care vouchers.

12. The Bureau shall be responsible for medical payment of pulmonary tuberculosis and mental illness to the point of diagnosis only.

13. The Department shall be responsible for payment of diagnostic X-ray and laboratory procedures for a patient who is a bed patient in any private or county hospital provided the screening physician deems the patient is ill enough to be hospitalized as a bed patient.

14. The Bureau shall be responsible for payment of X-ray and laboratory procedures when a patient is hospitalized for the purpose of diagnosis only, and when such hospitalization would not otherwise be necessary.

15. The Department shall be responsible for the payment of follow-up X-rays subsequent to hospitalization for fractures for a period of six months from original date of release from hospital.

16. Notwithstanding the provision contained in paragraph 31, it is mutually understood and agreed with respect to payment for physicians services including delivery fees on maternity cases that the Department will be responsible for payment on a fee-for-service basis during the first ninety (90) days from the date the recipient was certified as eligible; that the Bureau will be responsible for payment commencing from the ninety-first (91st) day providing the recipient has been certified eligible for a continuous period through date of delivery.

17. The Department shall furnish to the Washington Physicians Service, not later than the 15th of each month, a statement showing the total number of persons, by counties, on the assistance rolls in the previous month in all categories such as: Old Age Assistance, Continuing General Assistance, Disability Assistance, Aid to Dependent Children, Aid to the Blind, Foster Home Care, Excluding Medical Indigent and Non-continuing Assistance.

18. The Department shall each work day, or in any event not later than the next following work day, notify the Bureau of the names of the persons establishing beginning eligibility including changes of category and address and the names of those who are no longer on the eligible list in accordance with Chapter 74.09.070 R.C.W.

19. The Department shall furnish all forms and prescription blanks necessary for the administration of the Agreement and shall make changes in forms only after consultation with the Washington Physicians Service.

20. The Department agrees that when payments are made to a vendor that a duplicate copy of the voucher and date of payment be forwarded to the local Bureau for their files.

21. The Department shall be responsible for payment of the following services:
(1) Drugs and medication (2) Deep X-ray and radiation therapy or isotope
(3) Physical therapy (4) Administration of anesthesia.

22. The Department will assume payment for accidental emergency outpatient hospital care; however, neither the Department nor the Bureau will be responsible for any other outpatient hospital care.

23. It is understood and agreed that the Department is to provide as may be required, professional qualified medical screener or screeners licensed to practice in the State of Washington and approved by the local Bureau, and that these screening physicians will be paid directly by the Department on individual State warrants. (Said screeners shall have the duty to screen and determine in the interest of the Department medical questions that may arise hereunder.) All Departmental medical screening will be the responsibility of the screening physician.

24. The Department will furnish to each Bureau, with supplements from time to time as may be necessary, a list of all the local physicians who have an agreement with the Department to render medical services under this Agreement.

25. If the participating physician in charge of the case determines that the services of a specialist for diagnosis or treatment are necessary, this service will be paid by the local Bureau when authorized by the Screening physician, provided said specialist is a participating physician.

26. It is understood and agreed that in all cases in which a participating physician performs his services gratuitously, the Bureau will pre-audit, process, approve and forward to the Department all vouchers for hospital and ancillary services which were approved by the screening physician and rendered by other vendors to an eligible recipient even though the attending physician is not being paid.

Nothing in this Agreement shall be so construed as to preclude any participating physician from performing voluntary or gratuitous services when and if necessary ancillary services are properly approved by the screening physician.

27. All current records reflecting the operations of this program, subject to paragraph 8, herein, shall revert to the Department of Public Assistance upon the termination of this Agreement.

28. It is likewise understood and agreed that the hiring, training, supervision, and operational control of all medical caseworkers shall be vested in the Department and that the determination of financial eligibility for Medical Indigent and recipients of Non-continuing Assistance made by the said workers shall be conclusive. The medical caseworker shall cooperate with the Bureau to the end that efficient operations will result.

29. In all counties, except King and Pierce Counties, persons classified as Medical Indigents, recipients of Non-continuing Assistance, and Medical Assistance for the Aged shall be referred to any participating physician eligible to perform services hereunder, and the fees for such services, shall be billed by the local Bureau directly to the Department on the basis of the local Bureau fees paid for similar services rendered, and further provided payment to participating physicians for such services shall be made on the basis of 100 per cent of the local Bureau fee schedule, provided such payments are not in greater amounts than payments made by private patients.

It is further agreed between the contracting parties that fee schedules applicable to the payment for care provided to recipients of Non-continuing Assistance, Medical Assistance for the Aged, and the Medical Indigent shall not be increased without consultation with the Department with mutual agreement as to the need for such increase.

The Medical Indigent, or Medical Only, recipients of Non-continuing Assistance, and Medical Assistance for the Aged patients in King and Pierce Counties shall be referred only to the respective county hospitals.

30. This Agreement shall not cover services to which a recipient may be entitled to receive under the provisions of any other state or federal program or law, nor does this Agreement cover any services until the entire proceeds or benefits of any health insurance or third-party responsibility (as provided for in Chapter 74.09.180 R.C.W.) of whatsoever nature has been exhausted.

31. Upon completion of the aforementioned count, and as soon as reasonably possible thereafter, the Department shall pay the Washington Physicians Service for necessary medical and administrative services performed during said month, at the per-capita rate of $3.31 per month, for each of the persons enumerated in said statement, excluding those who are recipients of Non-continuing Assistance.

All persons in new or re-opened cases certified to the continuing assistance rolls shall not be covered under terms of this Agreement until one calendar month from the last day of the month in which such persons were certified for Continuing Assistance. During such waiting period, all medical services rendered to persons subject to the waiting period, shall be approved by the screening physician and payment for approved medical service shall be made

on a fee-for-service basis subject to Paragraph 29 of this Agreement. During the specified waiting period, prescribed above, no per-capitation payment shall be made to the Washington Physicians Service. On the first day of the month for which the per-capitation payment is made, the Bureau shall be responsible for the furnishing of all necessary medical services as herein defined.

32. This Agreement is intended to operate as a package contract and no party(s) hereto may subscribe to Physicians Service unless they likewise contract to that portion relating to administration.

33. The furniture and equipment used and owned by the State in Bureau offices remains the property of the State of Washington, Department of Public Assistance, and is reflected by inventory in the possession of the Department and shall continue to be used by personnel performing duties of the Medical Care Program, and no charge shall be made for said use of such furniture and equipment. In case of termination of this Agreement by either party, said furniture and equipment shall be returned to the Department.

This Agreement shall remain in force during the period July 1, 1961, through June 30, 1962, unless terminated at the request of either party after ninety (90) days' notice in writing.

DATED this _____ day of _____, 1961.

WASHINGTON PHYSICIANS SERVICE

By _____
Executive Administrator

STATE DEPARTMENT OF PUBLIC ASSISTANCE

By _____
Assistant Director

EXHIBIT B

HOSPITAL STATEMENT OF REIMBURSABLE COST
(To be used only in connection with Washington State Welfare Medical Care Program)

Date _____

Name of hospital _____

Address _____

Period covered by statement: From_____, 19___, to_____, 19___.

A. TYPE OF HOSPITAL

1. Type of control[1] (check one only):
   Nonprofit organization
   ( ) Church related
   ( ) Corporation or association
   Proprietary
   ( ) Individual or partnership
   ( ) Corporation
   Other
   ( ) Public hospital district
   ( ) County

2. Type of service[2] (check one):
   ( ) a. General
   ( ) b. Special
      ( ) Maternity
      ( ) Children's
      ( ) Orthopedic
      ( ) Other (specify)

B. STATISTICAL DATA

Hospital personnel (computed on a full-time basis):
1. Average number of employees on hospital payroll each month

In-patient statistics:
2. Beds (exclusive of bassinets) available at beginning of accounting period ..... _____
3. Beds (exclusive of bassinets) available at end of accounting period ..... _____
4. Total bed-days for the accounting period[3] ..... _____
5. Total in-patient days (exclusive of newborn-infant days)[4] _____
6. Total newborn infant days[5] ..... _____
7. Percent occupancy ..... _____
8. Discharges, including deaths (exclusive of newborn infants) _____
9. Average Length of stay (item 5, divided by item 8) ..... _____

Out-patient statistics:
10. Total out-patient visits during accounting period (sum of items 10a and 10b)[6] ..... _____
   a. Clinic patient visits[7] ..... _____
   b. Referred patient visits[7] ..... _____

Nursing home patient statistics:
11. Total nursing home patient days[8] ..... _____
   a. Class I patient days ..... _____
   b. Class II patient days ..... _____
   c. Class III patient days ..... _____
   d. Class IV patient days ..... _____
   e. Private Nursing Home patient days ..... _____

C. TOTAL OPERATION EXPENSES[9]

1. Total expenses claimed[20] .....
   a. Total expenses per books[10] .....
   b. Total other expenses claimed[11] .....

2. Expenses to be deducted per books[12]
   a. Research expense, medical and nursing education or tuition[13] .....
   b. Cost of gift shops, lunch counters, etc.
   c. Cost of guest meals or meals paid for by employees[14] .....
   d. Cost of telephone and telegraph charges paid for by patients, guests, or employees .....
   e. Cost of drugs or supplies purchased by individuals not admitted as in-patients or out-patients[16] .....
   f. Bad debts, or provision therefor: credit and collections expense; donations, charity and courtesy allowances[15] ..
   g. Nursing home expenses[16] .....
   h. Rent and real estate taxes on non-hospital facilities .....
   i. Expense of religious services[17] .....
   j. Others (specify)[18] .....
   .....
   m. Total, items a through j[21] .....

3. Total amount of hospital expenses applicable to out-patient and in-patient services (item 1 minus item 2-m; should be the same as amount under F-17, column 4) .....

D. CALCULATION OF REIMBURSABLE COST OF OUT-PATIENT VISIT[23]

1. Amount of hospital expenses for out-patient services (from item F-19 column 5) .....$
2. Number of out-patient visits (from item B-10) .....
3. Average computed reimbursable cost per visit (D-1 divided by D-2) .....$

E. CALCULATION OF NURSING HOME EXPENSES[16]

(1)	Patient Days (2)	Rate (3)	Total Cost (4)
1. Class I			
2. Class II			
3. Class III			
4. Class IV			
5. Total patient days			
6. Total Nursing Home expense			

F. HOSPITAL EXPENSES FOR CALCULATING REIMBURSABLE COSTS[19]

Classification of Expenses (1)	Total Expenses Claimed[20] (2)	Not Reimbursable[21] (3)	REIMBURSABLE EXPENSES Total[22] (4)	Out-Patient[23] (5)	In-Patient[24] (6)
OPERATING EXPENSES					
1. Administration					
2. Dietary					
3. Housekeeping					
4. Laundry					
5. Plant Operation					
6. Nursing (total)[25]					
a. Nursing service					
b. Nursing education ....[26]					
7. Medical & surgical services					
a. Salary of resident M.D..					
b. Supplies & misc.					
8. Pharmacy					
9. Medical records & library..					
10. Anesthesia service					
11. X-ray[27]					
12. Laboratories[27]					
13. Auto & ambulance[28]					
14. Other special services[29] ..					
(Specify)					
.....					
15. Sub-total items F-1 to F-14					
16. Depreciation[30]					
a. Building (cost of Property) $(_____)					
b. Fixtures (cost of Fixtures) $(_____)					
c. Equipment (cost of Equipment)$(_____)					
17. Total hospital expenses Item 15 plus item 16; should equal item C-3					
18. Less any subsidies from other sources[31]					
19. Total hospital expenses for calculating reimbursable cost					

G. CALCULATION OF REIMBURSABLE COST OF IN-PATIENT SERVICE

1. Total amount of hospital expenses for in-patient services (from item F-19, column 6) ..... $_____

2. Number of in-patient days (from item B-5) ..... _____

3. Average computed per diem reimbursable cost (G-1 divided by G-2) ..... $_____

H. FORM OF CERTIFICATION BY OFFICER OF HOSPITAL

I, _____ (Name), _____ (Title), of

the _____ (Name of Hospital), _____ (City), _____ (State)

do certify that I have examined the accompanying statement of total expenses, the allocation thereof between in-patient and out-patient services, and the calculation of reimbursable cost of in-patient service per patient-day and of out-patient service per visit for the hospital for the (calendar year) (fiscal year) ended _____, 19___, and that to the best of my knowledge and belief it is a true and correct statement prepared from the books and records of the hospital in accordance with instructions as contained in this statement.

A certification by a public accountant of the correctness of the amount entered in item C-1 is attached.

I FURTHER CERTIFY that the records of the hospital for the period covered by the operating statement were maintained on the _____ (Accrual, cash, or modified cash) basis, and that a properly authorized representative of the State Department of Public Assistance may examine the accounting books to verify this report.

(Signed) _____ (Officer or Superintendent of Hospital)

_____ (Title)

_____ (Date)

I. FORM OF CERTIFICATION BY PUBLIC ACCOUNTANT[32]

In our opinion the amount $_____ shown in item C-1 of the accompanying statement of total expenses of _____ (Name of Hospital) (calendar year) _____ (City), _____ (State), for the (fiscal year) ended _____

is in agreement with the books and records of the hospital after giving effect to all adjustments resulting from our examination of the books of the hospital and the instructions contained in this statement.

Scope of Examination:

We do - do not audit the books of _____ (Name of Hospital) annually. The date of the last audit was as of _____.

The statement was - was not prepared after completion of our audit.

The amount entered in item C-1 includes items listed under item C-2.[20]

The records of the hospital for the period covered by the operating statement were maintained on the accrual - cash basis. The fiscal year of the hospital is: from _____ to _____.

If on some other basis than accrual or cash, please explain deviation from general practice.

_____
(Signature of Public Accountant)

NOTE -- For any terms not defined here, see the manual "Handbook on Accounting, Statistics and Business Office procedures for Hospitals, Section 1, Uniform Hospital Statistics and Classification of Accounts, 1950 Edition". All further references to this book will be called "Handbook on Accounting and Statistics, Section 1".

FOOTNOTES:

1. Type of control indicates ownership or auspices under which the institution is conducted.

2. Type of service: If the hospital serves various types of patients, check "General". If the hospital cares for only a special type of patient (such as orthopedic), check the special group served or specify type if not listed.

3. Bed-days should be the sum of the count of the number of beds available each day; or, if this is not possible, the bed complement at the end of the accounting period multiplied by the total number of days in the period.

4. For the purpose of this form, only patient days computed on the basis of the midnight census plus all one-day stays shall be used. (Refer to page 17, Handbook on Accounting, Statistics, Section 1.)

5. Newborn infants remaining in the newborn infant nursery after discharge of the mother should continue to be recorded as newborn infants. Thus, a prematurely born infant shall continue to be counted as a newborn. An infant delivered at home and later admitted to the hospital or an infant transferred out of the nursery for an illness is included in the total in-patient days reported.

6. Out-patient visits for the purpose of this statement include visits of all out-patients (individuals registered for and receiving service in the institution but not occupying a regular hospital bed or bassinet) to regular clinics of an organized out-patient department, and also visits of referred patients who are not admitted to in-patient service but who receive care in emergency rooms, or X-ray, laboratory, physical therapy, and similar special services. No visit should be counted if a patient is interviewed or registered, but fails to receive service.

7. The visit is the unit of out-patient service corresponding to the patient-day for in-patient service. If an individual receives services in more than one subdivision of an out-patient department or clinic, a visit should be recorded for each separate subdivision. For the purpose of this statement, X-ray, laboratory (including basal metabolism, and cardiography), physical therapy, pharmacy, and similar special services, furnished to clinic patients are not to be counted as separate clinic visits in calculating inclusive cost per clinic visit.

   A referred patient visit is recorded for each patient referred to the hospital by physicians in public or voluntary health agencies or in private practice (but not admitted to in-patient service or to the out-patient department clinics) upon any single admission in any division of the hospital.

8. Nursing home patient days shall be computed on the same basis as outlined in footnote 4. Hospitals having individuals on a board and room basis shall indicate the number of such days which may be included under private.

9. The amount to be entered should be as follows:
   If reporting on the - - - Amount to be entered:
   Accrual basis ..... Total expenses recorded in the records.
   Cash basis ..... Total cash disbursements.
   Modified cash basis ..... Total cash disbursements after giving effect to adjustments.

10. All expenses included must be identifiable in the accounting records. For uniformity, hospitals shall include all recorded operating and non-operating expenses, both reimbursable and non-reimbursable.

11. Report here, if necessary, any expenses claimed that are not recorded in the accounting records for the period covered by this report. Example: post-closing adjustment made after audit.

12. Deduct all expenses not reimbursable as welfare patient related in-patient costs and all income received that serve to offset any in-patient expense. Hospitals having any nursing home patients shall exclude all costs for same, including prorated personnel costs. See footnote 16

13. Income specifically designated for research or education should be deducted from total hospital expenses to the extent that expenditures for such items have been included in the total cost. Total amount of income from tuition should also be deducted.

14. This amount should include only the cost of meals to guests and employees to the extent they are reimbursed to the hospital by guests and employees.

15. Deduct all bad debt expense included in item C-1 above. Deduct also any allowances for or charges against income for charity and for courtesy and other discounts normally regarded by the American Hospital Association as deductions from income to the extent that they have been included in Item C-1. Credit and collection expenses and donations of all types should also be deducted.

16. All costs for nursing home patients including pro-rated costs shall be excluded from the reimbursable in-patient costs. If separate accounting records are not maintained section E of this form shall be computed using in column (3) the rate as established by the department for the class of patient treated; multiply this by the patient days in column (2) and insert in column (4). If separate accounting records are maintained divide column (4) by column (2) to compute cost in column (3). The total from line E-6, column (4) should be inserted on line C-2-g. If not applicable, insert "NONE" in item E-5. Any additional income received from drugs or medical supplies provided nursing home patients should also be deducted.

17. Salary and/or board and room of Chaplains, expenses of Chapel, and other religious expenses shall be deducted if included in total operating expenses.

18. Payments to persons not on the hospital staff for whom the hospital acts as a billing and collection agency should be deducted under item C-2-j. Services by persons in X-ray, laboratory, and physical therapy are sometimes provided in this manner. Fuller explanation is made under footnote 27.

19. The actual expenses for all services provided by the hospital to all hospital patients are to be recognized in computing the patient-day cost, and are to be included in this section. See footnote 9. Detailed instructions of expenses to be included under each heading and a method for allocating out-patient and in-patient operating expenses are given in the manual "Handbook on Accounting Statistics, Section 1".

A hospital having fewer than 25 available beds may elect to submit a statement of operating expenses in accordance with the classification per books of the hospital instead of using the classification of expenses given in section F. Such a hospital should, however, complete all items in Sections A, B, C, D and E. Maintenance furnished by the hospital, such as room and board for student nurses and members of religious orders who serve in the hospital, would be included in the expenses of the appropriate departmental items F-1 through F-14. Both board and room and salaries cannot be claimed and one shall be shown as a deduction under C-2 unless the total of both is less than an amount normally paid for comparable services.

Payment to religious orders for services of Sisters (or members of other religious orders): Hospitals that have written agreements with Sisterhoods (or other religious orders) to cover payment by the hospital for the services of Sisters (or members of other religious orders) assigned to the hospital may include the amount paid for the full-time services of a Sister (or member of a religious order) (or a proportionate amount for part-time services) and such payments shall be supported by appropriate accounting records in the hospital.

20. Total of column F-(2) (item F-17) should equal total of items C-1-a and -b as shown in item C-1.

21. Total of column F-(3) (item F-17) should equal C-2-m.

22. Total of column F-(4) (item F-17) should equal item C-3. It is also the difference between the totals of columns F-(2) and F-(3).

23. Column F-(5), shall cover all expenses incurred for services to out-patients (see footnotes 6 and 7) as differentiated from in-patients.

If expenses for in-patient and out-patient services cannot be segregated according to the method advocated by the American Hospital Association or by a comparable method, estimated espenses for out-patient services may be computed by multiplying the total number of out-patient visits (B-10) by a unit cost to be determined by the hospital. This unit cost should be a reasonable estimate of providing out-patient service and will be subject to justification. If an estimated unit cost is used it should be inserted on line D-3. Then the computed total to be reported on line D-1 is to be obtained by multiplying D-2 by D-3.

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24. The total reported in F-19, column (6) should be equal to F-19, column (4) minus F-19, column (5).

25. Hospitals should separate nursing-education expenses from nursing-service expenses if possible.

26. Hospitals should enter the total expenses for medical and surgical services. This figure should include all operating and delivery rooms.

    Salaries of physicians in administration, X-ray, and laboratory should be allocated to their respective departments.

27. If the hospital provides all X-ray services, including the professional services of a radiologist, all expenses are to be included here. (This refers to any individuals who receive salaries, fees, commissions, or maintenance.)

    If the hospital does not pay a salary (fee or commission) to a radiologist, but furnishes supplies and technical services, only the expenses to the hospital should be included in this item.

    If the X-ray department of a hospital is rented outright to a radiologist, any expenses pertaining to that department recorded in the hospitals books are to be excluded from this item and shown in item C-2-j. Any income from this rental should be entered as a deduction under C-2-j and should be included as a part of F-5, column (3).

    If the hospital acts as the billing and collection agency for radiologists or other individuals not employed by the hospital who provide service in this department, the amounts collected for, and paid to, these individuals should be excluded from this item and should be shown in item C-2-j if recorded in the hospital's books.

    These instructions should be followed in determining cost for laboratory or physical-therapy service.

28. Automobile expenses should be apportioned between hospital and non-hospital costs on the basis of the relative amount of mileage traveled for each usage. Records subject to audit should be maintained to justify the reasonableness of the apportionment.

    Ambulance services are reimbursed separately and should not be included in the reimbursable cost, therefore any ambulance costs included in item C-1 should be reported on line F-13 in columns (2) and (3) and also included in item C-2-j.

29. List each special service not elsewhere included, such as cardiography, basal metabolism, and any other special expenses.

30. Depreciation expense is reimbursable within limits of recorded in the hospital's official accounting records. Depreciation recorded on the books in excess of limits prescribed below should be recorded in column (3) so that

the amount in column (2) minus the amount in column (3) to be recorded in column (4) would not be in excess of the limits prescribed below.

The basis of computing depreciation should be the cost of the property when acquired or completed, plus cost of additions or improvements. Depreciation on the appreciation resulting from appraisal is not reimbursable. The depreciation rate should be computed on the useful life of the property. Total depreciation taken over the years on any given piece of property should not be in excess of the difference between the cost and the salvage value at the time the property is retired from service. No depreciation may be taken on land, or on property that is rented or fully depreciated or not used for hospital purposes.

If the hospital apportioned the cost items listed in F-1 to F-14,inclusive, between out-patient and in-patient expenses then depreciation should be apportioned between expenses of out-patient and in-patient services in columns (5) and (6). In the same ratio as the operating expenses for out-patient and in-patient services under F-15.

a. The reimbursable depreciation expense on buildings will be the amount recorded on the hospital's books provided it is not in excess of two percent per year.

b. The reimbursable depreciation expense on fixtures will be the amount recorded on the hospital's books provided it is not in excess of five percent per year.

c. The reimbursable depreciation expense on fixtures will be the amount recorded on the hospital's books provided it is not in excess of ten percent per year.

d. If a hospital cannot take annual depreciation as based on actual cost of buildings and equipment in accordance with the methods suggested above, the hospital may provide for purposes of depreciation an amount of not more than 6 percent of item F-15, column (4).

31. Any income derived from taxes in district hospitals shall be deducted.

32. The statement of expenses should be based on the amount of total expenses certified to by a public accountant who is not an employee of the hospital. Statements signed by hospital trustees, attorneys, bankers, etc., in lieu of a public accountant will not be acceptable.

EXHIBIT C

PART I

RULES AND REGULATIONS

DRUG FORMULARY

Effective October 1, 1960

DIVISION OF MEDICAL CARE
DEPARTMENT OF PUBLIC ASSISTANCE
STATE OF WASHINGTON

I. GENERAL INFORMATION

1. By authority of Chapter 74.09 R. C. W. and within available funds, the Division of Medical Care may provide drugs for the following:
   a. Essential chronic, emergent and acute conditions of recipients of continuing public assistance.
   b. Conditions currently endangering life of the medical indigent (identified by M in the case number) and recipients of non-continuing assistance (identified by UN or EN in the case number) in accordance with provisions established herein.
2. Each participating physician is requested to adhere strictly to the above rules in prescribing medications consistent with good medical care at minimum cost to the taxpayer. Physicians are requested to use the drug items listed in this formulary except when a drug not listed in the formulary is deemed necessary to meet an emergent condition that might endanger the patient's life.
   Prescriptions for drugs not in the formulary will be paid only when proper signatures and justification appear on the prescription in the space provided for on SF 5889.
   Prescriptions bearing invalid formulary numbers will not be honored.

II. OTHER DRUGS AND SUPPLIES

1. Household Drugs.
   Household drugs which can be purchased without the use of a prescription are NOT PROVIDED by the Welfare Medical Care Program. Examples: nose drops, cough medicines, cotton, alcohol, etc.
2. Requests for Formulary Prescriptions:
   Drugs in this formulary when the single prescription cost

is less than ten dollars ($10.00) may be prescribed without additional authorization for the patient whose name appears on the prescription form (SF 5889).
The screening physician must approve single prescriptions costing more than ten dollars ($10.00).
The minimum price for any prescription contained in the drug formulary is one dollar and twenty-five cents ($1.25).

3. Requests for Non-Formulary Prescriptions:
All requests for non-formulary prescriptions must be submitted by the attending physician for prior approval by the screening physician.
4. Acute Emergency Requests:
In the event of an acute emergency and if the attending physician deems it lifesaving and essential that a special drug is needed, he may prescribe such a drug. The Local Medical Care Office must be notified within twenty-four (24) hours or the next working day. The SF 5889 setting forth in detail the nature of the emergency and medical facts must be in the hands of the Local Medical Care Office within seventy-two (72) hours for consideration by the screening physician.

III. WRITTEN AGREEMENT

1. Each physician and drug vendor is required to sign an agreement with the State Department of Public Assistance indicating his willingness to furnish services to eligible persons in accordance with the Rules, Regulations and Payment Procedure of the Division of Medical Care. The Agreement form, SF 8131 in duplicate, may be obtained from the Local Medical Care Office.

IV. PRESCRIPTION FORM

1. Official SDPA prescription blanks (Form No. SF 5889) are distributed by the Local Medical Care Office to all physicians who participate in the program.
The signing of prescription blanks and leaving them to be filled out by nursing home operators or pharmacists is not permitted and is sufficient reason for the dismissal from the program of all participating parties.
2. Only one prescription shall be written on any one prescription form.
3. All prescriptions must be signed by the prescribing physician.
Requests for refills shall be obtained by the attending physician initiating a new request on SF 5889 and approved by the screening physician when appropriate.
Prescriptions having a rubber stamp or typewritten signature, either with or without initials, will not be accepted for payment.

4. The pharmacist will not be paid for filling a prescription unless all required data are on the prescription. Improper prescriptions will be returned for necessary data or signature.
5. It is not necessary to fill in the justification blank for drugs listed in this formulary providing the cost is less than ten dollars ($10.00). Non-formulary drugs or formulary drugs costing ten dollars ($10.00) or more, shall be justified by an explanation describing why the drug prescribed is necessary.

V. DRUGS FOR HOSPITALIZED PATIENTS

1. Drugs ordered by a physician for a hospitalized patient are furnished by the hospital.

VI. DRUG BILLING PROCEDURE

1. Requirement for Prescription Forms.
   a. The name of the patient and complete case number must appear on the prescription. The quantity and kind of drugs and the formulary number must be written on each prescription.
   b. The prescription (Form No. SF 5889) must be signed by the attending physician, and must bear his narcotic number as a means of identification for statistical purposes. For non-formulary drugs, or formulary drugs costing ten dollars ($10.00) or more the authorization on the prescription must be signed by the attending physician and the screening physician before payment will be made.
2. Preparation of Claims by Druggist:
   a. Each prescription must be numbered, using the regular drugstore number. In preparing the voucher form, the drugstore prescription number, together with the price, is listed on the voucher. Prescriptions should be listed in numerical order. To obtain the desired federal participation in the cost of supplying medical care to needy persons, it is required that the state perform its accounting and payment functions separately by program category and month of service. It is also necessary that the billing-vouchering done by the vendor follow the same procedure.
   b. The Department administers eight public assistance programs in which medical care is furnished to needy persons. These programs are as follows:

Case Number Prefix	*Program (Category)*
A	Old Age Assistance
B	Aid to the Blind
C	Aid to Dependent Children
D	Foster Care
M	Medical Only (or Medical Indigent)
N (EN, UN, NCA)	Temporary Assistance
P	Aid to the Totally and Permanently Disabled
U (G, GA)	General Assistance

c. The alphabetic prefix mentioned above and county numbers are of particular importance for vendors to note in their separation of prescriptions in order to insure that any one voucher covers only prescriptions for one program category and for one county. The county identification numbers are:

County	*No.*	*County*	*No.*	*County*	*No.*
Adams	1	Grays Harbor	14	Pierce	27
Asotin	2	Island	15	San Juan	28
Benton	3	Jefferson	16	Skagit	29
Chelan	4	King	17	Skamania	30
Clallam	5	Kitsap	18	Snohomish	31
Clark	6	Kittitas	19	Spokane	32
Columbia	7	Klicktitat	20	Stevens	33
Cowlitz	8	Lewis	21	Thurston	34
Douglas	9	Lincoln	22	Wahkiakum	35
Ferry	10	Mason	23	Walla Walla	36
Franklin	11	Okanogan	24	Whatcom	37
Garfield	12	Pacific	25	Whitman	38
Grant	13	Pend Oreille	26	Yakima	39

All signed vouchers (SF 101-B) together with the yellow copy of the prescription (SF 5889) are forwarded to the Local Medical Care Office. The original, or white, copy of SF 5889 is retained by the pharmacy that fills the prescription. After listing prescriptions on the voucher, compute sales tax and show the grand total with tax included in space provided.

d. **The Law specifies that bills shall be submitted monthly and shall not be paid if submitted later than 60 days after month of service.**

e. Any prescription form submitted for payment on

which the prescribing or filling date has been altered will be disallowed.

f. Detailed information regarding the preparation of any claim for payment by the pharmacist may be secured from the Local Medical Care Office.

3. Signature on Prescriptions:
The pharmacist must obtain the signature of the patient on each prescription. When, for any reason, a signature or mark cannot be obtained, full explanation must be given by the pharmacist on the back of the prescription form. In those instances where the patient signs with an "X," his full name will be printed following his mark and in all cases the placing of the "X" will be witnessed by a person whose name and address will appear on the reverse side of the yellow copy SF 5889.

VII. PRICING SCHEDULE FOR NON-FORMULARY PRESCRIPTIONS

1. The prices charged the Department shall **at no time** exceed the amount being charged the general public.
2. List prices (wholesale cost plus 66⅔%) shall be the basis upon which the pharmacist will be reimbursed for all non-formulary prescriptions which have been properly filled out and approved.
3. The brand, trade and manufacturer's name must be shown on the prescription form.
4. The following pricing schedule shall be used for non-formulary prescriptions:
    a. On full packages, manufacturer's size, proprietary, powder, liquid, pill, tablet, or capsule in the unit of 100 or more, full list price will be charged.
    b. Up to and including 50% of manufacturer's size, proprietary, powder or liquid, or between one and fifty inclusive of any pill, capsule or tablet, charge will be based on pro-rated list price plus thirty-five cents ($0.35).
    c. Excess of 50% of manufacturer's size, proprietary, powder or liquid, but less than manufacturer's full size, and between 51 and 99 of any pill, capsule or tablet, charge will be based on pro-rated list price plus twenty-five cents ($0.25).
    d. The total amount charged the Department for a partial package shall never exceed the price of a full package.

5. Formulary Pricing:
   a. The pricing of medicaments for quantities not listed in the drug formulary will be priced on a pro-rated basis, from nearest amount listed in formulary.
      Example: Formulary List No. 41
      A. P. C. Codeine ½ Gr. 25 Tablets $2.25
      each $0.09
      Rx calls for 30
      30 x $0.09 equals $2.70
   b. For medicaments in excess of 100 tablets or capsules; and/or pints, gallons. The pharmacist will receive wholesale cost plus 66⅔% for the over formulary quantities.

PART II

DRUG FORMULARY
THERAPEUTIC CLASSIFICATION OF DRUGS

Formulary Number	*Drug*	*Strength*	℞ *amount*
		ANALGESICS	
41	Aspirin Compound With Codeine	¼ gr.	12 Tabs. 25 Tabs.
		½ gr.	12 Tabs. 25 Tabs.
270	Sodium Salicylate Tablets	Any Strength	100 Tabs.
		ANTHELMINTICS	
117	Crystoids, Adult	0.2 gm.	5 Pills
118	Crystoids, Child	0.1 gm.	6 Pills
155	Gentian Violet	½ gr. 3/20 gr.	100 Tabs. 100 Tabs.
237	Piperazine Citrate	500 mg. per dr. Tabs. 250 mg. Tabs. 500 mg.	16 oz. 100 Tabs. 100 Tabs.
		ANTI-EPILEPTICS	
131	Diphenylhydantoin With Phenobarbital	½ gr. 1½ gr. ¼ gr.	100 Caps. 100 Caps. 100 Caps.
235	Phenobarbital Elixir	¼ per dr.	8 oz.
236	Phenobarbital Tablets	Any Strength	100 Tabs.
		ANTI-HISTAMINICS	
30	Anti-Histamine Drugs		Tabs. or Caps. Not to exceed 15¢ per day for 30 days

Formulary Number	*Drug*	*Strength*	*℞ amount*
	ANTI-INFECTIVES (LOCAL AND SYSTEMIC)		
	LOCAL		
44	Antibiotic and Sulfa Ophthalmic Ointment		1 dr.
45	Antibiotic Topical Ointment		½ oz.
287	Sodium Sulfacetamide Ophthalmic Ointment	10%	1 dr.
286	Sodium Sulfacetamide Solution	10% 30%	Vial (½ oz.) Vial (½ oz.)
293	Sulfa Ear Drops		Dropper Bottle (½ oz.)
	SYSTEMIC		
116	Cremosuxidine		8 oz.
217	Penicillin, Injectable	Any Strength	Vial (1 to 10 c.c.)
224	Penicillin Tablets	100,000 Units	12 Tabs. 25 Tabs.
225	Penicillin Tablets	200,000 Units	12 Tabs. 25 Tabs.
226	Penicillin Tablets	250,000 Units	12 Tabs. 25 Tabs.
290	Sulfadiazine Tablets	7.7 gr.	25 Tabs.
291	Sulfadimethoxine (Madribon)	0.5 gm.	25 Tabs.
292	Sulfamethoxypridazine (Midicel, Kynex)	0.5 gm.	25 Tabs.
295	Sulfisoxazole Tablets (Gantrisin or Similar)	7½ gr.	50 Tabs.
297	Sulfasuxidine Tablets	7½ gr.	50 Tabs.
320	Triple Sulfa Liquid	Any Strength	4 oz.
321	Triple Sulfa Tablets	7½ gr.	25 Tabs. 50 Tabs.

Formulary Number	*Drug*	*Strength*	℞ *amount*
	AUTONOMIC DRUGS		
138	Anti-Vertigo Drugs (Dramamine or Similar)		15 Tabs.
34	Artane Tablets	2 mg. 5 mg.	100 Tabs. 100 Tabs.
140	Ephedrine Sulfate	⅜ gr. ¾ gr.	100 Caps. 100 Caps.
143	Epinephrine Solution		Vial
145	Ergotamine Tartrate (Cafergot, Gynergen Similar Types)	1.0 mg.	12 Tabs.
202	Metrazol	1½ gr.	50 Tabs.
280	Stramonium Tincture N. F.		1 oz.
	CARDIOVASCULAR		
12	Aminophyllin Suppositories		12
13	Aminophyllin Tablets	1½ gr. 3 gr.	100 Tabs. 100 Tabs.
15	Aminophyllin With Phenobarbital	1½ gr. ¼ gr.	100 Tabs.
16	Amodrine or Similar Aminophyllin Formulas		50 Tabs.
113	Coramine Solution	25%	1 oz.
195	Diuretics Mercurial		Vial (1 to 10 c.c.)
196	Diuretics Mercurial Tablets		30 Tabs.
123	Diuretics Non-Mercurial (Diamox, Diuril, Hydrodiuril, etc.)		30 Tabs.
124	Naqua	2 mg 4 mg.	50 Tabs. 50 Tabs.
125	Dicumarol	50 mg.	100 Tabs.

Formulary Number	*Drug*	*Strength*	*Amount*
126	Digitalis Tablets	1½ gr.	100 Tabs.
128	Digitoxin Tablets	0.1 mg.	100 Tabs.
		0.2 mg.	100 Tabs.
129	Digoxin	0.25 mg.	100 Tabs.
188	Mannitol Hexanitrate Tablets	½ gr.	50 Tabs.
			100 Tabs.
189	Mannitol Hexanitrate With Phenobarbital	½ gr. ¼ gr.	100 Tabs.
208	Nicotinic Acid	50 or 100 mg.	100 Tabs.
210	Nitroglycerin	Any Strength	100 Tabs.
			200 Tabs.
240	Potassium Chloride	5 gr.	100 Tabs.
253	Quinidine Sulfate	3 gr.	50 Tabs.
			100 Tabs.
255	Reserpine Tablets	0.25 mg.	50 Tabs.
			100 Tabs.

DERMATOLOGY

29	Anti-Histamine Ointment or Cream, any brand		1 oz.
64	Benzyl Benzoate Emulsion or Solution		4 oz.
95	Coal Tar Ointment U. S. P.	5%	2 oz.
101	Cortone or Hydrocortisone Ointment	1%	5 gm.

ENDOCRINE AND METABOLIC

108	Colchicine	1/100 gr.	100 Tabs.
171	Insulin	All Types and Units	
172	Insulin Needles	26 x ½"	

Formulary Number	*Drug*	*Strength*	*℞ amount*
173	Insulin Hypodermic Syringes	40-80 Unit	
213	Oral Anti-Diabetic Agents		50 Tabs.
252	Propylthiouracil	50 mg.	100 Tabs.
271	Stilbestrol	.1 mg. - 1.0 mg. 5.0 mg.	50 Tabs. 50 Tabs.
315	Thyroid Extract Tablets	Any Strength	100 Tabs.
	GASTRO-INTESTINAL		
1	Acid Hydrochloric	Dilute	Dropper Bottle (4 oz.) 50 Caps.
9	Aluminum Hydroxide gel		12 oz.
10	Aluminum Hydroxide gel	10 gr.	100 Tabs.
56	Belladonna Phenobarbital	⅛ gr. ¼ gr. or ½ gr.	100 Tabs.
57	Belladonna, Tincture U. S. P.		Dropper Bottle (1 oz.)
215	Paregoric, U. S. P.		2 oz.
	GENITO-URINARY		
18	Ammonium Chloride	5 gr. or 10 gr.	100 Tabs.
195	Diuretics Mercurial		Vial (1 to 10 c.c.)
196	Diuretics Mercurial		30 Tabs.
123	Diuretics Non-Mercurial (Diamox, Diuril, Hydrodiuril, etc.)		30 Tabs.
124	Naqua	2 mg. 4 mg.	50 Tabs. 50 Tabs.
183	Lower's Bladder Mixture or Similar		4 oz.
240	Potassium Chloride	5 gr.	100 Tabs.
261	Sedative Diuretic Mixture		4 oz.

Formulary Number	*Drug*	*Strength*	*℞ amount*
	HEMATOLOGICAL		
152	Ferrous Gluconate or Ferrous Sulfate Tablets		100 Tabs.
180	Liquid Iron For Children Only· Surplex Ferrous Mol-Iron or Similar Types		6 oz.
182	Vitamin B12 (Pernicious Anemia Only)	1000 mcgm. per c.c.	Vial (1 to 10 c.c.)
	NARCOTICS		
41	Aspirin Compound With Codeine	¼ gr.	12 Tabs. 25 Tabs.
		½ gr.	12 Tabs. 25 Tabs.
106	Codeine Hypodermic Tablets	¼ gr. ½ gr.	20 Tabs. 20 Tabs.
109	Codeine Phosphate Tablets	1 gr.	12 Tabs.
119	Meperidine Hydrochloride U. S. P.	50 mg per c.c. 50 mg 100 mg.	Vial (30 c.c.) 20 Tabs. 20 Tabs.
197	Methadon Ampules	10 mg. per c.c.	Amp. (20 c.c.)
198	Methadon Tablets	Any Strength	100 Tabs.
205	Morphine Sulfate	¼ gr.	20 Tabs.
	SEDATIVES		
96	Chloral Hydrate	7½ grs. per dr.	8 oz.
97	Chloral Hydrate	3¾ gr. 7½ gr.	24 Caps. 24 Caps.
235	Phenobarbital Elixir	¼ gr. per dr.	8 oz.
236	Phenobarbital Tablets	Any Strength	100 Tabs.

Formulary Number	*Drug*	*Strength*	℞ *amount*
		UNCLASSIFIED	
190	Mephenesin	0.5 gm.	100 Tabs.
247	Potassium Iodide	Saturated Solution	Dropper Bottle (1 oz.)
254	Quinine Sulfate	5 gr.	50 Tabs.

PART III

ALPHABETICAL LIST OF FORMULARY DRUGS

INTRODUCTION

1. Drugs in this formulary when the single prescription cost is less than ten dollars ($10.00) may be prescribed without additional authorization for the patient whose name appears on the prescription form (SF 5889).
The screening physician must approve single prescriptions costing more than ten dollars ($10.00).
2. The minimum price for any prescription in this drug formulary is one dollar and twenty-five cents ($1.25). The use of the minimum price is intended in the case of a prescription for which the total charge involved would be less than one dollar and twenty-five cents ($1.25). For example: if the prescription calls for twelve (12) tablets of a formulary drug and the price is one dollar ($1.00), the pharmacist is entitled to charge one dollar and twenty-five cents ($1.25). If, however, the prescription calls for twenty-four (24) tablets of a formulary drug, the pharmacist would be expected to charge the regular price for 24 tablets, two dollars ($2.00). The minimum price is not applicable in the case of a prescription for which the total charge involved would be more than one dollar and twenty-five cents ($1.25).
3. "The prices for drugs listed in this formulary are special prices, and considerably below the average prevailing prescription price. These prices refer only to welfare prescriptions and are extended to the State Department of Public Assistance by the pharmacists of the state in consideration of the economics of the whole medical care program. The pharmacists wish to give their wholehearted support to keep this program, which is tax-supported, within reasonable bounds." Washington State Pharmaceutical Assn.

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DRUG FORMULARY

Drug Formulary No.	*Drug*	*Strength*	*Amount*	*Price*
1	Acid Hydrochloric	Dilute	Drop. Bottle (4 oz.) 50 Caps	1.25 1.85
9	Aluminum Hydroxide gel		12 oz.	1.50
10	Aluminum Hydroxide gel	10 gr.	100 Tabs.	1.75
12	Aminophyllin Suppositories		12	2.60
13	Aminophyllin Tablets	1½ gr. 3 gr.	100 Tabs. 100 Tabs.	2.00 2.95
15	Aminophyllin With Phenobarbital	1½ gr. ¼ gr.	100 Tabs.	2.15
16	Amodrine or Similar Aminophyllin Formulas		50 Tabs. 100 Tabs.	2.90 5.00
18	Ammonium Chloride	5 gr. or 10 gr.	100 Tabs.	1.40
44	Antibiotic and Sulfa Ophthalmic Ointment		1 dr.	1.25
45	Antibiotic Topical Ointment		½ oz.	1.75
30	Antihistamine Drugs		Tab. or Cap.	List Price Not to exceed 15¢ per day for 30 days
29	Antihistamine Ointment or Cream, any brand		1 oz.	1.50
138	Anti-Vertigo Drugs (Dramamine or Similar)		15 Tabs	1.25
34	Artane Tablets	2 mg. 5 mg.	100 Tabs. 100 Tabs.	2.90 5.75

Drug Formulary No.	*Drug*	*Strength*	*Amount*	*Price*
41	Aspirin Compound With Codeine	¼ gr.	12 Tabs.	1.25
			25 Tabs.	2.00
		½ gr.	12 Tabs.	1.45
			25 Tabs.	2.25
56	Belladonna Phenobarbital	⅛ gr. ¼ gr. or ½ gr.	100 Tabs.	1.70
57	Belladonna, Tincture U. S. P.		Drop. Bottle (1 oz.)	1.25
64	Benzyl Benzoate Emulsion or Solution		4 oz.	1.55
96	Chloral Hydrate	7½ grs. per. dr.	8 oz.	2.00
97	Chloral Hydrate	3¾ gr.	24 Caps.	1.25
		7½ gr.	24 Caps.	1.50
95	Coal Tar Ointment U. S. P.	5%	2 oz.	2.25
106	Codeine Hypodermic Tablets	¼ gr.	20 Tabs.	1.50
		½ gr.	20 Tabs.	1.85
109	Codeine Phosphate Tablets	1 gr.	12 Tabs.	1.75
108	Colchicine	1/100 gr.	100 Tabs.	2.90
113	Coramine Solution	25%	1 oz.	2.70
101	Cortone or Hydrocortisone Ointment	1%	5 gm.	2.00
116	Cremosuxidine		8 oz.	3.75
117	Crystoids, Adult	0.2 gm.	5 Pills	1.25
118	Crystoids, Child	0.1 gm.	6 Pills	1.25
195	Diuretics Mercurial	Vial (1 to 10 c.c.)		List Price
196	Diuretics Mercurial Tablets		30 Tabs.	3.60

Drug Formulary No.	Drug	Strength	Amount	Price
123	Diuretics, Non-Mercurial (Diamox, Diuril, Hydrodiuril, etc.)		30 Tabs.	3.60
124	Naqua	2 mg. 4 mg.	50 Tabs. 50 Tabs.	2.50 4.00
125	Dicumarol	50 mg.	100 Tabs.	2.85
126	Digitalis Tabs.	1½ gr.	100 Tabs.	1.25
128	Digitoxin Tabs.	0.1 mg. 0.2 mg.	100 Tabs. 100 Tabs.	1.40 2.00
129	Digoxin	0.25 mg.	100 Tabs.	2.00
131	Diphenylhydantoin With Phenobarbital	½ gr. 1½ gr. ¼ gr.	100 Caps. 100 Caps. 100 Caps.	1.25 2.25 2.25
140	Ephedrine Sulfate	⅜ gr. ¾ gr.	100 Caps. 100 Caps.	2.30 3.55
143	Epinephrine Solution		Vial	List Price
145	Ergotamine Tartrate (Cafergot, Gynergen Similar Types)	1.0 mg.	12 Tabs.	1.90
152	Ferrous Gluconate or Ferrous Sulfate Tablets		100 Tabs.	1.25
155	Gentian Violet	½ gr. 3/20 gr.	100 Tabs. 100 Tabs.	1.65 1.25
171	Insulin	All Types and Units		Fair Trade
172	Insulin Needles	26 x ½"		Fair Trade
173	Insulin Hypodermic Syringes	40-80 Unit		Fair Trade
180	Liquid Iron For Children Only (Surplex Ferrous Mol-Iron or Similar Types)		6 oz.	1.85
183	Lower's Bladder Mixture or Similar		4 oz.	1.85

Drug Formulary No.	Drug	Strength	Amount	Price
188	Mannitol Hexanitrate Tablets	½ gr.	50 Tabs. 100 Tabs.	1.25 2.00
189	Mannitol Hexanitrate With Phenobarbital	½ gr. ¼ gr.	100 Tabs.	2.00
119	Meperidine Hydrochloride U. S. P.	50 mg. per c.c. 50 mg. 100 mg.	Vial (30 c.c.) 20 Tabs. 20 Tabs.	2.75 1.50 2.50
190	Mephenesin	0.5 gm.	100 Tabs.	2.00
197	Methadon Ampules	10 mg. per c.c.	Amp (20 c.c.)	2.25
198	Methadon Tablets	Any Strength	100 Tabs.	1.40
202	Metrazol	1½ gr.	50 Tabs.	2.65
205	Morphine Sulfate	¼ gr.	20 Tabs.	1.50
208	Nicotinic Acid	50 mg. or 100 mg.	100 Tabs.	1.25
210	Nitroglycerin	Any Strength	100 Tabs. 200 Tabs.	1.25 1.60
213	Oral Anti-Diabetic Agents		50 Tabs.	Fair Trade
215	Paregoric, U. S. P.		2 oz.	1.25
217	Penicillin, Injectable	Any Strength	Vial (1 to 10 c.c.)	List Price
224	Penicillin Tablets	100,000 Units	12 Tabs. 25 Tabs.	~~1.40~~ 1.25 ~~2.75~~ 2.00
225	Penicllin Tablets	200,000 Units	12 Tabs. 25 Tabs.	~~2.55~~ 1.95 ~~5.00~~ 4.00
226	Penicillin Tablets	250,000 Units	12 Tabs. 25 Tabs.	~~2.95~~ 2.20 ~~5.75~~ 4.25
235	Phenobarbital Elixir	¼ gr. per dr.	8 oz.	1.50

Drug Formulary No.	*Drug*	*Strength*	*Amount*	*Price*
236	Phenobarbital Tablets	Any Strength	100 Tabs:	1.25
237	Piperazine Citrate	500 mg. per dr.	16 oz.	4.90
		250 mg.	100 Tabs.	2.10
		500 mg.	100 Tabs.	2.90
240	Potassium Chloride	5 gr.	100 Tabs.	1.40
247	Potassium Iodide	Saturated Solution	Drop. Bottle (1 oz.)	1.50
252	Propylthiouracil	50 mg.	100 Tabs.	3.35
253	Quinidine Sulfate	3 gr.	50 Tabs	2.75
			100 Tabs.	4.95
254	Quinine Sulfate	5 gr.	50 Tabs.	2.00
257	Reserpine Tablets	0.25 mg.	50 Tabs.	1.25
			100 Tabs.	2.00
261	Sedative Diuretic Mixture or Similar		4 oz.	1.50
270	Sodium Salicylate Tablets	Any Strength	100 Tabs.	1.60
287	Sodium Sulfacetamide Ophthalmic Ointment	10%	1 dr.	1.25
286	Sodium Sulfacetamide Solution	10%	Vial (½ oz.)	1.60
		30%	Vial (½ oz.)	1.95
271	Stilbestrol	.1 mg. to 1.0 mg.	50 Tabs.	1.25
		5.0 mg.	50 Tabs.	2.20
280	Stramonium Tincture N. F.		1 oz.	1.25
290	Sulfadiazine Tablets	7.7 gr.	25 Tabs.	1.50
291	Sulfadimethoxine (Madribon)	0.5 gm.	25 Tabs.	4.00

Drug Formulary No.	Drug	Strength	Amount	Price
292	Sulfamethoxypyridazine (Midicel, Kynex)	0.5 gm.	25 Tabs.	3.90
293	Sulfa Ear Drops		Drop. Bottle (½ oz.)	1.25
295	Sulfisoxazole Tablets (Gantrisin or Similar)	7½ gr.	50 Tabs.	3.00
297	Sulfasuxidine Tablets	7½ gr.	50 Tabs.	3.45
315	Thyroid Extract Tablets	Any Strength	100 Tabs.	1.25
320	Triple Sulfa Liquid	Any Strength	4 oz.	2.35
321	Triple Sulfa Tablets	7½ gr.	25 Tabs. 50 Tabs.	1.50 2.80
182	Vitamin B12 Pernicious Anemia Only	1000 mcgm. per c.c.	Vial	List Price

EXHIBIT D

STATE DEPARTMENT OF PUBLIC ASSISTANCE,

Division of Medical Care

RULES AND REGULATIONS

388-80-010 APPLICANT. Any person who has made an application or on behalf of whom an application has been made, to the Medical Care Field Office for medical care, under the Medical Indigent or Medical Assistance for the Aged programs.

388-80-015 APPLICATION. Shall mean a request for medical care made to the Medical Care Field Office by a person in his own behalf or in the behalf of another person. An application has been made only when the applicant reduces a verbal request into writing on SF 8313.

388-80-020 CERTIFICATION. Is a document (SF 8643) confirming that an applicant has met the financial and medical eligibility requirements for Medical Assistance for the Aged or Medical Indigent for one condition and for a specified time.

388-80-025 CLASSIFICATION NURSE (CN). Shall mean a qualified registered nurse employed by the Division of Medical Care, State Department of Public Assistance, to classify recipients according to individual need for nursing care (exclusive of hospital care).

388-80-030 DEPARTMENT. Shall mean the State Department of Public Assistance (SDPA).

388-80-035 DIVISION. Shall mean the Division of Medical Care (DMC), State Department of Public Assistance (SDPA).

388-80-040 DOCTOR. Is a physician, osteopath, dentist or optometrist licensed to practice in the State of Washington.

388-80-045 FINANCIAL ELIGIBILITY. Shall mean the determination by the medical caseworker that an applicant meets the financial requirements to receive, if otherwise eligible, medical services under the Medical Indigent or Medical Assistance for the Aged programs.

388-80-050 HOME. Real property owned and used by an applicant as a place of residence, together with a reasonable amount of property surrounding or contiguous thereto.

388-80-055 HOSPITAL. Shall mean any institution licensed as a hospital by the State Department of Health.

388-80-060 LEGAL DEPENDENTS. Are persons for whom an applicant is, by law, legally responsible for their support.

388-80-065 MEDICAL CARE FIELD OFFICE (MCFO). Shall mean the office through which the Division of Medical Care, State Department of Public Assistance, carries out its administrative and medical care functions in the field.

388-80-070 MEDICAL CASEWORKER (MCW). Shall mean the caseworker employed by the Division of Medical Care, State Department of Public Assistance.

388-80-075 MEDICAL ELIGIBILITY. Shall mean a medical determination that an applicant or recipient is in need of essential medical care.

388-80-080 MEDICAL INDIGENTS (MO). Are persons without income or resources sufficient to secure necessary medical services who are not certified as recipients of continuing or non-continuing assistance or Medical Assistance for the Aged.

388-80-085 NURSING HOME. Unless otherwise described shall mean any institution or facility licensed as a nursing home by the State Department of Health and classified by the Division of Medical Care, State Department of Public Assistance.

388-80-090 RECIPIENT OF CONTINUING ASSISTANCE (CA). Is a person certified by the Public Assistance County Office as eligible to receive a continuing maintenance grant: i.e., a recipient of OAA (A), ADC (C), AB (B), Foster Care (D), Continuing General Assistance (U), Disability Assistance (P).

388-80-095 RECIPIENTS OF MEDICAL ASSISTANCE FOR THE AGED (MAA). Are those persons who are residents of the State of Washington, who are 65 years of age or older, who are not recipients of CA or NCA and who have been certified as eligible to receive medical care by the Medical Care Field Office.

388-80-100 RECIPIENT OF NON-CONTINUING ASSISTANCE (NCA). Is a person certified by the Public Assistance County Office as eligible to receive a maintenance grant on a temporary basis.

388-80-105 RESOURCES. Any non-exempt asset, tangible or intangible, which could be applied toward meeting medical need, either directly or by conversion into money or its equivalent.

388-80-110 SCREENING PHYSICIAN. Shall mean a physician appointed by the Department to evaluate requests for medical care and determine the medical care to be provided and paid for under the Medical Care Program.

388-80-115 STATE OFFICE (SO). Shall mean the state office of the Division of Medical Care, State Department of Public Assistance.

388-80-120 TRANSFER. Shall mean any act or any omission to act whereby title to property is assigned, or set over, or otherwise vested or allowed to vest in another person; including delivery of personal property, bills of sale, deeds, mortgages, pledges or any other instrument conveying or relinquishing whole or partial title to property.

388-81-010 ADMINISTRATION. The Division shall administer the State Medical Care Program. The Division shall establish, supervise and enforce Rules and Regulations, establish operating procedures and reports, allocate budgets on a local and statewide basis, collect and analyze statistics on services and costs and recommend changes in program and procedure based on such analyses.

388-81-015 STANDARD FORMS AND MATERIALS. The Division shall use standard forms and materials in its various MCFO. Such standard forms and materials are secured from the SO by the MCFO submitting Requisition, SF 2643.

388-81-020 INSTITUTION OF CONTROL. The Division shall establish and enforce such administrative controls as may be necessary in the program to prevent abuses by vendors or recipients, including but not limited to, screening and to determine the need for and duration of services, to assure justification of services and reasonableness of costs in all phases of the program. To operate the program within the limits of the Legislative appropriation, the Division shall initiate such controls as are permitted by law that will avoid the incurrence of a medical care fund deficiency.

388-81-030 COLLECTION AND ANALYSIS OF STATISTICAL DATA

1. Full reports of goods furnished and services rendered must be submitted to the Department by all vendors under the program. Such reports must show name, case number, age, and sex of the patient, the types and amounts of goods or services furnished, and dates on which they were furnished. The Department shall provide the vendor with standardized forms to report these data.

2. Data collected by the Department in this manner shall be tabulated and analyzed to secure statistics on costs of and the services rendered in the various phases of the program. Tabulations and analyses so prepared shall be available to the State Welfare Medical Care Committee, medical societies, medical service bureaus and other official organizations of vendor groups participating in the program.

388-81-040 GENERAL ELIGIBILITY CONDITIONS

1. Prior to the authorizations of medical benefits under the respective medical programs, it is required that any person who may otherwise be eligible shall first exhaust the medical benefits or resources which he may be entitled to receive from any source of whatsoever nature. Such sources may include but are not limited to other state, federal, or community programs or agencies, and the entire proceeds or benefits of prepaid health insurance or third party liability claims.

2. It is the express policy that voluntary or gratuitous services (in whole or part) may be provided; when so provided, the Department may pay for ancillary services in connection with such case when approved by the screening physician and within the standards of care of the Department.

3. The guardian, relative, agent or friend of any person who has been approved as a recipient of CA, NCA, MAA, or MO, shall be encouraged to voluntarily pay (in whole or in part) for standard medical services approved by the screening physician; if partial payment is made, the Department shall pay, within the approved services, the balance of the cost.

4. If medical services, other than the established and approved care, are paid by the recipient of CA, NCA, MAA, MO or his agent, the Department shall not be financially responsible for any portion of the charges.

5. The Department shall not pay for medical care furnished a recipient of CA in another state, except when planned care for specialized services has been approved by the screening physician and contract arrangements have been made by the Department for services and payments. A hospital in Oregon or Idaho bordering on the Washington State line may accept a recipient of CA for medical care provided:

    a. It maintains contractual arrangements with the Department,

    b. Is located within 15 miles of the line or nearer than the local hospital in a specific area in Washington State,

    c. Offers specialized services not available locally, and

    d. The screening physician approves the request for service.

6. Out-of-state emergency medical care for recipients of CA, NCA, or MO shall not be the responsibility of the Department. Medical care on an emergency basis will be provided otherwise eligible applicants for MAA if such applicants are residents of Washington but temporarily absent. Authorization is made in accordance with provisions set forth in 388-99-070.

7. The Department shall not be responsible for payment of nursing home care for CA, NCA, and MO recipients or applicants living outside of the State of Washington, although they maintain legal residence in the State of Washington.

388-81-050 CASE EXCEPTIONS. Medical care and its ancillary services are by their very nature not subject to an exacting science which can be described in writing by policy, rule or regulation. Professional judgment must be exercised in each case and exceptions granted in those instances where unusual circumstances exist. Accordingly, where undue hardship may result to the patient if medical care or service is denied if strict application of a rule or regulation is applied, the Assistant Director or his delegated State Office agent may grant exceptions when presented; providing, however, a case exception may not be granted if the request is contrary to a specific provision of the law.

388-81-060 BILLING LIMITATIONS - SIXTY-DAY PERIOD - EXCEPTION.

1. Pursuant to RCW 74-09-160 which provides that vendors shall submit their charges monthly and that they shall present their final charges not more than sixty (60) days after termination of service, the policy of the Department shall be:

   All vendors shall submit their charges on a monthly basis. The beginning date of the 60-day period within which vouchers for final charges must be submitted shall be the last date of the calendar month in which service was rendered. Thus, for all services rendered at any time in a calendar month prior to the last day of that month, the 60-day period shall begin on the last day of that month and continue for 60 days thereafter.

2. For MO and MAA cases, when it is realized that clearance of resources, etc., and final disposition of the application, may require more time than can be allowed within the 60-day billing period an immediate request for permission for late billing must be made to the SO. This request is to be made by the MCW and must be made prior to the expiration of the 60-day billing period. Such request shall include the name and case number of the patient, the date of application and the dates of medical services.

388-81-070 CONFIDENTIAL RECORDS. All records, both medical and administrative pertaining to applications and continuing services rendered recipients, medical indigents, and beneficiaries of medical assistance for the aged are confidential. Disclosure of information contained in such records, files, papers, and communications is prohibited except for purposes directly connected with the administration of the various state welfare and medical programs.

388-82-010 REQUEST FOR A FAIR HEARING

1. Any applicant for or recipient of medical care granted under the provisions of Chapter 74.09, RCW, who feels aggrieved by a decision rendered by the Division or its various representatives, has a right to a fair hearing which shall be conducted by the duly appointed fair hearing examiner for the SDPA.

2. Any such applicant or recipient may file a notice of appeal for a fair hearing within sixty (60) days from the date of oral or written notification of the denial of medical, dental, or related services, or within sixty (60) days after the last treatment by a participating doctor. A fair hearing request which is filed more than sixty (60) days after receiving notification of the decision appealed may be dismissed by the supervising examiner on the grounds that it is untimely.

3. The notice of appeal must be in writing and should show the approximate date of said alledged refusal of medical, dental or related services and the reasons for believing that said refusal was incorrect. The written appeal should include the address of the applicant or recipient and must be dated and signed by the claimant, or his legal guardian. If husband, or wife are claimants, one spouse may sign on behalf of the other. The request for a fair hearing shall be filed with the SDPA Director, the local MCFO, MCW within the county where the complainant resides, or with the Division SO. Any MCFO or MCW receiving a request for a fair hearing shall immediately forward such request to the supervising examiner of the SDPA.

4. Any applicant or recipient may withdraw his request for a fair hearing at any time prior to the decision thereon. Such withdrawal shall be made in writing, in which case the previous determination or decision rendered shall be final. The supervising examiner of the SDPA shall be immediately furnished with a copy of the withdrawal notice.

388-82-015 PROCEDURE PRIOR TO HEARING

1. All pre-hearing review is the responsibility of the Division.

2. The Medical Services Administrator (Legal) shall review all fair hearing requests of the appellant to determine:

   a. Whether or not appellant has filed request in accord with Rules and Regulations of the SDPA.

   b. Whether or not decisions of the Division and its representatives have been made upon complete and accurate evaluation to existing standards, regulations and policies.

3. All records and information necessary to determine the validity of the appellant's complaint, fair hearing request or appeal shall be furnished by the MCFO. All such required data or information requested by the Medical Services Administrator (Legal) must be forwarded to the Division SO not later than ten days from such request.

4. Upon receipt of the necessary material, evidence or reports, the previewing Medical Services Administrator (Legal) shall evaluate the appellant's request in accord with existing rules, regulations and policies of the Department and the Division.

5. The reviewing Medical Services Administrator (Legal)

   a. May reverse the decision of the Division and its representatives when such adverse decision has been made contrary to rules, regulations and policies of the Division.

   b. May resolve a situation resulting in the fair hearing request by compromise.

   c. When a situation cannot be resolved under paragraphs "a" and "b" immediately preceding, the Medical Services Administrator (Legal) will forward all records of the case to the office of the fair hearing examiner.

      Included in this report shall be the names of all witnesses including the attending doctor who shall be subject to call for attendance at a fair hearing procedure. Failure to attend the hearing without reasonable excuse shall constitute grounds for dismissal of a witness vendor from participating in the Medical Care Program.

   d. When the Medical Services Administrator (Legal) of the Division SO transmits all pertinent review records to the fair hearing examiner, a fair hearing shall be processed in accord with Chapter 388-08 of the Department's Rules: Provided that, references to the SDPA County Office responsibilities contained in the Regulations, shall be deemed responsibilities of the Division for the purposes of conducting fair hearing appeals from decisions of the Division and its representatives.

388-82-050 RESTITUTION

1. If a recipient of CA or NCA is found to have been ineligible for assistance received, the Public Assistance caseworker will request the MCFO to determine the recipient's eligibility for MO care. The MCFO shall make a determination of the eligibility of the person and notify the CO. If the person was ineligible for medical care as a MO the MCFO shall report to the CO all vendor payments for medical care for the person during the period of over-payment.

2. If a person receives MO or MAA care for which he was not eligible or comes into possession of resources which he fails to disclose to the MCFO or conceals resources, such as cash on hand, bank accounts, saving accounts or any kind of resource, the total amount of such medical care payment made by the Department on his behalf shall be a debt due the Department.

3. If it is determined that a recipient of MAA or MO has received medical care for which he was ineligible, the facts and circumstances upon which the determination of ineligibility was based shall be forwarded to the Division of Medical Care for further review and action. If the State Office, Division of Medical Care, concurs with the determination, the individual shall be so advised and repayment demanded. The due and owing amount will be the actual amounts paid by this Department to vendors on the recipient's behalf. If repayment is not obtained, the case and the files relative thereto shall be forwarded to the Attorney General for such further action as deemed necessary. However, in no event shall a lien be filed while the ineligible recipient of MAA or his dependent spouse is still living unless the claim has been reduced to judgment in a Superior Court of the State of Washington.

4. Any person who by means of a willfully false statement or representation, or by impersonation, or other fraudulent device, or failure to reveal resources as required, obtains or attempts to obtain or aids or abets any person to obtain medical care to which he is not entitled shall be guilty of larceny.

388-83-010 PERSONS AND AGENCIES ELIGIBLE TO RECEIVE PAYMENT FOR SERVICES RENDERED:

1. Persons currently licensed by the State of Washington to practice medicine, osteopathy, dentistry, pharmacy, optometry, and who agree in writing to abide by current rules and regulations and established fee and price schedules, are eligible to receive payment for approved services rendered eligible recipients of CA, NCA, MO, and MAA.

2. Persons currently licensed by the State of Washington as professional or practical nurses, or as physical therapists are eligible to receive payment for approved services rendered recipients of CA, NCA, MO, and MAA provided they agree to abide by current rules and regulations and fee schedules.

3. A nursing home licensed by the State Department of Health and classified by the Division shall be eligible to receive payment for approved services rendered eligible recipients of CA, NCA, MO, and MAA providing the nursing home operator executes in writing a contract with the Division to furnish such services as provided for under the terms of the contract and to comply with the regulations of the Division.

4. A hospital currently licensed by the State Department of Health shall be eligible to receive payment for approved services rendered eligible recipients of CA, NCA, MO, and MAA provided the hospital enters into a contract with the Division to abide by the Rules and Regulations and fee schedules established by the Department. County hospitals (inpatient and outpatient services) may be used to the maximum extent possible in compliance with RCW 74-09-090, and this use may be on a regional basis as determined by the Division. Other public facilities, such as all types of clinics, the crippled children's service and all other diagnostic and treatment programs of the State Department of Health shall be used to the maximum extent possible without payment from this Department.

5. Optical, appliance, oxygen, and ambulance firms and/or supply companies are eligible to receive payment for approved services rendered recipients of CA, NCA, MO, and MAA providing such companies have signed a vendor's agreement or have entered into a contract with the Division.

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388-83-020 VENDOR EXCLUSIONS. Under the mandatory and discretionary provisions of RCW 74-09-090 (4), and considering the limitation of available funds, the services of the following practitioners will not be furnished applicants or recipients of CA, NCA, MO, or MAA at the expense of the Department:

1. Chiropractors
2. Sanipractors
3. Naturopaths
4. Homeopathists
5. Herbalists
6. Masseurs or manipulators
7. Christian Science practitioners or theological healers
8. Any other licensed or unlicensed practitioners not otherwise specifically provided for in these rules.

388-83-030 VENDOR VIOLATIONS. Any violation of the Rules and Regulations or administrative policies established by the Division by vendors eligible to receive payment for services may be considered grounds for dismissal from participating in the Medical Care Program.

388-83-040 CONDITIONS OF PAYMENT. The Department shall not be responsible for payment of services rendered welfare patients of any category unless the services have been properly authorized and the patient certified as eligible. Except in emergencies, and then only under conditions set forth in these regulations, all vendors shall be responsible for obtaining prior approval for rendering their services if they intend to request payment from the Department.

388-84-010 STANDARDS OF CARE. Within the limitations of available funds, the Department shall furnish only essential medical care for:

1. Essential chronic, emergent and acute conditions of CA recipients

2. Emergent and acute medical conditions for recipients of NCA, MAA, and MO.

As used herein, the term "essential" is defined as important in the highest degree, indispensable; the term "chronic" is defined as long duration or characterized by slowly progressive symptoms deep-seated and obstinate; the term "emergent" is defined as occurring unexpectedly and demanding immediate action; "acute" is defined as having a short and relatively severe course, not chronic.

388-84-020 LIMITATIONS. Services to be provided are limited to essential medical care. Elective surgical procedures shall not be authorized unless prior approval is obtained from the Assistant Director, Division of Medical Care, or his authorized representative, upon submission of SF 5873 by the patient's attending doctor and approval recommended by the local screening physician.

388-84-050 MEDICAL CARE FOR PRISONERS. Medical care shall be furnished by the Department for an inmate of a city or county jail who:

1. Is determined to be eligible under the provisions of the MAA or MO programs

2. Requires hospital treatment of an acute or emergent medical condition in the opinion of the screening physician, and

3. Is placed in a participating hospital by the confining authority.

388-85-010 PROCUREMENT OF DOCTORS' SERVICES. Under the provision of RCW 74-09-120 the Division shall purchase necessary doctors' care by contract or on a fee-for-service basis. Accordingly, the Division has exercised this option and negotiated physicians' service agreements with the Washington Physicians Service, Inc., who, acting in behalf of the several Washington Medical Service Bureaus, provides, except in King County, doctors' services to recipients of CA. In King County doctors' services are provided on a fee-for-service basis and through the utilization of the King County Hospital System. Doctors' services throughout the state for recipients of NCA, MAA, and MO are purchased on a fee-for-service basis. The standards of care for either recipients or indigents as provided for by other section of these Rules and Regulations remain the same, irrespective of the purchase of care by contract or on a fee-for-service basis.

388-85-020 CONDITIONS TO RECEIVE SERVICE

1. Except in emergencies, all services for which the Department is to be held responsible must be approved in advance of the vendor's rendering of such services.

2. Persons certified as a recipient of CA or NCA will be issued a referral by the MCFO certifying their eligibility to receive medical services consistent with the Division's Standards of Care as requested by a specified doctor. Except in acute emergencies, service may be furnished only by a doctor who has agreed to participate in the program and is specified on the referral for the patient. The patient shall remain with the same doctor for at least six months, unless good and sufficient reason for change is shown and the change is authorized by the MCFO. Medical service shall be provided in the county where the patient resides, except when (1) an acute and emergent condition arises while the patient is temporarily absent from his county of residence or (2) approved plans have been made in advance with the screening physician in the patient's county of residence to insure more efficient service and effective administration elsewhere. Except when it is determined an emergency exists, the Department shall not be responsible for any services not authorized in advance. All providers of services shall be responsible for obtaining prior approval and verifying the eligibility of the patient before rendering service if they intend to collect for said services.

3. Persons certified as eligible recipients of MO or MAA will be notified in writing of their period of eligibility and of the authorized medical services as requested by a specified doctor. Except in acute emergencies, service may be furnished only by a doctor who has agreed to participate in the program. Medical service shall be provided only in the county in which the patient resides, except when approved plans have been made in advance with the screening physician and MCW in the patient's county of residence. Except when

it is determined an acute emergency exists, the Department shall not be responsible for any services not authorized in advance. All providers of services are responsible for obtaining prior approval and verifying the eligibility of the patient before rendering service if they intend to collect for such services.

388-85-030 PHYSICAL EXAMINATIONS. Approval of requests received from SDPA County Offices for physical examinations of general assistance applicants or recipients rests with the local screening physician. He may make the examination himself or request another physician in the area to make the examination.

1. Basic payment for this examination is $7.50 plus the cost of laboratory procedures authorized by the screening physician. The results of the examination are recorded on SF 7903.

2. Payment for physical examinations in King, Spokane, and Pierce Counties does not follow the above procedure. In King and Spokane Counties a doctor is hired on a monthly salary to make physical examinations for employability. In Pierce County, the examinations are made by the Staff of the County Hospital without additional charge to the Department.

388-86-010 HOSPITALIZATION AND ANCILLARY SERVICES

1. All hospitalization and ancillary services needed while so hospitalized shall be requested in writing by the attending doctor on SF 5873 and written approval obtained from the screening physician. Authorization for hospitalization, except for emergency cases, must be obtained prior to the date the service is rendered. If surgery or physicians' services have been approved by the screening physician, hospitalization will likewise be approved.

2. Medical approval for emergency hospitalization shall be obtained within twenty-four (24) hours or the next working day following admission.

3. CA recipients are eligible to receive such outpatient hospital service as requested by their attending doctor and approved by the screening physician.

4. Outpatient hospital service for applicants or recipients of NCA, MO, and MAA is limited to acute and emergent conditions when requested by the patient's attending doctor and approved by the screening physician (and by the MCW for MO and MAA).

388-86-020 HOSPITAL PAYMENT

1. Payment to hospitals is based on a daily reimbursable rate. Payment for hospital services begins on the effective date authorized by the screening physician to (but not including) the date of discharge.

2. Whenever a patient is admitted for less than 24 hours, the time of admittance and discharge should be shown. Generally, admittance to the hospital for less than 12 hours should be paid at only one-half the daily rate; however, there may be extenuating circumstances which would call for a full daily rate, i.e., an individual may be admitted for surgery early in the a.m. and dismissed late in the evening of the same day. Such instances may be biopsies, or other minor surgery. These cases could be kept for a full 24-hour period but are sometimes dismissed late in the evening for the convenience of the individual. Generally, if the length of time is less than 24-hours, but more than 12 hours, it should be paid at the full daily rate.

388-86-025 LENGTH OF STAY

1. Hospitalization for all major surgery shall be limited to a maximum of seven days.

2. Hospitalization for normal delivery shall be limited to three days.

3. Exception: If in the opinion of the attending doctor additional days of hospitalization are necessary, a new request on SF 5873, with justification, shall be submitted to the screening physician for approval prior to the expiration of the originally authorized period of hospitalization. Payment for additional days of care will be authorized only upon the prior approval of the screening physician.

338-86-030 COUNTY HOSPITALS AND INFIRMARIES

1. County Hospitals, operated by counties and supported by state funds, shall be used to a maximum for the care of welfare and indigent patients. The only exception to this would be in those county hospitals where complete facilities are not maintained. In these instances, private hospitals may be authorized, but the patients must be transferred to the county hospital at the earliest possible date consistent with good medical practice.

2. County hospitals having both hospital and nursing home patients shall be used to a maximum for the highest classification of nursing home patients.

3. County infirmaries, operated by counties and supported by state funds, shall be used to a maximum before private facilities in the community are used.

388-86-035 REFERRALS TO KING COUNTY HOSPITAL

1. Recipients who reside outside of King County and have a need for special services not normally available in their own community will be considered for care at King County Hospital.

2. Application for services shall be made on SF 5873 by the attending doctor, approved by the screening physician and submitted with SF 8904, Additional Clinical Information, in writing to King County Hospital, 325 Ninth Street, Seattle 4, Washington. SF 8904 shall be completed in detail. A duplicate copy of SF 8904 will be retained by the MCFO of the county in which the application for referral initiated.

3. No out-of-county public assistance case shall be admitted to King County Hospital without prior approval of the hospital management when possible in writing or by phone in an emergency.

4. If telephone admission to the hospital is granted, it shall be necessary that the properly completed and signed SF 5873 plus the Additional Clinical Information be submitted to King County Hospital as soon as possible.

5. An MO or MAA applicant whose county of residence is other than King County and who is admitted to King County Hospital on an emergency basis while visiting in King County shall be processed as a King County applicant.

Information may be requested from the MCW in the patient's county of residence as a service case.

6. Authorization for an MO or MAA recipient referred to King County Hospital on a planned admission basis shall be the responsibility of the referring county. Transportation plans, as well as planning for personal expenses while traveling to and from King County, shall be made in advance by the MCW in the referring county, and such information shall be provided to King County Hospital staff.

388-86-040 HOSPITALIZATION OF PATIENT IN DETENTION PENDING COMMITMENT. The Department is prohibited from paying for hospitalization of any citizen (1) in detention pending proceedings prior to commitment to a mental hospital or, (2) after a diagnosis of tuberculosis has been made.

388-86-045 ANESTHETIZATION SERVICES. When provided as an incident to authorized surgical procedures and not administered by the surgeon, his assistant, or a staff nurse of the hospital.

1. Each anesthesiologist rendering service under the State Medical Program shall submit his voucher in accord with existing voucher procedures to his local medical bureau indicating a charge of twenty (20) per cent of the surgeon's fee.

2. The local medical bureau involved shall then pre-audit the voucher in accord with the amount of money paid the surgeon by the local medical bureau for the particular surgery rendered. The vouchers will then be transmitted to the Department by the local bureau for audit and payment.

3. Minimum fees shall be the minimum fee established and being paid by each local medical bureau in accord with its existing fee schedule.

4. When a service can be performed in the doctor's office, provided a short, light, general anesthetic can be given, the Division of Medical Care will pay $5.00 for an anesthetic administered in the doctor's office, when authorized by the screening physician. Examples - myringotomy, small lacerations, slivers, etc.

5. Fees for nurse anesthetists are:

Major Surgery, first Hour	$15.00
Plus $1.25 for each 15-minute period thereafter	
Minor Surgery, first hour	15.00
Plus $1.25 for each 15-minute period thereafter	
Flat fee for delivery and tonsillectomy	15.00

6. No travel allowance will be authorized for anesthesiologists or anesthetists.

388-86-050 PHYSIOTHERAPY. Within the limitation of available funds, the Department shall pay for physiotherapy, diathermy, etc., when such services are performed by registered physiotherapists in the community, providing prior approval has been received from the local screening physician.

1. Separate payment will be made to hospitals for physiotherapy treatment only when such treatment is authorized in advance and is rendered to an outpatient in that hospital. Payment for this service will be in the same amount as indicated for outpatient services on the Reimbursable Cost Statement. No payment will be made to any hospital or employee for physiotherapy treatment given to someone not a patient in that hospital.

2. Payment for physiotherapy treatments furnished recipients outside hospitals shall be made to registered physiotherapists in accordance with the local Medical Service Bureau fee schedule.

3. The screening physician, in each instance, shall approve only those cases which would be expected to improve to such an extent that less medical care would be required.

388-86-060 X-RAY. Diagnostic, therapeutic, and followup X-ray will be provided when requested by the attending doctor and approved in advance of the rendering of such service by the screening physician; subject, however, to limitations consistent with necessary physician and hospital treatment as defined under the Standards of Care.

388-87-010 DENTAL SERVICES Recipients of Continuing Assistance (CA): Dental care to be provided in accordance with the standards as hereinafter directed for recipients of CA is purchased by contract on a per capita payment of forty-five cents ($.45) per person per month from the Washington Dental Service (WDS).

388-87-015 ACUTE DENTAL NEEDS:

1. Eligible recipients of CA, both children and adults, shall be eligible, subject to limitations as hereinafter described, for acute dental needs providing the service is recommended by a participating dentist who must be a licensed dentist who has agreed with the Department and the WDS to participate in the Welfare Dental Program.

2. Limitations: The dollar value, in accordance with the agreed fee schedule, shall not exceed $25 per month per individual. Exceptions may be granted by the Chief of Dental Services.

3. Acute need is:

   a. The relief of pain for an aching tooth where the most probable treatment is the extraction of the tooth or the placing of a restoration in that tooth. In most cases, experience has shown that a single tooth or perhaps two, will constitute an emergency.

      This may be further defined as the elimination of infection and the extraction of unsavable teeth.

      Multiple extractions in two or more quadrants of the mouth hardly can be justified under the limited program. Necessary X-rays should accompany all cases which might prove to be controversial.

   b. The treatment of acute infection.

   c. The replacement of a tooth in a denture or the repair of a broken denture.

388-87-020 PROSTHETIC AND OTHER EMERGENT DENTAL CARE. Such services may be furnished recipients of continuing assistance (CA) in the following priority if unexpended funds are available from the per capita payment, after acute dental needs and administrative expenses have been provided for and the services are recommended by a participating dentist and prior approval obtained from the Chief of Dental Services:

1. Prosthetic Needs:

   a. Dentures will be authorized only when a certificate is received from the participating dentist or the recipient's physician,

indicating that the necessary extractions and dentures are necessary due to acute infection, for proper mastication, or to assist the recipient in becoming employable.

b. No authorization for dentures will be granted for replacement of lost dentures or partial dentures or if any of the following statements are applicable:

1) There are sufficient anterior teeth and eight (8) posterior teeth, periodentally sound, in good occlusion and position.

2) That patient has masticated successfully without dentures for a period of one year or more.

3) The dental history shows that any or all dentures made in recent years have been unsatisfactory for reasons that are not remedial (psychological, etc.).

4) The relining or repairing of the recipient's denture would make it servicable.

5) The denture, in the patient's opinion only, is loose or ill-fitting, but is recently enough constructed to indicate deficiencies inherent in all dentures.

c. No immediate dentures shall be made unless the recipient can indicate that such will make the recipient employable and a position is available. The WDS or Department will not be responsible for relines for any immediate denture for a two-year period.

2. Other Emergency Care:

a. Children's care:
1) Repair of injured or carious permanent teeth
2) Repair of injured or carious primary teeth
3) Prosthodontic services.

b. Adult care:
1) Treatment of bone and soft tissue diseases
2) Repair of injured or carious teeth
3) Replacement of lost teeth and the restoration of function.

388-87-030 APPLICATION PROCEDURES FOR RECIPIENT OF CONTINUING ASSISTANCE (CA)

1. A recipient of CA will initiate his application for dental care by going to his local MCFO. If certified as an eligible recipient of CA, the representative at the MCFO will issue a certifying form that the patient is eligible. Said form and certification will be given for a 30-day period only. The patient will then select the dentist of his choice from a list available at the MCFO.

2. Acute dental care will be provided by the participating dentist who must submit a billing which may not exceed $25 in amount, to the WDS within 30 days from the date the services were provided.

3. If the patient's dental needs are for prosthetic or other emergency care, the patient will obtain the certifying form from the MCFO as described above, present it to the participating dentist, who will in turn forward the certifying document and such other dental diagnostic forms considered necessary to the Chief of Dental Services for approval prior to performing the service. Upon receipt of approval, the participating dentist may schedule the patient for treatment. Payment to the participating dentist for prosthetic care and other emergency needs will not be made unless prior approval is obtained. If services for prosthetic and other emergent needs are not provided for within 90 days from the date of approval by the Chief of Dental Services, a new eligibility certification and diagnostic data must be obtained.

388-87-035 PROCEDURES FOR RECIPIENTS OF MO, NCA, and MAA:

1. Dental care provided eligible recipients of MO, NCA, and MAA is procured on a fee-for-service basis from the WDS. The dental care provided is limited to the relief of pain and such emergent services as may be specifically authorized by the Chief of Dental Services prior to the furnishing of such care by the participating dentists.

2. An MO, NCA, or MAA applicant for dental services will contact a participating dentist who will execute the necessary dental diagnostic forms provided him by the WDS, and give such forms to the patient for return to the medical caseworker (MCW). The MCW will make the necessary determination as to the financial eligibility and forward the certification form, furnished by the WDS, certifying that he is financially eligible, along with the participating dentist's diagnostic forms to the Chief of Dental Services for approval. Financial certification will be valid for a period of 30 days and the service must be performed within 30 days after the participating dentist has received approval from the Chief of Dental Services.

3. The Chief of Dental Services will take into consideration funds available for purchasing dental care for recipients of MO, MCA, and MAA and the participating dental doctor's recommendations in arriving at his decision. Notification will be given the MCW and the participating dentist of the approval or rejection.

   The Department will not be responsible for payment of services rendered prior to approval by the Chief of Dental Services.

388-87-045 DENTAL FEE SCHEDULE

	Maximum
Dentures -- Acrylic	
Full Upper or Lower Denture, each	$ 90.00
Repairs, Dentures -- Acrylic:	
Broken Dentures, Repairing (No teeth involved)	10.00
Broken Dentures, Repairing and Replacing Broken Teeth, Each Tooth, Additional	3.00
Replacing Broken Teeth on Denture Only:	
First Tooth	8.00
Each Additional Tooth	3.00
Upper or Lower, Reline	30.00
Upper or Lower, Jump	35.00
Operative	
Amalgam Fillings, Single Surface	5.00
Each Additional Surface	4.00
Maximum	13.00
Synthetic Porcelain or Plastic	7.00
Infection	
First Treatment	5.00
Additional Treatment, each	4.00
Maximum Fee Allowed	13.00
Scaling to Prevent Infection	5.00
Additional Treatment	4.00
Recementing	
Recementing Crown or Inlays	3.00
Recementing Bridges	6.00
X-Rays	
One Film	2.00
Subsequent Films (up to six) each	1.00
Maximum -- Full Mouth	8.00
Hospital or House Call	5.00
Surgery	
Extractions:	
Single Teeth, Local Anesthetic	5.00
Each Additional Tooth	3.00
Anterior Tooth, General Anesthetic	8.00
Posterior Tooth, General Anesthetic	8.00
Impactions	15.00 to 30.00
Endodentia:	
Anterior Teeth of school children only	35.00

388-88-010 GLASSES AND REFRACTIONS. May be furnished recipients of CA within the limitations of available funds. In order that maximum use can be made of the limited funds available priority of approval will be given requests made on behalf of school age children when the child's history indicates that glasses are necessary for the continuation of his education.

1. All initial, replacement, or corrective adjustment requests for refractions, and/or glasses shall be recommended and justified in writing by a physician or licensed optometrist on SF 5873, and forwarded to the local screening physician of the county where the recipient resides.

2. Requests for refractions, limited to school age children in general, shall be submitted to the local screening physician for approval.

3. If glasses are needed as indicated by the refraction report the screening physician will forward the refraction report, relevant case history, along with a SF 5873 to the SO for approval.

4. Refractions, glasses, and replacements are not supplied for recipients of NCA, MO, or MAA.

388-88-030 FEE SCHEDULE FOR GLASSES. Prices listed below are the maximum allowed for material and service specified. In billing, standard sales tax should be added, but should be computed on the total amount of the voucher rather than on individual items.

Single Vision (Complete)	
Frame--Pair of lenses--Case (All powers of lens)	$15.40
One Lens (half pair)	5.65
Two Lenses (one pair)	11.30
Bifocals (Complete)	
Frame--Pair of lenses--Case (All powers of lens)	20.95
One Lens (half pair)	8.40
Two Lenses (one pair)	16.80
Frame Only	4.15
Regrind - Per Surface	
Single Vision	2.50
Bifocal	3.00
Prism	
Any Power - per Lens	2.50

The above fees shall be paid only when prior approval of the service has been obtained.

388-89-010 HEARING AIDS. Within the limitation of available funds by quarterly allotment, hearing aids may be furnished on a loan basis to recipients of CA. Hearing aids are not supplied for recipients of NCA, MO, or MAA. The Department cannot financially assist recipients in the purchase of private hearing aids.

388-89-015 HEARING AID PROGRAM. A hearing aid consultant from the Division SO administers the Hearing Aid Program on a statewide basis. A stock of hearing aids is maintained from which instruments are selected for issuance. When a case is terminated or a hearing aid is no longer wanted, the instrument is returned to the State Hearing Aid Pool for reconditioning and subsequent re-issue. As instruments become obsolete or worn beyond repair, authorized destruction is requested. Replenishment of Pool instruments is made by periodic purchases of new instruments through the Division of Purchasing.

388-89-020 SPECIFIC SERVICES

1. Issuance of hearing aids is on a loan basis. Recipients using state hearing aids must provide their own batteries and receiver cords except at the time of original issuance. The MCW should refer recipients to local dealers for these supplies.

2. State hearing aids which become defective while being used by a recipient may be submitted to the local MCFO or the Hearing Aid Consultant and a replacement will be made. Recipients who own their own hearing aids must have fifty per cent binaural hearing loss before such hearing aids may be repaired at State expense, and a clinic appointment for a hearing test may be made to determine eligibility for service to such privately-owned hearing aids.

3. Recipients may be given Hearing Aid Clinic appointments for the purpose of obtaining advice and information on their hearing problems. If deemed necessary by the Consultant, an audiometric examination may be included as part of the service.

4. Plastic earmolds may be provided to recipients who evidence at least a fifty per cent hearing loss.

5. Special hearing aid accessories are provided to qualified recipients when use is indicated for medical reasons or when reasonable hearing improvement cannot be obtained with a conventional hearing aid fitting. Such decisions rest with the Hearing Aid Consultant and when required for medical reasons, with the attending doctor.

388-89-025 ELIGIBILITY. Recipients must have a fifty per cent binaural hearing loss or greater. Determination of percentage hearing loss is made through pure tone audiometric testing and computation based on American Medical Association tables for computing percentage hearing loss. Speech hearing testing is also utilized in determining individual hearing aid requirements. Factors which may effect eligibility of an otherwise qualified hearing aid applicant are:

1. An applicant who evidences physical or personality traits which would prevent reasonably successful hearing aid use may be considered ineligible by the Hearing Aid Consultant.

2. Applicant's need of improved hearing from the standpoint of personal safety.

3. Applicant's need of improved hearing from the standpoint of essential verbal communication as it is related to social need.

4. Families of hearing aid applicants should be encouraged to assist the applicant in obtaining a hearing aid through a private purchase from reputable hearing aid dealers; however, it is not the policy of the Department to endorse any individual commercial product to the exclusion of the others.

388-89-030 CLINIC SCHEDULES AND PROCEDURES. Recipients apply for Hearing Aid Clinic appointments to the MCW. It is the responsibility of the MCW to schedule the applicants and notify them of their appointment times. Information about the applicant's home environment and general activities should be obtained as completely as possible by the MCW prior to each applicant's clinic appointment and by the Hearing Aid Consultant during the initial clinic appointment.

1. In areas where clinic services are available monthly, the MCW will be notified of that month's clinic date at the beginning of the month.

2. At the time of the recipient's initial application for a clinic appointment, the MCW determines the nature of the recipient's request and schedules the recipient as follows:

    a. Screening appointments - 15 minutes
    b. Fitting appointments - 30 minutes
    c. Counselling appointments - 15 minutes
    d. Applicants currently using hearing aids, and applicants who require equipment replacements - 15 minutes.

3. Requests for home calls should be forwarded to the Hearing Aid Consultant. The MCW should justify such requests. Home calls are to be considered justified when it is medically inadvisable for the recipient to attend a clinic or when travel involved in such attendance may work a hardship on the recipient. Recipients should be made aware of the possibility of a waiting period.

388-89-035 REPLACEMENT SERVICE. Recipients may submit defective State hearing aids to the MCW or the Hearing Aid Consultant. When submitted to the MCW, the Hearing Aid Consultant is notified by mail that a replacement has been requested. When available, a permanent replacement will be mailed to the MCW for delivery. When a recipient submits his hearing aid to the MCW, a receipt should be given to the recipient showing complete instrument information. SF 6436 is provided for this purpose. When submitting their hearing aids, recipients should be instructed to keep their batteries, cords, and earmolds as these will not be provided with the replacement instrument.

388-89-040 TERMINATIONS. Whenever a recipient who is assigned a State hearing aid terminates, the hearing aid should be returned to the Hearing Aid Section, State Office.

In cases of termination because of death, the next of kin should be requested to return the hearing aid. If the return of the hearing aid cannot be effected without considerable effort on the part of the MCW, the case should be referred to the Hearing Aid Consultant for action.

A recipient of public assistance becoming ineligible for reasons of employment and having in his possession a State-owned hearing aid may retain the hearing aid for a period not to exceed 120 days subsequent to the date of termination. When notified of such a termination by the Medical Service Bureau, the MCW notifies the terminated recipient, in writing, that he may retain the hearing aid until the end of the extended period, and that he must notify the MCW of any change of address during that period. A copy of the letter is sent to the Hearing Aid Consultant. The MCW is responsible for returning the hearing aid after the expiration of the extension.

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388-90-010 SURGICAL APPLIANCES AND PROSTHETIC DEVICES. Appliances and prosthetic devices may be provided eligible recipients only in those cases considered essential by the screening physician. When the cost exceeds ten dollars ($10.00) SF 5873 will be transmitted for approval to the State Office, SDPA with adequate justification.

The serviceability of all appliances and prosthetic devices furnished must be determined by the attending doctor and/or screening physician before payment is approved.

388-91-010 DRUGS AND PHARMACEUTICAL SUPPLIES. Within the limitation of available funds, drugs and pharmaceutical supplies may be provided recipients and eligible medical indigents when prescribed by their attending doctor and when applicable as approved by the screening physician in accordance with the provisions as set forth in the Drug Formulary as adopted by the Department.

388-92-010 AMBULANCE AND TRANSPORTATION FOR MEDICAL REASON. The screening physician is responsible for approving the use of an ambulance for a recipient of CA, NCA, MAA, or MO. The MCW is responsible for determining that such service is not available through family, friends, or other sources. When another type of transportation can be used without hardship to the patient, ambulance transportation shall not be approved. Approval for ambulance service shall be obtained in advance except in emergencies.

1. Payment for approved ambulance services shall not exceed the rate(s) established by the Department; taxi costs should be approved at the established local rate.

2. The Department shall not be responsible for transportation for patients who are being taken to mental hospitals after commitment.

3. If a patient in one nursing home desires, for personal reasons, to go to a different nursing home, the Department shall not be responsible for the cost of transportation.

4. The Department shall not be responsible for the transportation of patients to tuberculosis hospitals.

388-92-030 RATES OF PAYMENT - PRIVATE AMBULANCE SERVICE. The rate of payment to private ambulance companies for authorized services provided recipients of CA, NCA, MAA, and MO shall be:

1. Twenty-five cents (25¢) a mile from point of pick up to destination multiplied by two (2), plus a basic fee of ten dollars ($10.00).

2. When mileage from point of pick up to destination totals 100 miles or more, the basic fee of $10 per call will not be paid.

3. When two patients are simultaneously picked up and carried in a single ambulance to the same destination, the rate for the second patient will be one-half that of the first patient, i.e., twelve and one-half cents (12½¢) per mile from point of pick up to point of destination multiplied by two (2), plus a basic fee of five dollars ($5.00).

4. No additional charges shall be paid by the Department for members of the family that may accompany a patient while traveling in an ambulance.

388-92-040 RATES OF PAYMENT - OTHER AMBULANCE SERVICE. Payment for ambulance service rendered by any nonprofit, community-operated, eleemosynary organization or volunteer fire department shall be made by the Department not to exceed the following schedule:

1. For any one authorized round trip within confines of town or city limits: $5.00 flat fee.

2. For any one authorized round trip beyond confines of town or city limits: $5.00 flat fee plus 12½¢ per mile from point of pick up to destination multiplied by two (2).

The above fee schedule shall not nullify or be applicable to present existing payment schedule agreement between the Department and several non-profit ambulance services.

388-94-010 NURSING HOME CARE:

1. The Department, through the Division, has the administrative and legal responsibility to purchase nursing home care for CA, NOA, MAA, and MO recipients. In discharging this responsibility and to assure to the State that adequate care, service, and protection is provided, it is required that payment for nursing home care on behalf of a recipient or indigent shall be made only where the vendor is (1) a private hospital (2) a county hospital or infirmary; or, (3) is the operator of a classified nursing home who:

   a. Is in possession of a valid nursing home license issued by the State Department of Health

   b. Has his home classified by the Division

   c. Has executed in writing a contract with the Division to furnish such services as are provided for under the terms of the Contract and to comply with those Rules and Regulations of the Division pertaining to nursing homes. A signed copy of this contract shall be kept available in the nursing home at all times.

2. The Department will make payment for nursing home care furnished to eligible recipients when recommended by the attending doctor and approved by the classification nurse or screening physician. Payment is not to be made for nursing home care furnished a recipient in unlicensed areas of a hospital or classified nursing home.

3. The Division classifies nursing homes and recipients in need of nursing home care on four levels. The Department pays for nursing home care according to the level at which the nursing home is classified and/or the level at which the welfare patient is classified, whichever is lower. The classification of the patient is independent of the classification of the nursing home. If the patient is classified below the level of the home, payment is at the rate of the patient's classification; if the patient's classification is above the level of the home, payment is at the rate of the home's classification.

388-94-013 CLASSIFICATION OF PATIENTS. Classification decisions are made by the classification nurse or screening physician and will be rendered in accordance with best professional judgment. Such judgment will be based on information supplied by the patient and/or relatives, the supervising and/or attending nurse(s), the attending doctor where indicated, the nursing home record, and professional observations made by the screener.

Nursing Home Criteria for the Classification of Patients (to be used by the screener):

1. Class I

   Status A

   a. Confined to bed

   b. Helpless

   Status B

   a. Confined to bed

   b. Semi-mobile

   c. Additional problems must be (one or combination of)

      1) Complete incontinence (urinary and/or fecal)

      2) Tube feedings

      3) Medications and treatments of maximum complexity (includes dressings)

      4) Severe behavior problem due to mental confusion and/or communication problem(s)

      5) Feeding problem - maximum or complete.

   Status C

   a. Semi-ambulatory

   b. Additional problems must be (one or combination of)

      1) Complete incontinence (urinary and/or fecal)

      2) Tube feedings

      3) Medications and treatments of maximum complexity (includes dressings)

      4) Severe behavior problem due to mental confusion and/or communication problem(s)

      5) Feeding problem - maximum or complete.

2. Class II

   Status A

   a. Confined to bed

   b. Semi-mobile

Status B

a. Semi-ambulatory or ambulatory

b. Additional problems must be (one or combination of)

1) Frequent incontinence (urinary and/or fecal)

2) Major modification of regular diet

3) Medications and treatments of moderate complexity (includes dressings)

4) Moderately severe behavior problem due to mental confusion and/or communication problem(s)

5) Feeding problem - moderate or partial.

3. Class III

Status A

Bedrest (intermittent, daily)

Status B

a. Semi-ambulatory or ambulatory

b. Additional problems must be (one or combination of)

1) Infrequent incontinence (urinary and/or fecal)

2) Minor modification of regular diet

3) Medications and treatments of moderate to minimal complexity (includes dressings)

4) Moderate to minimal behavior problem due to mental confusion and/or communication problem(s)

5) Feeding problem - minimal

4. Class IV

Status

a. Ambulatory or semi-ambulatory

b. Additional problems must be (one or combination of)

1) Oral medications

2) Treatments of minimal complexity (includes dressings)

3) Mild behavior problem due to senility and/or communication problem(s)

4) Requires supervised care

388-94-015 CLASSIFICATION OF NURSING HOMES

1. The classification of nursing homes is the responsibility of the Division.

2. The nursing home operator makes application for classification or change in classification to the Division SO through the local MCFO.

3. Forms and materials used in the classification process are:

   a. The Contract

   b. Rules and Regulations of the Medical Care Program, SDPA.

   c. SF 8622, Application for Classification.

   d. SF 8622-A, Acknowledgment of Explanation of Requirements for Classification.

   e. SF 8610, Work Schedule and Staffing Report.

   f. SF 9238, Authorization for Voucher Signature.

   g. SF 8705, Notification of Admission and Discharge.

   h. SF 101-B, Voucher for Payment.

   Instructions for the use of these forms are provided and must be followed.

388-94-017 CLASSIFICATION OF NEW OR REOPENED NURSING HOME

1. When the operator makes request for classification, the MCW:

   a. Gives operator a copy of Rules and Regulations, reviewing and explaining each of these rules to the operator.

   b. Secures operator's signature on two copies of SF 8622-A (one copy for MCFO file, the other for SO); both copies also requiring MCW signature.

c. Reviews and explains to the operator the Contract and the forms which the operator must complete and return to MCW: The Contract in duplicate; SF 8622 in triplicate; SF 8610 in triplicate (operator keeping a fourth copy for his files); SF 9238.

d. At some time during the classification process, during the initial or subsequent interview with the operator, the MCW shall explain to the operator the manner in which payment is received by the operator from the Department. The MCW shall explain SF 8731, Nursing Home Statement, which will be sent to the operator by the Department for each month of service. The MCW will correlate the use of SF 101-B as submitted by the operator to the Department. The MCW will at this time provide the operator with a supply of SF 101-B.

e. The MCW will further explain to the operator the use of SF 8705 and provide the operator with a supply of these forms for the prompt reporting of admissions and discharges.

f. Visits the nursing home at his earliest convenience to familiarize himself with the home and the operator and to further acquaint the operator with the classification process, the obligations incurred by classification with particular reference to the contract and the Rules and Regulations.

g. When the operator has filled out and returned both copies of the Contract and SF 8622-A, the MCW examines all forms to insure that they have been completed correctly and then shall forward all forms to SO (2 copies of Contract; 3 copies of SF 8622; 1 copy of SF 8022-A; 3 copies of SF 8610; and 1 copy of SF 9238), accompanied with a narrative statement describing the nursing home and the proposed plan of its operation and the recommendation of the MCW relative to the classification of the nursing home.

h. Will submit all forms to SO immediately. The application for classification shall not be held in MCFO pending issuance of State Department of Health license. Work schedule shall not be held for actual staffing pending the opening date of the nursing home. Work schedules should be submitted to SO with the word "tentative" written at the top of the form.

2. The SO shall hold the application and forms until an official copy of the State Department of Health license is received. The SO will then fill in the license number and correct,if necessary, the licensed bed capacity on SF 8622. If the license indicates there are beds restricted to ambulatory patients, SO will request specific information as to the number of beds restricted and will enter the number on SF 8622. SO will make the effective date of classification coincide with the date of license, providing that the application is in order and was received in SO prior to the issuance of the license.

3. After the application for classification has been approved, the SO will return one copy of the Contract and of SF 8622 to the operator, and one copy of SF 8610, SF 8622, and a copy of the license to MCW.

4. Within 30 days after the opening of a new or reopened nursing home, the MCW shall secure new work schedules showing the final staffing. If the staffing arrangements do not differ from the "tentative" schedule the MCW shall advise the SO of "no change in work schedule". If the staffing arrangements differ from the "tentative" work schedule, the MCW shall submit SF 8610, in duplicate, to SO, one of which shall be returned to MCW by SO.

388-94-020 CLASSIFICATION OF NURSING HOME UPON CHANGE OF OPERATORS.

1. The classification of a nursing home is in the name of the operator and is not transferrable from one operator to another.

2. It is the responsibility of the operator to notify the MCW well in advance of the consummation of the sale, or transfer or possession by lease or rental, of the property and/or operation of his nursing home. Failure to do so will result in the withholding of any monies due and owing the home.

3. The former operator will be held responsible for the care and protection of welfare patients until the new operator is in possession of a valid license issued by the State Department of Health and the home has been classified in the name of the new operator by the Division.

4. In the event the operator transfers responsibility for the operation of the nursing home to the new operator, or any other individual, prior to the time the home is licensed and classified in the name of the new operator, the Department reserves the right, without giving advance notice, to withhold payment for nursing care and to advise welfare patients that payment for their care can no longer be authorized and to suggest they move to a properly licensed classified home.

5. When the MCW first hears of a probable or prospective change in operator of an established nursing home, the MCW shall remind the current operator of the Rules and Regulations, and alert SO of the prospective change in operator. If SO first hears of a probable or prospective change in operators, then SO shall alert the MCW.

6. When the prospective new operator requests classification, the MCW follows the same procedure as for a new or reopened home, except that the work schedule (SF 8610) must show the actual staffing.

388-94-022 CHANGE IN CLASSIFICATION OF NURSING HOME.

1. When an operator applies for a change in classification to a group with higher staffing requirements:

   a. The MCW secures from the operator a properly executed contract (2 copies), SF 8622 (3 copies) and SF 8610 (3 copies) and forwards these to the SO, accompanied with the MCW narrative statement and recommendation regarding the requested change in classification.

   b. If the SO approves the requested change in classification, one copy of SF 8622 and the Contract will be returned to the operator; and one copy of SF 8622 and SF 8610 to the MCW.

2. When the operator applies for a change in classification to a group with less staffing requirements:

   a. The MCW secures from the operator a properly executed contract (2 copies), SF 8622 (3 copies) and SF 8610 (3 copies) and forwards these to SO, accompanied by MCW narrative statement and recommendation regarding the requested change in classification. Such statement and recommendation shall include the number and classification of patients for whom adequacy of care would appear doubtful if the classification of the home is reduced.

   b. Concurrent with receipt of request for a change in classification of a home to a group with less staffing requirements, the MCW shall consider the adequacy of care which would be available to those patients whose classification is higher than the requested group classification of the home. The MCW shall then advise the operator that if the group classification of the home is lowered and the licensed staff is correspondingly reduced, that each welfare patient requiring skilled care, his attending doctor and guardian or relatives will be notified, and if a transfer of the patient is requested, the patient will be moved to a nursing home which is classified at a level commensurate with the patient's need for care.

   c. If the SO approves the requested change in classification, one copy of SF 8622 and the contract will be returned to the operator, and one copy of SF 8622 and SF 8610 to the MCW. The SO shall jointly plan with the MCW relative to the transfer of the patients for whom adequacy of care appears doubtful.

388-94-025 PERSONNEL REQUIREMENTS FOR CLASSIFICATION OF NURSING HOMES The following minimum personnel requirements determine the level at which a nursing home will be classified. As used below, the term "registered nurse" means a nurse currently licensed by the State of Washington to practice as a registered nurse; and the term "licensed practical nurse" means a nurse currently licensed by the State of Washington to practice as a practical nurse. The nursing home operator is responsible for verifying the license status of his employees.

1. GROUP I LICENSED NURSING HOME

A licensed nursing home to be classified as a Group I home shall employ the following full-time active staff:

a. One registered nurse employed as Supervising Nurse, on day duty, who shall direct all nursing care given in the home; and who shall be employed full-time (minimum 8-hour day, 40-hour week).

b. One registered nurse on evening duty.

c. One licensed practical nurse on night duty.

d. One registered nurse for relief duty.

e. Sufficient additional nursing personnel to adequately care for the type and number of patients in the nursing home.

f. Arrangements must be made so that at all times there is either a registered or a licensed practical nurse on duty.

2. GROUP II LICENSED NURSING HOME

A licensed nursing home to be classified as a Group II home shall employ the following full-time active staff:

a. One registered nurse employed as Supervising Nurse, on day duty, who shall direct all nursing care given in the home, and who shall be employed full-time (minimum 8-hour day, 40-hour week).

b. One licensed practical nurse on evening duty.

c. One licensed practical nurse on night duty.

d. One licensed practical nurse for relief duty.

e. Sufficient additional nursing personnel to adequately care for the type and number of patients in the nursing home.

f. Arrangements must be made so that at all times there is either a registered or a licensed practical nurse on duty.

3. GROUP III LICENSED NURSING HOME

A licensed nursing home to be classified as a Group III home shall employ the following active staff:

a. One licensed practical nurse on day duty who shall direct all nursing care given in the home, who shall be employed full-time (minimum 8-hour day, 40-hour week).

b. One licensed practical nurse for relief duty must be employed full-time to cover vacations or sick leave periods.

c. One or more attendants full-time on night duty to insure safety protection and needed care of patients.

d. Sufficient additional nursing personnel to adequately care for the type and number of patients in the nursing home.

4. GROUP IV LICENSED NURSING HOME

A licensed nursing home to be classified as a Group IV home shall employ the following full-time active staff:

a. One licensed practical nurse employed full-time on day duty who shall direct all nursing care given in the home.

b. Sufficient additional personnel to adequately care for the type and number of patients in the nursing home.

388-94-027 COMPLIANCE WITH STAFFING REQUIREMENTS. Classification of the home, at the group level for which the operator makes application, cannot be initially approved unless compliance with the required staffing is indicated on the work and staffing schedule (SF 8610); nor can this classification be continued if subsequent work schedules indicate continued failure of the home to comply with staffing requirements.

1. The nursing home operator or authorized manager is responsible for submitting SF 8610 or SF 8677 upon the request of the MCW. Failure by the operator or authorized manager to comply with such request within five days following the receipt of same may result in the withholding of payment to the nursing home.

2. The Division SO holds the MCW responsible for supervision of nursing homes with reference to their compliance with staffing requirements. This entails the collection, review and approval of work schedules submitted by the nursing homes; the forwarding of these to Division SO, as well as action appropriate to the correction of the nursing home's noncompliance with the staffing requirements.

3. The MCW is responsible for securing work schedulest :

   a. As a part of the classification process.

   b. In the annual (midwinter) review of staffing in every classified nursing home in the MCW area. This will be accomplished by the MCW sending SF 8610 (4 copies) to the operator of each home, having previously entered on SF 8610 the name of the home and the specific week for which the staffing is to be reported. MCW will advise the operator that 3 copies of this form are to be completed and returned to the MCW within five days following the operator's receipt of same. When the MCW receives the completed copies of SF 8610, these will be initially reviewed and approved by the MCW before being forwarded to SO. After SO reviews the SF 8610, one copy will be returned to the MCW.

   c. As a check (at any time or frequency as indicated) on the staffing of any home not in compliance with requirements. SF 8610 or SF 8677 may be used for this purpose.

4. The MCW (utilizing the consultation service of the classification nurse, if one is assigned to the area) is responsible for the initial review and approval of work schedules submitted by nursing home. This responsibility of the MCW includes:

   a. Holding the operator responsible for personal verification of the license status of every registered nurse and licensed practical nurse listed on SF 8610; and refusing to approve any work schedule on which Washington license numbers for the required licensed nurses are not listed unless there appears to be a valid reason.

   b. Refusing to approve any work schedule on which a required RN or LPN is listed "on call" rather than shown actually on duty.

   c. Refusing to accept any work schedule not signed by operator or authorized manager, and, in Group I and II homes, not countersigned by the supervising nurse.

   d. Explaining to operator that the supervising nurse be so designated on the work schedule.

   e. Checking the work schedule to verify compliance with staffing requirements according to the classification of the home; and refusing to accept any work schedule on which the specific duty hours of staff are not listed.

5. In a situation where noncompliance with staffing requirements has been promptly reported to the MCW by the home, the responsibilities of the MCW include:

   a. Advising the operator to direct to Division SO a request for exception to staffing requirements, stating reasons for request. If the operator of a Group I home wishes to secure SO permission to employ an LPN for coverage of a shift on which an RN is required, then the supervising RN must send SO a signed statement expressing her opinion of the LPN competence to handle the responsibility involved.

   b. Advising the operator of a Group I home that under no circumstances may the night shift be entrusted solely to an aide. If unforseen circumstances result in temporary lack of licensed coverage on the night shift, the operator must at least arrange for a licensed nurse to sleep in the home and be immediately available to take charge in case of an emergent change in a patient's condition.

   c. Advising SO when a home has not been in compliance with staffing requirements. The MCW shall exercise judgment (in consultation with the classification nurse if one is assigned to the area) in determining the length of time of noncompliance before reporting the situation to SO; but in no instance shall this period of time exceed 30 days. When the Division SO is notified, the MCW shall cite the circumstances involved and recommend the administrative action, if any, to be taken by SO.

6. In a situation where noncompliance with staffing requirements has not been reported to MCW by the home, but is discovered by the MCW, it is the MCW responsibility to report the situation to SO without delay. SO is responsible for administrative action relative to the violation. If noncompliance is discovered by classification nurse or screening physician, the facts should be promptly reported to MCW who will immediately transmit the information to SO.

388-94-030 JUSTIFICATION OF RATE PAYMENT. The Division reserves the right at all times to obtain from the home, upon reasonable request, such information as is necessary to justify the rate of payment made by the Department in accordance with RCW 74-09-120.

388-94-035 ADEQUATE NURSING HOME CARE. As a requirement for classification and as contained in the Contract which each operator signs, the nursing home is obligated to provide adequate nursing home care which includes, but is not limited to: medical supervision; medications and treatments competently administered; personal hygiene; promotion of self help; meeting the

emotional needs and/or behavior problems; safeguarding personal possessions; and compliance with the State Department of Health Rules and Regulations for nursing homes.

1. Medical Supervision signifies the responsibility of the home to:

   a. Secure from attending doctor the admission diagnosis and treatment orders for each patient.

   b. Report to doctor any change in the patient's condition.

   c. Record in proper manner the doctor's orders on "Doctor's Orders" sheet in the patient's chart, securing the doctor's signature at first opportunity if orders were given by telephone.

   d. Request doctor to visit in case of emergency or critical change in patient's condition.

   e. Allocate to nursing personnel the function of communication with the doctor and the recording of his orders; and allocate in this order of priority; supervising RN, the registered nurse on duty, the LPN, or the aide in charge on a shift not covered by a licensed nurse.

2. Medications and Treatments mean the responsibility of the home to:

   a. Provide the equipment and secure the supplies and drugs needed to carry out the doctor's orders for medication and/or treatments (limited by the Department's rules and regulations as interpreted by screening physicians).

   b. Provide the following equipment and supplies (according to classification of home):

      1) Hot water and ice bags, rectal tubes (including enema equipment), catheterization sets, rubber gloves, thermometers, hypodermic syringes and needles, equipment for taking blood pressure, intravenous, oxygen and aspiration equipment where needed;

      2) A dressing tray with standard equipment and supplies such as adhesive, band-aids, gauze, bandage, cotton, burn ointment, one or more antiseptics;

   c. Allocate to the supervising nurse the responsibility for insuring that all medications and treatments are administered and recorded by staff members with requisite knowledge and skill for the particular medication or treatment. The supervising nurse is to be aware of medications continued over a long period of time, and to check with attending doctor at periodic intervals regarding continuance.

d. Insure that labels on containers of all medications, whether prescriptions or over-the-counter items, clearly state the drug(s) as well as the dosage and directions.

e. Provide, at no additional charge to the Department or patient, clinitest tablets, aspirin, mineral oil, body lotions including alcohol, milk of magnesia, and antidiarrhetics (medications for the control of diarrhea).

3. Personal Hygiene includes all aspects of personal care which promote a healthy condition of body surface, including orifices, and improve body functioning. This care may be given wholly or partly by staff or may be almost entirely a matter of supervised self-care. Personal hygiene means the responsibility of the home to provide a competently supervised nursing staff of sufficient number to insure for each patient:

a. Daily care of teeth or dentures

b. Clean skin and hair, with complete bath and shampoo spaced at sufficient intervals to prevent deterioration of skin from too frequent application of soap and water

c. Cleansing of body area affected in incontinence or drainage at sufficiently frequent intervals to prevent, so far as possible, excoriation or ulceration

d. Clean and trimmed fingernails

e. Care of feet and toe-nails, with sufficient soaking, lubrication and use of nail clippers to prevent, so far as feasible, deterioration of skin and nails

f. Handwashing, according to need, and

g. Making available for each patient haircuts and shaves at intervals required for comfort, physical and/or mental.

4. Promotion of Self-Help implies the rehabilitative component in nursing care of the patient, thus meaning the responsibility of the home to:

a. Encourage and promote patient interest in simple tasks within the patient's ability to perform, which contribute to his psychological and emotional well-being

b. Secure a nursing service characterized by such practices as: (1) bed patients able to be moved are gotten up each day; (2) incontinent care is by change of pads and cleansing of skin, rather than retention catheters; (3) bedpan training by anticipation of need; (4) emphasizing self-help activities and exercises which will encourage mobility and ambulation.

5. Meeting emotional needs and/or behavior problems signifies the responsibility of the home to:

   a. Provide an environment of comfortable and comforting interpersonal relationships, an environment which insures kind and friendly attitude of staff toward each patient, an atmosphere where warmth in staff-patient relationships is unmistakable

   b. Provide for a certain amount of diversional activity for patients, encouraging friends, relatives and organizations to contribute to this phase of care

   c. Encourage visitors and facilitate visits to patients

   d. Secure personnel capable of caring for the senile patient or the patient with severe behavior problem with patience, understanding and kindness

   e. Make clear to all personnel a philosophy based on respect for the individual patient and his possessions which will protect, so far as possible, the patient's right to privacy.

6. Safeguarding personal possessions (including money) means the responsibility of the home to:

   a. Provide a method of identification of the patient's suitcases, clothing and other personal effects, and a listing of these on a sheet attached to patient's chart when the patient is admitted to the home

   b. Provide adequate storage facilities for the patient's personal effects, and these facilities accessible to the patient if ambulatory

   c. Provide reasonable protection of patient's possessions, particularly clothes, against theft, and damage from moths, mildew, and destruction

   d. Exercise careful judgment in the release of the patient's personal property to other than the actual owner, and to secure on an itemized statement of release the signature of the patient, duly authorized agent, or next of kin.

   e. Insure that all mail is delivered unopened to the patient to whom it is addressed, except for those patients too confused to receive it. Assistance in opening and reading personal mail should be given only on the basis of the patient's need or request.

   f. Provide and maintain a system of accounting for expenditures from the patient's money allowance for incidentals. This accounting

system must be adequate for, and subject to audit, by a representative(s) of the Department :

1) A ledger is required. The beginning ledger sheet must be credited with the patient's total incidental money on hand.

2) Ledger account must be kept current on a monthly basis.

3) Each debit item in the ledger account must be supported by a signed, dated receipt. Receipt must indicate article furnished for patient's benefit.

4) Receipts for each patient must be kept until cancelled by a Department audit. Receipts may be kept in an individual Patient Ticket Envelope, or otherwise safely and systematically filed to insure against loss and to facilitate audit.

5) Incidental money is for the exclusive personal use of the patient as he desires. Patients must not be charged for such items as chux, tri-pads, toilet paper, gauze, wheel chairs, etc., or other nursing home maintenance items. The Department reserves the right to charge back to the nursing home operator any such maintenance items that are charged to the patient's incidental money account in ledger, since such charges constitute double payment.

6) Incidental money must not be turned over to persons other than a duly accredited agent or guardian of the patient. With the consent of the patient, the operator may turn over incidental money belonging to said patient to a close relative or friend for the purchase of particular article (example: clothing) for the patient's benefit; however, a signed, itemized dated receipt will be required for deposit in the Patient's Ticket Envelope or in other type file of receipts for individual patients.

7) The ledger and the receipts for each patient must be made available for periodic audit by accredited representatives of the Department. Audit certification will be made by a Department representative at the bottom of the Ledger Sheet. Supporting receipts may then be discarded.

8) Upon a patient's decease, a receipt must be obtained from next of kin or duly qualified agent of the deceased before releasing balance of incidental money.

9) Upon a patient's decease, the ledger account of patient's incidental money must be audited and certified by a representative of the Department.

7. Compliance with the State Department of Health Rules and Regulations. These regulations are designed to insure adequate nursing home care, which includes a safe and comfortable environment and a nutritionally adequate diet.

388-94-037 ABUSE, NEGLECT OR MISTREATMENT OF WELFARE PATIENTS AND THE INVESTIGATION, HEARING AND PENALTIES IMPOSED.

1. When it comes to the attention of the Department that a welfare patient has been subjected to an assault, abuse, mistreatment and/or neglect while a patient at a classified nursing home, the Department shall cause an investigation of the allegation to be made by a representative of the Division. During the course, or at the completion of said investigation, if it is determined that evidence has been adduced to support such allegation, the Assistant Director of the Division of Medical Care shall advise the operator of the nursing home involved that before a final decision is made, to either revoke the nursing home classification and drop the home from the list of classified homes or suspend the referral of new welfare patients to the nursing home for a period not in excess of six months, he will be served with a notice to appear at a hearing to show cause why such decision or order should not be issued.

2. The determination by the Assistant Director of the Division of Medical Care that a notice to appear and show cause hearing is necessary will be construed as a "Contested Case" as defined in the Administrative Procedures Act, Sec. 1 (3), Ch. 234, L.59 and the provisions contained in Sec. 9 through Sec. 14 of said act shall apply.

3. The hearing shall be conducted by an authorized agent appointed by the Director of the State Department of Public Assistance at a place in the county where the nursing home is situated at a time specified by the Department.

4. The notice to appear and show cause will be issued by the authorized agent upon advise from the Assistant Director of the Division of Medical Care. Service to the nursing home operator will be made by registered mail at least three days in advance of the date set for hearing.

5. A decision shall be rendered by the Director within 30 days after the hearing. Said decision will, in addition to findings of fact and conclusions of law, include the penalty to be invoked, if any, as determined to be reasonable and just.

388-94-039 CHANGE IN NAME OF NURSING HOME.

1. When the operator of an established home wishes to change the name of the home, the MCW:

   a. Advises the operator to direct a request for change in name of the home to the State Department of Health.

   b. Secures SF 9238 and forwards this to SO.

   c. Explains to operator that the new name cannot be recognized by the SDPA until such time as a new license is issued by the State Department of Health making the new name official.

   d. Enters the new name of the home on MCFO copy of SF 8622 with the date of official change (as shown on new license) when a copy of the new license is received in MCFO.

2. When there is a change in operator and the new operator wishes to change the name of the home, the new name of the home will appear on the license to the new operator. Therefore, the MCW should instruct the new operator to enter the proposed new name on all documents involved in the classification process.

388-94-040 CHANGE IN LICENSED BED CAPACITY. When a new license is issued by the State Department of Health because of a change in bed capacity, the SO will send a copy of the new license to the MCW. If there should be an increase in bed capacity sufficient to suggest the need for additional staff, two copies of SF 8610 shall be secured and forwarded to SO. No other action is required.

388-94-042 CHANGE IN AUTHORIZED MANAGER. When the Application for Classification (SF 8622) names an authorized manager and subsequently there is a change in manager, the MCW shall secure SF 9238 and forward this to SO with a statement that the MCW has received verbal or written notification of the change in authorized manager from the operator of the home.

The MCW shall notify SO of a change in authorized manager when the operator of the nursing home is a corporation and an officer of the corporation is not available locally to execute SF 9238. The SO will then secure SF 9238 from an official of the corporation and notify the MCW who will make notation of the change on the MCFO copy of SF 8622.

388-94-045 VIOLATIONS OF CONTRACT AND STAFFING REQUIREMENTS. When an operator, after due warning, continues to violate the terms of the contract, particularly the staffing requirements for classification, the Department may terminate the Contract. This does not prevent the operator from applying for (1) classification of the home at a lower group level and (2) a new contract. The decision to renegotiate a contract rests with the Department.

388-94-047 UNCLASSIFIED FACILITIES FOR NURSING HOME CARE:

1. County infirmaries are licensed nursing homes but they are not classified.

2. Some licensed nursing homes are not classified because of no desire to admit welfare patients or because they have been dropped from the list of classified nursing homes as a result of SDPA administrative decisions. Periodically, the SO distributes a list of unclassified licensed nursing homes for the purpose of assisting MCW in out-of-county placement of nursing home patients.

3. County hospitals may have a nursing home unit which is not subject to classification.

4. Private hospitals:

   a. Any private hospital wishing to allocate a given number of beds for recipients in need of nursing home care must agree in writing to provide adequate nursing care for the rate of compensation paid by the Department to classified nursing homes, according to the classification of the patient.

   b. Establishment of the agreement between the hospital and the Department involves only one document, SF 6439-N, Hospital Agreement for Care of Nursing Home Patients (in quadruplicate).

   c. When the Division SO completes or renews a Hospital Agreement, one copy of the SF 6439-N will be sent to the MCW.

   d. If the hospital informs the MCW of desire to reduce the number of nursing home beds, as stated in the agreement, the MCW will advise the hospital to communicate with the Division SO requesting a new Agreement.

5. Some homes are not subject to licensing by the State Department of Health. These are homes which provide care for no more than two persons who are unrelated to the operator by blood or marriage. These homes are not eligible for classification because they are not subject to licensing.

388-94-050 PAYMENT FOR NURSING HOME CARE. Rate of Payment - Vendor payment made on behalf of welfare nursing home patients shall not be higher than the group classification of the nursing home:

Class I	patient	$6.38
Class II	patient	5.27
Class III	patient	4.66
Class IV	patient	4.14

per patient day less income available to the recipient as determined by the Department to be available to meet nursing home cost.

388-94-052 PAYMENT PROCESS. For recipients of CA and NCA, the procedures as set forth in SDPA Manual II apply. The operator of a nursing home must submit a separate billing on SF 101-B for each MO and MAA case. This shall bear the signature of the MCW under the section "Local Agency" and certify that such bills were properly authorized. Billings will originate with the nursing home operators and it is the operators responsibility to prepare and submit them to the MCW for preaudit and transmittal to the Medical Audit Section. When an MO or NCA case is placed in a nursing home, the MCW will explain the method of billing to the nursing home operator as shown below.

NURSING HOME CARE

September 19	John V. Jones 31-X-1234-1 Class III Nursing Home Care Sept. 3 to Sept. 19	$74.56

or

NURSING HOME CARE

September 30	John V. Jones 31-X-1234-1 Class III Nursing Home Care *Sept. 1 to Sept. 30*	139.80

The asterisk in front of the first date indicates that the patient was in the home the previous month; an asterisk after the last date indicates that the patient is still in the home.

1. MCW is responsible for post auditing SF 8731 (Nursing Home Statement). If corrections are indicated on the SF 8731 of any home, the MCW shall prepare a separate memorandum (in triplicate) for each home, listing the corrections. The original of such memorandum shall go to CO, a copy to Medical Audit and a copy for MCFO.

2. Payment of Additional Compensation for Nursing Home Care

   a. The Department encourages relatives to contribute toward the total cost of nursing home care. In furtherance of this policy, when a possible source of revenue or contribution comes to the attention of a nursing home operator which would result in a contribution, or an increase in contribution toward the total cost of care of a nursing home patient according to the classification of the patient, the nursing home operator shall report such fact to the caseworker in charge of the case.

   b. The operator of a classified nursing home shall not receive or accept money from a recipient or from any one for or on behalf of the recipient in excess of the amount properly payable according to the classification of the recipient for nursing home care. Any operator who accepts or receives money in excess of the amount properly payable according to the classification of the recipient shall be dropped from the list of classified nursing homes.

c. The nursing home operator shall not seek or accept any additional compensation for services included in 388-94-035.

d. The nursing home operator may charge the recipient for personal care services including, but not limited to, haircuts, shaves, and personal laundry. The operator is required to submit to the MCW a list of the fees charged recipients for personal care services.

388-94-055 PATIENT PLACEMENT

1. Placement may be in a county infirmary or hospital, a private hospital, a classified nursing home, the patient's own home, or the home of another person. The MCW is responsible for placement of patients in classified nursing homes, county infirmaries or hospitals, or private hospitals. In placement planning, the MCW will inform the patient, his guardian, relatives, and/or attending doctor that a classified nursing home reserves the right to refuse to admit or continue to care for a recipient whose care is found undesirable by the home; and on the other hand, there is nothing to prevent a recipient, his guardian or relatives from exercising the right to request the recipient transferred from a nursing home to some other facilty, when authorized by the Division. When the patient, his guardian, relatives, or attending doctor choose placement of the patient in his own home or in the home of another person, the MCW and classification nurse or screening physician share with the CO caseworker the responsibility for placement planning, but final decision is the responsibility of the county office.

2. The Department shall not be responsible for payment for care of a recipient in a classified nursing home unless the placement of that patient has had prior approval. (For exception, see 388-94-057(2).)

388-94-057 PLACEMENT PROCEDURE

1. Requests for nursing home placement are often transmitted verbally to MCW or may be on SF 5873 from attending doctor. When the initial request is made by the patient, his guardian or relative, the MCW usually refers this source of request to the attending doctor who makes formal request on SF 5873. When a request for placement is received, the MCW:

   a. Secures current information on the patient's condition from available sources -- e.g., relatives, county office, MCFO records, attending doctor, hospital, or nursing home in case of transfer.

   b. Records this information on SF 8604 unless there is available a recent SF 8604 from classification nurse or screening physician.

c. Secures SF 5873 from attending doctor if this was not previously received. In some circumstances SF 5873 may be completed by screening physician or classification nurse upon recommendation of attending doctor.

d. Secures a classification of the patient on SF 5873 and SF 8604.

e. Checks with homes regarding vacancies appropriate to the classification of the patient, describing condition of patient and his nursing needs.

f. Discusses the possibilities for placement with the patient and/or his relatives; explains that the responsibility for selection of home rests with the patient, or if he is unable to make a choice, with his guardian, relatives, close friends, or attending doctor; and secures signature on SF 8557 as verification of free choice in selection of home.

g. Plans, during placement interview or subsequently, for the transportation of the patient to the nursing home.

h. Explains and stresses, during placement interview with patient and/or guardian, relatives, friends, that payment to a classified nursing home for care of a welfare patient cannot be made unless placement in the home has had prior authorization. It should be clearly understood by the patient, relatives, and attending doctor that this rule of nonpayment for days of unauthorized nursing home care applies to transfer from hospital to nursing home, from one nursing home to another, and from private home to nursing home.

i. Confirms with operator of the selected home the time of admission; and, in case of placement of patient from hospital, clears with hospital charge nurse regarding the most suitable time for discharge.

j. Sends SF 5873 and/or referral form if one is used by MCFO, to the admitting home.

k. Requests the nursing home to notify MCW, by telephone, if possible, of the patient's arrival and to follow up immediately with SF 8705.

l. Promptly submits SF 8706 to CO. In preparing the SF 8706, the MCW follows instructions in Manual II.

2. In case of the emergency admission of a patient to a home, when the MCFO is not open during regular working hours, the MCFO must be notified by the home the morning of the first working day following the emergency admission.
3. When the patient leaves the nursing home for more than 24 hours, the home must immediately notify the MCW. The MCW then plans with the operator regarding discharge and re-admittance.

388-94-060 TRANSFER OF PATIENTS Transfer of a patient from one nursing home to another nursing home (selected as stated in 388-94-057) shall be approved by the screening physician or classification nurse and MCW prior to the date of transfer. If such transfer of patient takes place without prior authorization, no payment will be made for the patient's care in the admitting home until the transfer is approved.

388-94-062 INTER-COUNTY TRANSFER OF PATIENTS

1. When a nursing home patient (his guardian, or relative) desires a transfer to a nursing home in another county, the transfer must have prior authorization by the MCW in the county from which the patient is transferred as well as the MCW in the county to which the patient is to be transferred. The procedure for transfer is as follows (using Cowlitz and Lewis counties for purpose of clarity):

   a. The MCW (Cowlitz) after receiving a request for transfer of a patient from a home in Cowlitz County to one in Lewis County, secures current information and classification of patient on SF 8604 and SF 5873.

   b. The MCW (Cowlitz) contacts MCW (Lewis) in order to convey essential information concerning patient and obtain a list of homes with vacancies appropriate to the patient's classification.

   c. Selection of a home in Lewis County follows the procedure as stated under 388-94-057.

   d. MCW (Cowlitz) secures from MCW (Lewis), the date for transfer (as agreed to by the admitting home in Lewis County) and completes the arrangements for transfer.

   e. MCW (Cowlitz) forwards a copy of SF 8604 and SF 5873 to MCW (Lewis).

   f. MCW (Cowlitz) secures SF 8705 from the home the patient has left; prepares the SF 8706; submits this to Cowlitz CO.

   g. The MCW (Lewis) secures SF 8705 showing admission to the nursing home; makes a copy of SF 8705 for Lewis MCFO; forwards the original SF 8705 to MCW (Cowlitz) who then prepares SF 8706 in triplicate, sending the original to Cowlitz CO, one copy to Lewis MCFO, keeping one copy for Cowlitz MCFO.

2. If a patient transfers from a home in one county to a home in another county without prior approval according to the above procedure, the admitting home will not be paid for the patient's care during the period required for completion of authorizing procedure.

388-94-065 . OUT-OF-COUNTY PLACEMENT

1. When a recipient (his guardian or relative) desires nursing home placement in another county, the placement must have prior authorization by the MCW in the recipient's county of residence as well as the MCW in the county in which the recipient desires placement.

2. The procedure outlined under 388-94-062, is to be followed, except for 1-f and 1-g. The MCW (Lewis) receives SF 8705 from the home to which the patient has been admitted and prepares SF 8706 in triplicate, sending the original to Cowlitz CO, one copy to Lewis CO and retaining one copy for Lewis MCFO. SF 8705 is retained in Lewis MCFO.

3. In the event of an emergency placement of a Cowlitz County recipient in a Lewis County nursing home, the MCW (Lewis) will immediately inform the MCW (Cowlitz) of the circumstances. The MCW (Lewis) will secure SF 5873 from the attending doctor (Lewis) and will forward this to MCW (Cowlitz) for the approval of the classification nurse or the screening physician (Cowlitz). When the MCW (Lewis) receives the approved SF 5873 from Cowlitz MCFO and receives SF 8705 from the admitting nursing home, the MCW (Lewis) prepares SF 8706 in triplicate, sending the original to Cowlitz CO, one copy to Lewis CO and retaining one copy for Lewis MCFO. SF 8705 is retained in Lewis MCFO.

388-94-070 PLACEMENT OF PATIENTS DISCHARGED FROM STATE HOSPITALS. The State Department of Public Assistance and Institutions share the responsibility for the most satisfactory placement of public assistance applicants discharged from state hospitals.

1. When the state hospital recommends a patient for discharge, classification of the patient is requested by the hospital and accomplished by the local classification nurse and/or screening physician. If the patient is approved and classified for nursing home care, the necessary forms and materials are assembled at the hospital and sent to the Adult Placement Specialist, SDPA-SO. These documents are:

   Social Summary, 4 copies 3 copies.
   SF 5873, Additional Service Recommendations, Medical Care Program,/
   SF 8604, Classification of Nursing Home Patient, 1 copy
   SF 5115, Authorization for Release of Information, 2 copies
   SF 6478, Application for Assistance, 1 copy
   SF 2523, Statement of Resources, 1 copy
   SF 2511, Face Sheet, 1 copy
   SF 7903, General Medical Examination Report, 2 copies
   SF 8635, Summary Referral to Nursing Homes, 2 copies

2. The Adult Placement Specialist will forward three copies of the social summary and all other forms enumerated above, with a cover letter to CO of the county in which placement of the patient is recommended.

3. The CO responsibility is defined in SDPA Manual II, Section 408.143.

4. The MCFO receives from the CO:

SF 8604, Nursing Home Patient Classification, 1 copy
SF 5873, Additional Service Recommendation, all three copies
SF 8635, Summary Referral to Nursing Home, 2 copies
Social Summary, 1 copy
Cover letter from CO indicating eligibility

5. Placement Procedure

a. The MCW:

1) Reviews the case with the local classification nurse or screening physician with reference to nursing homes where vacancies exist.

2) Contacts guardian, relatives, or friends to consider choice of nursing home, doctor, and other placement factors.

3) Contacts the selected nursing home for preliminary discussion of the patient's needs in order to secure the operator's agreement to provide necessary care and the date patient may be admitted.

4) Notifies state hospital, CO, and Adult Placement Specialist of name and address of nursing home for placement of the patient and the proposed date of admission (also the name and address of attending doctor if known to MCW at this time). Telephone notification must be confirmed in writing by MCW.

b. The state hospital, upon receipt of above information from MCW, will:

1) Notify the MCW of the anticipated date of the patient's arrival at the nursing home.

2) Provide transportation for the patient to the nursing home, including an attendant.

3) Send with the patient his personal effects, and, if possible, an adequate supply of clothing; also, a supply of prescribed medication(s) sufficient for three weeks.

4) Send a medical summary to the patient's attending doctor if he has been named in MCW report to SH.

c. The MCW, when notified by SH of anticipated date of arrival of patient at the selected nursing home will:

1) Send one copy of SF 5873 and SF 8635 from the home following admission of the patient.

2) Secure prompt submission of SF 8705 from the home following admission of the patient.

3) Complete SF 8706 and forward same to CO.

6. If placement cannot be made within 2 or 3 weeks, the MCW shall return all forms with cover letter citing circumstances to CO, with a copy to Adult Placement Specialist.

388-94-072 UNSUCCESSFUL PLACEMENT OF STATE HOSPITAL DISCHARGEES:

1. Return to State Hospital

Whenever the return of a nursing home patient to state hospital is proposed, the discharge status of the patient must be considered. If the patient is on "terminal leave" there should be no difficulty encountered in effecting the return of the patient. If the patient has been "discharged" from the state hospital, voluntary admission can be effected by the cooperation of the relatives or legal guardian. If there is no alternative to recommitment, the prosecuting attorney should be contacted by the guardian, relatives, attending doctor or nursing home operator relative to commitment procedure.

a. If the nursing home feels that a patient has become unmanageable and should be returned to the state hospital it is the responsibility of the operator or supervising nurse to contact the patient's attending doctor and to alert the MCW. If the attending doctor feels the patient should be returned to the state hospital he should contact the physician at the state hospital who had charge of the case.

b. If the attending doctor is not available or declines to contact the state hospital physician, the supervising nurse at the nursing home should contact the state hospital physician who had the case.

c. The MCW should not accept the responsibility for contacting the state hospital physician relative to a patient's possible return to the hospital.

d. When the state hospital is requested to provide transportation for the return of the patient, the condition of the patient should be clearly described to the state hospital by the attending doctor or supervising nurse, particularly if the patient is physically ill. Such information will allow state hospital to determine whether transportation by ambulance is required.

e. When a patient is returned to state hospital from a nursing home, a report on the patient's condition and behavior should be prepared by the supervising nurse in the home. This report, along with the patient's personal effects and medicines should be given to the SH attendant who calls for the patient.

f. The MCW will send to the superintendent of the hospital a brief statement of the pertinent facts concerning the patient's return to the state hospital, with a copy to CO and to Adult Placement Specialist.

2. If the original nursing home placement proves unsuccessful it may be that the patient can make a satisfactory adjustment in another home. Upon the recommendation of the attending doctor, placement in another classified nursing home may be an alternative to return of the patient to the state hospital. The transfer of the patient in this type situation would be in accordance with 388-94-060.

388-94-075 MONTHLY REPORT OF NURSING HOME PLACEMENTS. The MCW will complete SF 8632, Monthly Report of Nursing Home Placements (in duplicate) on the last working day of each month, sending original to Division - SO, retaining one copy in MCFO.

388-94-080 PLACEMENT OF PATIENTS FROM ALASKA. The Division of Medical Care, Nursing Home Section, is responsible for making arrangements for the placement of nursing home patients referred by the Alaska Department of Health and Welfare. In case of a direct referral from Alaska Department to either a CO or MCFO, such referral must be forwarded to Division SO.

388-95-010 VOLUNTARY CHILD CARE AGENCIES. Medical care for children and/or unmarried mothers who are dependent as determined by the Department and are receiving the services of a voluntary child care agency is provided by two different plans. The plan to be followed is worked out by the voluntary agency.

1. Plan A -

   a. Under this plan, an agreement is signed by the agency and the Department whereby the Department makes a per capita payment to the voluntary agency and the agency provides all necessary medical, dental, hospital, and nursing care and all necessary ambulance service, drugs, medicines, hearing aids, optical supplies, and other appliances to the eligible child and/or unmarried mother. The agency under this plan is required to pay for all medical, dental and related services and may not seek remuneration from the Department over and above the agreed upon per capita rate.

   b. Within available funds, the rate of the per capita payment made by the Department to the voluntary agency is based on the medical care expenditures of the agency as reported annually to the Department. The rate does not include duplication of payment for a service gratuitously provided or otherwise available from any other source such as the crippled children's program. The Department's per capita medical care rate may not exceed $5 per month for a child in a foster home or child-caring institution, nor a total payment of $242 for an unmarried mother in a maternity home, wage home or boarding home. The per capita rate for a new agency is negotiated until the agency's experience permits the review of a two-year average of expenditures. The agency must bill monthly at the per capita rate; however, the total payment for any one unmarried mother cannot exceed $242 which must cover the cost of delivery, hospitalization and regular medical-dental care.

2. Plan B - Under this plan, the voluntary agency secures medical service for the eligible child and/or unmarried mother through the Medical Service Bureau in the area of the agency's location, with the exception of King County: where medical services are secured through the King County MCFO, 325 - 9th Avenue, Seattle 4.

3. Exceptions to Plans A and B:

   Some voluntary agencies choose not to utilize either of the above plans but provide their own medical services.

388-97-010 NCA ELIGIBILITY CRITERIA. The determination of financial eligibility for NCA is the responsibility of the local County Office of the SDPA.

1. Medical eligibility shall be established in accordance with the provisions applicable to MO applicants.

2. Payment for office calls to a doctor and home calls by a doctor shall not be the responsibility of the Department, except that upon receipt of special authorization by the screening physician, evidenced by properly completed SF 5873, office or home calls by the attending doctor may be authorized for a limited number of conditions that are acutely emergent.

388-98-010 OBJECTIVE. The medical program for the MO is designed for persons under the age of 65 years whose income, potential earnings, or resources are insufficient to meet the cost of emergent and acute life-saving physician and hospital care and who are not recipients of public assistance from the State of Washington.

388-98-020 EXCLUSIONS AND LIMITATIONS. Payment for doctors' calls, office and/or home shall not be the responsibility of the Department except that after certification of financial eligibility by the MCW and upon receipt of special authorization by the screening physician, evidenced by properly completed SF 5873, office or home calls by the attending doctor may be authorized for a limited number of conditions that are acutely emergent.

388-98-025 APPLICATION PROCESS. Except in emergencies, all applications for medical only care shall be approved prior to date service is rendered.

1. When possible, application for MO shall be made by an applicant or by another on his behalf with the MCW at the local MCFO. When this is not possible, an application may be taken elsewhere by the MCW who is the representative responsible for accepting and processing applications.

2. In emergencies, the application for MO must be initiated by the applicant or another in his behalf within 24 hours or the next working day from the date of admission except in those cases where specifically different arrangements for a delayed application are approved (in advance) by the MCW.

3. Applications initiated later than 24 hours or the first working day following the date of admission shall be approved from the date of application only if otherwise eligible, except in those cases where arrangements for a delayed application are made in advance by the MCW.

4. When a person in a coma or unable to provide necessary information because of medical condition is admitted to a hospital and no information is available regarding the patient, the date of application shall be the date the patient becomes rational, but certification shall be retroactive to date of emergency admission if otherwise eligible, and if such admission was reported to the MCFO within 24 hours or the next working day from the date of admission.

5. At the time the application is initiated, the applicant must complete and sign SF 8313 (application-eligibility form) and SF 5115, Authorization to Release Information, and/or any other documents determined necessary by the MCW.

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6. The first step in establishing MO eligibility is the determination by the screening physician as to the essential medical care required by the applicant, as recommended by the attending doctor on SF 5873, and the approximate cost of this service based on established local fee schedules.

   In emergencies, SF 5873 must be received in the MCFO within 24 hours or the next working day from the date of emergency admission.

7. The next step is the MCW determination of the applicant's financial eligibility -- his ability to pay for the essential medical care as recommended by the attending doctor on SF 5873 and as approved by the screening physician in accordance with the criteria established by the Division.

8. Upon completion of the application process, the applicant and vendors shall be notified, in writing, as to approval or denial of his application.

9. Certification shall be completed on SF 8643 in triplicate. For all cases, the original copy shall be forwarded to Medical Audit Unit, one copy shall be retained by the MCW, and the triplicate shall be sent to the local Medical Service Bureau.

388-98-030 FINANCIAL ELIGIBILITY -

1. The following factors shall be considered in determining the financial eligibility of an applicant for medical-only care:

   a. The medical-only care determined necessary by the attending doctor and screening physician

   b. Approximate cost of the required medical-only care

   c. The approximate period of time the applicant will be unemployed as a result of the required medical care

   d. The applicant's actual resources and potential resources to pay for the required medical-only care.

2. In determining the applicant's financial eligibility for care, the MCW shall be guided by the recommendation of the applicant's attending or examining doctor and the screening physician as to the probable duration of loss of earning power while under medical treatment. The cost of medical care shall be considered in relation to the loss of wages or income caused by medical treatment.

3. When it has been medically determined that the applicant is in need of medical care and that the required medical care can be provided within the policies and regulations of the Medical Care program, the MCW shall explore with the applicant all potential or immediately available resources which could be utilized in paying for required medical care. Independent investigation of resources, as indicated, shall be made to determine the extent to which the available resources may be utilized. The applicant and/or family are required to participate to the fullest extent possible with the MCW in the application process. It is the responsibility of the applicant to provide the MCW with such information and material pertinent to the applicant's financial affairs and/or resources, etc., as is necessary to establish a determination of financial eligibility.

4. The applicant, patient or his relatives or friends shall be encouraged to participate in paying the cost of the approved medical services. Payment by the applicant, patient or relatives must be applied toward the cost of medical-only care authorized by the screening physician, otherwise the Department shall not pay any part of the bill.

5. In determining financial eligibility, consideration shall be given to the basic requirements of the applicant and the dependent members of his family as measured by the current standards of assistance of the Department. Basic requirements include food, clothing, personal incidentals, shelter, household maintenance and transportation as required. The dollar value of these items shall be the amount(s) currently used by the Department in establishing eligibility for public assistance.

6. Consideration shall also be given to additional requirements, the postponement of which will seriously affect the procurement of food, clothing and shelter. Only those obligations, determined by the MCW as necessary to maintain the basic requirements, shall be considered in determining financial eligibility.

7. Consideration shall be given to any resource which can be converted into cash, such as cash surrender value on insurance, payment on investments, real, personal or mixed property, automobiles, etc. When an applicant has any property against which a loan can be made, consideration shall be given to the amount of cash that can be secured by such a loan, or from the sale of such property. The applicant shall utilize such resources to the maximum in meeting his medical requirements.

8. Equal consideration shall be given to the potential earning power of the applicant. For example, if an applicant has no immediately available cash resources, his current job or his possibilities for employment in the future may be such that he could be expected to pay for his medical care out of future earnings.

9. An applicant who shall have transferred any interest in real or personal property within two years prior to the date of application without receiving adequate monetary consideration therefrom shall be ineligible for MO, unless the fair market value of the property so transferred is first applied toward meeting the cost of medical care requested. In determining whether adequate consideration has been received, the caseworker will be guided by the provisions contained in SDPA Manual II, Sections 411.1413.

10. The provisions of the MO program shall not apply to applicants whose personal injuries are occasioned by negligence or wrong of another: Provided, however, that the Director of the Department of Public Assistance may, in his discretion, furnish medical care under the provisions of the MO program, for the results of injuries to an applicant, and the Department shall thereby be subrogated to the applicant's right of recovery therefor to the extent of the value of medical care furnished by the Department of Public Assistance.

11. A person receiving medical-only care shall notify the MCW immediately if, during the period care is provided, he becomes possessed of property, resources, or income in excess of the amount previously declared.

12. An applicant for a medical service which is available from and is the responsibility of another agency shall be referred directly to that agency. The Department shall not be responsible for medical care for a person entitled to medical care from another agency or organization.

13. The applicant must fully utilize all resources determined by the MCW as being available toward meeting the cost of approved medical services prior to certification for any portion of approved medical services.

14. If a relative, or responsible person, or the patient admitted to a hospital signifies his intention to pay for the cost of care by contract arrangement, the MCW shall consider this fact in determining financial eligibility.

15. The Department shall not be responsible for payment when a person admitted by a hospital as a private patient for an acute and emergent medical condition is later found to be a poor financial risk by the hospital prior to his discharge.

16. The Department shall not be responsible for payment when a person with an acute or emergent condition is admitted by a hospital on the assumption that he can pay for his emergency care and is discharged from the hospital without paying for his care.

388-98-035 CONDITIONS OF CERTIFICATION. Eligibility for MO care shall be for ONLY one ailment or one condition. Each MO shall be certified individually and for a specified time. Certification of the head of the family unit does not constitute certification of other dependent members of the family.

388-98-040 LIMITS OF CERTIFICATION. Eligibility of persons currently receiving medical-only care shall be reviewed at least each 30 days and recertified, if eligible, for extended care. Recertification shall include a review of the financial resources of the patient and a review of the medical condition of the patient. Recertification for extended care shall be accomplished on SF 8643 completed by the screening physician and MCW.

388-98-045 MEDICAL CARE FOR NON-RESIDENT INDIGENT. When a resident of another state, and specifically a resident of a state bordering Washington, while temporarily visiting or temporarily residing in Washington, suffers an accidental injury, or requires medical care and/or hospitalization for an emergent and acute condition within the boundaries of the State of Washington, eligibility shall be determined according to the rules of this Chapter except as provided below:

1. The benefits of the MO program shall not be available to residents of other states who enter Washington for the purpose of obtaining care under the Washington MO program.

2. The benefits of the Washington MO program shall also not apply to residents of other states whose accidental injuries or emergent and acute conditions are manifest concurrently with entrance to the State.

388-99-010 OBJECTIVE. To provide a state-wide program administered by the Division to furnish medical care for acute and emergent conditions to persons of the State of Washington who are 65 years of age or older who are not recipients of public assistance from the State of Washington.

388-99-015 ELIGIBILITY DETERMINATION GENERAL. The determination of medical and financial eligibility for applicants for MAA is the responsibility of the Division as herein provided. No enrollment fee, premium payment, or similar charge shall be charged or assessed against the applicant as a condition of eligibility.

388-99-020 GENERAL EXCLUSIONS AND LIMITATIONS. Payment for doctor's calls, office and/or home shall not be the responsibility of the Department except that after certification of financial eligibility by the MCW and upon receipt of special authorization by the screening physician, evidenced by properly completed SF 5873, office or home calls by the attending doctor may be authorized for a limited number of conditions that are acutely emergent.

388-99-025 AGE. An applicant otherwise eligible for MAA must be 65 years of age or older. Proof of age shall be verified by the presentation of such documentary evidence as is acceptable to the MCW as proof of the applicant's age. In event the applicant is unable to present satisfactory verification of his age to the MCW, a sworn statement may be furnished by two individuals (may include relatives) to the effect that to the best of their belief and knowledge the applicant is 65 years or older. Such statement must be accomplished before a person authorized to administer oaths and acknowledgments. SF 2680 is provided for this purpose. The manner by which age is verified is to be recorded on SF 8313.

388-99-030 RESIDENCE.

1. No durational residence requirement is imposed. Except as hereinafter provided, on applicant for MAA must be present in this state at the time of application.

2. When a resident of another state, and specifically a resident of a state bordering Washington, while temporarily visiting or temporarily residing in Washington suffers an accidental injury, or requires medical care and/or hospitalization for an emergent and acute condition eligibility shall be determined subject to the following restrictions:

   a. The benefits of the Washington medical care program shall not be available to residents of other states which have adopted an MAA program.

b. The benefits of the MAA program shall not be available to residents of other states who enter Washington for purpose of obtaining care under the Washington MAA program.

c. The benefits of the Washington MAA program shall not be available to residents of other states whose accidental injuries or emergent and acute condition are manifest concurrently with entrance to this state.

3. A person claiming to be a resident of Washington but temporarily absent from the state at the time of application, may be found eligible for MAA providing the applicant meets medical and financial eligibility criteria and the application is processed in accordance with 388-99-070.

388-99-035 APPLICATION PROCEDURE. Except in emergencies, all applications for MAA shall be approved prior to date service is rendered.

1. When possible, application for MAA shall be made by an applicant, his attending doctor, or by another on his behalf with the MCW at the local MCFO. If the applicant is physically unable to go to the MCFO, an application may be taken elsewhere by the MCW who is the representative responsible for accepting and processing applications.

2. In emergencies, except when the applicant is outside the state, the application for MAA must be initiated within twenty-four hours or the next working day following the date of emergency hospital admission. Application received later than twenty-four hours, or the first working day following the date of emergency admission shall be approved from the date of application only if otherwise eligible. Exceptions may be granted for delayed application if prior oral arrangements are made with the MCW.

3. When a person in a coma or unable to provide necessary information because of medical condition is admitted to the hospital and no information is available regarding the patient, the date of application shall be the date the patient becomes rational, but certification shall be retroactive to date of emergency if otherwise eligible.

4. At the time of application, the applicant must complete and sign SF 8313, Application for Eligibility, and SF 5115, Authorization to Release Information, and/or any other documents determined necessary by the MCW.

5. The first step in processing an application for MAA is the determination by the screening physician as to the essential medical care required by the applicant, as recommended by the attending doctor, and the approximate cost of this service based on established local fee schedules. For conditions which do not require emergent hospitalization, the applicant's attending doctor must submit SF 5873 prior to

further application processing. In emergencies, SF 5873 must be submitted by the applicant's attending doctor and received in the MCFO within twenty-four hours or the next working day from the date of hospital admission.

6. Secondly, the MCW determines if the applicant meets the age, residence and financial eligibility criteria.

7. The MCW will make a thorough investigation of the application and reach a decision within 30 days or advise the applicant and vendors that the application is still pending. The applicant and vendors shall be notified in writing as to approval or denial of the application and reasons therefor.

8. Every applicant shall be informed at the time of the application of his right to a fair hearing in the event he feels aggrieved by any decision of the Division.

9. Certification shall be completed on SF 8643 to be accomplished in triplicate. For all cases, the original copy will be forwarded to the Medical Audit Unit, one copy will be retained by the MCW, and the triplicate will be sent to the local Medical Service Bureau.

10. All cases shall be assigned a case number with program code identification "X" (example: 35 X 1345-1).

11. A case record shall be prepared by the MCW for all applicants of MAA, The content of such records will include but is not limited to:

    a. Application-Eligibility, Release of Information and Certification forms: SF 8313, SF 5115, SF 8643

    b. Physician Diagnosis

    c. Nursing Home Placement and Classification documents, SF 8705, SF 8604 and SF 5873, when pertinent

    d. Correspondence including letters of approval and denial.

388-99-040 NON-EXEMPT AND EXEMPT RESOURCES:

1. Non-exempt:

    a. Net income in cash or kind regularly and predictably received by the applicant and his spouse, the combined dollar value of which is in excess of that needed to meet basic requirements of the applicant and the dependent members of his family as measured by the Department standards of assistance shall be considered an available resource.

b. Any monies on deposit in a bank, savings and loan association or held by another for safe keeping on order of the applicant and/or his spouse, or cash on hand, or other liquid assets such as bonds, securities, and cash surrender value of life insurance held by the applicant, spouse, or dependent members of his family in excess of the applicant's and his dependents' monthly requirements shall be considered as available resources.

c. Medical insurance carried by the applicant which is in force and effect at the time of application, must be utilized to the fullest extent prior to the participation by the Department in payment for medical care provided otherwise eligible applicants.

2. Exempt Resources:

a. Household furnishings and personal clothing used and useful to the applicant and dependent members of his family.

b. A home used by the applicant or legal dependents, together with a reasonable amount of property surrounding and contiquous thereto in accordance with SDPA Manual II, Sections 411.211 through and inclusive of 411.212.

c. One automobile owned by the applicant and/or spouse which is used and useful.

d. Other personal property and belongings owned by the applicant and/or his legal dependents which are used and useful or which have great sentimental value as construed in accordance with numbered paragraphs 1, 2, and 3 of SDPA Manual II, Section 411.2261.

388-99-050 FINANCIAL ELIGIBILITY. The following factors shall be considered in determining the financial eligibility of an applicant for MAA care:

1. The approximate cost of the essential medical care as determined necessary by the attending doctor and as approved by the screening physician.

2. The amount of the applicant's non-exempt resource which may be applied or made available toward meeting the cost of the approved medical care. Independent investigation of resources, as indicated, shall be made to determine the extent to which the available non-exempt resources may be utilized. The applicant and/or family are required to participate to the fullest extent possible with the MCW in the application process. It is the responsibility of the applicant to provide the MCW with such information and material pertinent to the applicant's financial affairs and/or resources, etc., as is necessary to establish a determination of financial eligibility.

3. The applicant, patient or his relatives or friends shall be encouraged to participate in paying the cost of the approved medical services. Payment by the applicant, patient or relatives must be applied toward the cost of MAA care authorized by the screening physician, otherwise the Department shall not pay any part of the bill.

4. In determining financial eligibility, consideration shall be given to the basic requirements of the applicant and the dependent members of his family as measured by the current standards of assistance of the Department. Basic requirements include food, clothing, personal maintenance and necessary incidentals, shelter, household maintenance and transportation. The dollar value of these items shall be the amount currently used by the Department in establishing eligibility for public assistance.

5. Consideration shall be given to additional requirements, the postponement of which will seriously affect the procurement of food, clothing and shelter. Only those obligations, determined by the MCW as necessary to maintain the basic requirements, shall be considered in determining financial eligibility.

6. Consideration shall be given to any non-exempt resource which may be converted into cash. Such non-exempt resource must be utilized to the fullest extent prior to participation by the Department in payment for authorized medical care.

7. An applicant who shall have transferred any interest in real or personal property within two years prior to the date of application without receiving adequate monetary consideration therefrom shall be ineligible for MAA, unless the fair market value of the property so transferred is first applied toward meeting the cost of medical care requested. In determining whether adequate consideration has been received, the MCW shall be guided by the provisions contained in SDPA Manual II, Sections 411.1413.

8. The provisions of the MAA program shall not apply to applicants whose personal injuries are occasioned by negligence or wrong of another: Provided, however, that the Director of the Department of Public Assistance may, at his discretion, furnish medical care under the the provisions of the MAA program, for the results of injuries to an applicant, and the Department shall thereby be subrogated to the applicant's right of recovery to the extent of the value of medical care furnished by the Department.

9. A person receiving MAA care shall notify the MCW immediately if, during the period care is provided, he becomes possessed of property, resources, or income in excess of the amount previously declared.

10. An applicant for a medical service which is available from and is the responsibility of another agency shall be referred directly to that agency. The Department shall not be responsible for medical care for a person entitled to medical care from another agency or organization.

11. The Department shall not be responsible for payment when a person with an acute or emergent condition is admitted by a hospital on the assumption that he can pay for this emergency care and is discharged from the hospital without paying for his care.

12. The Department shall not be responsible for payment when a person admitted by a hospital for an acute or emergent medical condition is later found to be a poor financial risk by the hospital prior to discharge.

13. If a relative, or responsible person, or the patient admitted to a hospital signifies his intention to pay for the cost of the care by contract arrangement, the MCW shall consider this fact in determining financial eligibility.

388-99-060 CONDITIONS OF CERTIFICATION. Eligibility for MAA shall be for ONLY one ailment or one condition. Each MAA shall be certified individually for a specified time. Certification of the head of the family unit does not constitute certification of other dependent members of the family.

388-99-065 LIMITS OF CERTIFICATION. Eligibility of persons currently receiving MAA care shall be reviewed at least each 30-days, except as provided for in 388-99-075 and recertified for extended care. Recertification shall include a review of the financial resources of the patient and a review of the medical condition of the patient. Recertification for extended care shall be accomplished on SF 8643 completed by the screening physician and the MCW.

388-99-0, APPLICATION PROCEDURE FOR RESIDENT TEMPORARILY OUTSIDE OF THE STATE.

1. A resident of the State of Washington who is temporarily absent may apply for MAA while in another state by forwarding a letter of request to the MCFO in the county from which he claims residency. If the applicant, because of his physical or mental condition is unable to forward his application, a relative or his attending physician may initiate the request on the applicant's behalf.

2. Effective date of eligibility may not precede the date the initial application was received at the local MCFO, or date applicant was hospitalized or placed in a nursing home whichever is later.

3. Upon receipt of an out-of-state application, the MCW shall acknowledge receipt of such request in writing and forward to the applicant the forms listed below with instruction that to process the application, it will be necessary they be completed and returned within 15 days after date of receipt.

   State Forms to be completed by the applicant:

   a. SF ,Consolidated Affidavit of Age, Residency, and Current Living Expense Statement

   b. SF 2523 and 2523-A, Statement of Resources

   c. SF 5115,Authorization to Release Information.

   State Forms to be completed by applicant's attending doctor

   a. SF 7903, Medical Evaluation

   b. SF 5873, Request for Additional Services

   c. SF 8604, If nursing home care is requested

   d. A statement from the applicant's attending doctor estimating the approximate doctor charges, hospitalization costs, ancillary charges, and whether nursing home care is anticipated.

4. Upon receipt of the completed forms, the MCW shall refer the medical forms together with SF 8643 to the screening physician for review and determination of medical eligibility. When it is concluded that the applicant is medically eligible, the MCW shall then review the forms relating to age, residence, and financial eligibility. If additional information is needed to arrive at a final decision, a supplemental request shall be directed as appropriate to either the applicant or to his doctor.

   If it is determined that the applicant is ineligible, the MCW shall advise the applicant in writing of such fact and include a brief statement as to reason(s). A copy of the notification letter shall be forwarded to the patient's attending doctor.

   If it is determined that the applicant is eligible, the MCW shall notify the applicant, in writing, of such fact. The notification shall include but is not limited to a statement showing the effective date of approval, the extent of services or procedures authorized, the maximum authorized allowances, that applicant should instruct the vendors to forward their statements of service to SDPA, Medical Audit, P.O. Box 1162, Olympia, Washington. Copies of this notification shall be forwarded to the patient's attending doctor and other interested vendors. In addition, the MCW shall complete SF 8643 and forward forward the original to Medical Audit together with a copy of the applicant's notification letter.

388-99-075 LIMITATION OF ELIGIBILITY FOR OUT-OF-STATE APPLICANTS

1. Certification of eligibility for approved applicants of MAA temporarily residing outside the state shall be for a single medical or surgical condition.

2. Initial certification for hospital care shall be for the period requested by the attending doctor but in no event in excess of 7 days unless specifically approved by the screening physician. Requests for additional hospital stay may be made by the attending doctor on or before the expiration of the original certification.

3. Out-of-state hospital care shall be authorized only when such service is rendered in a hospital licensed by the state where situated.

4. Payment for out-of-state hospital services shall be made on the basis of established rates paid the hospital by either the State Welfare or Health Departments for their resident welfare patients.

5. Drugs for post-hospital care shall not be provided unless a prior request is made by the patient's attending doctor and approved by the screening physician within 10 days after date of discharge.

6. Payment shall be authorized only for services provided by physicians or osteopaths licensed by the state in which they practice.

7. Payment for out-of-state physicians, osteopaths, and anesthesiologists shall be made on the basis of established fee schedules paid for such services by either the State Welfare or Health Departments for their resident welfare patients.

8. Nursing home patients shall be classified by the screening physician or classification nurse from the information contained on the SF 8604. Payment shall be made at the rate paid nursing home operators by either State Welfare or Health Departments for similar care provided their resident nursing home patients.

9. Payment shall only be authorized to a nursing home which is licensed by a governmental agency of the state or county in which it is located.

10. Nursing home care shall not be furnished out-of-state applicants for a consecutive period in excess of three (3) months unless the attending doctor certifies that the patient, because of his condition, is unable to return to the State of Washington.

EXHIBIT E

DENTAL SERVICE CONTRACT

This CONTRACT entered into this _____ day of _____ 1961, by and between the Washington Dental Service, a Washington Corporation hereinafter referred to as the Corporation, and the Division of Medical Care of the Department of Public Assistance, State of Washington hereinafter referred to as the Department acting pursuant to the authority contained in Title 74.09, R.C.W.

NOW, THEREFORE in consideration of payment to be made by the Department to the Corporation as hereinafter provided for in Paragraphs VI and VIII, it is mutually agreed by and between the parties as follows:

For the purposes of this contract, the following definitions shall apply:

"Chief of Dental Services" shall mean a duly licensed dentist in the State of Washington, chosen by the Department with the advice of the Dental Welfare Liaison Committee, and employed and paid by the Department as a supervising, professional screener and dental administrative consultant.

"Screening Dentist" shall mean a duly licensed dentist in the State of Washington, chosen by the Department, with the advice of the Dental Welfare Liaison Committee, and employed by the Department as professional screener on a fee-for-service basis.

"Participating Dentist" shall mean any duly licensed and practicing dentist in the State of Washington, who has agreed in writing with the Department and the Corporation to participate in the program.

"Medical Care Field Office" (MCFO) shall mean the office through which the Division of Medical Care, State Department of Public Assistance, carries out its administrative and medical care functions in the field.

"Recipient of Continuing Assistance" (CA) is a person certified by the Public Assistance County Office as eligible to receive a continuing maintenance grant; i.e., a recipient of OAA (A), ADC (C), AB (B), Foster Care (D), Continuing General Assistance (U), Disability Assistance (P).

Recipient of Non-continuing Assistance (NCA) is a person certified by the Public Assistance County Office as eligible to receive a maintenance grant on a temporary basis.

"Medical Indigents" (MO) are persons without income or resources sufficient to secure necessary medical services who are not certified as recipients of continuing or non-continuing assistance or medical assistance for the aged.

"Recipients of Medical Assistance for the Aged" (MAA) are those persons who are residents of the State of Washington, who are 65 years of age or older, who are not recipients of CA or NCA and who have been certified as eligible to receive medical care by the Medical Care Field Office.

"Necessary Dental Service" shall mean the furnishing of general and special dental services, laboratory services, and prothesis by the Corporation through participating dentists to recipients of CA, NCA, MO, and MAA in accordance

with the provisions herein contained and as provided for by Rules, Regulations, and Policy of the Department.

I. The Corporation agrees to permit all practicing dentists licensed in the State of Washington to participate and furnish necessary dental services as authorized in accordance with the criteria hereinafter set forth providing however such dentists agree in writing with the Corporation and the Department to participate and agree not to seek or accept compensation from the recipient over and above the amounts payable by or through the Corporation under the terms of this contract.

II. The Corporation agrees to make payment to participating dentists who provide necessary dental services to eligible recipients of CA and their dependents in accordance with the Standards of Dental Care as provided for in the Department's regulations, attached hereto, marked as Schedule I, and made a part hereof as if fully set forth in full herein and providing further that payment to the participating dentists shall be made by the Corporation on the basis of the fee schedule attached hereto, marked as Schedule II and made a part hereof as if fully set forth in full herein. Revision of the regulations and/or fee schedule may be made during the life of this contract by mutual agreement of the parties hereto evidenced by an executed supplemental or contract modification agreement.

III. The Corporation agrees to furnish and distribute, at their expense, standardized forms to participating dentists and MCFO's as deemed necessary for the orderly administrative implementation of this contract provided however no forms will be utilized until approval for such use has first been obtained from the Department.

IV. The Corporation agrees to provide necessary office space at their place of business in Seattle, office equipment, telephone service, clerical help, and miscellaneous office supplies to maintain the Chief of Dental Services employed by the Department as hereinafter referred to in Paragraph K.

V. The Corporation agrees to maintain at all times during the life of this contract accounting records, to be made available for audit by the Department upon request, that reflect the Corporation payments to participating dentists, individual accounts recording services provided each recipient served, cost of operating the Pierce County Hospital Dental Clinic, and administration cost breakdown incident in carrying out the provisions of this contract; to submit a monthly report to the Department by not later than the 20th of the second month following the date the service was rendered, a report showing by category of assistance the number of recipients receiving dental services, the type of service provided, payments made to participating dentists, cost of operating the Pierce County Hospital Dental Clinic, and a breakdown of the Corporation administration costs allocated to this contract during the month of report; to submit to the Department on/or before September 1, 1962, an annual report showing the name, category, case number, and type of dental service received by all recipients under the terms of this contract during the preceding year commencing with July 1, 1961.

VI. For and in consideration of the Corporation furnishing dental and administration services as provided for under the terms of this contract, the Department

agrees to pay to the Corporation the per capita sum of forty-five cents ($.45) per person per month for each recipient on the continuing assistance rolls as enumerated on the monthly statement furnished the Corporation by the Department as provided for in Paragraph VII below.

VII. The Department agrees to furnish the Corporation by not later than the 15th of each month a statement showing the total number of persons, by county and category, who were recipients of CA during the previous month. To obtain payment, the Corporation will, after receipt of said statement, forward to the Department their request for payment upon a duly authenticated voucher approved for use by the Department.

VIII. It is mutually understood and agreed that the per capita payment made by the Department to the Corporation as referred to in Paragraph VI is the fixed amount of consideration to be paid the corporation for dental services provided recipients of CA, however, the Corporation does agree to process and pre-audit all vouchers and documents covering dental services furnished recipients of NCA, MO, and MAA when properly certified as eligible by the medical caseworker and approved by the Chief of Dental Services. Payment to participating dentists for authorized services rendered recipients of NCA, MO, and MAA will be made by the Corporation in accordance with Schedule II attached, and the Department agrees to reimburse the Corporation for actual payments made when submitted on duly authenticated vouchers approved for use by the Department.

IX. It is mutually understood and agreed that the Corporation will continue to operate the Dental Clinic (closed panel program) at the Pierce County Hospital and that the services provided recipients of CA, NCA, MO, and MAA will be in accordance with the criteria as set forth in Schedule I, and that the entire cost of operating said Clinic will be born by the Corporation from per capita payment made to the Corporation by the Department in accordance with Paragraph VI.

X. It is mutually understood and agreed that the Department will employ and pay for a Chief of Dental Services who will be officed at the Seattle office of the Corporation, and such other screening dentists to be located throughout the various counties of the State as deemed necessary by the Department. The Chief of Dental Services shall supervise the screening dentists and under the direction of the Assistant Director of the Division of Medical Care shall render final determinations on dental questions relating to eligibility of recipients for dental services and interpretation of policy and rules of the Department.

XI. It is mutually understood and agreed that the Corporation will not be required to provide dental service to recipients under the terms of this contract until the recipient has exhausted all dental benefits that may be available through health insurance, or other State, Federal, or charitable programs, or when the condition which necessitates dental care was caused by the wrongdoing or negligence of another person provided, however, if dental services are furnished and the Corporation subsequently receives knowledge of such resource or potential, the Corporation will furnish to the Department a report relating the circumstances under which the care was provided and the reason why they believe the service was erroneously rendered.

XII. This contract shall become effective on July 1, 1961, and shall remain in full force and effect until June 30, 1962, subject to the right of modification by mutual written agreement signed by both parties, and subject to the right of either party to cancel at the expiration of any calendar month during the life of this contract upon giving thirty days written notice of such cancellation to the other party.

DATED this _____ day of _____. 1961.

WASHINGTON DENTAL SERVICE

By_____
R. E. Paulsen
Executive Director

STATE DEPARTMENT OF PUBLIC ASSISTANCE

_____
Robert P. Hall, M.D.
Assistant Director

STATE DEPARTMENT OF PUBLIC ASSISTANCE
Olympia, Washington

TO: STAFF
BUREAUS

MEMORANDUM NO. M-18-61
Issued October 6, 1961

FROM: DIVISION OF MEDICAL CARE
Robert P. Hall
Assistant Director

SUBJECT: REVISED APPLICATION PROCEDURES FOR DENTAL SERVICES

Sections 388-87-030 and 388-87-035 regarding application procedure for dental services are being revised and the following listed procedures apply. These changes will subsequently be incorporated in the official Rules and Regulations.

388-87-030 APPLICATION PROCEDURES FOR RECIPIENT OF CONTINUING ASSISTANCE (CA):

1. A recipient of CA will initiate his application for dental care by going to his MCFO. If certified as an eligible recipient of CA, the Medical Service Bureau Representative at the MCFO will issue a Certificate of Eligibility form to the patient to be presented to the dentist of his choice selected from an available list of participating dentists. The Certificate of Eligibility will be valid for the calendar month in which issued. A new certificate must be obtained if the patient requires treatment in any subsequent month. A duplicate copy of the certificate may be completed and retained for MCFO files.

2. Care for acute dental need (Priority A) will be provided by the participating dentist, who must submit dentist Report and Invoice for Acute Treatment, which may not be in an amount to exceed $25, along with the Certificate of Eligibility to the WDS within 60 days from the date the services were provided.

3. If the patient's dental needs are for prosthetic or other emergency care (Priority B and/or C), the patient will obtain the Certificate of Eligibility from the MCFO as directed above, present it to the participating dentist who will, in turn, forward the Certificate of Eligibility and Report and Invoice for Prosthetics, or Report and Invoice for Other Emergent Care to the Chief of Dental Services for approval prior to performing the service. Upon receipt of approval, the participating dentist will advise and schedule the patient for treatment. Payment to the participating dentist for prosthetic care and other emergent care (Priorities B and C) will not be made unless prior approval is obtained. The approval from the Chief of Dental Services is valid, contingent upon the patient's continued CA eligibility status for a period not to exceed 90 days from the date of issue. A new Dental Report and Invoice must be submitted and approved after the expiration of 90 days. If the services have not been furnished or completed during the month the patient was certified as indicated on the Certificate of Eligibility, a new certificate must be obtained by the participating dentist from the local MCFO verifying the fact that the patient remains a recipient of CA. No payment may be made for services rendered after a recipient's case has been closed or terminated.

4. The participating dentist will advise the patient if the service has been denied by the Chief of Dental Services.

388-87-035 APPLICATION PROCEDURES FOR RECIPIENTS OF MO AND MAA:

1. Dental care provided eligible recipients of MO and MAA is procured on a fee-for-service basis from the WDS. Dental care provided is limited to acute dental need for relief of pain only, the cost of which may not exceed $25 for services rendered, charged on the basis of the fee schedule set forth in Section 388-87-045.

2. The MO and MAA applicant initiates a request for obtaining dental care for acute need by making application to the MCW at the local MCFO.

3. The MCW will determine the applicant's financial eligibility on the basis of the criteria set forth in Chapter 388-98 Section 030 and Chapter 388-99 Section 050. In determining financial eligibility, the MCW will consider $25 as the maximum estimated cost of the required dental care.

4. If it is determined that the applicant is eligible, a Certificate of Eligibility (furnished MCFO by WDS) will be prepared and signed by the MCW in duplicate. The original will be given the applicant who presents it to a participating dentist selected from a list available at the MCFO. The duplicate is retained for the case file.

5. The Certificate of Eligibility will be valid for a period of 3 consecutive working days. Payment will not be made for services provided after the expiration date of eligibility. In completing the Certificate of Eligibility, the MCW will insert on Line 11, the inclusive dates of eligibility. If the patient is to participate in the payment for dental care, the amount to be applied will appear on Line 10, "Limitations of Eligibility". This amount will be subtracted from the payment made to the dentist. Item "B" on the Certificate of Eligibility will be crossed out on all MO and MAA cases.

6. If the patient is in acute need of care for the relief of pain, the treatment may be provided by the dentist within the period of eligibility. The dentist will complete a "Report and Invoice for Acute Treatment" form. The completed Report and Invoice and Certificate of Eligibility will be forwarded by the dentist within 60 days from the date the service was performed to the Chief of Dental Services, WDS, for review and transmittal, if approved, to Medical Audit, State Office for payment. A copy of the Report and Invoice indicating the action taken by the Chief of Dental Services will be returned to the MCW who executed the Certificate of Eligibility, for the case file.

388-87-037 APPLICATION PROCEDURES FOR RECIPIENTS OF NCA:

1. Dental care provided eligible recipients of NCA is procured on a fee-for-service basis from the WDS. Dental care provided is limited to acute dental needs for relief of pain only, the cost of which may not exceed $25 for services rendered, charged on the basis of the fee schedule set forth in Section 388-87-045.

2. A recipient of NCA will initiate his application for dental care by going to his local MCFO. If he has been certified as an eligible NCA recipient, the Medical Service Bureau Representative will prepare and sign a Certificate

of Eligibility. The certificate will be given the applicant who presents it to a participating dentist selected from a list available at the MCFO. A duplicate copy of the certificate may be executed and retained for MCFO file.

3. The Certificate of Eligibility will be valid for a period of 3 consecutive working days, but in no event shall the period of dental eligibility extend beyond the dates of NCA eligibility as certified by the CO. Payment will not be made for services provided after the expiration date of dental eligibility. In completing the Certificate of Eligibility, the Medical Service Bureau Representative will insert on Line 11 the inclusive dates of dental eligibility. Item "B" on the certificate will be crossed out for all NCA cases.

4. If certified as eligible, the NCA recipient will present the Certificate of Eligibility to the participating dentist of his choice within the eligible dates as appear on the certificate. If the patient is in acute need of care for the relief of pain, the treatment may be provided by the dentist within the period of eligibility. The dentist will complete a "Report and Invoice for Acute Treatment" form. The completed Report and Invoice and Certificate of Eligibility will be forwarded by the dentist within 60 days from the date the service was performed to the Chief of Dental Services, WDS for review and transmittal, if approved, to Medical Audit, State Office for payment.

Additional documents submitted by Dr. Ross E. Hamilton, Director, Extended Services Program

State of Washington
STATE BOARD FOR VOCATIONAL EDUCATION
Division of Vocational Rehabilitation
Olympia

Laws of the State of Washington Session Laws 1933

Chapter 176 (H.B. 350)

An Act providing for the acceptance of the benefits of an Act of Congress making provision for the promotion of vocational rehabilitation of persons disabled in industry or otherwise and their return to civil employment, designating the State Board for Vocational Education as the Board to cooperate with the Federal Board for Vocational Education in carrying out the provisions of said Act of Congress, and defining duties and powers of said Board and making an appropriation and declaring an emergency.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF WASHINGTON:

Section 1. That in order to provide for the vocational rehabilitation of physically disabled persons, there is hereby established, under the direction and control of the state board for vocational education, a division for the vocational rehabilitation and placement in remunerative employment of persons whose capacity to earn a living is or has been destroyed or impaired.

Section 2. That for the purpose of this act the term "physically disabled person" means any person who, by reason of a physical defect or infirmity, whether congenital or acquired by accident, injury or disease, is, or may be expected to be, totally or partially incapacitated for remunerative occupation; the term "vocational rehabilitation" means the rendering of a disabled person fit to engage in a remunerative occupation.

To be eligible for rehabilitation a person must be vocationally handicapped, and must be susceptible for rehabilitation.

Section 3. The state board for vocational education is hereby authorized and directed:

(a) To disburse all funds provided by law and funds from private sources unconditionally offered for the rehabilitation of disabled persons;

(b) To appoint and fix the compensation of the personnel necessary to administer this act;

(c) To vocationally rehabilitate, and place in remunerative occupations, persons eligible for the benefits of this act;

(d) To make such rules and regulations as may be necessary for the administration of this act; and

(e) To report annually to the governor of the state on the administration of this act.

Section 4. The state board for vocational education and the department of labor and industries, or other agency charged with the administration of the state workmen's compensation or liability laws, are hereby empowered and directed to formulate a plan of cooperation, to become effective when approved by the governor of the state.

Section 5. The state of Washington does hereby:

(a) Accept the provisions and benefits of the act of congress entitled "An act to provide for the promotion of vocational rehabilitation of persons disabled in industry or otherwise and their return to civil employment," approved June 2, 1920, as amended June 5, 1924, and June 9, 1930;

(b) Designate the state treasurer as custodian of all moneys received by the state from appropriations made by the congress of the United States for vocational rehabilitation of persons disabled in industry or otherwise, and authorize the state treasurer to make disbursements therefrom upon the order of the state board for vocational education; and

(c) Empower and direct the state board for vocational education to cooperate with the federal board for vocational education in carrying out the provisions of the federal civilian vocational rehabilitation act.

Section 6. There is hereby appropriated from the federal vocational rehabilitation fund two thousand five hundred dollars ($2,500.00) to be expended by the state board for vocational education in carrying out the provisions of this act; and

There is hereby appropriated from the general fund of the state treasury the sum of two thousand five hundred dollars ($2,500.00) to secure the federal vocational rehabilitation fund.

Section 7. This act is necessary for the immediate support of the state government and its existing public institutions and shall take effect immediately.

Passed the House March 5, 1933.
Passed the Senate March 8, 1933.
Approved by the Governor March 20, 1933.

State of Washington
STATE BOARD FOR VOCATIONAL EDUCATION
Division of Vocational Rehabilitation
Olympia

Laws of the State of Washington Session Laws 1955

CHAPTER 371
(H.B. 547)

VOCATIONAL REHABILITATION OF DISABLED PERSONS

AN ACT relating to vocational rehabilitation of disabled persons and providing for acceptance by the state of benefits of the acts of congress; and amending section 5, chapter 176, Laws of 1933 and RCW 28.10.050.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF WASHINGTON:

SECTION 1. Section 5, chapter 176, Laws of 1933 and RCW 28.10.050 are each amended to read as follows:

The state of Washington does hereby:

(1) Accept the provisions and benefits of the act of congress entitled "An Act to provide for the promotion of vocational rehabilitation of persons disabled in industry or otherwise and their return to civil employment," approved June 2, 1920, as amended June 5, 1924, and June 9, 1930; also as amended on August 3, 1954, by the "vocational rehabilitation amendments of 1954," or other federal acts which provide benefits for the purposes of this act;

(2) Designate the state treasurer as custodian of all moneys received by the state from appropriations made by the congress of the United States for vocational rehabilitation of persons disabled in industry or otherwise, and authorize the state treasurer to make disbursements therefrom upon the order of the state board for vocational education; and

(3) Empower and direct the state board for vocational education to cooperate with the federal board for vocational education in carrying out the provisions of the federal civilian vocational rehabilitation act.

Passed the House March 3, 1955.
Passed the Senate March 8, 1955.
Approved by the Governor March 21, 1955.

State of Washington
STATE BOARD FOR VOCATIONAL EDUCATION
Division of Vocational Rehabilitation
Nondisabled Program

Laws of the State of Washington Session Laws 1955

CHAPTER 380.
(H.B. 575)

PUBLIC ASSISTANCE--VOCATIONAL REHABILITATION OF NONDISABLED PERSONS.
An Act relating to vocational rehabilitation of certain nondisabled persons.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF WASHINGTON:

SECTION 1. This act provides for the return to full or partial self-support of nondisabled recipients of public assistance whose capacity to earn a living is impaired.

SEC. 2. As used in this act:

(1) "Nondisabled person" means an individual:

(a) Who does not have a substantial physical or mental handicap:
(b) Who is receiving public assistance and may be expected to remain a public charge of the state; and
(c) Who is "vocationally handicapped," because of lack of training, experience, skills, or other factors which, if corrected, would lead to self-support instead of dependency.

(2) "Board" means the state board for vocational education and includes the division of vocational rehabilitation of the "board."

SEC. 3. To be eligible for vocational rehabilitation under this act, a person must:

(1) Be a "nondisabled person," as defined in section 2 of this act; and
(2) Either be responsible for his own maintenance, or be the responsible head of a household; and
(3) Have a potential capacity which would warrant development with a reasonable chance for employment after rehabilitation services; and
(4) Be accessible to services, or be willing to move if necessary to take advantage of the services offered; and
(5) Be referred by a public assistance agency.

The public assistance agency, referring a nondisabled person for vocational rehabilitation, shall forward with such referral any medical, psychiatric, social, financial, or other information that the board may request.

SEC. 4. The board shall:

(1) Disburse all funds provided by law, and all funds obtained from private and other sources, that are unconditionally offered for the rehabilitation program provided for by this act;
(2) Appoint and fix the compensation of the personnel necessary to administer this act;

(3) Vocationally rehabilitate and place in remunerative occupation, insofar as it is deemed possible and feasible, persons eligible for the benefits of this act;
(4) Provide for the training of personnel as may be needed to carry out and to develop vocational rehabilitation services for the rehabilitation of those eligible for the benefits of this act;
(5) Make such rules and regulations as may be deemed necessary for the administration of this act.

SEC. 5. The state treasurer is designated custodian of all moneys received from appropriations, or otherwise, for purposes of this act, and is authorized to make disbursements therefrom upon the order of the board.

SEC. 6. The board is authorized to cooperate with other agencies in carrying out the provisions of this act and may formulate a plan of cooperation with the state department of public assistance.

SEC. 7. The state of Washington accepts the provisions and benefits of any acts of congress which provide for the rehabilitation of nondisabled persons as defined in section 2 of this act.

SEC. 8. If any clause, sentence, or section of this act shall be held ineffective or unconstitutional, such ineffective clause, sentence, or section shall not affect the constitutionality of the remaining portions of this act.

Passed the House March 2, 1955.
Passed the Senate March 8, 1955.
Approved by the Governor March 21, 1955.

State of Washington
STATE BOARD FOR VOCATIONAL EDUCATION
Division of Vocational Rehabilitation
Olympia

Laws of the State of Washington — Session Laws 1957

CHAPTER 223
(S.B. 357)

VOCATIONAL REHABILITATION

AN ACT relating to vocational rehabilitation; amending sections 1, 2 and 3, chapter 176, Laws of 1933 and RCW 28.10.010, 28.10.020 and 28.10.030; and section 5, chapter 176, Laws of 1933 as amended by section 1, chapter 371, Laws of 1955 and RCW 28.10.050 and adding a new section to chapter 176, Laws of 1933 and chapter 28.10 RCW.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF WASHINGTON:

SECTION 1. Section 2, chapter 176, Laws of 1933 and RCW 28.10.010 are each amended to read as follows:

"Physically disabled person" means a person who is or may be expected to be totally or partially incapacitated for remunerative occupation.

"Vocational rehabilitation" means the rendering of a physically disabled person fit for a remunerative occupation.

"A person eligible for rehabilitation" means a vocationally handicapped person of fourteen years of age or over susceptible of rehabilitation.

"Self-care" shall mean a reasonable degree of restoration from dependency upon others for personal needs and care and includes but is not limited to ability to live in own home, rather than requiring nursing home care and care for self rather than requiring attendant care.

SEC. 2. Section 1, chapter 176, Laws of 1933 and RCW 28.10.020 are each amended to read as follows:

There is established, under the direction and control of the state board for vocational education, a division designated as the division of vocational rehabilitation, for the vocational rehabilitation and placement in remunerative employment of persons whose capacity to earn a living has been destroyed or impaired and to render necessary services to enable persons lacking social competence or mobility to attain and maintain self-care and self-support.

SEC. 3. Section 3, chapter 176, Laws of 1933 and RCW 28.10.030 are each amended to read as follows:

The Division of vocational rehabilitation shall:

(1) Disburse all funds provided by law and funds from private sources unconditionally offered for the rehabilitation of disabled persons;

(2) Appoint and fix the compensation of the necessary personnel;

(3) Vocationally rehabilitate, and place in remunerative occupations, eligible persons;

(4) Make necessary rules and regulations;

(5) Report annually to the governor on the administration of this chapter.

SEC. 4. There is added to chapter 176, Laws of 1933 and chapter 28.10 RCW a new section to read as follows:

The division of vocational rehabilitation shall render to persons lacking social competence or mobility necessary services to enable them to obtain and maintain the maximum degree of self-support and self-care. This shall include continuing services including supervisory services to maintain their maximum degree of self-support and self-care.

SEC. 5. Section 5, chapter 176, Laws of 1933, as amended by section 1, chapter 371, Laws of 1955, and RCW 28.10.050 are each amended to read as follows:

The state of Washington does hereby:

(1) Accept the provisions and benefits of the act of congress entitled "An Act to provide for the promotion of vocational rehabilitation of persons disabled in industry or otherwise and their return to civil employment," approved June 2, 1920, as amended June 5, 1924, and June 9, 1930; also as amended on August 3, 1954, by the "vocational rehabilitation amendments of 1954," or other federal acts which provide benefits for the purposes of this chapter;

(2) Designate the state treasurer as custodian of all moneys received by the state from appropriations made by the congress of the United States for vocational rehabilitation of persons disabled in industry or otherwise, and authorize the state treasurer to make disbursements therefrom upon the order of the division of vocational rehabilitation; and

(3) Empower and direct the division of vocational rehabilitation to cooperate with the federal government in carrying out the provisions of the federal civilian vocational rehabilitation act.

Passed the Senate March 13, 1957
Passed the House March 12, 1957
Approved by the Governor March 22, 1957

State of Washington
STATE BOARD FOR VOCATIONAL EDUCATION
Division of Vocational Rehabilitation
Olympia

Laws of the State of Washington Session Laws 1959

CHAPTER 307
(H.B. 612)

REHABILITATION OF HANDICAPPED

AN ACT relating to vocational rehabilitation; adding a new section to chapter 28.10 RCW.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF WASHINGTON:

SECTION 1. There is added to chapter 28.10 RCW a new section to read as follows:

For the purposes of rehabilitation the division of vocational rehabilitation, subject to the approval of the state board for vocational education, may assist public or non-sectarian private agencies in the development, operation, or maintenance of sheltered workshops, supervised work opportunities, or other facilities needed for the rehabilitation of the handicapped.

All grants for independent living rehabilitation made under this section to non-sectarian private or public agencies shall be consistent with project plans recommended by the division of vocational rehabilitation and approved by the state board for vocational education. The length of time state funds shall be available to any non-sectarian private or public agency for any such project plans shall be determined by the state board for vocational education, but no state funds shall be granted for any one project for a period in excess of thirty-six months.

Passed the House March 1, 1959.
Passed the Senate March 9, 1959.
Approved by the Governor March 24, 1959.

COEUR D'ALENE, IDAHO, *November 16, 1961.*

Senator FRANK CHURCH,
Chairman, Subcommittee on Health Insurance Benefit Act of 1961,
Spokane, Wash.

DEAR SIR: I hereby request that the following statement be included as part of the hearing to be held in Spokane, Wash., Friday, November 17, 1961, in regards to the Health Insurance Benefit Act of 1961, 87th Congress, 1st session, S. 909.

I am the administrator of Coeur d'Alene General Hospital, of Coeur d'Alene, Idaho. This is a 33 bed institution, licensed by the State of Idaho.

I wish to go on record as being opposed to the King-Anderson bill, in its present form, for the following reasons.

I fully realized that the indigent and medically indigent members of our aged population have some problems in receiving proper health care. I also realize that this problem is probably more acute in the Coeur d'Alene area because of the large number of aged retired people who live in this area, and for this reason I realize that some form of legislation is needed to provide the care required by these individuals.

However, I believe that some form of legislation which would give local agencies of the Government more control of the care given to these individuals would be more effective than the King-Anderson bill. The local, State or county agencies have the primary responsibility for the care of such individuals in Idaho, and they should be encouraged to provide better programs of health care. State agencies should assist local agencies, if necessary, to help these plans along.

Therefore, I feel that the best plan, or rather the best approach to the problem of providing medical care for the indigent, would be through the State and local agencies, and when necessary, and upon request of the local agencies, more funds should be made available to the local agencies.

I respectfully submit this for your committee's consideration. Thank you.

GABRIEL L. BETIT,
Administrator, Coeur d'Alene General Hospital.

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906 PINE AVENUE, COEUR D'ALENE, IDAHO,
November 15, 1961.

Senator FRANK CHURCH,
Chairman of U.S. Senate Committee on Aging,
Spokane, Wash.

DEAR COMMITTEE: I am unable to be present at the hearings, but would like to submit this statement on two points.

In the field of housing many of our public assistance and social security recipients are living in substandard housing. This points up the need for either increased public assistance and social security payments or a broad public works housing project at a low rate of interest. This would be a shot in the arm for our lumber industry and help the inadequate housing.

Enclosed find a picture of a place in the town of Post Falls, Idaho, that is a disgrace to see in America.

This home had no toilet facilities, no bath, no hot or cold water and one cook stove for heat.

We asked Elmer Mueller, of the Kootenai County commissioners, to go and see it. He said he never thought anyone in America ever lived in a place like this. We offered to help fix up a better place for this lady to live if the county would buy the material. Needless to say, no material was furnished.

In the field of medical care the same reason exists for this program as it did when our first social security program was passed.

Our aged and low income groups cannot afford private insurance and the State public assistance and county commissioners program does not meet the need. Kootenai County spent $140,000 last year and could have spent another $140,000 as this county has a heavier load because of the influx of people from other areas.

The Eagles Lodge in Coeur d'Alene, Idaho, voted support for medical care for the aged under social security.

We also have petitions signed or already sent in with 500 signatures for medical care under social security. These signatures were solicited under the leadership of Joseph D. Brasseur, 417¼ Sherman Avenue, Coeur d'Alene, Idaho.

Sincerely,

ALBERT W. MANLY.

PREPARED STATEMENT OF L. W. MARKHAM, GENERAL MANAGER, SPOKANE CHAMBER OF COMMERCE, SPOKANE, WASH.

The Spokane Chamber of Commerce is extremely concerned with the welfare of senior citizens, as it is of all citizens of the Spokane area. Our chamber trustees who decide policy for our organization believe that the responsibilities for social and economic programs for the aged can best and most economically be met at the local level. They believe that need rather than any benchmark of age, should decide who should be assisted, regardless of the agency that provides assistance.

They believe that recreational, medical, and welfare programs can be financed by local communities, counties, and States.

They believe the local areas will meet these responsibilities, provided broad national programs are not activated which will result in abdication of local efforts and automatically shift the entire responsibility to the Federal level.

They believe available medical care for the aged in the State of Washington is adequate and is being efficiently financed through utilization of the Kerr-Mills legislation which was adopted by the last Congress. Washington State is taking full advantage of the provisions of this legislation in administering its medical programs for senior citizens.

Our trustees believe that passage of legislation incorporating medical assistance in the social-security program is not necessary. Further, that including medical-aid features in the social security program will result in costly abuses and increased deficits in our social security program. They fear this extension will endanger the entire program itself.

They also fear that including medical provisions in the social security program will lead to federally paid medical benefits for all of our Nation's citizens and thus bring about the socialization of our medical system, which is the concern of many of our citizens.

They urge the return of responsibility for individual welfare to the local communities and States.

PREPARED STATEMENT OF WASHINGTON STATE FARM BUREAU

The Washington State Farm Bureau welcomes the opportunity to present this statement to the Senate Special Committee on Aged.

The Washington State Farm Bureau is a general, bipartisan, nonsecret, nongovernmental, voluntary organization of nearly 4,000 farm families in the major agricultural counties of our State and is affiliated with the 1,600,000 member American Farm Bureau Federation.

Policies are decided on the basis of discussion and debate throughout the membership with final decision based on majority opinion.

Farm Bureau members believe that the centralization of power and authority in the Federal Government, the movement to socialize America, the apathy of the American people toward this trend and the apparent lack of responsibility on the part of individual citizens, are among the greatest dangers threatening our Republic and our system of competitive enterprise.

We further believe that the establishment by the Government of organizations of citizens which may in any way remain under its political influence or control threatens the continuation of self-government.

Farm Bureau believes that social security programs should be designed to supplement rather than replace individual thrift and personal responsibility. The increasing costs of liberalized benefits are becoming a serious financial burden. We, therefore, recommend that existing programs be modified so that they will require no further tax increases.

Social security taxes should not be increased to pay medical costs for any portion of the population. The need for medical insurance should be met with expansion of existing private insurance programs without Federal subsidy.

If we continue to follow our present course toward making the Government the provider for all our aging citizens, it is inevitable that taxes and inflation will destroy the private initiative so essential to the maintenance of our competitive enterprise system and republican form of government.

As Thomas Jefferson once said: "We must make our choice between economy and liberty, or profusion and servitude. If we can prevent the Government from wasting the labors of the people under the pretense of caring for them, they will be happy."

The Communist plan for America is based on the premise that we will continue the present trend toward an all-powerful, paternalistic Government and ultimately commit national suicide. We still have the opportunity to prevent this from happening if we will rededicate ourselves to the principles that have made this country the greatest Nation on earth.

Again we appreciate having the opportunity to express our views to this committee.

MAX E. BENITZ,
President, Washington State Farm Bureau.
ROBERT LONEY,
President, Walla Walla County Farm Bureau.

HAYDEN LAKE MEDICAL-DENTAL CLINIC,
Hayden Lake, Idaho, November 6, 1961.

HON. FRANK CHURCH,
Boise, Idaho.

DEAR SENATOR CHURCH: This letter expresses some views of our local county medical society regarding the problems of the aging segment of our population. We wish to have it admitted as part of the official record during your hearing pertinent to these problems in Spokane on November 17, 1961.

We feel that in dealing with these problems as physicians we are in an excellent frontline position to assess medical needs of this part of our population. It is to this particular phase of problems of the aging that we address the following remarks.

We believe that problems are frequently created for political purposes. This has been particularly true in the field of medical care for the aged. Problems, thus planted in the minds of a segment of the population, are frequently found to have a ready answer put forth by the social planners of our day. The motive of the collectivist planners is to centralize more power for control of the day-to-day lives of the individual in the hands of an exaggerated Central Government. We do not deny that the acquisition of medical care by some of our senior citizens is at times above their financial means. The medical profession has constantly stood in readiness to solve the problem of these particular individuals. We wish to reaffirm our willingness to cooperate in this endeavor.

However, the principle of compulsion in any State or Federal governmental scheme to solve social problems is distasteful to us as it should be to every free American. Compulsory taxing of the majority to care for the few is unfair. Already in the law of our land is the Kerr-Mills bill for the care of the needy aged. This bill is working well to care for those who cannot afford medical care. It may have several administrative problems on the local level, but these should be solved on the local level, with the needs of these local recipients in mind. We feel that this program should be given adequate trial before it is substituted by a social panacea much more costly and misrepresented when compared to a prepaid medical insurance plan.

We favor coverage for health needs on a voluntary basis such as through the purchase of health insurance, with care to be provided where needed by governmental funds administered on the local level.

Sincerely yours,

W. PAUL SCHRUM, M.D.,
President, Kootenai County Medical Society.

COEUR D'ALENE, IDAHO, *November 15, 1961.*

HON. FRANK CHURCH,
Spokane, Wash.

DEAR SENATOR CHURCH: As volunteer workers in a volunteer health agency, the American Cancer Society, Idaho division, we would like to express our feelings on problems for the aging, as concerned with the medical aspect of these problems.

Probably cancer victims require the most lengthy and costly care of any medical patient, and we who work with these people are keenly aware of this condition. We want the best possible care for our aging population, and feel that this care can best be given at the local level of home, through insurance plans, or by local county care.

At this critical time in the history of our great democracy we are dedicated to the feeling that we must maintain all of the freedoms we are privileged to enjoy, that we must lose no more to socialized type of planning.

We, therefore, urge you to help this Nation and its peoples in this freedom of free medicine, for free Americans, without governmental interference with this relationship.

We wish to request that this letter be admitted as part of the official record during your hearing on these problems in Spokane on November 17, 1961.

Sincerely,

Mrs. MERLE STODDARD,
District Lay Director.
REX KOURY,
Board member, Kootenai County.
Mrs. CHARLES HENDRIX,
Board member, Boundary County.
Mrs. H. W. EBBETT,
Board member, Bonner County.
Mrs. STANLEY W. MCDOUGALL,
Board member, Kootenai County.

WASHINGTON STATE JUNIOR CHAMBER OF COMMERCE,
November 17, 1961.

Mr. WILLIAM G. REIDY,
Staff Director, Special Committee on Aging,
U.S. Senate,
Washington, D.C.

DEAR MR. REIDY: In compliance with your telegram of November 16, 1961, in which you state that the agenda is too full for the Spokane hearing of the Special Committee on Aging to allow me time to appear as a witness, I am submitting my written statement for inclusion in the records of that hearing.

As an elected director of both the Washington State Junior Chamber of Commerce and the U.S. Junior Chamber of Commerce, I wish to express the beliefs of both these organizations in the free enterprise system of living and their never ending dislike of any form of socialism. Because the young men of the United States and of Washington feel that the proposal of House bill 4222 is in direct opposition to both of these ideals, the attached resolution entitled "Opposition to Socialized Medicine" was passed by these organizations in session at their annual conventions.

I would, therefore, respectfully request that this resolution be included as part of the testimony reported at the Spokane hearing, and that it be listed as the expression of opinion of the Washington State Junior Chamber of Commerce and of the U.S. Junior Chamber of Commerce.

Very truly yours,

RICHARD R. RAMEY, *National Director.*

U.S. JUNIOR CHAMBER OF COMMERCE RESOLUTION ON OPPOSITION TO SOCIALIZED MEDICINE ADOPTED JUNE 1961

Whereas the U.S. Junior Chamber of Commerce is ever mindful of Federal legislative enactment which affects the economic and social lives of the people of this great Nation; and

Whereas there is currently pending in the Congress of the United States House bill 4222 initiating compulsory medical health care benefits under the social security system which is not in the best interest of the American people; and

Whereas enactment of this or similar legislation would be detrimental to the high standards of medical care, would deprive the citizens of the United States of the opportunity to provide their own medical care, would discourage our citizens of today from preparing for their old age, and at the same time, tend to remove the responsibility of men and women of America from caring for their own families; and

Whereas such legislation would be another step toward socialism and would jeopardize our free enterprise system which has made steady progress in extending and improving voluntary hospital insurance coverage of the aged under commercial programs; and

Whereas one of the present proposals has in it the element of Government determination of the price of hospital nursing home and medical service fees and would restrict the beneficiaries in their choice of hospitals and physcians; and

Whereas this bill if enacted would increase the cost of social security and would possibly be extended progressively to include comprehensive care for larger and larger segments of our population, thereby decreasing the take-home pay of the American citizen; and

Whereas the U.S. Junior Chamber of Commerce believes this country has become great through the individual initiative of its citizens and that legislation of this type tends to suppress this initiative: Now, therefore be it

Resolved, That the U.S. Junior Chamber of Commerce, in convention assembled this 21st day of June 1961, in Atlanta, Ga., hereby opposes the House bill 4222 now pending before the Congress of the United States or any similar legislation that may be introduced; be it further

Resolved, That the newly elected president of the U.S. Junior Chamber of Commerce be directed to request time to present personal testimony before the House Ways and Means Committee in July 1961; be it further

Resolved, That we believe that said proposed legislation would destroy our voluntary health program in the United States and further that it violates constitutional freedoms and the creed of the U.S. Junior Chamber of Commerce; be it further

Resolved, That copies of this resolution be presented to the President and the Vice President of the United States of America, Secretary of Health, Education, and Welfare, and each Member of the Congress of the United States of America.

ST. JOSEPH'S HOSPITAL,
Fourth Avenue and Sixth Street,
Lewiston, Idaho, November 15, 1961.

Re: Statement from the Northern Council of Hospitals of the Idaho Hospital Association, hearing on Federal-State activities in the field of aging.

Mr. WILLIAM G. REIDY,
Staff Director, Special Committee on Aging,
Spokane, Wash.

DEAR MR. REIDY: Attached hereto are six copies of the statement that we request to be included in the testimony of the hearing to be held in Spokane on Friday, November 17, 1961.

This statement is being made jointly by the member hospitals of the northern council of hospitals in Idaho. These member hospitals are located in any one or more of the 11 northern countries within the State of Idaho. They are in numerical order as follows: Community Hospital, Bonners Ferry, Boundary County; Lake City General Hospital and Coeur d'Alene General Hospital, Coeur d'Alene, Kootenai County; St. Mary's Hospital, Cottonwood, Idaho County; General Hospital, Grangeville, Idaho County; West Shoshone General Hospital, Kellogg, Shoshone County; St. Joseph's Hospital, Lewiston, Nez Perce County; Gritman Memorial Hospital, Moscow, Latah County; Clearwater Valley Hospital, Orofino, Clearwater County; Benewah Community Hospital, St. Maries, Benewah County; Bonner General Hospital, Sandpoint, Bonner County; Providence Hospital and Wallace Hospital and Clinic, Wallace, Shoshone County.

These 13-member hospitals at a total combined bed capacity of 529 beds exclusive of bassinets in northern Idaho have an adult daily census of 299 (exclusive of newborns) and an annual admission rate of 22,273.

The classification or ownership control breakdown is as follows: Five hospitals are owned or controlled either by city, country, or hospital district governmental agencies. Four hospitals are voluntary nonprofit not church-related. Three are voluntary nonprofit church-related hospitals and one is a proprietary partnership hospital.

If additional biographical facts are essential and necessary, please advise.

Very truly yours,

MRS. VENA GARDNER,
President, Northern Council of Idaho Hospitals.
By JOHN ERNSDORFF.

75660—62—pt. 8——15

FOURTH AVENUE AND SIXTH STREET, LEWISTON, IDAHO,
November 15, 1961.

Memorandum to: Senator Frank Church, Hearing Officer
From: Northern Council of Hospitals of the Idaho Hospital Association
Subject: Hearing on Federal-State activities in the field of aging

The member hospitals of the Northern Council of the Idaho Hospital Association recognizes the need for an improved program financing the health care of the indigent and medically indigent among the aged population in Idaho and that they may have some problems in receiving proper health care. We do not, however, have adequate facts at our disposal to know how acute the problem may be, and we suggest an evaluation of the problems on a statewide basis probably through a State commission.

Assuming that the problem is acute enough to require rather immediate action both in health services rendered and in the adequate financing of such services for the indigent and medically indigent in Idaho, we believe the best approach to be by encouragement of State and local agencies of government to provide proper programs of health care. The local and State agencies of government have, we believe, the primary responsibility for the care of such aged residents.

Assuming further that additional funds are necessary for the local and State agencies in Idaho to develop more fully an adequate health care program, such funds should be made available on a need basis.

Respectfully submitted.

MRS. VENA GARDNER,
President, Northern Council of Idaho Hospitals.
By JOHN ERNSDORFF.

EAST 219 GLASS AVENUE, SPOKANE, WASH.,
November 17, 1961.

DEAR SENATOR CHURCH: Here is what I would have said at the hearing of your subcommittee of the Special Committee on Aging if there had been time for everyone to speak:

I am against H.R. 4222 or any similar legislation because:

(1) So few senior citizens need or would collect the limited hospital benefits.

(2) The cost would be terrific to social security taxpayers who would have little chance of ever receiving any benefits.

(3) It would be just another segment of freedom loss and another step toward all-out socialism and/or complete welfare state.

(4) There are many ways and means for senior citizens to provide for payment of future costs of hospitalization through private insurers who are themselves heavy taxpayers.

(5) Encouragement should be given to those proud individuals and communities who strive to help themselves without asking for Federal matching funds when a problem arises.

(6) Let our Government, the best in the world, stop penalizing the thrifty and ambitious because it is such people who have made possible all the good things we have in America.

(7) If we continue to destroy incentive for profit in our free enterprise system, then we will eventually have no freedom or anything else of value.

I was born may 2, 1895, in Indian Territory (now Oklahoma).

JAMES E. BODINE, Sr.

UNITED ASSOCIATION OF JOURNEYMEN & APPRENTICES OF THE PLUMBING & PIPE FITTING INDUSTRY OF THE UNITED STATES & CANADA,
LOCAL UNION 44,
Spokane, Wash., December 18, 1961.

Mr. WILLIAM G. REIDY,
Staff Director of Special Committee on Aging,
Senate Building, Washington, D.C.

DEAR SIR: At our last regular meeting our membership voted unanimously to urge your support of social security extension to cover medical costs for the aging.

Yours truly,

BURTON P. TAYLOR,
Business Manager, Local 44.

SEATTLE, WASH., *November 17, 1961.*

CHAIRMAN, U.S. SENATE SPECIAL SUBCOMMITTEE ON AGING,
Spokane Hotel, Spokane, Wash.:

Seattle Auditorium almost empty at widely advertised group health program on medical care for the aged last night. Strong audience sentiment emerged for better implementation Kerr-Mills rather than an enactment of King bill. Outside lobby practically no sentiment here for its enactment. Request this be read and made part of record hearing.

JAMES HAVILAND, M.D.,
President-elect, King County Medical Society.

WEST 1417 MANSFIELD AVENUE, SPOKANE, WASH.,
November 18, 1961.

Re problems of aging aired.

Hon. FRANK CHURCH,
U.S. Senate, Washington, D.C.

DEAR SENATOR: The local scribes described the problems of the aged very well; of course we expected the medical folks, hospital association, to sound off.

Briefly, I would remind you that a large percentage of above neglected folks are veterans of World War I and for several reasons the recent bill, which the American Legion recommended to the Veterans Committee and was enacted into law, really added numbers to your social security victims. Many lost their pensions. Many are on our welfare programs, because they do not qualify for veterans pensions. And a great number did not have the required number of credits to obtain social security. Yes, it is a pitiful situation and the answer is just this: when Congress convenes in January, demand that something be done for this group. What difference does it make whether they get financial support from Peter or Paul (the social security or veterans benefits), why not grant a pension of $78.75 to all of the World War I oldsters. As you know we are averaging 70 years of age. Let's forget the $100 sum.

Yours truly,

CHARLES J. O'LEARY.

EAST 1523 BOONE AVENUE, SPOKANE, WASH.

DEAR SENATOR CHURCH: Here is what I would have said at the hearing of your subcommittee of the Special Committee on Aging if there had been time for everyone to speak:

We the members of Opportunity Club No. 1, Townsend organization, would like to have the Townsend plan enacted as it stands at present. Give the buying power into the hands of people.

Mr. Kennedy is anxious to have employment for the young people finishing school. Here is our idea of how he can do it by paying the pension plan as drawn by the Townsend organization.

OPPORTUNITY CLUB NO. 1, OF SPOKANE, WASH.
By DORA VALENTINE, *Acting Secretary.*

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712 FOSTER AVENUE, COEUR D'ALENE, IDAHO,
November 17, 1961.

DEAR SENATOR CHURCH: Here is what I would have said at the hearing of your subcommittee of the Special Committee on Aging if there had been time for everyone to speak:

My objection to the King bill is that, if enacted, it will add greatly to our ever-growing burden of caring for a willfully semidependent group.

I have been engaged in some form of social service work for more than 60 years and have been disillusioned as to the merit of trying to help those, who, under such a program, quickly lose interest in helping themselves. We are following up a fool's alley when we think we can encourage people to be strong and self-sufficient by teaching them to be helpless.

No doubt, there are areas in the world where it is impossible to earn a decent living. Those areas should be our determined concern. Even then, our help should be given in the form of an improved agriculture, increased industrialization, and the stimulation of education, rather than in handouts.

I understand the King bill provides for an additional social security tax. That will increase the tax burden upon this and future generations and will result in more people running to the Government for help. It is becoming too easy now for young people to say, "I don't have to work like my father and mother did. When I'm young, I'll take it easy and have a good time. When I become 65 the Government will take care of me."

There will always be those who never learn to take care of themselves, but let's not encourage everyone to join that clan. I believe the average American is made of better stuff. He doesn't want to be coddled or told that his Government will take care of him on every pretext. He wants to be free to make and direct his own life. If he succeeds it will be by his own enterprise. He likes to place his bets on his own ability.

It is my belief that we should set up standards everywhere looking toward a new era of thrift, independence, and old-fashioned self-reliance. That will help reduce our lists of semidependents more than anything we can do.

ORLAND A. SCOTT.

EAST 1712 39TH AVENUE, SPOKANE, WASH.,
December 9, 1961.

Mr. FRANK CHURCH,
Senate Office Building,
Washington, D.C.

HONORABLE SENATOR: Recently a hearing was held by you in Spokane, Wash., for a committee of the U.S. Senate for a more complete hospital coverage and care in connection with the present social security law.

July 1, 1961, my retirement became effective on the Spokane International Railroad Co. The only insurance available for myself and wife after long years of service with this company was a maximum total coverage in the amount of $150 for any one illness at a cost of $9.08 per month with the Travelers Insurance Co.

It became necessary to use this service recently in which the Travelers Insurance Co. would only allow the doctors fee for surgery in taking the stitches in the wound but not allowing anything for further treatment or in taking out the stitches.

Due to such discrimination and inadequate hospital coverage against senior citizens and aged I wish to assure you that I stand wholeheartedly in favor of President Kennedy's plan to place hospital and medical services under the provisions of the Social Security Act.

If proper to do so please place the above statement in the regular file as my position in the matter.

Sincerely yours,

J. W. CORNELL.

WEST 1211 SINTO AVENUE, SPOKANE, WASH.,
November 18, 1961.

DEAR SENATOR CHURCH: I surely enjoyed the hearing yesterday, and I have a few things to bring out that has bothered me for some time.

May 4, this year, I was operated on for a hernia then when the surgeon operated he found that my intestines were wrapped around my appendix, so he removed it too.

Dr. Sinclair of the welfare clinic, came to see me just a day or so before I went to the hospital, he said I can't do anything for you, and that I would have to go to the screening doctor, * * * the hateful thing (then put in that position). I was ill in bed. I was told that it wasn't necessary to be taken to the emergency room.

I was going to go to Dr. Schlicke's office in a cab next morn, but wasn't able to walk, so Dr. Schlicke's office called an ambulance; they had to bring the stretcher in the apartment.

Now they (welfare) won't pay the $18 ambulance fee, and I don't have anything to pay it with. I have told the ambulance that too.

Welfare said they have no money. What goes with it?

I know that thousands of dollars, surplus from the welfare program, was put in the general fund. When the legislature convened at Olympia, a retired judge was receiving $10,000 or $15,000, I don't remember (I didn't clip that out of the paper). They increased his up to $22,000, also pushed Governor Roselini's up to $22,000.

But the aged are cut out of a clear blue sky some not getting a bit of social security either. Would to God that could be stopped. Also 114 chief jobs and officeworkers got a raise from $4,540 to $5,412. There's always plenty for them, but a bare existence for us.

The caseworkers tell us when they will be in their office, the aged have to go there, instead of them coming to them. It isn't fair to the aged. I only receive $70.30 from the welfare, $40 social security. Have to pay $40 rent, pay my fuel, which they only allow $8.75 a month; pay my lights, only allowed $5.20; cut bus fare from $5 to $4. I pay for my phone and paper. Am paying on a TV so there isn't anything much left for clothing, food, household supply, essentials. I'm very alert and love anything educational. Am 70 years past, have arthritis very bad and enjoy the TV as I don't go out very much. If the undeserving were taken off welfare there would be more money for the aged, but they won't do it.

I worked up until December 31, 1954, then I had to be taken to the hospital for 9 days with pleurisy in back of my lungs, water on them.

So when I came back the welfare gave me general assistance until I was 65. I had been doctoring for some time and had a doctor bill of $25 yet to pay and my bill was $201.30.

I had a sickness and accident policy, they paid $180 so I had the balance there to pay.

Then in May and June together they cut me $7.20. I starved some more, for I paid the hospital $5 a month, also on doctor bill $5. Just got it paid when they cut me.

Then the welfare wouldn't keep up my $500 burial policy, they told me I was paid up for 5 years. When that time was about up, I had the agent come and found out it was the same as canceled.

They told me because I am on part welfare and social security they won't reinstate me. If I die by January 1, 1962, I would get the $500, but no benefits. If I live longer than that I will just be out. Sure makes me blue for I kept insurance because I didn't want to leave a big bill for my children to pay. It is all they can do to get by now with their families.

Thanks so much for giving me this opportunity to express just how I feel.

Yours very truly,

MYRTLE A. PETERSON.

PREPARED STATEMENT OF MISS INEZ A. WOOLF, NORTH 28 MADISON, SPOKANE, WASH., RE INFLATION, AUTOMATION, AND ECONOMY

When automation reduces payrolls in a community other businesses take a cut, reduce costs, and make other adjustments (a chain reaction).

When pensions are cut, results are the same. Note cut made in John L. Lewis' coal miner's pensions.

If all pensions (including Federal employees) were put on a pay-as-we-go basis, the entire economy would be stabilized, reducing many depressed areas and unemployment.

This system is not socialism but a simple, efficient method (tied to our free enterprise system), revolving the whole sum (less expenses) each month.

Only the first month's amount is necessary. While the money is being spent, (money turns over approximately 10 times in 3 weeks) a small gross income tax above $250 per month takes it out of circulation ready to be spent in the next month. Study this. The 3 percent for social security is a gross tax.

Germany has a most generous social security system but does not accept the usual myth that such a system is necessarily linked with high, progressive taxes. The pension is $212. West Germany spends 34 percent of gross national product; United States spends 26 percent; Belgium 23 percent; England 28 percent. England's health program takes 3½ percent of national resources.

Our pension systems have too large reserve funds on which interest is paid out of general taxes, increasing our interest item (on our debt) of 0.12 out of every $1. This will be eliminated in a pay-as-we-go system. Too much redtape also. Since 1946 only 9 percent of our gross national product used for nonmilitary public purposes.

Some union pension funds are speculated with on the stock market while their pensioners need more money to live in this inflated economy. Liberty magazine states the International Brotherhood of Teamsters loaned $1 million to a Catholic diocese in Miami for any purpose.

A study made by Marion B. Folsom showed the cost of social security, etc., to Eastman Kodak Co. was four times the cost in a pay-as-we-go system. This is also part of the cost in our cold war (true of all business) basis inflation.

Teachers are now organized to obtain a pay-as-we-go for themselves but this is effective only as a national system.

The railroads need this simple efficient system. Two years ago they had 1 million employees to carry their pension systems. Today the figure is 745,000 and the suggested tax is 15 or 25 percent gross. How would you like one-fourth deducted from your wages? Railroad unions are now striking for 25 cents per hour increase in wages. The change can easily be made. Constantly more important Senator Taft.

A genuine pay-as-we-go system, honestly managed, will not need a cost-of-living clause. That is automatic in the increase of business created plus the tax in the approximate 10 times turnover in 3 weeks.

Read A–1512 Congressional Record March 6, 1961, re social security also: "Din of Inequity" in Records after March 6, 1961.

Please vote for $173 pension at 60. Thank you.

Recently in a speech Governor Rockefeller mentioned, favorably, several times, the pay-as-we-go method, using the word "economical" in his last comment.

From A–7380 Congressional Record: "The plotters of Government medicine admit they desperately desire the passage of the King bill to create a foundation upon which can be erected a more grandiose scheme than limited medical care for the elderly." The Kerr-Mills bill is economical and efficient. Senator Humphrey said, p. 19012, Congressional Record: "We have carefully limited and delayed benefits to make sure that this program (social security) will be properly financed with an adequate reserve on sound insurance principles."

The money has been spent by Government and I O U's issued.

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