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# Finances in the Older Patient with Cognitive Impairment:

## He didn't want me to take over

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## Abstract

Financial capacity is the ability to manage money and financial assets in ways that meet a person's needs and which are consistent with his/her values and self-interest. Financial capacity is essential for an individual to function independently in our society; however, dementia eventually leads to a complete loss of financial capacity. Many patients with cognitive impairment and their families turn to their primary care clinician for help with financial impairment, yet most clinicians do not understand their role or how to help. We review the prevalence and impact of financial incapacity in older adults with cognitive impairment. We also articulate the role of the primary clinician which 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. Clearly delineating the clinician's role in financial impairment can lead to the establishment of effective financial protections and can limit the economic, psychological, and legal hardships of financial incapacity on patients with dementia and their families.

## The Patient's Story

Mr L is a 76-year-old retired salesman of Japanese descent with a history of Alzheimer-type dementia (AD), transient ischemic attacks, carotid stenosis, type 2 diabetes, hypertension, dyslipidemia, presbycusis, and radiation treatment 4 years ago for parotid carcinoma. He presented as a new patient to a geriatrics primary care clinic accompanied by his daughter. He had been diagnosed with AD two years earlier at a memory disorders clinic and had been taking donepezil 10mg and memantine 10mg twice a day since that time. His other medications included metoprolol 25 mg, simvastatin 20 mg, clopidogrel 75 mg, and loratadine 10 mg.

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Mr L had been widowed for 16 years. He lived by himself in a modest apartment, had a paid caregiver during the day, and was able to safely stay alone at night. He was independent in his activities of daily living (ADL) except that he needed assistance with bathing. He was dependent for most instrumental activities of daily living (IADL), such as medication management, but was reportedly still signing checks. Records from the memory clinic revealed a Mini Mental State Exam (MMSE) of 24/30 2 years ago, and 16/30 1 year ago. At the time of the dementia diagnosis, Mr L completed a durable power of attorney for health care, but never completed a durable power of attorney for financial matters. All bank accounts remained solely under his name.

During a follow-up clinic visit 3 months later, Mr L's daughter reported to the geriatrician that he was becoming increasing 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. The daughter also stated that the bank had called her on a number of occasions over the past year to make her aware of questionable transactions. For example, since the patient liked an air humidifier he had ordered, he ordered three more resulting in costs close to a thousand dollars. Mr L's daughter asked the geriatrician to write a letter to the bank stating 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."

Ms L and Dr Y were interviewed by a Care of the Aging Patient series 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 manage money and financial assets in ways that meet a person's needs and which are consistent with his/her values and self-interest."[1] Financial capacity comprises a range of conceptual, pragmatic/procedural, and judgmental skills acquired over a lifetime,[2] and is highly vulnerable to the cognitive changes accompanying conditions such as mild cognitive impairment (MCI) and AD.[3–6] Impairment of financial capacity usually occurs very early in the course of cognitive impairment,[7] at a time when both patients and family members may be largely unaware of encroaching deficits in financial skill.[8–11]

Financial capacity can be distinguished from medical decision-making capacity by its multidimensionality[12] and scope of activity.[2] While 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.

There are core financial skills all adults must retain to live independently. These include basic monetary skills such as identifying and counting money, understanding debt and loans,

conducting cash transactions, paying bills, and maintaining judgment so as 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,[13] as did Mr L's daughter. In this paper, we review the prevalence and impact of financial incapacity in older adults with cognitive impairment, the physician's role in recognizing and assessing financial impairment, and in 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 search terms for activities of daily living, finances, financial capacity, financial management, dementia, Alzheimer disease (AD), and related cognitive disorders. We specifically selected articles that pertain to financial skills, financial capacity assessment, and elder abuse in addition to dementia or MCI. We excluded studies that pertain to financial impairment from non-dementia 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 AD as a paradigm for dementia-related disorders, and our recommendations were informed by our clinical experience caring for patients with AD.

## EPIDEMIOLOGY

More than 5.3 million Americans currently have AD, a number that is expected to reach between 11 and 16 million by 2050.[14] In AD, progressive declines are seen in cognitive and functional abilities, gradually resulting in complete loss of independence. Functional disability is a core feature of dementia, initially manifesting in impairments in IADL, such as managing medications, using the telephone, shopping, and handling finances,[15] followed eventually by impairments in basic ADL, such as bathing and dressing.[16]

The ability to manage finances is one of the first IADL to decline in MCI and AD and becomes progressively impaired over the course of AD[4, 6, 17, 18] (FIGURE 1). Patients with amnestic MCI, a condition generally thought to represent a transitional stage between normal cognitive aging and AD,[19, 20] demonstrate mild impairments in complex financial tasks, including financial conceptual knowledge, bank statement management, and bill payment skills.[18, 21] Moreover, patients with amnestic MCI who convert to AD over a 1-year period demonstrate overt declines in checkbook management and overall financial capacity.[6] Patients with mild AD demonstrate emerging global impairments of both simple (eg, counting currency) and complex financial skills (eg, paying bills, balancing checkbook). [2] Over a 1-year period, these financial deficits often rapidly worsen.[4] Patients with moderate and advanced AD show a global loss of financial skills and lack capacity to manage their finances independently.[2, 3]

## 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 AD and their families, financial capacity is a crucial IADL, impairment of which 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.[22] Financial impairment can also lead to important economic and safety consequences for patients, and significant stress and burden for caregivers.[23] Because caring for patients with AD and helping them to maintain independence requires significant out-of-pocket costs,[24] 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.[25]

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 (APS) in 1996.[26] Patients with cognitive impairment often have significant deficits in financial judgment, making them vulnerable to scams and other financial exploitation,[27, 28] concerns noted by both Mr L's physician and his daughter. In addition, once a patient loses his/her financial capacity, courts may need to appoint a conservator to manage the patient's finances or resolve family disputes over the patient's 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 the expertise to be financial capacity or estate planning experts. However, because finances are central to an elderly person's independence and well-being, regardless of socioeconomic status, patients and families increasingly seek and expect help from their clinicians, as did Mr L's daughter. We believe that the physician's role in financial capacity 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 on to 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, either due to an acute or chronic illness, can be highly stressful for patients and families. In such circumstances, having a designated, trusted person 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. When a patient signs a DPOAF, he/she authorizes another

person or entity, such as a family member or lawyer, to make designated financial decisions on his/her 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.[29] Although it is advisable that a lawyer draft a DPOAF, most states provide statutory DPOAF forms that can be acquired for free, often on state Bar Association web sites. A disadvantage of a DPOAF is the lack of ongoing supervision by a court, potentially increasing the risk for abuse.[30] For further financial planning, clinicians can encourage patients and their families with means to seek out qualified legal or financial advisors. The Alzheimer's Association (1-800-272-3900) can also provide contact information for financial and legal resources within one's community. Area Agencies on Aging and state Bar Associations may also be able to help locate free or subsidized legal aid (see Resources).

**Other advance financial planning options:** More sophisticated advance financial planning advice is beyond the physician's role. In such cases, patients and families should be encouraged to seek help through a lawyer, their local Alzheimer associations, or legal aid offices (see Resources). However, other practical options include creating joint bank accounts which allow dual access to, and oversight over, funds and automatic ownership of the funds by the surviving account holder upon the patient's death.[31] The risk of 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 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 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 there are statutory forms that 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. This evidence may derive from the physician's assessment or from direct reports from patients, family members, or caregivers (Box 1). Medical diagnoses affecting cognition or functional ability, such as MCI, AD, or stroke, should alert physicians to potential current or future impairment of financial capacity. In this regard, Mr L's initial diagnosis of AD should have prompted clinicians to recommend a DPOAF completion. Furthermore, commonly used cognitive and functional assessments in primary care may also indicate possible financial impairment. For instance, a patient may not be able to do serial 7s or 3s on a MMSE.[32] These tests were not designed to measure financial capacity,[33] but they may prompt the clinician to probe further about financial impairments. As was the case for Mr L, direct reports from patients or families may be the first indication of financial impairment. For instance, patients may complain about forgetting to pay bills, or family members may acknowledge that their loved one has fallen victim to a marketing scam. In some instances, these direct reports may come before a formal diagnosis of MCI or AD and can be the first signal to the provider to pursue further cognitive testing.[34]

**Box 1**

**Evidence Signaling Possible Financial Impairment**

| **Evidence from clinicians' assessments** |
| --- |
| • A diagnosis of a medical condition that may affect cognition or functional ability (i.e., MCI, AD, stroke) |
| • Impairments in basic cognitive tests (abnormal Mini-Cog, MMSE <24 depending on age and education norms,[49] or problems with serial 7s or 3s) |

**Evidence from clinicians' assessments**

- 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 visit

**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 his/her money

Once evidence of financial impairment is suspected, clinicians should educate patients, families, and caregivers about the progressive course of AD, the inevitable loss of financial capacity and financial judgment, and the risks of financial mismanagement and exploitation (Table 1). They should also educate about patients' common lack of awareness of their own financial difficulty and the "warning signs" of financial impairment, such as missing or late payment of bills.[9–11] Family members of patients with cognitive impairment are receptive to such financial planning education.[35] They also prefer that these discussions occur at or soon after the time of the diagnosis of AD, as opposed to waiting until problems arise, as occurred in this case.[36]

### 3. Clinician Assessment of Financial Impairment and/or Financial Abuse

> 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. Brief assessment may be necessary because patients with AD, 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.[37]

Brief questions should begin by assessing the general environmental demands placed on the patient in managing his/her finances, as well as changes from the patient's pre-morbid level of financial functioning (Table 2). If needed, clinicians may then ask more specific questions such as whether the patient has recently bounced checks or had money stolen. Patients' responses should be compared to 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.[38] Although a number of elder abuse screening instruments are available, not all screen for financial abuse.[39] 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.[40] If elder abuse is suspected, clinicians have an obligation to call APS and/or other public agencies as mandated by state law.[41]

### 4. Practical Interventions to Help Patients Maintain Financial Independence—

In addition to recommending a DPOAF, physicians or other allied health professionals, such as social workers, can recommend practical financial interventions to help patients maintain independence. For example, financial institutions can help by automatically depositing checks into one'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 Social Security administration, Veterans Affairs, civil service, and railroad pension programs, and some state programs can appoint a representative payee, commonly known as a "rep payee," to receive and manage benefits.[42] 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.[43] These programs are offered by a variety of public, non-profit agencies and private, for-profit organizations (see Resources).

### 5. When to Make Medical and Legal Referrals

> Dr Y: There are tests that you can do that try to determine someone's capacity to make financial decisions. Mr L has significant dementia. This man had been followed 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:** Clinicians may consider formal referral in cases where the patient is impaired but lacks insight; there is family conflict and an independent opinion is needed; financial abuse is suspected; a relationship with the patient or family is not established; or the clinician needs guidance in making a sound decision in the patient's best interest. Given Mr L's lack of insight and cooperation, 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 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.[44] Table 3 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 table 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)[45] and the Independent Living Scales (17 financial items),[46] which assess basic financial skills as part of a broad-based IADL evaluation. Tests specific to financial capacity that have been most well studied include the Financial Capacity Instrument (112 financial items within 20 tasks and 9 domains)[2, 6, 18, 47] (Table 3). 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 mistreatment.

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 he or she experiences in everyday life. An existing DPOAF can often be implemented following a clinical determination of financial incapacity.[48] 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 over financial activities. Court proceedings for conservatorship can take months and involve substantial legal expenses.[33] 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.

## CONCLUSION

Financial capacity is essential for an individual to function independently in our society. AD is a relentlessly progressive disease which inevitably leads to a complete loss of financial capacity. Physicians are playing increasingly active roles in assisting patients with MCI and

AD and their families with financial concerns. Diagnosis of cognitive impairment generally, and MCI and AD specifically, should signal possible financial impairment 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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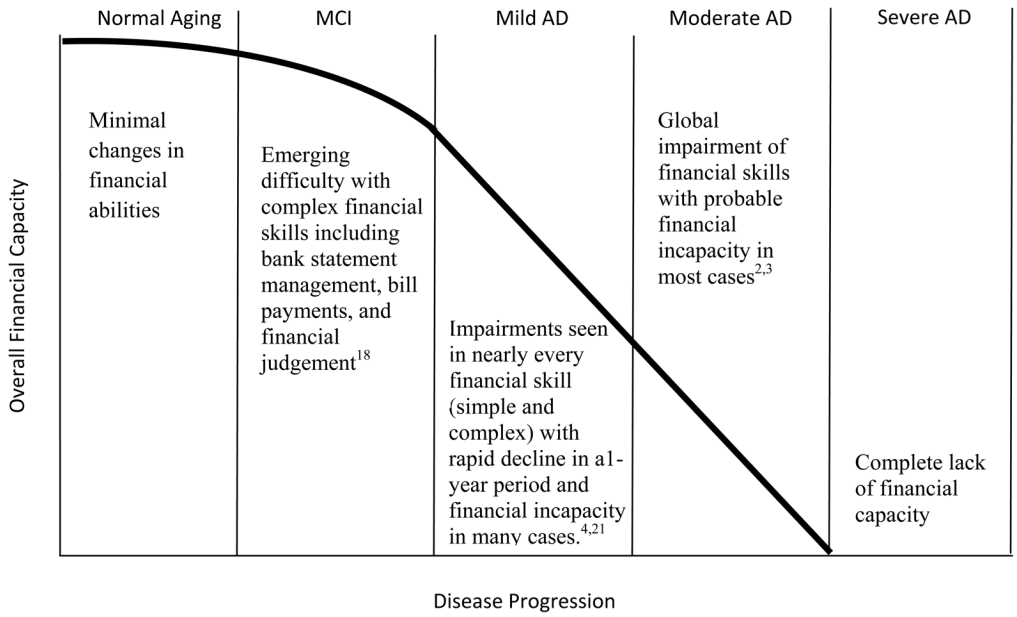


**Figure 1.**
Schematic of Progressive Decline in Financial Capacity Seen in AD

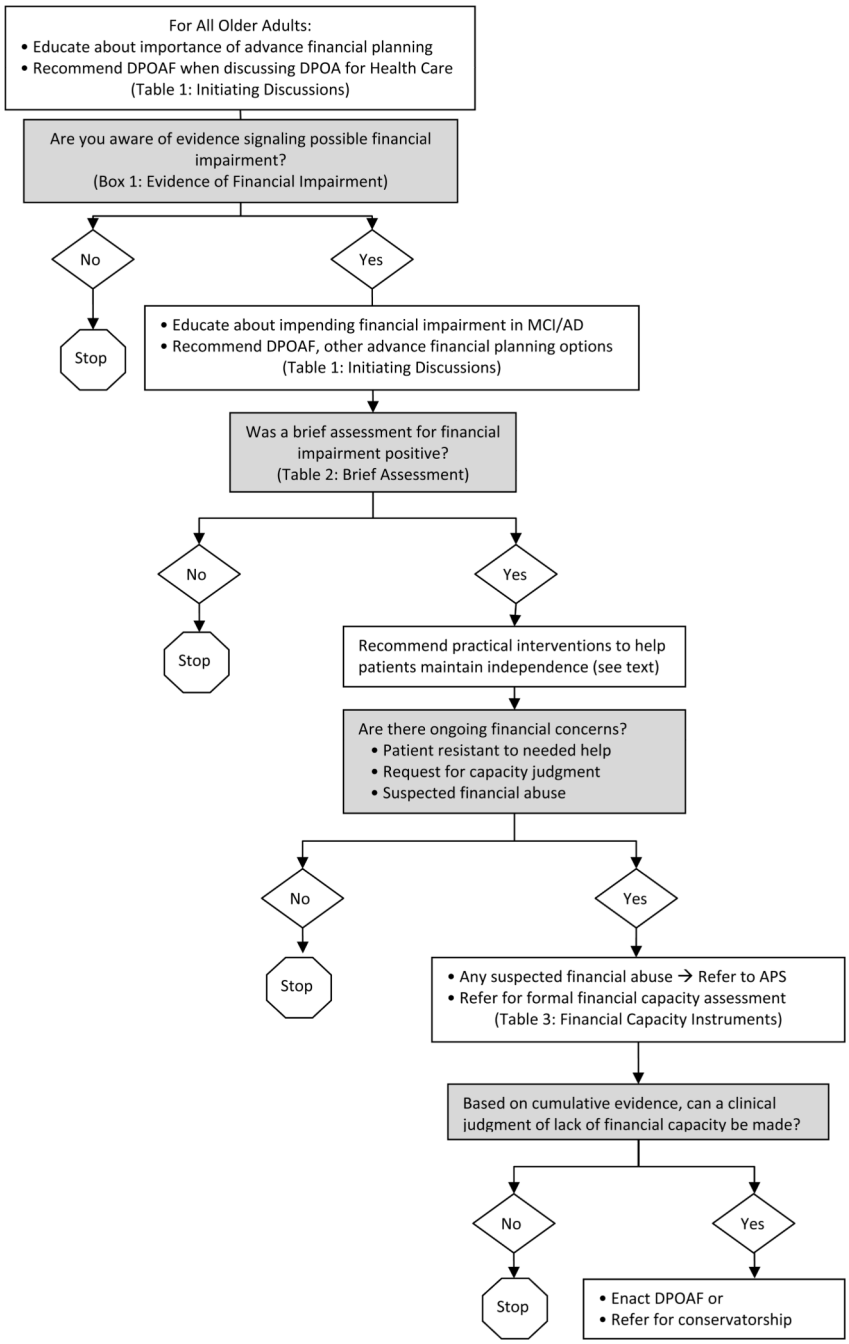


**Figure 2.**
Approach to Financial Issues in the Elderly

## TABLE 1

Initiating Advance Financial Planning and Referral Discussions*

| **For All Patients and Their Families/Caregivers Prior to Diagnosis of Cognitive Impairment** | |
|---|---|
| **Intervention** | **What to Say** |
| Recommend a Durable Power of Attorney for Finances | "Because of serious illness, memory problems, or being in the hospital, everyone, at least for a short while, may need help with their money and paying bills."<br>"Have you thought about who you would trust to help you with your money and property in case you could not manage on your own?"<br>"A special form called a durable power of attorney for financial matters allows you/your loved one to name someone to help you/them with your/their money now or when you/they are unable to manage on your/their own." |
| **For Patients With Cognitive Impairment and Their Families/Caregivers** | |
| **Intervention** | **What to Say** |
| Educate about future financial impairments | "It is common for patients with memory problems and dementia to have problems managing money. Many times, patients do not realize they have a problem. But, it is important to think about what you/they can do now to protect your/your loved one's money and property. Have you thought about this?"<br>"Signs that you/your loved one may need help with your/their money or property include having difficulty balancing your/their checkbook, paying bills, or making correct change." |
| Recommend practical interventions to support patients with financial impairment | "There are some things you can put in place now to help manage your/your loved one's money. This includes automatic bill pay and direct deposits through your/their bank. There are also services that help manage your/their money. You can call the Alzheimer's Association (1.800.272.3900) for referrals or suggestions. It may also be a good idea to talk with a social worker or someone at your bank." |
| Refer for formal financial capacity assessment | "I am worried that your/their memory loss is causing you/them to have problems managing your/their money. I would like to get some special tests. If you/they do have problems managing your/their money, the tests will tell us what kinds of things you and your family can do to keep your/their money safe." |

* This table includes examples statements/questions that clinicians can use in order to meet the individual preferences of the clinician, patients, and surrogates. These statements/questions can and should be modified as needed.

## Table 2

Informal Assessment: Brief Questions to Probe for Potential Financial Impairment or Vulnerability

| | **Questions for patients and family** |
|---|---|
| General Questions | "Who manages your/their money, property (and/or investments)?"<br>"Do you have anyone besides yourself on your checking and savings accounts?"<br>"How long has it been like this?"<br>"Are you/they having any problems?" |
| Specific Questions | "Are you/they having any new problems making change (and/or calculating tips)?"<br>"When was the last time you/they were late paying a bill?"<br>"When was the last time you/they bounced a check?"<br>"Have you received any letters or phone calls from your/their bank with concerns about your/their account?"<br>"Has anyone stolen or cheated you/them out of money?" |

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**Table 3**

Performance-based Tests to Request In Making a Referral for Financial Capacity Assessment *

| Measure | Domains Measured | # financial items/total items | Administration time for all items ** | Initial Validation Samples | Reliability | Validity |
|---|---|---|---|---|---|---|
| Global functional tests that include financial capacity tasks | | | | | | |
| Direct Assessment of Functional Status (DAFS)[45] | • Time orientation<br>• Communication skills<br>• Transportation skills<br>• Financial skills<br>• Shopping skills<br>• Grooming skills<br>• Eating skills | 21/85 items | 25–40 min | 18 elderly controls, 30 cognitively impaired patients including AD | **IC**: unknown<br>**IR**: Overall DAFS Cohen's Kappa range 0.91 to 1.00; financial subscale = 0.99<br>**T-RT**: Overall DAFS Spearman rank order correlation coefficients range 0.71 to 1.00; financial subscale = 0.88 | **Convergent validity**: Correlated with caregiver report of function (ie, Blessed Dementia Rating Scale[50]) for overall DAFS only, r = 0.59, 0.66 in AD patients Correlated with functional impairment identified by chart review with overall DAFS sum of squares, biserial r range .59–.63; financial subscale = 0.63 |
| Independent Living Scales (ILS)[46] | • Memory/orientation<br>• Managing money<br>• Managing home and transportation<br>• Health and safety<br>• Social adjustment | 17/68 items | 45 min | Independent and dependent adults (n = 80); dementia (n = 20); other conditions (n=228);<br>IC & IR Factor Analysis and Validity: healthy sample, n=590<br>T-RT: Independent and dependent adults (n = 80); | **IC**: Overall ILS coefficient α = range .72–.92; financial subscale α =0.87<br>**IR**: Overall ILS intraclass correlation 0.99 4; financial subscale = 0.99<br>**T-RT:** Overall ILS reliability coefficient *r* = 0.91; financial subscale r=0.92 | **Factor validity**: Factor analysis with 2 factors (eigen value of 18.0 and 2.5) with individual items having factor loadings ≥ 0.30.<br>**Convergent Validity**: Correlated with Wechsler Adult Intelligence Scale-revised, overall ILS correlation coefficient r = 0.73; financial subscale r=0.76 & Activities of Daily living scale, overall ILS =0.71; financial subscale 0.60 |
| Occupational Therapy Assessment Scale (OTAS)[51] | • Personal hygiene<br>• Dressing<br>• Demeanor<br>• Home management<br>• Telephone use<br>• Planning transport<br>• Money management<br>• Planning leisure<br>• Practical recall | 5/30 items | 30–40 min | Range of cognitive impairment including dementia<br>IC: n=42<br>IR: n=23<br>Validity: n=29 | • **IC:** Crohnbach α overall OTAS = 0.89<br>• **IR** : Overall OTAS kappa statistic range 0.63 to 1.0; financial subscale range 0.86–1.0<br>• **T-RT**: unknown | • **Convergent Validity**: Correlated with Lawton IADL[15] (Pearson correlation, r = 0.75), MMSE (r = 0.73), Barthel ADL Index[52](r = 0.38), Nottingham extended IADL index[53] (0.67) of overall OTAS. |

| Measure | Domains Measured | # financial items/total items | Administration time for all items** | Initial Validation Samples | Reliability | Validity |
|---|---|---|---|---|---|---|
| Structured Assessment of Independent Living Scale (SAILS)[54] | • Fine Motor Skills<br>• Gross Motor Skills<br>• Dressing, Eating<br>• Expressive Language<br>• Receptive Language<br>• Time and Orientation<br>• Money-Related Skills<br>• Instrumental activities<br>• Social Interaction | 5/50 items | 60 min | 18 elderly controls<br>18 AD patients<br>IC & IR: n=10 AD patients<br>T-RT: n=10 controls | • **IC**: Overall SAILS Cronbach α = .90<br>• IR = Overall SAILS reliability coefficient, r=0.99<br>• T-RT:Overall SAILS reliability coefficient, r= 0.81 | • **Discriminant validity**: Significant worse SAILS scores for patients with AD than controls, P<.05.<br>• **Convergent Validity**: Correlated with visuospatial abilities, attention, and visual memory (correlation coefficients range 0.50 to 0.84) |
| Texas Functional Living Scale (TFLS)[55] | • Dressing<br>• Time<br>• Money<br>• Instrumental activities<br>• Memory | 4/21 items | 15–20 min | 21 elderly controls<br>22 AD patients | • IC: Overall TFLS Cronbach α range for patients with AD 0.61–0.94; financial subscale 0.90<br>• IR unknown<br>• **T-RT:** Overall TFLS reliability coefficient =0.93 for AD, r=0.53 for healthy controls. | • **Concurrent Validity**: Correlated with MMSE (correlation coefficient = 0.92)<br>• **Convergent Validity**: Additional studies: correlated with ILS (r=0.892)[56] |
| Specific tests designed to measure financial capacity | | | | | | |
| Financial Capacity Instrument (FCI)[2, 6, 18, 57] | • Basic monetary skills<br>• Financial conceptual knowledge<br>• Cash transactions<br>• Checkbook management,<br>• Bank statement management<br>• Financial judgment<br>• Personal financial knowledge (assets and estate)<br>• Bill payment | 112 items, 20 tasks within 9 domains¶ | 40 min for older controls, 60 min for AD patients | FCI[2] (6 domain)<br>23 elderly controls<br>30 mild AD<br>20 moderate AD<br>FCI[57] (8 domain) ¶<br>23 elderly controls<br>20 mild AD<br>FCI[18] (9 domain) ¶<br>21 elderly controls<br>21amnestic MCI<br>22 mild AD | • **IC**: α = 0.85– 0.98 for FCI-6 domains. α = 0.81–0.93 for core FCI-8 domains[57]<br>• **IR**: % agreement = 81.0–100.0 for FCI-6, and =90.6–100.0 for FCI-8[57]<br>• **T-RT**: Pearson r range = 0.85–0.98 for FCI-6 domains, and = 0.78–.92 for core FCI-8 domains[57] | • **Discriminant Validity**: Significant differences in FCI scores between elderly controls, MCI, mild AD, moderate AD[2, 4, 6, 18]; mild AD patients show rapid decline over 1 year[4], MCI patients converting to AD show selective decline over 1 year[6]<br>• **Convergent Validity**: Overall financial capacity |

| Measure | Domains Measured | # financial items/total items | Administration time for all items** | Initial Validation Samples | Reliability | Validity |
|---|---|---|---|---|---|---|
| | • Investment decision | | | | | (FCI-9) in controls, MCI, and mild AD strongly predicted by written arithmetic, and also executive skills[5]<br>• **Factor Validity**: Factor analysis of FCI-9 tasks revealed 6 factor structure with eigen values ≥ . 96, and factor loadings =.39–.60 [n=322] |
| Semi-Structured Clinical Interview for Financial Capacity[3] (SCIFC) | • Basic monetary skills,<br>• Financial conceptual knowledge;<br>• Cash transactions;<br>• Checkbook management;<br>• Bank statement management<br>• Financial judgment;<br>• Bill payment;<br>• Knowledge of personal assets & estate | 26 tasks in 8 domains | 25 minutes | 75 elderly controls<br>58 amnestic MCI<br>97 mild AD<br>31 moderate AD | • **IC**: unknown<br>• **IR**: ≥80 percent judgment agreement by 5 physicians achieved in 78% of global SCIFC outcomes [n=261]<br>• **T-RT**: unknown | **Discriminant Validity**: SCIFC outcomes distinguish elderly controls, MCI, mild AD, and moderate AD on 8 domains and global score |
| Financial Competence Assessment Inventory (FCAI)[58] | • Everyday financial abilities<br>• Financial judgment<br>• Estate management<br>• Debt management<br>• Cognitive functioning related to finances<br>• Support resources | 38-items in 6 domains | Unknown | Acquired brain injury (n=36); Schizophrenia (n=29); AD (n=29); Intellectual disability (n=32) healthy controls (n=59)<br>T-RT, 20 health controls | • **IC**: Cronbach α = 0.96 (range 0.54–0.91)<br>• **IR**: Percent agreement on 10 pairs of raters range, 83–98%, average 89% Cohen's Kappa =0.86<br>• **T-RT**: overall Pearson's correlation coefficient=0.93, range 0.57–0.98 | • **Convergent Validity**: Correlated with Money Management subscale of ILS, the Financial Decision Making scale of the Hopemont Capacity Assessment Interview[59]<br>• **Discriminant Validity**: Significant worse FCAI scores for patients needing |

| Measure | Domains Measured | # financial items/total items | Administration time for all items** | Initial Validation Samples | Reliability | Validity |
|---|---|---|---|---|---|---|
| | | | | | | a financial administrator, P<.01. |

* Measurements were chosen if they have been validated in older adults with cognitive impairment and included multi-dimensional financial assessment

† IC: Internal Consistency

‡ IR: Interrater reliability

§ T-RT: Test Retest

¶ Additional domains in revised Financial Capacity Instrument

** All tests can be administered by trained allied health professionals, most commonly by occupational therapists, neuropsychologists, and psychiatrists,