Financial capacity can be defined as the ability to independently manage one’s financial affairs in a manner consistent with personal self-interest. Financial capacity is essential for an individual to function independently in society; however, Alzheimer disease and other progressive dementias eventually lead to a complete loss of financial capacity. Many patients with cognitive impairment and their families seek guidance from their primary care clinician for help with financial impairment, yet most clinicians do not understand their role or know how to help. We review the prevalence and impact of diminished financial capacity in older adults with cognitive impairment. We also articulate the role of the primary care clinician, which includes (1) educating older adult patients and their families about the need for advance financial planning; (2) recognizing signs of possible impaired financial capacity; (3) assessing financial impairments in cognitively impaired adults; (4) recommending interventions to help patients maintain financial independence; and (5) knowing when and to whom to make medical and legal referrals. Clearly delineating the clinician’s role regarding identification of financial impairment could establish for patients and families effective financial protections and limit the economic, psychological, and legal hardships of financial incapacity on patients with dementia and their families.

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www.jama.com

See also p 707.

CME available online at www.jamaarchivescme.com and questions on p 723.
increasingly irritable, angry, and “stingy” with respect to money. For example, he refused to sign a check to purchase hearing aids, stating that they were “too expensive,” and refused to hire a substitute caregiver while his main caregiver was on vacation. His daughter also stated that the bank had phoned on a number of occasions over the past year to make her aware of questionable transactions. For example, since Mr L liked an air humidifier he had ordered, he purchased 3 more, resulting in costs of approximately $1000. Mr L’s daughter asked the geriatrician to write a letter to the bank stating that her father lacked financial capacity. The daughter remarked, “I could get him to sign papers in order to sign over his assets to me, but if he really knew what it was about, he would never sign. He would be furious.”

Mr L’s daughter, Ms L, and Dr Y were interviewed by a Care of the Aging Patient editor in April 2010.

PERSPECTIVES

Ms L: My father . . . always . . . knew exactly when bills were coming and when he had to pay. At this point, he would say that he didn’t order whatever the bill was for and he would refuse to pay it . . . . He just kept saying that his memory wasn’t very good, but he was fine. He was okay with me checking his mail, but not with me paying his bills. He didn’t want me to take over.

Dr Y: The daughter . . . wanted a letter to the bank saying that her father lacked capacity to make decisions about his own finances. He still had access to his money and there was a lot of stress between them.

Overview

Financial capacity can be defined as “the ability to independently manage one’s financial affairs in a manner consistent with personal self-interest.” Financial capacity comprises a range of conceptual, pragmatic/procedural, and judgmental skills acquired over a lifetime and is highly vulnerable to the cognitive changes accompanying conditions such as mild cognitive impairment (MCI) and Alzheimer disease. Impairment of financial capacity usually occurs very early in the course of cognitive impairment, at a time when both patients and family members may be largely unaware of encroaching deficits in financial skill.

Financial capacity can be distinguished from medical decision-making capacity by its multidimensionality and scope of activity. Although medical decision making is primarily a verbally mediated activity occurring at discrete points in time, financial capacity involves a range of knowledge, performance, and judgment skills that are exercised on an ongoing basis.

The core financial skills that all adults must retain to live independently include basic monetary skills such as identifying and counting money, understanding debt and loans, conducting cash transactions, paying bills, and maintaining judgment to conduct financial activities prudently and avoid financial abuse. When these core skills become impaired, families and caregivers often turn to physicians to make determinations about financial capacity, as did Mr L’s daughter. We review diminished financial capacity in older adults with cognitive impairments and the physician’s role, which includes knowing when and to whom to refer patients with suspected financial impairment for further medical or legal aid.

Methods

We searched MEDLINE, PsycINFO, CINAHL, and the Cochrane database for peer-reviewed English-language articles from 1966 through June 2010 on the following topics: (1) financial abilities of older adults with dementia or MCI; (2) outcomes of financial impairment including that of elder abuse; and (3) structured instruments to assess financial capacity. We included the search terms activities of daily living; finances; delirium, dementia, amnestic cognitive disorders; financial capacity; financial management; and mild cognitive impairment. We specifically selected articles that pertained to financial skills, financial capacity assessment, and elder abuse in addition to dementia or MCI. We excluded studies that pertained to financial impairment from nondementia causes such as psychiatric disorders. When searching articles on financial capacity instruments, we excluded studies that did not present primary research data. Our data synthesis was based on Alzheimer disease as a paradigm for dementia-related disorders, and our recommendations were informed by our clinical experience caring for patients with MCI and Alzheimer disease.

Epidemiology

More than 5.3 million individuals in the United States currently have Alzheimer disease, a number that is expected to reach between 11 million and 16 million by 2050. Functional disability is a core feature of dementia, initially manifesting in impairments in IADLs, such as managing medications, using the telephone, shopping, and handling finances, followed eventually by impairments in basic ADLs, such as bathing and dressing.

The ability to manage finances is one of the first IADLs to decline in MCI and Alzheimer disease, and becomes progressively impaired (FIGURE 1). Patients with amnestic MCI are at high risk of progressing to Alzheimer disease. These patients have memory impairment alone or in combination with other cognitive impairments such as verbal or executive functioning. However, these impairments are not as severe as those seen in dementia. MMSE scores generally are greater than 24 out of 30 points depending on age and education. IADL impairments may emerge in amnestic MCI, particularly impairments in complex financial tasks such as financial conceptual knowledge, bank statement management, and bill...
payment skills.17,18 Even at this early stage in cognitive decline, older adults are vulnerable to financial mismanagement and abuse. Moreover, patients with amnestic MCI who progress to Alzheimer disease over a 1-year period demonstrate overt declines in checkbook management and overall financial capacity.6

Patients with mild Alzheimer disease demonstrate emerging global impairments of both simple (eg, counting currency) and complex financial skills (eg, paying bills, balancing a checkbook).2 Over a 1-year period, these financial deficits often worsen rapidly.4 Patients with moderate and advanced Alzheimer disease show a global loss of financial skill and usually lack capacity to manage their finances independently.2,3 It is important to note that a few patients may retain varying financial skills and judgment even through the moderate dementia stage, and an evaluation beyond MMSE is needed before financial incapacity is determined.2

The Importance of Financial Capacity to Patients and Families

Dr Y: He lacks the capacity . . . to know what . . . he’s paying for. He’s at risk for being taken advantage of by telemarketers. If he has access to his credit cards, then he could lose a lot of money.

Ms L: He was just writing checks for small things like books and vitamins, but it could turn into him writing checks for larger amounts.

For patients with Alzheimer disease and their families, financial capacity is a crucial IADL impairment that has clinical, psychological, economic, and legal implications. Financial impairment is often one of the earliest clinical signs of an emerging dementia and, like loss of other capacities such as driving, can be psychologically distressing.24 Financial impairment can also lead to important economic and safety consequences for patients and significant stress and burden for caregivers.25 Caring for patients with Alzheimer disease and helping them to maintain independence requires significant out-of-pocket costs,26 and financial mismanagement or abuse may significantly compromise patients’ and their families’ quality of life. Furthermore, the inability of cognitively impaired patients to manage their finances has been identified as one of the strongest predictors of perceived caregiver burden.27

Financial abuse and loss of financial skill may also necessitate interaction with the legal system. Elder financial abuse is common and accounted for an estimated 30% of all substantiated elder abuse reports to adult protective services in 1996, the most recent year for which national data are available.28 Concerns about elder financial abuse were noted by both Mr L’s physician and his daughter. Individuals with cognitive impairment often have significant deficits in financial judgment, making some vulnerable to scams and other financial exploitation.29,30 Vulnerability to abuse can occur even early in the course of MCI and may increase as individuals continue to decline cognitively.17,18 However, this does not occur in all cases. Once patients lose financial capacity, courts may need to appoint a conservator to manage finances or resolve family disputes over assets.

The Physician’s Role

Ms L: I think that the doctor should, immediately after assessing a patient, tell the parent and the child that the child should be a signer on their bank account. They should do it before they get sick. [S]ometimes it happens so fast . . . you don’t have time to take care of it.

Busy clinicians do not have the time, training, or expertise to be financial capacity or estate planning experts. However, finances are central to an elderly person’s independence and well-being, regardless of their socioeconomic

Figure 1. Conceptual Schematic of Progressive Decline in Financial Capacity in a Person With Alzheimer Disease (AD)
status. As a result, patients and families increasingly seek and expect help from their clinicians, as did Mr L’s daughter. A professional team that includes social work services and case managers can provide invaluable help with these requests. However, many primary care physicians lack access to such support and need a clear guide on how to effectively help patients and their families. We believe that the physician’s role in monitoring financial capacity of patients includes (1) educating older adult patients and families about the need for advance financial planning; (2) recognizing signs of possible impaired financial capacity; (3) assessing financial impairments in cognitively impaired adults; (4) recommending interventions to help patients maintain financial independence; and (5) knowing when and to whom to make medical and legal referrals (FIGURE 2).

1. Educating Patients and Families About the Need for Advance Financial Planning.

Ms L: The doctor really needs to talk to them [patients and families] about what would happen “if” . . . and to make sure that they have some sort of contingency plan in the event that something happens. I just felt that I needed to have the ability to get onto his accounts so I could take care of his finances or at least pay his bills so they wouldn’t shut off the electricity.

A loss of ability to manage finances due to acute or chronic illness can be highly stressful for patients and families. In such circumstances, having a trusted designee to act in one’s stead is essential to avoid devastating financial consequences. Therefore, we recommend that clinicians educate all patients about the need for advance financial planning and recommend that patients complete a durable power of attorney for finance matters (DPOAF).

The Durable Power of Attorney. Executing a DPOAF is an important initial step in advance financial planning (Figure 2, step 1). When a patient signs a DPOAF, the patient authorizes another individual or entity, such as a family member, to make designated financial decisions on the patient’s behalf. The DPOAF can take effect immediately or only after the patient has been deemed to lack capacity, and can grant global financial authority or restrict authority to certain transactions. Most states provide statutory DPOAF forms that can be acquired free of charge—often on state bar association Web sites (Resources, available at http://www.jama.com). However, it is advisable that a lawyer draft a DPOAF so that it can be tailored to patients’ individual needs. For further financial planning, clinicians can encourage patients and their families with means to seek out qualified legal or financial advisors. Legal aid and subsidized legal services can be found through local and national Alzheimer Associations around the world and, in the United States, through area agencies on aging and state bar associations (Resources).

Other Advance Financial Planning Options. Online banking is one means by which a family member can assist and oversee the finances of a cognitively impaired older person. Another option is the joint bank account, which allows dual access to and oversight over funds, as well as automatic ownership of the funds by the surviving account holder upon the patient’s death. The risk associated with this type of account is that the joint account holder is under no legal obligation to act in the patient’s best interest. For patients with financial means, a living trust, which should be prepared by a lawyer, provides instructions for how the trust assets are to be managed during the patient’s lifetime.

Figure 2. Approach to Financial Issues in Elderly Patients

| Step 1 (for all older adults) | Educate patient and family about importance of advance financial planning
| Recommend Durable Power of Attorney for Finance (DPOAF) when discussing DPOA for health care (Table 1) |

| Step 2a | Is there evidence signaling financial impairment? (Box) |
| Yes | Continue monitoring |
| No | Perform brief assessment for potential financial impairment |
| Is the assessment positive? (Table 2) |
| No | Continue monitoring |
| Yes | Recommend practical interventions to help patients maintain independence (see text) |

| Step 3 | Any suspected financial abuse, refer to adult protective services |
| Yes | Refer for formal financial capacity assessment (eTable 1) |
| No | Based on cumulative evidence, can a clinical judgment of lack of financial capacity be made? |
| Yes | Enact DPOAF or refer for conservatorship |
| No | Are there ongoing financial concerns? |
| Yes | Skeptical to needed help |
| Request for capacity judgment |
| Family conflict |
| Suspected financial abuse |
| Continue monitoring |

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Box. Evidence That Signals Possible Financial Impairment

Evidence From Preexisting Diagnoses or Clinicians’ Assessments

A diagnosis of a medical condition that may affect cognition or functional ability (ie, mild cognitive impairment, Alzheimer disease, stroke)

Impairments in basic cognitive tests (abnormal Mini-Cog, Mini-Mental State Examination <24 depending on age and education norms,36 Montréal Cognitive Assessment <26, or problems with reciting serial 7s or 3s)

Noticeable change in appearance or poor hygiene

A history of recent loss of a partner who may have been managing finances

New family members or caregivers accompanying patient to clinic visits

Evidence From Direct Reports of Patients, Family Members, or Caregivers

New difficulty with common financial skills (calculating change, writing a check, organizing financial documents, managing assets)

Forgetting to pay utility bills or rent; eviction or service disconnection

Concern or confusion about “missing funds” in bank accounts

Reports of erratic, unusual, or uncharacteristic purchases, withdrawals, or gifts

Accusations that people are stealing or mismanaging the patient’s money

and distributed after death. Unlike joint accounts, trustees can be held legally liable for breach of fiduciary duties. Finally, wills give individuals control over the disposition of their property after they die. Assistance of a lawyer is strongly recommended in preparing a will, although some statutory forms can be obtained online.

2. Recognizing Signs of Possible Impaired Financial Capacity.

Clinicians need to be aware of evidence that a patient has, or is at risk for financial impairment (Figure 2, step 2a). This evidence may derive from preexisting medical diagnoses that predispose patients to financial incapacity, the physician’s assessment of cognition, or direct reports from patients, family members, or caregivers that the patient is having financial difficulty or cognitive impairment. The Box lists specific examples that signal potential financial impairment based on our clinical experience and our review of the literature.2

Preexisting medical diagnoses that can affect cognition or functional ability, such as MCI, Alzheimer disease, or stroke, should alert the clinician to potential current or future impairment of financial capacity. In this regard, Mr L’s clinicians should have recommended completion of a DPOAF either at the initial diagnosis of Alzheimer disease or when he presented to his outpatient physician with a preexisting diagnosis of Alzheimer disease. However, the diagnosis of dementia can often occur well after the onset of cognitive impairment. Brief and effective screening tools are available that can aid in identifying dementia, including the MMSE and the Mini-Cog,37,38 although these lack sensitivity to detect early stages of cognitive impairment. The Montréal Cognitive Assessment (MoCA) is a free, brief, and validated screening tool with high sensitivity and specificity for detecting MCI and dementia (http://www.mocatest.org).39,40 Impairments in these commonly used cognitive assessments may indicate possible financial impairment. For instance, a patient may not be able to recite serial 7s or 3s on the MMSE.41 However, these tests were not designed to measure financial capacity,42 and, as noted previously, no studies have determined the exact cutoff scores for cognitive screening tests to determine which patients become financially impaired. Thus, deficits in any of these tests may best serve as a prompt for the clinician to probe further about financial capacity.

Direct reports from patients or their family members may come before a formal diagnosis of MCI or Alzheimer disease.43 These reports may be the first signal to the clinician of the need to pursue further cognitive testing or of the potential for impairment in financial capacity. Examples of direct reports include patients mentioning they have forgotten to pay bills or family members acknowledging that their loved one has fallen for a marketing scam.

Once evidence of financial impairment is suspected, clinicians should educate patients, families, and caregivers about the progressive course of Alzheimer disease, the inevitable loss of financial capacity and financial judgment, and the risks of financial mismanagement and exploitation (Figure 2, step 2b; Table 1). Clinicians should also provide education about patients’ common lack of awareness of their own financial difficulty and the “warning signs” of financial impairment, such as missing, late, or repeated payment of bills.44 Family members of patients with cognitive impairment are receptive to such education. For instance, a Finnish study of 1943 spouses of individuals with Alzheimer disease found that only 10% had discussed legal preparations with the patients’ physician,41 but 48% expressed a need for financial discussions. Families also prefer that these discussions occur at or soon after the time of the diagnosis of Alzheimer disease, as opposed to waiting until problems arise. In one study of 100 dementia caregivers in Great Britain, 94 wanted to know about financial issues related to Alzheimer disease, with most wanting to have the discussion at the time of diagnosis.44


Ms L: It had gotten to the point where it took him a half hour to write a check. First he couldn’t find his checkbook,
then he would find it and it would . . . take so long. He'd forgotten how to spell, so he would ask me: “How do you spell hundred?” The doctor . . . spent time talking to us so she could learn more about my dad's mental and physical state. . . . One of the things that she asked me about was how I was dealing with his finances.

**Brief Questions to Probe for Possible Financial Impairment.** Clinicians may need to ask patients and caregivers a few targeted questions to further assess for financial impairment. A brief assessment may be necessary because patients with Alzheimer disease, such as Mr L, are often unaware of or in denial about the nature and extent of their decline in financial function. In addition, family and caregivers often give inaccurate or fluctuating estimates of patients' financial abilities.45

Brief questions should begin with an assessment of the patient's financial functioning (Figure 2, step 3). **Table 2** offers screening questions that are based on previously defined key financial domains2 and our clinical experience. If needed, clinicians may then ask more specific questions such as whether the patient has recently written checks that were not paid by the bank due to insufficient funds in the account or had money stolen. Patients' responses should be compared with collateral reports from family or caregivers with significant knowledge of the patient's financial affairs. Answers to these brief questions are often sufficient to alert the clinician to the presence of financial impairment and to recommend interventions to help patients maintain financial independence, and in some cases, make medical and legal referrals (Figure 2).

**Addressing Suspected Financial Abuse.** Physicians have an ethical and professional obligation to assess for and address elder financial abuse.46 Although a number of elder abuse screening instruments are available, not all screen for financial abuse.47 Physicians should be alerted to potential financial abuse by patients' reports of not being able to afford food or medications they could once afford, reports of new acquaintances who take up residence or come to appointments with a cognitively impaired person, and reports of others taking or mismanaging the patient's assets. Interviewing the caregiver and the patient separately is recommended.48 In a vast majority of US states, clinicians are mandated to report suspected elder abuse.49-51 The jurisdiction and the older individual's living arrangements would dictate which state's laws apply. The clinician should make this determination for each case, with state-specific laws available online.46
situation will dictate whether to report suspected abuse to adult protective services and/or other public agencies. Reporting numbers, government agencies, and state-specific laws can be found at the National Center on Elder Abuse Web site (Resources).


In addition to recommending a DPOAF, physicians or other health professionals, such as social workers, can recommend practical financial interventions to help patients maintain independence (Figure 2, step 4). For example, financial institutions can help by automatically depositing checks into an individual’s account, paying bills, setting up overdraft protections, and notifying a third party if bills are not paid on time. In addition, benefit providers including the US Social Security Administration, US Department of Veterans Affairs, civil service and railroad pension programs, and some state programs can appoint a representative payee to receive and manage benefits.52 The rules for eligibility, implementation, and monitoring will vary among programs, although most require some type of regular accounting of how the benefits are used. Daily money management programs can also assist with tasks such as bill paying, checkbook management, insurance claims, and tax preparation.53 These programs are offered by a variety of public nonprofit agencies and private for-profit organizations (Resources).

5. When to Make Medical and Legal Referrals.

Dr Y: There are tests that you can do that help determine someone’s capacity to make financial decisions. Mr L has significant dementia. This man had been followed up for a couple of years with a known diagnosis of dementia, so I saw no problem with writing the letter that he lacked capacity.

Although clinical judgments are not legal adjudications, a clinician’s opinion about a patient’s financial capacity carries a great deal of weight with families, financial institutions, and legal professionals.13 A clinical judgment of incapacity may ultimately work to protect patients from financial harm, but may also unfairly result in a loss of autonomy and financial independence. Thus, clinicians should have a high level of confidence before making a written attestation concerning a patient’s financial capacity, and therefore may wish first to refer to experts in financial capacity assessment.

Referral for Formal Financial Capacity Assessment. There may be ongoing concerns even after a clinician recommends practical planning and financial interventions. In these situations, clinicians may need to consider a formal referral for financial capacity assessment (Figure 2, step 5a). Referrals may be necessary in cases in which (1) the patient is impaired but lacks insight and is resistant to needed help; (2) there is family conflict and an independent opinion is needed; (3) financial abuse is suspected; (4) a relationship with the patient or family is not established and the clinician is being asked to make a financial capacity determination; or (5) the clinician needs guidance in making a sound decision in the patient’s best interest. In Mr L’s case, given his lack of insight and cooperation, as well as the concern for financial mismanagement and risk for abuse, outside referral for formal assessment of financial capacity appeared warranted.

If available, physicians need to know where they can refer patients for financial capacity assessments and the strengths of different professional disciplines in making these determinations.13 For example, neuropsychologists, geropsychologists, and forensic psychologists use standardized psychometric testing to assess a patient’s cognitive, emotional, and everyday functioning in order to make clinical judgments of financial and other capacities. In addition, forensic psychiatrists can also advise on financial and legal issues within the context of a comprehensive understanding of a patient’s cognitive and medical circumstances. Also, occupational therapists are experts in qualitatively assessing a wide range of functional skills, formulating impressions of capacity for independent living, and making recommendations for possible supportive interventions.

In addition to knowing where to refer patients, it is helpful for clinicians to know what tests to request from these consultants.54 This study provides a Web-only table (eTable, available at http://www.jama.com), which describes existing performance-based tests (ie, the patient performs specific tasks) that assess financial abilities in older adults with cognitive impairment. For each test, the eTable presents financial domains measured, as well as reliability and validity data. Global functional measures that have the most robust validity and reliability data and the most direct application to clinical assessment of financial capacity include the Direct Assessment of Functional Status (21 financial items)55 and the Independent Living Scales (17 financial items),56 which assess basic financial skills as part of a broad-based IADL evaluation. Tests specific to financial capacity that have been well studied include the Financial Capacity Instrument (112 financial items within 20 tasks and 9 domains)26,37,38 (eTable). Neuropsychological and neuropsychiatric evaluations can be used to supplement the objective financial capacity findings. As a qualification, to date, none of the identified global or specific tests of financial impairment have been associated with hard financial outcomes such as legal incapacity or elder financial abuse.

Objective information from performance-based financial tests can assist both clinicians and family members in arriving at more sound judgments regarding a patient’s financial capacity and can support negotiations with patients who are reluctant to acknowledge impairment or seek help. Such information can also guide clinicians in advising whether, when, and in which financial areas families or caregivers need to assume proxy financial responsibility.
Court-Appointed Conservatorship

Dr Y: Sometimes there has to be a catastrophe before you can intervene or you have to go for conservatorship.

A clinical judgment of financial incapacity is generally made when there is substantial incongruence between an individual’s current financial abilities and supports, and the financial needs and demands the patient experiences in everyday life. An existing DPOAF can often be implemented following a clinical determination of financial incapacity.58 If a DPOAF has not already been executed and the patient lacks decision-making capacity to sign a DPOAF, pursuing a court-appointed conservator (or guardian in some states) may be the only option for securing oversight of financial activities. Court proceedings for conservatorship can take months and involve substantial legal expenses.42 In addition, the probate court judge will decide if a conservator is needed and who the best choice of conservator will be. In many situations, courts will give preference to involved family members. This may be problematic if the patient has a domestic partner who is not recognized by the state to act on the patient’s behalf, or the patient has a contentious relationship with family members. Conservatorship is generally an option of last resort and underscores the importance of advance financial planning. At the same time, seeking conservatorship and the protection of the court can be an effective strategy in cases of significant family conflict, where there is concern for abuse, or where there is misuse of an existing DPOAF.

CONCLUSIONS

Financial capacity is essential for an individual to function independently in society. Alzheimer disease is a relentlessly progressive disease that inevitably leads to a complete loss of financial capacity. Physicians need to take active roles in assisting patients with MCI and Alzheimer disease and their families with financial concerns. Diagnosis of cognitive impairment generally, and MCI and Alzheimer disease specifically, should signal possible diminished financial capacity and prompt the physician to encourage patients and families to proactively engage in financial and legal advance planning. Timely identification and informal assessment of financial impairment can often lead to the establishment of effective financial protections and can limit the economic, psychological, and legal hardships of financial incapacity in dementia.

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Online-Only Material: A list of relevant Web sites and the eTable are available at http://www.jama.com.

Call for Patient Stories: The Care of the Aging Patient editorial team invites physicians to contribute a patient story to inspire a future article. Information and submission instructions are available at http://geriatrics.medicine.ucsf.edu/agpatient/.

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REFERENCES

CARE OF THE AGING PATIENT: FROM EVIDENCE TO ACTION


WEB RESOURCES

GENERAL RESOURCES
Alzheimer’s Association
http://www.alz.org
or (800) 272-3900
This Web site offers resources for patients and their families living with Alzheimer disease including information on legal and financial planning. The Alzheimer’s Association also offers a 24-hour helpline, open daily, which provides information and support for patients, caregivers, and health care professionals.

For a listing of Alzheimer’s Associations in countries other than the United States, visit http://www.alz.co.uk/

Eldercare Locator
http://www.eldercare.gov
or (800) 677-1116
Eldercare Locator, a public service of the Administration on Aging, connects older US residents and their caregivers with state and local agencies on aging and community-based organizations that serve older adults and their caregivers. Eldercare Locator also provides state reporting numbers for suspected elder abuse.

LEGAL ASSISTANCE
American Bar Association Commission on Law and Aging
http://www.abanet.org/aging
or (312) 988-5000
This American Bar Association Web site includes a comprehensive listing of the statewide resources available to help older individuals with law-related issues. The American Bar Association also maintains a database of all national, state, and local bar associations at http://www.abanet.org/barserv/stlobar.html.

Legal Services Corporation
http://www.lsc.gov
or (202) 295-1500
The Web site of the Legal Services Corporation, a nonprofit corporation established by the United States Congress, offers a directory of high-quality civil legal assistance to low-income US residents.

National Academy of Elder Law Attorneys
http://www.naela.org
or (703) 942-5711
This Web site includes a searchable directory of elder law attorneys with expertise in durable powers of attorney, estate planning and probate, conservatorship, and elder abuse.

FINANCIAL ASSISTANCE
AARP (American Association of Retired Persons) Money Management Program
http://www.aarpmp.org
or (888) 687-2277 for English and (877) 627-3350 for Spanish
The AARP Web site provides one of the largest networks of money management programs available to help seniors manage their financial affairs.

Benefits Check Up
http://www.benefitscheckup.org/
Developed and maintained by The National Council on Aging (202) 479-1200, Benefits Check Up is a comprehensive Web-based service to screen for benefits programs for seniors with limited income and resources.

ELDER ABUSE RESOURCES
National Committee for the Prevention of Elder Abuse
http://www.preventelderabuse.org
or (202) 682-4140
This Web site provides information related to elder abuse, including what to do if you feel someone you know is being abused, provides services available to stop abuse, and offers resources in the community.

The National Center on Elder Abuse
http://www.ncea.aoa.gov/
or (302) 831-3525
The National Center on Elder Abuse Web site contains information on elder abuse, including financial exploitation. It provides contact information for reporting elder abuse for each state and other resources on a state-by-state basis.