NYSBA SUMMER 2003 | VOL. 13 | NO. 3

Elder Law Attorney

A publication of the Elder Law Section
of the New York State Bar Association

Chair to Chair

Cora A. Alsante
Outgoing Chair

It has been my great privilege to serve as Chair of the Elder Law Section of the New York State Bar Association this past year. I could not have served in this position without an outstanding group of officers—Joan Robert, Ira Miller, Howard Krooks and, of course, Mitchell Rabbino, and I thank each of them for their assistance and for the tremendous support they have given me, not only during my term as Chair, but over the years. I would also like to thank Terry Scheid for all of her hard work and dedication as our staff liaison.

As I look back over the year, I am proud of what our Section has accomplished. Our Strategic Plan has been finalized and approved by our Executive Committee. Since that time, we have worked diligently to begin implementing the Plan goals, an effort I know will be continued by Joan Robert during her leadership of our Section.

At our April Executive Committee meeting, our Meetings Task Force shared its preliminary report on its assigned task of developing a plan of action to ensure that future meetings will be accessible to all members and to encourage maximum attendance.

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Joan L. Robert
Incoming Chair

It is a great honor to serve as Chair of the Elder Law Section. I follow the energetic and dedicated Cora Alsante, who now becomes Past Chair and continuing adviser to the officers. The death of Chair-Elect Mitch Rabbino left not only a hole in our hearts but also a vacancy in the officers. In accordance with the bylaws, the Executive Committee met in April and elected Howard Krooks as our Chair-Elect. He brings with him the experience he has gained by serving as Treasurer this past year and as active Executive Committee member and chair of numerous Special Committees over several years. Lawrence Davidow, elected our Secretary at the Annual Meeting, will now serve as Vice Chair. Ellen Makofsky remains as incoming Treasurer, and David Pfalzgraf stays on as our Financial Officer. Dan Fish was elected Secretary. He brings years of experience as an elder law attorney and as a former President of NAELA. His column on elder law issues in the *New York Law Journal* keeps many of us apprised of cutting-edge issues. Welcome, Dan.

All of the officers are committed to the growth and strength of the Section by continuing to imple-

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Inside this Issue

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Outgoing Chair's Message *(Continued from page 1)*

Kathryn Grant Madigan, Chair of the Task Force, is working with the other members on a final report to be reviewed by our Executive Committee at the next meeting.

The new revisions to the Part 36 Rules of the Chief Judge governing fiduciary appointments have triggered several CLE programs which had to be implemented quickly, since the Rules become effective June 1, 2003. Through the hard work and dedication of Terry Brooks and the CLE Department of the New York State Bar Association, training and orientation programs were held in May. During each program, practitioners were provided the opportunity to complete the forms that are required if they wish to continue to serve in fiduciary roles. In addition, a training and orientation program for judges was conducted in April under the direction of Charlie Devlin, Director of the Office of Guardianship Services.

Our next Section meeting will be held in Newport, Rhode Island, August 14–17. Lawrence Davidow will chair what looks to be another outstanding program. Our meetings provide a unique opportunity for first-time attendees to meet other Section members. The members are always more than willing to share important information and personal experiences. I have found that the relationships I have formed, both professional and personal, while attending these meetings have been invaluable. Please join us.

I cannot imagine turning the reins over to more capable hands than those of Joan Robert. Joan has the enthusiasm, the dedication and the skills that are vital to the continued success of our Section. I know she will enjoy, as I did, working with an outstanding team of officers, including some who were elected at our Executive Committee meeting in April in accordance with our bylaws. At that time, the Committee elected Lawrence Davidow as Vice Chair and Howard Krooks as Chair-Elect to fill the vacancy left by Mitchell Rabbino's untimely and unfortunate death. We also welcome Daniel Fish, who was elected Secretary. Also, Ellen Makofsky will begin her role as Treasurer and David Pfalzgraf will remain our Financial Officer. I am pleased to leave the Section in such capable hands as I move to my new role as Past Chair.

Our Section faces many new challenges as we look ahead into the future. The state Senate has just introduced a bill which seeks to extend the lookback period to five years for any transfer, to make the transfer rules apply to home care, and to abolish spousal refusal. We need to stay connected as a Section, as we have in the past, in order to effectively challenge proposed laws that will adversely affect our clients and our practice.

As always, we welcome all of you to become involved in our Section and its many activities. Please join a committee or take on an issue which is of particular interest to you. Write an article for our newsletter or attend one of our outstanding programs. We must continue to share our wealth of knowledge and experience within the Section. By doing so, we not only benefit our clients, whom we work so diligently to represent, but we also enrich each other.

Cora Alsante

Editor's Message

In 1989, I worked for the staff of the old U.S. House of Representatives Select Committee on Aging. It was an experience that was my calling to devote my legal career to representing the elderly. One of my responsibilities at that time was to assist in the coordination of a Congressional hearing on the growing problem of elder abuse. When I learned of my assignment, my first thought was that although it seemed like a really bad thing, how bad could it really be? I then wondered how widespread could it possibly be to require a hearing in the U.S. Congress? It didn't take very long to discover the terrible answers.

As our nation grows older, the numbers of seniors who are dependent upon family members and others for support of all types increases dramatically. Perhaps the most troubling aspect of elder abuse is that the majority of cases are perpetrated by family members, typically the caregivers. Whether due to caregiver stress, personal family problems, drug and/or alcohol addiction, or financial difficulties, it is often the caregiver who commits the abuse. The problem is real, and it is growing. This issue's theme is elder abuse.

After years of research, studies, reports, and hearings, Congress may finally take the necessary steps to deal with elder abuse. The Elder Justice Act (S. 333) is an important development in the fight. Introduced by Senator John Breaux of Louisiana and Senator Orrin Hatch of Utah, this legislation is an encouraging example of bipartisan action for a critical cause. It is also extremely gratifying to see the benefits of Senator Breaux's outstanding leadership on issues affecting our nation's seniors.

As the Executive Director of the New York State Coalition for the Aging (NYSCA), Greg Olsen is well-versed in the ever-growing problem of abuse against the elderly. NYSCA is a membership organization

representing nearly 200 community-based senior service providers throughout New York State. He has written an article that, in addition to discussing abuse, contains reporting and contact information for caregivers and advocates.

Eleanor Crosby is a member of the Board of the National Center for the Prevention of Elder Abuse and Neglect. Her article is an excellent report of the developments in this area as well as a compelling plea that more needs to be done.

In this issue, we can also see advocates in action. Attorney Michael Kutzin's testimony before the U.S. Senate's Special Committee on Aging is an example of a story that had to be told to our representatives in the Congress. The story of Mollie Orshansky is one that many elder law practitioners have experienced. Also, Jane Pollack's account is a powerful reminder of the real-life issues that caregivers face every day.

Elder law attorneys are required to provide counsel not only on legal matters, but to assist clients with their finances, at least in a cursory way. Stephen Davis's article is an enlightening explanation of how investing really works.

As always, this edition's NEWS section contains timely and useful articles by some of the most experienced practitioners in our section. Thanks to all of them for their continued commitment.

Please enjoy this edition of *Elder Law Attorney*.

Steven Stern

Request For Articles

If you would like to submit an article, or have an idea for an article, please contact

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Articles should be submitted on a 3 1/2" floppy disk, preferably in WordPerfect or Microsoft Word, along with a printed original and biographical information.

ment our Strategic Plan. This Plan envisions the Section as the leading resource and advocate for elder law attorneys and the clients they represent. Increasing opportunities for members to participate actively in the Section and raising public awareness of issues affecting the elderly and persons with disabilities are among the goals we seek to achieve this year. Expanding the Section's breadth to incorporate issues of persons with disabilities and depth of membership to identify and mentor future Section leaders are priorities. A strong Section is necessary to help elder law practitioners and their clients face legislative, fiscal and philosophical challenges which undermine the essence of our practices.

We face these challenges on the 10th anniversary of seminal legislation that has shaped the practice of elder law and expanded the rights of the incapacitated. On April 1, 1993, article 81 of the Mental Hygiene Law was enacted. This statute directs a guardian to exercise those powers necessary to manage property and/or personal needs of an incapacitated person in the least restrictive manner. In recognition of the time-consuming nature of the services provided by the guardian, the statute does not mandate that the court order compensation solely based upon the amount of assets managed. However, in response to criticism of abuses perceived to have occurred in guardianship appointments and compensation, Part 36 of the Rules of the Chief Judge will now prevent new appointments of fiduciaries who have received an aggregate compensation of more than $50,000 in a calendar year. This limitation will eliminate a cadre of experienced guardians, court examiners and supplemental needs trustees from receiving new appointments as they fulfill their difficult roles as ongoing fiduciaries.

In July 1993, EPTL 7-1.12 was enacted. This Supplemental Needs Trust statute authorized third parties to establish supplemental needs trusts for the future-care planning of persons with disabilities. In June 1994, this statute also encompassed "payback" trusts funded with the assets of persons with disabilities under the age of 65. Many lay guardians serve as these trustees. They need guidance as to the effect of their expenditures on government entitlements of the beneficiary. Our Committee of Persons under a Disability, chaired by Charles Robert, is preparing a "Guidelines for Trustees of Supplemental Needs Trusts," similar to that prepared previously for guardians by the Guardianship and Fiduciary Committee of Bob Kruger. The public and the judiciary have purchased the guardianship pamphlet, which was recently updated for its second printing.

On August 10, 1993, the federal Omnibus Budget Reconciliation Act was enacted by Congress. This statute fixed the lookback period for transfers of assets at three years prior to an application for Medicaid in a skilled nursing facility or in a waivered home care program. For transfers to or from a trust there is a five-year lookback. This statute gives certainty to those planning for their future needs who are desirous of retaining assets for their own supplemental needs as nursing home patients or for a spouse or for family members. Articles critical of "Medicaid planning" have appeared in *Newsweek* and in the *Wall Street Journal*. These articles do not equate the asset preservation available to our clients with that available to estate-planning clients. These articles do not acknowledge or explain our society's decision to cover acute treatment of illnesses such as cancer and heart transplants by Medicare but not to insure chronic long term care necessitated by other illnesses such as Alzheimer's disease or Parkinson's disease. Perhaps in response to these articles, legislation has been proposed in the New York State Senate which seeks to eliminate the lookback period mandated by federal law.

Our Section must continue to be proactive when legislation or rules are proposed which affect our members and their clients. The Guardianship and Fiduciary Committee, chaired by Bob Kruger, worked with the State Bar and responded to concerns of the Chief Judge and to the original Part 36 Rules, which are less onerous as enacted. Charlie Devlin, Director of the Office of Guardianship Services, welcomed a dialogue with our Section members. Our Public Agency and Legislation Committee, chaired by Ron Fatoullah, is actively tracking different legislative initiatives and will work with the substantive committees to issue reports and even to propose legislation needed to serve our clients. The Committee of Health Care Issues, chaired by Ellyn Kravitz, is examining various surrogate health care decision statutes, while Lou Pierro will complete our Section's report on Long Term Care Reform. We urge any Section member interested in working on various projects by these and other committees to contact the committee chair or any of the officers.

Our Strategic Plan, approved in October 2002, mandates that the Section focus on five areas in order to best serve our members and their clients: educational and professional development, public awareness and advocacy on issues involving elder law, increased membership and expanding opportunities for active participation in the Section, dissemination of accurate and timely information, and the growth of

the Section and its responsiveness to the needs of the members. These five areas, of course, are interrelated. We thank our indefatigable Membership Chair, Martin Petroff, for the continued growth of our Section. We also acknowledge the importance of our Section's Web site and listserve in attracting and retaining members, and are indebted to David Goldfarb, Technology Chair, for his efforts. *The Elder Law Attorney*, of course, is yet another reason why our Section's membership is growing. Under Steve Stern's editorship, this publication continues to be an invaluable resource for the elder law practitioner.

In order to implement the educational component of this mandate, some CLE programs will be cosponsored with other Sections. A primer on pooled income trusts was organized by Lisa K. Friedman, cosponsored by the Committee of Persons under Disability of the State Bar; and Planning for the Middle Class Family was a joint effort of our Section and the Trusts & Estates Law Section, thanks to Bernie Krooks, our CLE Committee Chair, and to Bob Freedman, a member of the CLE Committee of the State Bar. The Summer Meeting is jointly held with the General Practice Section.

The Meetings Task Force presented a preliminary report which endorsed the concept of a Fall Meeting to be held at various locations over the state. The Summer Meeting need not be in New York State, but an effort will be made to choose locations in the Northeast. The dates and locations of these meetings will be fixed several years in advance to help members plan their schedules to include these opportunities for educational and professional development (and fun).

Consistent with these recommendations, the Fall Meeting will be at the Hudson Valley Resort and Spa, November 5–7. Ellen Makofsky is the program Chair and has developed a program replete with practical approaches to trusts in the elder law practice. As a special treat (and 2 CLE Ethics Credits) Hon. Joel Asarch will present "Dramatic Lawyers," a panel discussion of ethical considerations of celluloid lawyers. On Friday, November 7, both the Advanced Institute, chaired by Tony Lamberti and Dave Stapleton, and a new Beginners Institute, chaired by Jim Cahill and Ed Wilcenski, will take place. People wishing to speak at these programs should contact the program chairs. Ron Fatoullah will chair the Annual Meeting in January.

In order to expand opportunities for active participation in the Section, vice chairs have been appointed for many of the Committees. To the extent possible, chairs and vice chairs will come from different geographic areas of the state. District delegates are to identify interested practitioners in their district who wish to speak at programs or become active members of committees. Call your district delegate or chair of any committee if you wish to suggest a project or work on one that is pending.

You, our members, are our strength. We often represent the most vulnerable in society. I am proud to be Chair at this important time and look forward to working with you to strengthen our Section and to advocate on behalf of our clients.

Joan Robert

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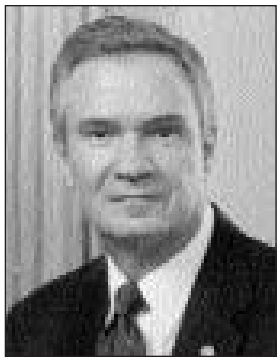
ELDER LAW NEWS

REGULAR COLUMNS

The Elder Justice Act, S. 333

By U.S. Senator John Breaux and U.S. Senator Orrin Hatch

On February 10, 2003, the Elder Justice Act, S. 333, was introduced in the United States Senate. Currently, S. 333 has 21 bipartisan co-sponsors.[1] The introduction of this groundbreaking legislation marks the first comprehensive federal effort to address elder abuse, neglect and exploitation, and would provide protections and dignity of life to older Americans. As of this date, a companion bill in the United States House of Representatives has approximately 20 co-sponsors and will be introduced shortly.



Sen. John Breaux

The Elder Justice Act has garnered broad support from scores of seniors, their families and an extremely diverse group of aging and other organizations. Whether at home or in institutions, older Americans should not have to wait a day longer to be better protected from the devastation of physical, sexual and psychological abuse, from neglect, or from financial exploitation. This bill will identify measures that are cost-effective, that work, and that will begin to contain mounting costs of elder abuse, for example, by reducing the countless millions spent on unnecessary acute care.

Reports reflect that 500,000 to 5 million of America's senior population will be victims of some form of abuse every year, causing untold illness, suffering, and premature death. It is a largely unreported phenomenon that will only grow as 77 million baby boomers age. The Elder Justice Act would, for the first time, provide much-needed support to state and local entities, which are on the front lines in combating this largely unknown, but growing problem.

Over the past two decades Congress has held dozens of hearings on many devastating aspects of elder abuse, neglect and exploitation, calling it a "disgrace," and a "burgeoning national scandal." Nonetheless, those decades of hearings have resulted in no comprehensive law. In fact, no single federal employee works full-time on elder abuse, neglect and exploitation issues. Elders deserve attention and resources commensurate with those devoted to child abuse and violence against women. Indeed, we have taken the lessons learned in those fields and applied them in the Act's efforts to combat elder abuse, neglect and exploitation. We need a combined law enforcement, public health, and social service approach to study, detect, treat, prosecute and, most importantly, prevent elder abuse, neglect and exploitation.

Sen. Orrin Hatch

"Elder justice" is the term we use to encompass the broad array of approaches outlined in the Elder Justice bill to address the increasingly pressing problem of elder abuse, neglect and exploitation that has long been invisible and presents among the gravest issues facing millions of American families. From a societal perspective, elder justice means ensuring adequate public-private infrastructure and resources to prevent, detect, treat, understand, intervene in and, where appropriate, prosecute elder abuse, neglect and exploitation. From an individual perspective, elder justice is the right of every older person to be free of abuse, neglect and exploitation. The Elder Justice Act would promote both aspects of elder justice with the following provisions:

- **Elevating elder justice issues to national attention**. Creation of (1) Offices of Elder Justice at the Departments of Health and Human Services and Justice to serve programmatic, grant-making, policy and technical assistance functions relating to elder justice, (2) a public-private Coordinating Council to coordinate activities of all relevant federal agencies, states, communities and private and not-for-profit entities, and (3) a consistent funding stream and national office for Adult Protective Services (APS).
- **Improving the quality, quantity and accessibility of information**. An Elder Justice Resource Center and Library will provide information for consumers, advocates, researchers, policy makers, providers, clinicians, regulators and law enforcement and thereby prevent "re-inventing" the wheel. A national data repository also will be developed to increase the knowledge base and collect data about elder abuse, neglect and exploitation.

- **Increasing knowledge and supporting promising projects**. Given the paucity of research, Centers of Excellence will enhance research, clinical practice, training and dissemination of information relating to elder justice. Priorities include a national incidence and prevalence study, jump-starting intervention research, and developing community strategies to make elders safer. The Elder Justice Act also enhances multi-disciplinary efforts.
- **Developing forensic capacity**. There is scant data to assist in the detection of elder abuse, neglect and exploitation. Creating new forensic expertise (similar to that in child abuse) will promote detection and increase expertise. New programs will train health professionals in both forensic pathology and geriatrics.
- **Providing victim assistance, "safe havens," and support for at-risk elders**. Elder victims' needs, which are rarely addressed, will be better met by supporting creation of "safe havens" for seniors who are not safe where they live and development of programs focusing on the special needs of at-risk elders and older victims.
- **Increasing prosecution**. Technical, investigative, coordination, and victim assistance resources will be provided to law enforcement and prosecutors to support elder justice cases. Preventive efforts will be enhanced by supporting community policing efforts to protect at-risk elders.
- **Improving and increasing training**. Training to combat elder abuse, neglect and exploitation is supported both within individual disciplines and in multi-disciplinary (such as public health/social service/law enforcement) settings.
- **Developing special programs to support underserved populations, including rural, minority and Indian seniors.**
- **Developing model state laws and practices.** A study will review state practices and laws relating to elder justice to identify those that are most effective.
- **Increasing security, collaboration, and consumer information in long-term care.**
  - Improving prompt reporting of crimes in long-term care settings
  - Criminal background checks for long-term care workers
  - Enhancing long-term care staffing
  - Information about long-term care for consumers through a Long-Term Care Consumer Clearinghouse
  - Promoting accountability through a new federal law to prosecute abuse and neglect in nursing homes.
- **Ensuring evaluations and accountability**. Provisions to determine "what works" and ensure funds are properly spent.

The importance of defending our right to live free of suffering from abuse and neglect does not diminish with age. If we can unlock the mysteries of science to live longer, what do we gain if we fail to ensure Americans live longer with dignity? More and more of us will enjoy longer life in relative health, but with this gift comes the responsibility to prevent the needless suffering too often borne by our frailest citizens.

We appreciate the work of our fellow members and more than 140 members of the growing Elder Justice Coalition on behalf of the Elder Justice bill and look forward to continued support from both sides of the aisle in both houses and from the Administration to make elder justice a reality for those Americans who need it most. The first step is passage of the Elder Justice bill. What we learn from the many studies and demonstration projects and data collected, as outlined in the bill, will dictate the next steps.

Endnote

1. The Elder Justice Act of 2002 was announced first in May 2002 and was introduced as S. 2933 at the close of the 107th Senate.

Senator John Breaux (D-Louisiana) is the Ranking Member of the Special Committee on Aging, where he served as Chairman during the 107th Congress. In addition, he is a senior member of the Finance Committee, where the Elder Justice bill was referred.

Senator Orrin Hatch (R-Utah) is the Chairman of the Judiciary Committee and a member of the Special Committee on Aging. In addition, he is a senior member of the Finance Committee, the committee of jurisdiction over the Elder Justice bill.

Elder Abuse: A National Approach Is Needed

By Eleanor M. Crosby

Introduction

As our population has aged, the problem of elder abuse has begun to gain attention at the federal, state and local levels. However, elder abuse is by no means a new phenomenon. In fact, Congress has been debating the problem of elder abuse for over twenty years. In 1980, committees in both the House and the Senate held hearings on the problem and gathered information from experts. In 1981, the House Select Committee on Aging issued a report that concluded that 4% of adults over age 65, or one million seniors nationwide, were victims of abuse.[1] Nevertheless, researchers have long believed that the reported incidence of elder abuse falls far short of capturing the real extent of the issue.

This article examines the problem of elder abuse, examines civil and criminal law responses to the problem under applicable New York law, and provides an overview of a proposed federal response to this dilemma.

Scope of the Problem

Since the report in 1981, Congress has continued to study the issue by holding hearings, collecting testimony and funding research on elder abuse. Through each of these examinations, Congress noted the discrepancy between funding for child protection services and funding for adult protection services. The 1981 report recommended that Congress follow a similar approach to that employed to combat child abuse and pass an elder abuse law at the federal level modeled after the "Child Abuse Prevention and Treatment Act" of 1974.[2]

Representative Claude Pepper, himself then a senior and widely known in Congress as an advocate for older Americans, issued a report in 1985 as Chair of the Subcommittee of Health and Long Term Care of the U.S. House Select Committee on Aging. This report mirrored many of the recommendations first made by Congress in 1981, specifically calling for a national approach to the problem modeled after national efforts against child abuse. This report estimated that 1 in 25 older Americans were subject to abuse and that only 1 out of every 5 cases was reported to authorities.[3]

Only five years later, in 1990, the same subcommittee issued a follow-up report. This again called for a national approach to elder abuse to follow the national model for child protection adopted by Congress in 1974. The report highlighted the huge discrepancy in funding and resources devoted to elder abuse as compared to those targeting child abuse.[4] The report also examined problems of abuse in long-term care settings and made recommendations for increased funding and better coordination among programs.

Despite this national attention, elder abuse remains a difficult problem to understand and illuminate. One reason is that little is known about elder abuse, relative to child abuse and other similar crimes. In fact, there has been only one national study exploring the prevalence of elder abuse in our society—the Nation Elder Abuse Incidence Study (NEAIS), which was released in 1998. This study was mandated by Congress and funded by the Administration on Aging and the Administration for Children and Families. The NEAIS was conducted by the National Center on Elder Abuse and used two methods to collect data to attempt to determine the severity of the problem.

The study looked at local data using a representative national sample from 20 counties in 15 states. The survey considered reports received by local adult protective services agencies as well as reports from 1,100 local community "sentinels" who were comprised of specially trained employees of agencies or businesses likely to come into contact with older persons. Sentinels were senior center directors, home care workers, law enforcement, medical professionals, financial personnel, and others in a position to encounter potential victims of abuse, neglect or exploitation.

However, many older persons live alone and are isolated from friends and family, limiting their opportunities to come into contact with those trained to recognize and report potential abuse. Unlike children, who usually come into contact with teachers and others in the community on a daily basis, isolated, abused elders may not be readily identified by those in a position to help. The NEAIS had no reliable way to survey this part of the population.

Nevertheless, the findings of the NEAIS were surprising and concerning. The study estimated that spouses or relatives had committed almost 90% of abuse, neglect or exploitation. This figure was consistent with both adult protective services and sentinel data. Older adults (those who are 80+) comprised around half of all victims in the study but were only 19% of the population at that time. With the exception of abandonment, the vast majority of elder abuse victims studied were female.[5]

Based on the data collected, the NEAIS estimated that less than 20% of all elder abuse cases are reported. And, of those cases that are reported, the study found that the majority of reports were substantiated by investigators. Given the results of that groundbreaking study, researchers concluded that elder abuse is a hidden problem and that we have little idea of its true scope and impact on our older population.

Although reports and data collection are not yet standardized across states, in recent years, the National Association of Adult Protective Services Administrators (NAAPSA) has begun to track and record state data on elder/adult abuse in order to gain a national perspective on the problem. In 2003, the National Center on Elder Abuse will release a NAAPSA study showing that adult protective service programs received almost 500,000 reports of elder/adult abuse during the study period.[6]

The Role of the Attorney

Many attorneys learn about elder law through attempts to help an older friend or family member. As attorneys, our families and friends often expect us to know about all areas of law, whether we are experienced in a particular area or not. Attorneys are in a unique position to know a family over time, understand a client's underlying values, and become aware of changes over time that may be cause for concern. Because we have every reason to believe that the incidence of elder abuse is much greater than documented reports indicate, it is important that those who come into contact with older persons or their families are aware of the potential problem and familiar with laws and programs designed to combat abuse, neglect and exploitation.

The law in this area often struggles to find the appropriate balance between protection of the autonomy of an older person and the need to protect a vulnerable person from harm. If a court has not adjudicated someone as incapacitated, then it is assumed that this person has the right to make decisions for him or herself, even when those decisions might not seem to be in his or her best interest. Advocates sometimes call this "the right to folly." This philosophy underlies the approach taken in New York State by protective services workers. An older client who has not been adjudicated as incapacitated is presumed to be able to make choices and to refuse the services offered.[7]

Under the New York statute governing Adult Protective Services, a case worker can provide assistance with the client's consent, or petition the court, when a client lacks capacity and yet needs assistance. In these cases, a client has the right to have an attorney present at the hearing, and the court may appoint a guardian *ad litem*, as well.

"Because we have every reason to believe that the incidence of elder abuse is much greater than documented reports indicate, it is important that those who come into contact with older persons or their families are aware of the potential problem and familiar with laws and programs designed to combat abuse, neglect and exploitation."

Definition of Elder Abuse

One problem encountered by researchers in the NEAIS concerned the variety of ways elder abuse is defined in the states, because there is no uniform national definition of elder abuse. States address the problem of elder abuse in a variety of ways, including both civil and criminal responses in their codes. Typically, elder abuse is defined by statute to include physical or psychological abuse, neglect or deprivation, and exploitation. New York law follows this general pattern, with the definitions of elder abuse found in Chapter 395 of the Social Service Laws of 1995 and in the Adult Protective Services Law. Although self-neglect is arguably not abuse, some states, including New York, include self-neglect in their elder abuse statutes.

Elder abuse laws are designed to protect dependent adults in the community as well as those in long-term care settings. In New York, abuse laws cover "dependent adults," meaning not only those

who are dependent due to age, but also those younger adults who are dependent because of a physical or mental disability.

Physical Abuse

The statute defines physical abuse as "(T)he non-accidental use of force that results in bodily injury, pain, or impairment, including but not limited to, being slapped, burned, cut, bruised or improperly physically restrained."[8] Indicators of physical abuse include bilateral injuries, burns, broken bones, or abrasions, among other physical injuries. Examples of physical abuse include domestic violence, improper use of restraints to confine a person, or other acts that cause a physical injury to a dependent adult.

Neglect

The New York statute addresses two types of neglect, active and passive. Active neglect is defined as "the willful failure by the caregiver to fulfill the caretaking functions and responsibilities assumed by the caregiver, including abandonment, willful deprivation of food, water, heat, clean clothing and bedding, eyeglasses or dentures, or health-related services."[9] Passive neglect "means non-willful failure of a caregiver to fulfill care-taking functions and responsibilities assumed by the caregiver, including but not limited to, abandonment or denial of food or health related services because of inadequate caregiver knowledge, infirmity, or disputing the value of prescribed services."[10]

Indicators of both passive and active neglect include malnourishment, pressure sores, and failure to bathe or to properly clothe for the weather, among other things. Examples of neglect include denial of food, clothing, heat, or needed medical or dental care or essential services.

Self Neglect

Although arguably not elder abuse, the statute addresses self-neglect, gives Adult Protective Services authority to investigate and intervene in cases involving extreme self-neglect, and defines it as follows:

> "Self neglect" means an adult's inability, due to physical and/or mental impairments to perform tasks essential to caring for oneself, including but not limited to, providing essential food, clothing, shelter and medical care; obtaining goods and services necessary to maintain physical health, mental health, emotional well-being and general safety; or managing financial affairs.[11]

Indicators of self-neglect include but are not limited to absences of necessities including food, water or utilities, lack of or inadequate shelter or living environment, malnourishment and/or weight loss, untreated medical or mental conditions and failure to pay bills.

Exploitation

New York law defines financial or material exploitation as "(T)he improper use of an adult's funds, property or resources by another individual, including but not limited to, fraud, false pretenses, embezzlement, conspiracy, forgery, falsifying records, coerced property transfers or denial of access to assets."[12]

Indicators of financial exploitation include improper use of an adult's funds for one's own benefit, misappropriation of bank funds, and theft of property or services. Examples of exploitation include stealing from a dependent adult, improper use of his or her Social Security check or other resources, or failure to deliver purchased goods or services.

Sexual Abuse

Sexual abuse is defined in the statute as "non-consensual sexual contact of any kind, including, but not limited to, forcing sexual contact or forcing sex with a third party."[13]

Indicators of sexual abuse are more likely to be encountered by health care personnel, but include unreasonable fear of another, vaginal bleeding or sores, and unexplained appearance of a sexually transmitted disease. Examples of sexual abuse include rape, sodomy, and improper touching or fondling of a dependent adult.

Emotional Abuse

The Adult Protective Services statute also includes emotional abuse in its scope. Under New York law, "emotional abuse" means willful infliction of mental or emotional anguish by threat, humiliation, intimidation or other abusive conduct, including but not limited to, frightening or isolating an adult."[14]

Indicators of emotional abuse include isolation, loss of interest in activities previously valued, depression, fearfulness, constant crying and hopelessness. Examples of emotional abuse are threats to

place an elder in a nursing home, threats of abandonment, blaming, yelling, and forced isolation from friends and family.

Civil Statutes

Differences in state laws extend beyond definitions, however. Some states require that certain categories of people (medical professionals, social workers, etc.) report suspected cases of abuse to protective services or law enforcement while other states make such reports discretionary. New York falls into the latter category, by not mandating reports of abuse to authorities. Reports in New York are confidential and should be made to the local protective services office, which will investigate and attempt to resolve the problem. Other civil statutes may apply to the area of elder abuse, particularly in cases where financial exploitation or fiduciary abuse is present. Attorneys should consider a full range of responses, and use either civil or criminal statutes, or both, to address a client's particular issues in a way that meets the client's goals.

Criminal Law

All general criminal laws apply to situations in which the victim is a senior. Unlike some other states, New York laws do not include enhanced criminal or civil penalties where the victim is an older or vulnerable adult. However, one law that may be helpful in cases involving a volatile family situation is the state law governing orders of protection.[15] In New York, an order of protection may be issued by either a Family Court (where the abuser is or was related by blood or marriage to the victim, among other things) or the Town Court (where a criminal charge has been filed and signed by the victim or an officer). Protective orders are designed to address family violence situations, however, and may not always be the most appropriate course in a case involving elder abuse. Because many older victims are ashamed or afraid to report abuse, many states have expanded the use of warrantless arrest statutes to cover incidents of elder abuse. New York law governing protective orders allows an arrest to be made, at the officer's discretion, in cases involving the violation of a protective order.

As mentioned above, protective orders are not always the best option for an older victim of family violence, because the victim may not be willing or able to testify, may be fearful of abandonment by the abuser and unable to live independently at home. Nevertheless, such an order can be an effective tool in certain cases. Protective orders can order the abusive behavior to stop, order the perpetrator to stay away from the victim, or order the abuser to leave a shared residence. Because an older victim may need special assistance in order to navigate the court system, some jurisdictions have begun to develop special court projects (such as Senior Victim Advocates or TRIAD programs) to address the needs of older victims and guide them through the criminal process.

New York Programs

New York has a number of programs designed to prevent and combat elder abuse in the community. S. 554-b established an Elder Abuse Education and Outreach Program under the auspices of the New York State Office for Aging. This state office funds a number of local and regional elder abuse prevention projects, whose goal is to educate the public, seniors, families and caregivers about all problems related to elder abuse. At the local level, there are a variety of programs and services that exist to combat elder abuse. Information on these programs can be obtained through the state Office for the Aging or from a local or regional area agency on aging, the office that coordinates and funds all services to seniors within a designated region.

S. 844-b authorized the creation of a statewide multidisciplinary task force on crimes against seniors, entitled "The New York State Committee for the Coordination of Police Services to Elderly Persons." This committee is to meet at least twice a year, study issues related to crimes against the elderly in New York, and make recommendations as to the need for programs (such as TRIADS, where law enforcement and older individuals meet regularly at the local level to address victimization of older New York residents).

A National Approach to Elder Abuse

The Elder Justice bill is currently pending in Congress and seeks to take a national approach to the problem of elder abuse. Introduced in February 2003 by Senators John Breaux and Orrin Hatch, the proposal would:

a) coordinate efforts and develop leadership at the national level, by creating an Office of Elder Justice within the Department of Justice and the Department of Health and Human Services, creating a federal home and secure funding for adult protective services activities at the federal level, and creating a public and private Elder Justice Coordinating Council to

assure coordination of efforts at all levels and to fund and assist such entities at the state and local levels;

b) create an "Elder Justice Research Center" and library to educate the public and to provide information on the prevention of elder abuse and best practices in addressing the problem to interested entities throughout the country, funding research entities throughout the country to better develop our knowledge base on the issue, including the area of "at risk" elders, providing a focus on the development of forensic capacity in the area of elder abuse, and increasing the capacity of prosecutors throughout the country to bring elder abuse charges;

c) develop resources to protect consumers, increase collaboration and prevent abuse in long-term care settings; and

d) evaluate funded projects and research to identify successful approaches to elder abuse prevention, prosecution, and victim services.

Through the above mechanisms, the Act would provide funding to projects at the state and local levels and would strengthen and support the work of adult protective services, local law enforcement and aging services providers. It would result in increased prosecution of elder abuse cases at the federal and state level as well as stricter sentencing guidelines.

Conclusion

As the number of older Americans continues to grow dramatically over the next several decades, it will become even more important to have increased understanding and knowledge of the crime of elder abuse and its impact on victims and families. States and local communities are making efforts to address problems and prevent further harm, but the demand for services in many places far exceeds available resources. More research is needed in this area in order to address effectively the myriad of issues related to elder abuse. The time has come for a comprehensive approach to elder abuse.

Endnotes

1. House Select Comm. on Aging, Elder Abuse: An Examination of a Hidden Problem (Apr. 1981).
2. *Id.*
3. Subcomm. on Health and Long-term Care, House Select Comm. on Aging, Elder Abuse: A National Disgrace (1985).
4. Subcomm. on Health and Long-term Care, House Select Comm. on Aging, Elder Abuse: A Decade of Shame and Inaction (1990).
5. National Elder Abuse Incidence Study, National Center on Elder Abuse, in collaboration with Westat, Inc. (Sept. 1998).
6. P.B. Teaster & Colleagues, "A response to the abuse of vulnerable adults: The 2000 survey of states Adult Protective Services," National Center on Elder Abuse (2003).
7. N.Y. Adult Protective Servs. Law (tit. 19B) § 473 ("Adult Protective Servs. Law").
8. Adult Protective Servs. Law § 473(6)(a).
9. Adult Protective Servs. Law § 473(6)(d).
10. Adult Protective Servs. Law § 473(6)(e).
11. Adult Protective Servs. Law § 473(6)(f).
12. Adult Protective Servs. Law § 473(6)(g).
13. Adult Protective Servs. Law § 473(6)(b).
14. Adult Protective Servs. Law § 473(6)(c).
15. S. 459(a) (Domestic Violence Prevention Act).

*The National Committee for the Prevention of Elder Abuse is a partner in the National Center on Elder Abuse, which is funded through the U.S. Administration on Aging, grant # 90AP2144.

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Elder Abuse

By Greg Olsen

Most people find it hard to imagine that elder abuse can happen. The thought of physically, sexually, emotionally or financially abusing an older and/or vulnerable individual is difficult to comprehend and understand. Elder abuse, like other types of domestic violence, is extremely complex. Many experts and researchers believe that the problem is underreported and that we will never really know the true scope of the problem. This is due to many factors associated with reporting and the difficulties individuals and family members have in reporting this type of abuse.

Generally, a combination of psychological, social, and economic factors, along with the mental and physical conditions of the victim and the perpetrator, contribute to the occurrence of elder maltreatment. Federal definitions of elder abuse, neglect, and exploitation appeared for the first time in the 1987 Amendments to the Older Americans Act. These definitions were provided in the law only as guidelines for identifying the problems and not for enforcement purposes.

State laws define elder abuse, and state definitions vary considerably from one jurisdiction to another in terms of what constitutes the abuse, neglect, or exploitation of the elderly. In general, however, there are three basic categories of elder abuse:

- **domestic elder abuse**—refers to any of several forms of maltreatment of an older person by someone who has a special relationship with the elder (e.g., a spouse, a sibling, a child, a friend, or a caregiver).
- **institutional elder abuse**—refers to any of the above-mentioned forms of abuse that occur in residential facilities for older persons (e.g., nursing homes, foster homes, group homes, board and care facilities). Perpetrators usually are persons who have a legal or contractual obligation to provide elder victims with care and protection (e.g., staff, paid caregivers, etc.).
- **self-neglect or self-abuse**.

In 1996, the Administration on Aging (AoA), the federal agency that administers dollars to the states under the Older Americans Act, commissioned a study to document the extent of elder abuse in the United States. Called the National Elder Abuse Incidence Study (NEAIS), the study estimates the incidence of abuse, neglect and self-neglect of persons 60 years and older. The best national estimate is that a total of 449,924 elderly persons, aged 60 and over, experienced abuse and/or neglect in domestic settings in 1996. The best national estimate is that a total of 551,011 elderly persons experienced abuse, neglect and/or self-neglect in institutional settings in 1996.

Types of Abuse

Physical Abuse

Physical abuse is defined as the use of physical force that may result in bodily injury, physical pain, or impairment. Physical abuse may include but is not limited to:

- striking (with or without an object), hitting, beating, pushing, shoving, shaking, slapping, kicking, pinching, and burning,
- inappropriate use of drugs and physical restraints,
- force-feeding, and
- physical punishment of any kind.

Signs of Physical Abuse

- bruises, black eyes, welts, lacerations, and rope marks;
- bone fractures, broken bones;
- open wounds, cuts, punctures, untreated injuries in various stages of healing;
- sprains, dislocations, and internal injuries/bleeding;
- broken eyeglasses/frames, physical signs of being subjected to punishment, and signs of being restrained;
- an elder's report of being hit, slapped, kicked, or mistreated;
- an elder's sudden change in behavior; and
- the caregiver's refusal to allow visitors to see an elder alone.

Sexual Abuse

Sexual abuse is defined as non-consensual sexual contact of any kind with an elderly person. Sexual contact with any person incapable of giving consent is also considered sexual abuse. It includes but is not limited to unwanted touching, and all types of sexual assault or battery such as rape, sodomy, coerced nudity, and sexually explicit photographing.

Signs and symptoms of sexual abuse include but are not limited to:

- bruises around the breasts or genital area;
- unexplained venereal disease or genital infections;
- unexplained vaginal or anal bleeding;
- torn, stained, or bloody underclothing; and
- an elder's report of being sexually assaulted or raped.

Emotional or Psychological Abuse

Emotional or psychological abuse is defined as the infliction of anguish, pain, or distress through verbal or nonverbal acts. Emotional/psychological abuse can include assaults, insults, threats, intimidation, humiliation, or harassment, or the isolation of an elderly person from his/her family, friends, or regular activities.

Signs of emotional/psychological abuse include:

- being emotionally upset or agitated;
- being extremely withdrawn and non-communicative or non-responsive;
- an elder's report of being verbally or emotionally mistreated.
- unusual behavior usually attributed to dementia (e.g., sucking, biting).

Neglect

Neglect is defined as the refusal or failure to fulfill any part of a person's obligations or duties to an elder. Neglect may also include failure of a person who has fiduciary responsibilities to provide care for an elder (e.g., pay for necessary home care services) or the failure on the part of an in-home service provider to provide necessary care.

Signs of neglect include:

- dehydration, malnutrition, untreated bed sores, and poor personal hygiene;
- an elder's report of being mistreated;
- unsanitary and unclean living conditions (e.g. dirt, fleas, lice on person, soiled bedding, fecal/urine smell, inadequate clothing);
- unattended or untreated health problems; and
- hazardous or unsafe living conditions/arrangements (e.g., improper wiring, no heat, or no running water).

Abandonment

Abandonment is defined as the desertion of an elderly person by an individual who has assumed responsibility for providing care for an elder, or by a person with physical custody of an elder.

Signs of abandonment include:

- the desertion of an elder at a hospital, a nursing facility, or other similar institution;
- the desertion of an elder at a shopping center or other public location; and
- an elder's own report of being abandoned.

Financial or Material Exploitation

Financial or material exploitation is defined as the illegal or improper use of an elder's funds, property, or assets. Examples include cashing an elderly person's checks without authorization/permission; forging an older person's signature; misusing or stealing an older person's money or possessions; coercing or deceiving an older person into signing any document (e.g., contracts or will); and the improper use of conservatorship, guardianship, or power of attorney.

Signs of financial or material exploitation include:

- sudden changes in bank account or banking practice, including an unexplained withdrawal of large sums of money by a person accompanying the elder;
- substandard care being provided or bills unpaid despite the availability of adequate financial resources;
- unexplained disappearance of funds or valuable possessions;
- the inclusion of additional names on an elder's bank signature card;
- unauthorized withdrawal of the elder's funds using the elder's ATM card;
- abrupt changes in a will or other financial documents;

- discovery of an elder's signature being forged for financial transactions or for the titles of his or her possessions;
- sudden appearance of previously uninvolved relatives claiming their rights to an elder's affairs and possessions;
- an elder's report of financial exploitation;
- unexplained sudden transfer of assets to a family member or someone outside the family; and
- the provision of services that are not necessary.

Self-neglect

Self-neglect is characterized as the behavior of an elderly person that threatens his or her own health or safety. Self-neglect generally manifests itself in an older person as a refusal or failure to provide himself or herself with adequate food, water, clothing, shelter, personal hygiene, medication (when indicated), and safety precautions. The definition of self-neglect *excludes* a situation in which a mentally competent older person, who understands the consequences of his or her decisions, makes a conscious and voluntary decision to engage in acts that threaten his or her health or safety as a matter of personal choice.

Signs of self-neglect include:

- dehydration, malnutrition, untreated or improperly attended medical conditions, and poor personal hygiene;
- inappropriate and/or inadequate clothing, lack of the necessary medical aids (e.g., eyeglasses, hearing aids, dentures);
- unsanitary or unclean living quarters (e.g., animal/insect infestation, no functioning toilet, fecal/urine smell);
- hazardous or unsafe living conditions/arrangements (e.g., improper wiring, no indoor plumbing, no heat, no running water); and
- grossly inadequate housing or homelessness.

Who Are the Perpetrators of Elder Abuse?

More than two-thirds of elder abuse perpetrators are family members of the victims, typically serving in a caregiving role. Many times, spouses make up a large percentage of elder abusers, and a substantial proportion of these cases are "domestic violence grown old": partnerships in which one member of a couple has traditionally tried to exert power and control over the other through emotional abuse, physical violence and threats, isolation, and other tactics.

In the case of adult children, abusers often are dependent on their victims for financial assistance, housing, and other forms of support. Oftentimes they need this support because of personal problems such as mental illness, alcohol or drug abuse, or other dysfunctional personality characteristics. The risk of elder abuse seems to be particularly high when these adult children live with the elder.

Which State and Local Agencies Are Helping Victims and Their Families Involved in Elder Abuse?

When domestic elder abuse occurs, it can be addressed—if it comes to the attention of authorities. In most states, the Adult Protective Services (APS) agency, typically located within the human service agency, is the principal public agency responsible for both investigating reported cases of elder abuse and for providing victims and their families with treatment and protective services. In New York, the county departments of social services maintain an APS unit that serves the need of local communities.

However, many other public and private agencies and organizations are actively involved in efforts to protect vulnerable older persons from abuse, neglect, and exploitation. Some of these agencies include: the state unit on aging; the law enforcement agency (e.g., the police department, the district attorney's office, the court system, the sheriff's department); the medical examiner/coroner's office; hospitals and medical clinics; the state long-term care ombudsman's office; the public health agency; the area agency on aging; the mental health agency; and the facility licensing/certification agency. Depending on the state law governing elder abuse, the exact roles and functions of these agencies vary widely from one jurisdiction to another.

Although most APS agencies also handle adult abuse cases (where clients are between 18 and 59 years of age), nearly 70 percent of their caseloads involve elder abuse. The APS community is relatively small compared with the groups working for other human service programs, but it is composed of a few thousand professionals, nationwide.

New York State Numbers for Reporting Elder Abuse

Many states have instituted a 24-hour toll-free number for receiving reports of abuse. Calls are confidential.

National ELDERCARE LOCATOR—(800) 677-1116

New York State Office for the Aging Information Line
(800) 342-9871

New York State Domestic Violence Hotline
(800) 942-6906 (English)
(800) 942-6908 (Spanish)

New York State Crime Victims Hotline
(800) 771-7755

New York State Attorney General
Crime Victims Hotline: (800) 771-7755
Web site—http://www.oag.state.ny.us/contact.html

Criminal Division

In New York State, doctors and other medical professionals are required to report suspected cases of elder abuse. If you suspect a friend or relative is being abused, speak to your doctor or contact your local police or the Attorney General's Criminal Division.

Regional Offices:

Binghamton
44 Hawley Street, 17th Floor
Binghamton, NY 13901-4433
(607) 721-8778

Brooklyn
55 Hansen Place
Brooklyn, NY 11217-1523
(718) 722-3949

Hauppauge
300 Motor Parkway
Hauppauge, NY 11788-5127
(631) 231-2400

Harlem
163 West 125th Street
New York, NY 10027-8201
(212) 961-4475

Mineola
200 Old Country Road
Mineola, NY 11501-4241
(516) 248-3302

Plattsburgh
70 Clinton Street
Plattsburgh, NY 12901-2818
(518) 562-3282

Poughkeepsie
235 Main Street, 3rd Floor
Poughkeepsie, NY 12601-3194
(845) 485-3900

Rochester
144 Exchange Boulevard
Rochester, NY 14614-2176
(585) 546-7430

Syracuse
615 Erie Blvd. W., Suite 102
Syracuse, NY 13210-2339
(315) 448-4800

Utica
207 Genesee St., Room 504
Utica, NY 13501-2812
(315) 793-2225

Watertown
317 Washington Street
Watertown, NY 13601-3744
(315) 785-2444

White Plains
101 East Post Road
White Plains, NY 10601-5008
(914) 422-8755

References

- National Elder Abuse Incidence Study; Final Report, September 1998: http://www.aoa.gov/abuse/report/default.htm
- National Center on Elder Abuse (NCEA): www.elderabusecenter.org

Greg Olsen, M.S.W., is Executive Director of the New York State Coalition for Aging, Inc. (NYSCA), a nonprofit organization representing community-based senior service providers throughout New York State. He has worked in the field of aging as a community organizer and advocate since 1992 as the Assistant Executive Director of the New York Statewide Senior Action Council and the Nutrition Consortium of New York State. He received his master's degree in social work with a specialty in gerontology from Syracuse University and its Maxwell School of Gerontology. He is currently a board member of Common Cause New York and Legislative Director for the New York State Association of Nutrition and Aging Service Programs (NYSANASP). He serves on various other committees, and speaks at local, state and national conferences on a variety of topics relating to aging.

New York Case News

By Judith B. Raskin

Article 81

Petitioner appealed the denial of her appointment as Article 81 guardian for her mother for lack of jurisdiction where petitioner brought her mother into New York where she had no property or contacts. Reversed. *In re Verna HH*, 92039 (3d Dep't, Feb. 13, 2003).

Verna HH had been living in Kentucky for ten years with one of her children when petitioner, another child of Verna HH, went to Kentucky and brought her mother to New York. Once in New York, petitioner brought an Article 81 proceeding seeking her appointment as guardian for her mother. Respondent, Verna's child living in Kentucky, argued that New York Supreme Court did not have jurisdiction or in the alternative, should decline the case based upon *forum non conveniens*. The Supreme Court held it did not have jurisdiction based upon lack of property and insufficient contacts in New York. Petitioner appealed.

The Third Department reversed, holding that physical presence in New York is sufficient. Mental Hygiene Law § 81.04 provides for the appointment of a guardian for "a nonresident of the state present in the state." The court dismissed the *forum non conveniens* argument, stating that the respondent had not sufficiently shown that New York was an inconvenient forum.

Attorney appealed from an order in an Article 81 proceeding granting him a fee he deemed insufficient. Order modified. *In re Tijuana M.*, 2002-03919 (2d Dep't, Feb. 26, 2003).

In an Article 81 proceeding, the Supreme Court, Queens County, awarded the attorney a fee of $1,000 from the incapacitated person's funds. The attorney appealed, arguing that his fee was insufficient.

The Second Department modified the order by awarding the attorney a fee of $8,250. Although the lower court has discretion in determining fees, it failed to explain the basis upon which the fee was determined. The required explanation must refer to:

> "(1) the time and labor required, the difficulty of the questions involved, and the skill required to handle the problems presented, (2) the attorney's experience, ability, and reputation, (3) the amount involved and the benefit flowing to the ward as a result of the attorney's services, (4) the fees awarded in similar cases, (5) the contingency or certainty of compensation, (6) the results obtained, and (7) the responsibility involved."

Petitioner, an Article 81 guardian, brought an article 78 proceeding seeking a writ of mandamus compelling respondent, a Supreme Court Justice, to hold a timely hearing to modify an Article 81 order. Granted. *In re Levy*, 756 N.Y.S.2d 35 (1st Dep't, 2003).

Rita Levy, a diabetic and suffering from dementia, had been hospitalized due to her refusal to take insulin treatments at home. Hospital personnel advised her Article 81 guardian that the only safe discharge would be to a nursing home where her condition and treatment would be monitored. When Ms. Levy refused nursing home placement, the guardian petitioned to modify the order to permit him to permanently place Rita Levy in a nursing home. Supreme Court Justice William J. Davis referred the matter of involuntary placement to a Special Referee "to hear and report." The Special Referee scheduled a hearing for a date three months after the request for modification was filed. Meanwhile, Rita Levy remained in the hospital, incurring costs of over $100,000.

The guardian brought an article 78 proceeding seeking a writ of mandamus vacating the order appointing the Special Referee and compelling a timely hearing on the issue of involuntary nursing home placement.

The First Department vacated the order and required the respondent, Justice Davis, to hold a hearing within 14 days and render a decision within the time limits set forth in section 81.13. Without good cause, the respondent was required to conduct a hearing in accordance with the time limits set forth in section 81.36. The court rejected respondent's argument that the time requirements of 81.36 apply only to proceedings for the appointment of a

guardian and stated that the same procedural requirements should apply to modification proceedings and all other proceedings brought under Article 81. In addition, a Special Referee cannot be appointed in an Article 81 proceeding because the judge's experience is necessary in evaluating testimony.

Thank you to James H. Cahill, Jr., Esq., Brooklyn, for going out of his way the day after the birth of his daughter to find this case for me.

Supplemental Needs Trust

Petitioner sought a court ordered supplemental needs trust (SNT) for his benefit without the appointment of a guardian. Granted. *In re Gillette*, N.Y.L.J., Apr. 4, 2003, p. 23, col. 3 (Sur. Ct., Broome Co.).

Mr. Gillette was under 65 and the recipient of payments from SSD, SSI and Medicaid. When he received a retroactive award from the Social Security Administration, Mr. Gillette's agent under a power of attorney created a supplemental needs trust (SNT) for Mr. Gillette's benefit to protect the award. The SNT was signed by Mr. Gillette's attorney-in-fact and by the trustee, and the SNT was funded. Upon review of the SNT, Social Security informed Mr. Gillette that because the SNT was not created by a parent, grandparent, legal guardian or court order, the funds in the SNT were countable resources disqualifying him for SSI.

Mr. Gillette then petitioned the court to establish the SNT already created and funded, *nunc pro tunc*. In the petition, Mr. Gillette stated he did not need and did not seek the appointment of a guardian.

The court denied Mr. Gillette's request to establish the SNT already in existence *nunc pro tunc*. *Nunc pro tunc* cannot be granted where a person will be prejudiced. In this case, the Social Security Administration would be prejudiced because it would have to make retroactive SSI payments to Mr. Gillette. Also, an order *nunc pro tunc* cannot be used to correct an improper act. The SNT was already established by Mr. Gillette. He created the SNT (through his attorney-in-fact), the trustee signed it and it was funded.

The court did approve a new SNT. Mr. Gillette's attorney submitted a proposed SNT that the court accepted as an amendment to the petition. The proposed SNT met the requirements of section 366(2)(b)(2). The court approved the new SNT where Mr. Gillette was the grantor. A guardian was not appointed. The expense of a guardianship proceeding was avoided.

Thank you to Beth Polner Abrahams, Esq., Garden City, for sending this case to me and for her helpful comments.

Judith B. Raskin is a member of the law firm of Raskin & Makofsky, a firm devoted to providing competent and caring legal services in the areas of elder law, trusts and estates, and estate administration.

Judy Raskin maintains membership in the National Academy of Elder Law Attorneys, Inc.; the New York State Bar Association, where she is a member of the Elder Law and Trusts and Estates Law Sections; and the Nassau County Bar Association, where she is a member of the Elder Law, Social Services and Health Advocacy Committee, the Surrogate's Trusts and Estates Committee and the Tax Committee.

Ms. Raskin shares her knowledge with community groups and professional organizations. She has appeared on radio and television and served as a workshop leader and lecturer for the Elder Law Section of the New York State Bar Association as well as for numerous other professional and community groups. Ms. Raskin writes a regular column for the *Elder Law Attorney*, the newsletter of the Elder Law Section of the New York State Bar Association, and is a member of the Legal Committee of the Alzheimer's Association, Long Island Chapter. She is past president of Gerontology Professionals of Long Island, Nassau Chapter.

Legislative News

Senate Introduces Bill to Eliminate Spousal Refusal and Impose Harsher Penalties for Transfers of Assets

By Howard S. Krooks and Steven H. Stern

Howard S. Krooks

With New York State experiencing a budget crisis, and the costs of the Medicaid program spiraling out of control, legislation has been introduced in the New York State Senate that would severely restrict Medicaid eligibility. The stated purpose of the new Senate bill (S.4627) is "to limit the ability of individuals with means to avoid responsibility for their long term care needs by transferring assets or by refusing to contribute to the care of a spouse in order to have Medicaid pay for needed care."

Under the bill, section 366(a), subdivision 3, of the Social Services Law would be amended to remove language in that section which allows spouses and other responsible relatives to refuse to contribute toward the cost of care. Social Services Law section 366(e), subdivision 5, would also be amended to a) extend the lookback period for transfers of assets from 36 months to 60 for institutional care, 2) implement a 60-month lookback period/penalty period for home care services (which is not presently penalized under New York law), 3) change the date of commencement of the penalty period from the date of the transfer (actually, the month following the month of transfer under *Brown v. Wing*, 693 N.Y.S.2d 475 (1999)) to the date of the application for benefits. Finally, the bill directs the Commissioner of Health to apply for any federal waivers as "may be necessary within 60 days to carry out the provisions of" the bill. An immediate effective date is called for under the bill as proposed, and would apply to applications and recertifications for Medicaid submitted on or after February 1, 2004.

The stated justification for the bill, as set forth in the Sponsor's Memorandum, is as follows:

> Medicaid was envisioned and designed as a program to care for the poor. It has become a program which, in large part, also provides long term care to those who would never be considered poor. Instead, advanced planning has encouraged families to use various means, including transferring assets, in order to qualify their loved ones for Medicaid and have state taxpayers foot the bill.

Steven H. Stern

> New York State has been very generous and particularly sensitive to the issues involved. We are one of the first and only states to have established a long term care insurance program and a tax credit for its purchase. Importantly, we also have strong spousal impoverishment laws. However, we cannot continue to place the burden of long term care expenses on the backs of state tax payers when those families often have significant resources to cover the expenses or insure against the risk.
>
> Nobody expects taxpayers to build them a new house if they suffer loss in a fire. Instead they protect themselves with insurance. Most people are not insuring themselves against the risk of long term care expenses because they have Medicaid—the state—to cover that risk with some relatively simple advanced planning.
>
> New York State can no longer afford to pay the rising costs of Medicaid for those who were not intended to be covered.

Editors' Comment—by introducing this bill on April 14, 2003, New York State joined a growing number of states that are grappling with limited resources and rising health care costs. The following points are worth noting:

- Under a proposal now pending before the United States Department of Health and Human Services, the Connecticut Department of Social Services is seeking an 1115 Medicaid Waiver from the otherwise applicable federal Medicaid rules that would delay the date a penalty period begins to run until the person applies for Medicaid. Furthermore, the Connecticut proposal would create a 60-month lookback period for transfers of real property (which is presently subject to a 36-month lookback period). There are serious issues with the Connecticut proposal in that the waiver requested does not further the objectives of the Medicaid program but merely restricts Medicaid eligibility (*see* Daniel G. Fish, *Connecticut 1115 Medicaid Waiver Proposal*, N.Y.L.J. , March 12, 2003).
- Minnesota's Department of Human Services has asked for permission from The Centers for Medicare and Medicaid Services to extend its lookback period for transfers of assets from 36 months to 72 months, thereby doubling the lookback period. Minnesota sought permission for a similar change in 1996, which was formally rejected in 2000.
- Massachusetts is considering a bill (H. 3732) that would seek a federal waiver that would treat annuities similar to trusts (thereby exposing them to a 60-month lookback period) and require Massachusetts to become named beneficiary to the extent of benefits provided, start the penalty period when an individual enters a nursing home or when he or she applies for Medicaid (called MassHealth), whichever is later, and expand the lookback period to 60 months for all asset transfers.
- With respect to the New York bill, spousal refusal is not only permissible, but is required pursuant to 42 U.S.C. § 1396r-5(c)(3). Furthermore, by extending the lookback period to 60 months across the board, rather than limiting this period solely to transfers involving trusts (mandated by OBRA 1993), New York would be adopting a more restrictive approach to Medicaid eligibility than is permitted under currently applicable federal Medicaid rules.

Howard S. Krooks is a partner in the law firm of Littman Krooks LLP, with offices in New York City and White Plains. Mr. Krooks devotes substantially all of his professional time to elder law and trusts and estates matters, including representing elderly clients and their families in connection with hospital discharge and nursing home admission issues, preservation of assets, Medicaid, guardianship and related elder law matters. Mr. Krooks is Chair-Elect of the Elder Law Section of the New York State Bar Association. Mr. Krooks co-authored a chapter ("Creative Advocacy in Guardianship Settings: Medicaid and Estate Planning, Including Transfer of Assets, Supplemental Needs Trusts and Protection of Disabled Family Members") included in *Guardianship Practice in New York State*, a book published by the New York State Bar Association. Mr. Krooks has lectured frequently on a variety of elder law topics for the National Academy of Elder Law Attorneys, the National Guardianship Association and the New York State Bar Association. In addition, Mr. Krooks has served as an instructor for the Certified Guardian & Court Evaluator Training: Article 81 of the Mental Hygiene Law program sponsored by The Association of the Bar of the City of New York.

Steven H. Stern is a partner in the law firm of Davidow, Davidow, Siegel and Stern, LLP, with offices in Islandia and Melville, Long Island. Founded in 1913, the firm concentrates solely in the practice areas of elder law, business and estate planning. Mr. Stern is a member of the National Academy of Elder Law Attorneys and is the current Co-Chairman of the Suffolk County Bar Association's Elder Law Committee. He also serves as a member of the Suffolk County Elder Abuse Task Force's Consultation Team. With a strong commitment to educating the local senior community, he is a frequent speaker and published author and also hosts "Seniors Turn to Stern," a radio program on WLUX dedicated to the interests of seniors and their families.

Practice News

Is Long Term Care Insurance a Part of Your Elder Law Practice?

By Vincent J. Russo

As time goes on, it becomes very clear that long term care insurance will be (and in many cases already is) a necessary tool in the protection of assets in the event one requires long term care. At this time, there is no movement toward a Medicare solution to long term care. The Medicaid program is also under attack both at the federal and state level. With rising deficits, the federal government and New York State are looking for ways to cut services and decrease the number of seniors eligible for Medicaid. Some states are raising the level of care required for Medicaid approval for nursing home care. One state even attempted unsuccessfully to discontinue existing nursing home benefits for residents whose level of care was below the newly raised level.

In light of this climate, seniors concerned about paying for long term care will have to consider long term care insurance as part of an overall asset protection plan. As elder law attorneys, we need to make sure that our practice is meeting the needs of seniors. We are often in a position to advise seniors as to appropriateness of long term care insurance as part of an asset protection plan. As planners, we understand when long term care insurance may make sense. We can also advise clients as to the types of coverage and the amounts of coverage.

There are quality long term care policies on the market today that will cover both nursing home, assisted living, and home care. Since there is no uniformity from one carrier to another and the policy provisions can be complex and confusing, we should educate ourselves on the nuts and bolts of long term care insurance, the different types of policies, and the rating of the various carriers.

Considerations. For seniors of modest means, Medicaid often is the safety net for the payment of this care. For seniors of wealth, the question becomes more complicated. Should the senior purchase long term care insurance to cover the cost of long term care? Should the senior privately pay for this care? Is Medicaid an option when it comes to long term care?

Typically, seniors purchase coverage for a period of time such as three, four or five years. The longer the term of coverage, the higher the annual premium will be. Lifetime coverage will be the most expensive. Often, long term care insurance is the bridge which will allow seniors safe passage against the high cost of catastrophic illness. But if one crosses the bridge (i.e., the coverage term runs out), then it will be critical that appropriate Medicaid planning be implemented. Hence, one of the primary benefits of long term care insurance is that it allows seniors to keep control over their assets.

The elder law attorney should raise the following questions:

Identification of Issues. First, is the senior eligible to purchase the coverage? Currently, there are policies available for seniors who are in their eighties. Next, is the senior insurable? The insurance company will decide whether it is worth the risk to insure any one individual senior. These factors will eliminate a number of seniors from obtaining the insurance. It is important to note that all carriers are not alike; one carrier may insure while another may not. It is also important to be aware that there are independent agents who work with several companies. If denied by one company, the agent can seek coverage from another.

Once we pass this hurdle, we need to look at the coverage provisions. Will the policy actually cover the senior's potential long term care needs? Today, the policies are becoming more comprehensive. Unfortunately, there is no standardization of coverage provisions, so each policy must be carefully examined and compared with other similar policies that are available to the senior. Also, regulation of the insurance companies will vary state by state, which may impact on the quality of the policies issued in a particular state.

Let's say that the senior is insurable and has found a policy which will fit the bill as to coverage. What will be the cost of this insurance? This will be a factor in the senior's decision. The premiums are level, but the cost will be higher if one purchases at a later age. Should one simply purchase the insurance at age 75 instead of at age 55 or even age 65 because statistics tell us the need for care will be much greater for one at age 75, as opposed to age 55 or age 65? Yes, that would make sense if you are a soothsayer and know in advance when you will need the care. That is what insurance is all about. Notwithstanding, this does raise an interesting question as to what is the right age to purchase the insurance. Based upon a number of factors, purchasing the insurance when one is between ages 55 to 70 is typically a good time.

The cost of the insurance will be greatly impacted by whether a rider for inflation is included or not. Whether to purchase the rider will depend upon the age of the insurer, the amount of coverage being purchased, and the cost of long term care in the senior's community.

The Candidate for Long Term Care Insurance. So, who are the seniors that should purchase long term care insurance?

First, *Low Tolerance to Risk.* For seniors who do not like being subject to risk. This is the person who would be upset if he would have to spend his income (or even worse, spend down his principal) for long term care.

Second, *Increase Access to Long Term Care.* For seniors who will not access care if they have to pay privately for such care. In my experience, I have found that some seniors will go without care if they have to pay privately for the care. This is true without regard to the senior's ability to pay for such care. Since most seniors are at home and there is a high degree of likelihood that they will need care at some point during their lives, long term care insurance can cover the cost of necessary long term care and the senior will access such care because of the insurance coverage.

Third, *The Economic Benefit.* The next analysis considers whether the senior will be economically better off by having the insurance if the need for care should arise. Here, we look at the potential for a spend-down of income which would adversely impact the available funds for living expenses. This may occur when the senior is heavily invested in low- or no-income-producing investments or a business—for example, the senior whose assets are all invested in the family farm. It would be devastating to the senior if the family business would have to be sold. There may be insufficient income for the senior's living expenses without liquidating the investment or business.

Is the senior's value system to preserve principal and live off income? This is a very common value system of seniors today, who lived though a depression. The potential loss of this income to pay for long term care makes this senior a candidate for the purchase of long term care.

Fourth, *The Need to Preserve Assets.* Now, let's compound the problem. The monthly cost of care not only exceeds the monthly income but creates a spend-down of principal. Over an extended period of time, there could be a depletion of asset holdings.

There may also be situations where the senior has a legitimate need to preserve principal, such as when the spend-down of principal could impact the economic quality of life of the senior. We need to understand the senior's value system. Is it preservation of assets at all cost? Would the senior prefer to go without the luxuries of life in order to accumulate wealth? Perhaps there is another motive, and that is to make sure there are sufficient assets to take care of a spouse or child who is disabled or to leave the maximum inheritance to one's family.

The Partnership Policy. Long term care insurance and Medicaid can work together to offer the senior a comprehensive long term care plan. In fact, this concept became a reality for New Yorkers with the New York State Partnership for Long Term Care, which allows seniors to purchase a Partnership long term care policy; when the benefits run out, the senior is automatically eligible for New York Medicaid. This type of policy is not for everyone and an elder law attorney is in a position to advise clients as to what strategy is best for the client. With Medicaid limiting access to long term care, Partnership policies that guarantee Medicaid eligibility will become more attractive.

For some seniors, long term care insurance is not an option because either the senior is uninsurable or the policy is unaffordable. In such situations, the elder law attorney can explore other available options for a sound asset protection plan.

The elder law attorney can provide a valuable service in advising clients as to how long term care insurance can be part of a solution as to asset protection, the types of coverage and the amounts of coverage. The attorney can review the proposal of the long term care insurance agent to make sure that it meets the client's objectives. This is another service which seniors are seeking that we can provide as an expansion of our elder law practices.

Can elder law attorneys sell long term care insurance under the New York State Code of Professional Responsibility? If so, would it be appropriate? This is a subject for another day.

Vincent J. Russo, J.D., LL.M., CELA, Managing Shareholder of the law firm of Vincent J. Russo & Associates, P.C. of Westbury, Lido Beach and Islandia, New York, has a Masters of Law in Taxation, and is admitted to the New York, Massachusetts and Florida state bars. Mr. Russo is certified as an elder law attorney by the National Elder Law Foundation and is the co-author of *New York Elder Law Practice*, published by West Group. Mr. Russo is a Founding Member, Fellow and Past President of the National Academy of Elder Law Attorneys, Founding Member and Past Chair of the Elder Law Section, New York State Bar Association and Past Chair of the Legal Advisory Committee of the Long Island Chapter of the Alzheimer's Association. He is also a Co-Founder of the Theresa Alessandra Russo Foundation, which enriches the lives of children with disabilities.

Fair Hearing News

By Ellice Fatoullah and René H. Reixach

We actively solicit receipt of your Fair Hearing decisions. Please share your experiences with the rest of the Elder Law Section and send your Fair Hearing decisions to either Ellice Fatoullah, Esq., at Fatoullah Associates, Two Park Avenue, New York, New York 10016 or René H. Reixach, Esq., at Woods Oviatt Gilman LLP, 700 Crossroads Building, 2 State Street, Rochester, New York 14614. We will publish synopses of as many relevant Fair Hearing decisions as we receive and as is practicable.

In re Appeal of R.A.

Holding

Ellice Fatoullah

A community spouse residing in an assisted living facility may be awarded additional income above the minimum monthly maintenance needs allowance (MMMNA) due to exceptional circumstances that threaten her with significant financial distress, upon a showing that part of the cost of her assisted living facility goes to pay for personal care services, that the services are medically necessary, and that because of the exceptional expenditures she can not meet her expenses on an unadjusted MMMNA, and that her self-sufficiency is threatened.

Facts

The Appellant, age 78, has been in receipt of medical assistance (Medicaid), including institutional care, in the Wellesley Healthcare Center, where the Appellant has resided since May 18, 2001.

On July 19, 2002, the Agency determined that the amount of Appellant's net available monthly income (NAMI) to be applied toward the cost of institutional care is $1,149.68. Appellant's total income, including Social Security and pension income, was $3,187.44. Deducted from Appellant's income was a contribution to the community spouse in the amount of $1,764.88.

The community spouse's Social Security and interest income totaled only $690 per month. After deduction of health insurance and Medicare premiums, the net income available to the community spouse was only $467.12. Since the MMMNA existing at that time was $2,232 per month, Appellant's spouse was awarded a contribution of $1,764.88 per month to bring her up to the MMMNA.

The community spouse sought additional income to meet her allegation of significant financial distress, due to her need to live in an assisted living facility that provides personal care services. The additional personal care services cost approximately $784.75 per month.

The community spouse's physician submitted a letter that the spouse had rheumatoid arthritis, polymyalgia and peripheral vascular disease which limit to her ability to walk and move around due to severe pain. The doctor noted that the spouse is significantly disabled due to these illnesses.

René H. Reixach

The community spouse's monthly expenses are as follows:

Medical Costs	
Prescription co-payments	$265.78
Physician co-payments	$22.50
Dental expenses	$101.82
Insurance	
Life insurance	$121.25
Utilities	
Cable	$37.63
Telephone	$42.00
Residence	
Rent at Prestwick Chase	$1,300
Personal care services	$784.75
Vehicle	
Insurance	$75.00
Gas/maintenance	$40.00
Personal Needs	
Food, necessaries, clothing	$270.00
Church contribution	$166.00
Credit Cards	
JC Penney	$50.00
Trust Co.	$50.00
Macy's	$50.00
Total	**$3,376,73**

On September 16, 2002, the Appellant requested this Fair Hearing.

Applicable Law

Social Services Law section 101 provides that the spouse or parent of a recipient of public assistance, or person liable to become in need thereof, shall, if of sufficient ability, be responsible for the support of such person.

N.Y.C.R.R. title 18, section 360-4.10 provides for the treatment of income and resources when a married Medicaid applicant or recipient requires institutional care, and his or her spouse continues to reside in the community. This section provides, in pertinent part, as follows:

(a) . . . when used in this section:

(2) Community spouse means a person who is the spouse of an institutionalized person and who is residing in the community.

(3) Community spouse monthly income allowance means the amount by which the community spouse's minimum monthly maintenance needs allowance, as defined in paragraph (8) of this subdivision, exceeds the community spouse's otherwise available monthly income, or such greater amount as may be established by fair hearing decision or court order for the support of the community spouse.

(7) Institutionalized spouse means a person: who is in a medical institution or nursing facility and is likely to remain there for at least thirty consecutive days or is receiving home and community-based services provided pursuant to a waiver under Section 1915(c) of the federal Social Security Act and is likely to receive such services for at least thirty consecutive days; and whose spouse is not in a medical institution or nursing facility, and is not likely to receive such home and community based services for thirty consecutive days.

(8) Minimum Monthly Maintenance Needs Allowance ("MMMNA") means an amount equal to one thousand five hundred dollars, to be increased annually by the same percentage as the percentage increase in the federal consumer price index.

(10) Significant financial distress means exceptional expenses which the community spouse cannot be expected to meet from the monthly maintenance needs allowance or from amounts held in resources. Such expenses may be of a recurring nature or may represent major one-time costs, and may include but are not limited to: recurring or extraordinary non-covered medical expenses; amounts to preserve, maintain or make major repairs on the homestead; and amounts necessary to preserve an income-producing asset.

(b) Treatment of Income.

(1) At any time after the commencement of a continuous period of institutionalization, an assessment of the amount of the community spouse's monthly income allowance and/or family allowance may be requested in accordance with subdivision (c) of this section.

(2) Unless rebutted by a preponderance of the evidence, for purposes of determining MA eligibility the following presumptions will apply with respect to the availability of income to an institutionalized spouse.

(i) No income of the community spouse will be considered available to the institutionalized spouse except as provided for in this section.

(ii) Income solely in the name of the institutionalized spouse or the community spouse will be considered available only to that spouse.

(iii) Income in the names of the institutionalized spouse shall be considered available only to that spouse.

(iv) Income in the names of the institutionalized spouse or the community spouse, or both, and also in the name of another person or persons, will be considered available to each spouse in proportion to the spouse's interest or, if in the names of both spouses and no share is specified, one-half of the joint interest will be considered available to each spouse.

(3) The eligibility of an institutionalized spouse for MA for the first month or partial month of institutionalization will be determined by comparing his/her net available income, computed in accordance with section 360-4.6(a)(1) and (2) of this Part, and any income actually contributed by the community spouse, to the appropriate MA or PA income standard for one person. Thereafter, the institutionalized spouses eligibility for MA and liability for the cost of care will be determined in accordance with this section and with sections 360-1.4(c) and 360-4.9 of this Part until the month following the month in which he/she ceases to be an institutionalized spouse.

(4) In determining the amount of the institutionalized spousal income to be applied toward the cost of medical care, services and supplies in accordance with section 360-4.9(b) of this Part, the following items will be deducted from the otherwise available monthly income of the institutionalized spouse in the following order:

(i) a personal needs allowance;

(ii) a community spouse monthly income allowance, but only to the extent that the income is made available to or for the benefit of the community spouse:

(6) If either spouse establishes that the community spouse needs income above the level established by the social services district as the minimum monthly maintenance needs allowance, based upon exceptional circumstances which result in significant financial distress as defined in paragraph 360-4.10(a)(10) of this section, the department must substitute an amount adequate to provide additional necessary income from the income available to the institutionalized spouse.

(iii) Notice of right to a fair hearing. At the time of an assessment or a determination of allowances pursuant to this paragraph, the social service district must provide to each spouse who received a copy of such assessment or determination a notice of the right to a fair hearing under section 358-3.1(g) of this Title. If the assessment or determination is made in connection with an application for MA, the fair hearing notice must be sent to both spouses at the time the eligibility determination is made. Section 358-3.1(g) of this Title provides a fair hearing right to an institutionalized spouse or community spouses, after a determination has been made on the institutionalized spouses MA application, if the spouse is dissatisfied with the determination of the community spouse monthly income allowance, the amount of monthly income determined to be otherwise available to the community spouse, the amount of resources attributed to the community spouse or to the institutionalized spouse, or the determination of the community spouse resource allowance.

Discussion

The uncontroverted evidence establishes that the community spouse is in receipt of the minimum monthly maintenance needs allowance (MMMNA) in the amount of $2,232 for 2002. It is further established that her own total net income is $467.12 and that her husband's community spouse contribution is $1,764.88, to bring her up to the MMMNA. It is undisputed that Appellant's contribution toward the cost of his care is $1,149.68 (his NAMI). Counsel contended that the community spouse needs additional income to cover high prescription expenses and personal care services provided at an adult living facility. He argued that Mrs. A. has severe illnesses, including: severe rheumatoid arthritis; polymyalgia, peripheral vascular disease; glaucoma; asthma; and obstructive pulmonary disease. Counsel submitted a letter, dated July 10, 2002, from Dr. Burchell and a letter dated July 29, 2002, from Dr. Cosgrove, a rheumatologist. Both physicians confirmed Mrs. A's diagnosis and indicated that she suffers from severe joint pain, swelling, fatigue and difficulty walking and moving around, according to their letters. Dr. Burchell noted that Mrs. A is significantly disabled due to her illnesses. Counsel contended that as a result of these illnesses, the community spouse is unable to live by herself and pay privately for an adult living facility, which provides various personal care services, including housekeeping, evening meals, grocery delivery and staff monitoring. He indicated that the housing portion of the rent is approximately $1,300 with heat and utilities included, and the services portion is approximately $784.75.

Counsel also contended that the community spouse has a high prescription cost of approximately $265.79 per month, based on total costs from November 2001 through September 2002 of $2,923.60. He noted that the community spouse had to pay $1,120 for dental work in June and July 2002 to replace two crowns and caps for her teeth. Counsel also submitted copies of canceled checks into evidence.

The community spouse testified that she moved into the Prestwick Chase Adult Living Community after her husband went into a nursing home because she could no longer live by herself. She further testified that she suffers from very painful rheumatoid arthritis and heart problems, which limit her ability to walk, use her hands and climb stairs. Mrs. A indicated that Prestwick Chase provides housekeeping and cleaning services twice a week and 20 dinners a month. She further indicated that, often, she is in too much pain to prepare her dinner and so she can either have it sent to her apartment or, when she feels up to it, walk down to the dining room. Mrs. A stated that an important service at Prestwick Chase is that the staff checks on them in the morning and at night. She further stated that, if she does not go to dinner or open her door in the morning, a staff member calls her room to check on her.

The decision found that the record established that Mrs. A suffered from severe rheumatoid arthritis, polymyalgia and peripheral vascular disease. According to Dr. Burchell, these conditions limit her ability to walk and move around due to severe pain; and she is disabled. Given the undisputed medical documentation, the community spouse's need for housekeeping, meal preparation and monitoring at the adult living facility is reasonable. Personal care services to keep the spouse in the community constitute exceptional services under Chronic Care Medicaid. Further, the record establishes that the community spouse had high prescription costs and a dental bill, which were not covered by health insurance. Medical expenses for the community spouse also constitute exceptional circumstances.

After establishing exceptional circumstances, the community spouse must also show that they threaten her with significant financial distress. A review of Mrs. A's monthly expenses show that she gives $166 per month, or about $2,000 per year, to her church. Although this charitable expense could be used to pay for more essential expenses, the cost of personal care services at Prestwick Chase and her prescription and dental cost threaten her financial self-sufficiency. Based on the figures provided at the hearing, the community spouse's total monthly expenses are $3,376.73, or $1,144.33 above the MMMNA. The Agency should allow additional income above the MMMNA toward the cost of the personal care services for the community spouse, and high prescription costs and dental expenses for the crowns and caps. Accordingly, the case is remanded to the Agency to increase the MMMNA based upon the above.

Fair Hearing Decision

The Agency's determination that Appellant apply net available monthly income (NAMI) in the amount of $1,149.68 toward the cost of institutional care was correct when made.

The Agency is directed to increase the MMMNA to help pay for the community spouse's personal care expenses, prescription costs not covered by insurance and dental expenses for the crowns and caps.

Should the Agency need additional information from the Appellant in order to comply with the above directives, it is directed to notify the Appellant promptly in writing as to what documentation is needed. If such information is required, the Appellant must provide it to the Agency promptly to facilitate such compliance.

Editor's Comment

The case is interesting in the way the decision so clearly separates the need to show both compelling exceptional circumstance as well as the fact that the exceptional expenses would amount to significant financial distress. In other words, Appellant must show both exceptional expenditures as well as the fact that because of the exceptional expenditures the community spouse can not meet her expenses on an unadjusted MMMNA and that her self-sufficiency is threatened.

Also, the case is interesting because it broke down the "hotel" costs from the costs associated with personal care services in an assisted living facility. In discussion with counsel, he advised us that he submitted a letter from the Realtor stating how much a comparable room would cost to rent. Prepared food, which could be delivered to the spouse when needed, was counted as part of personal care expenses. Finally, it is interesting to note that charitable contributions were not disallowed in this case in computing the community spouse's monthly expenses.

The Appellant at this Fair Hearing was represented by Albert B. Kukol, Esq., of Binghamton, New York.

Copies of the Fair Hearing decisions analyzed above may be obtained by visiting the Western New York Law Center, at www.wnylc.net/fairhearingbank.

Ellice Fatoullah is the principal of Fatoullah Associates, with offices in New York City and New Canaan, Conn. She is Chair of the Litigation Committee of the New York State Bar Association's Elder Law Section, a Fellow of the National Academy of Elder Law Attorneys, on the Executive Committee of the Elder Law Section of the Connecticut Bar Association, and a Board Member of FRIA, a New York City advocacy group monitoring quality of care issues in nursing homes. Ms. Fatoullah was the founding Chair of the Elder Law Committee of the New York County Bar Association, founding Chair of the Public Policy Committee to the Alzheimer's Association–NYC Chapter, and a member of its board for seven years. In addition, Ms. Fatoullah was appointed to serve on the New York State Task Force on Long-Term Care Financing, an advisory group created by Governor Pataki and the New York State Legislature to study long-term care reform. She has taught Health Law at both Columbia and New York University Schools of Law, and litigation skills at Harvard Law School. She writes and lectures regularly on issues of concern to the elderly and the disabled. In 2002, the New York State Bar Association's Elder Law Section awarded her their first "Outstanding Practitioner Award" . . . "in recognition of her dedication and achievements in the practice of Elder law."

René H. Reixach is an attorney in the law firm of Woods Oviatt Gilman LLP, where he is a member of the firm's Health Care Group and responsible for handling all health care issues. He is Chair of the Committee on Insurance for the Elderly of the New York State Bar Association's Elder Law Section. Prior to joining Woods Oviatt, Mr. Reixach was the Executive Director of the Finger Lakes Health Systems Agency. Mr. Reixach authors a monthly health column in the *Rochester Business Journal* and has written for other professional, trade and business publications. He has lectured frequently on health care topics. Mr. Reixach has been an Adjunct Assistant Professor in the Department of Health Science at SUNY Brockport. He also appeared as an expert witness on Medicaid eligibility for the New York State Supreme Court. Mr. Reixach also has served on many advisory committees, including the New York State Department of Health Certificate of Need Reform Advisory Committee and the Community Coalition for Long Term Care. Among Mr. Reixach's civic and charitable involvements are serving as a Board Member and President of the Foundation of the Monroe County Bar, President of the Greater Upstate Law Project, and a Board Member of the Yale Alumni Corporation of Rochester.

Elder Care News

Mental Health Issues in the Aging Population—Alcohol Abuse

By Barbara Wolford

I recently attended a conference sponsored by the New York State Coalition for the Aging that addressed issues surrounding mental health and the aging population. I was stunned to hear statistics relating to the number of elders that are affected by but not identified as alcohol or medication abusers. In this article I will address alcohol abuse.

The *Merck Manual of Geriatrics* defines alcohol abuse as "the use of alcohol to such an extent that causes physical or psycho-social harm." Physiologic dependence implies tolerance (i.e., greater amounts are needed to get the same effect) and withdrawal symptoms arise when consumption ceases. According to Glantz (1985), abuse is defined as a deliberate use of a substance that requires that the frequency of use, or the substance itself, is somehow inappropriate or improper with the substance used despite knowledge that undesirable physical, psychological or social consequences are likely to result. In contrast, misuse is characterized by inadvertency, and with seniors often involves persons other than the user. These others may be family members, caregivers or friends. It should be noted that misuse over time can become abuse.

As the population continues to age, health care professionals will be working with a greater number of elders with complex interrelated medical, psychosocial, legal, ethical and financial issues. Substance abuse (alcohol and prescription drugs) among adults 60 and older is one of the fastest growing health problems that we are facing.

From 2% to 10% of community-based elders meet the criteria for alcohol abuse or dependence. Prevalence of heavy drinking in the elderly is 6% of the population. Men abuse alcohol more than females, and women have a tendency to abuse psychoactive drugs.

Substance abuse in the elderly is often overlooked, but is a significant chronic medical disorder. A survey in the late 1990s indicated that the medical cost related to substance abuse was the single largest category of Medicare costs in the United States. Conditions stemming from alcohol consumption can cause alcohol-related hospitalizations of the elderly due to risk of high blood pressure, strokes, liver disease, gastrointestinal bleeding, trauma and malnutrition. Alcohol-related hospital discharges occur as frequently as discharges for myocardial infarcts, although the discharge diagnosis is more likely to reflect the presenting reason for admission such as a broken hip, rather than the underlying cause that led to the incident.

Substance-related disorders are identified by two categories:

- Those who have been treated for alcohol or addiction earlier in life—and because of the addiction suffered significant life consequences, but may never have been diagnosed.
- Those who before the age of 60 never experienced or developed signs of tolerance, withdrawal or mental preoccupation with any substance.

Although there has not be significant research in this area it has been estimated that between half and two-thirds of elderly alcoholics are found in the first category.

I grew up as a child of an alcoholic—late in life my father made the decision that he would no longer drink. This resolution held fast until retirement age, depression, loneliness, loss of self-identity and dementia set in. The stage had been set many years ago and it was very easy to allow old patterns to surface. For a few years, the abuse was held secret and although I knew something was "not right," I attributed these symptoms to "normal" aging, perhaps loss of social interactions and no longer having a purpose in life. Surely, my mom would not allow the consumption of alcohol at this stage in dad's life. I was shocked to discover that not only was my mother allowing the drinking, but encouraging it. She felt that it "quieted" my dad; she reasoned that it gave him something to look forward to. Her ability to overlook his past abuse and allow the dependency to begin again was that she thought that if she was there to control the quantity, how frequently he drank (and it was "only wine and beer"), it would not be a problem.

After mom passed away and I became the primary caretaker, I, too, thought I had the situation under control and didn't want to "rock the boat." As is typical with an alcoholic personality, dad persevered and found clever ways to purchase and hide his "booty." Now, I not only had to deal with the issues and ramifications of his progressing dementia—but needed to syphon the behaviors and symptoms he presented to determine if they were medically, psychologically or alcohol driven.

I also had to deal with my own issues of denial and embarrassment as the adult child of an alcoholic

and almost had myself convinced—so what—until I realized what the consequences of his abuse could manifest.

Some factors that may enhance addiction in the elderly are: chronic medical problems, mental disorders, acute medical conditions, personality disorders, physical limitations and cognitive deficits.

Vulnerability to alcohol may increase when clients undergo life transitions or undertake stressful roles—caregiving for a loved one; having adult disabled children; being forced into early unplanned retirement; sudden changes in physical, emotional, or intellectual functioning; being relocated to new homes or communities; and confronting deaths of siblings, spouses or close friends. These situations can create loneliness, isolation, depression or physical disabilities. Some turn to ways that they can use to lessen the pain of their despair. If the client has a previous history of abuse the realization and feelings of embarrassment, plea for relief from the despair can all attribute to relapse. "If we sit idle, the dance of self-destruction intensifies."

Family members, caregivers and the persons abusing are often not aware that consumption is creating a problem in their daily lives or adversely affecting their health. Chronic medical problems may be obscured by the impact of alcohol by creating deterioration, decline in functional capacity and quality of life. Many prescriptions and over-the-counter drugs interact with alcohol, producing harmful and unexpected physical and mental side effects and reactions.

A large number of prescription medications and over-the-counter drugs have a direct negative effect and interaction with alcohol and can create co-morbid conditions. In addition, the combination of alcohol and medications can have a detrimental influence on judgment, cognitive ability and sensory abilities; can cause imbalance and slow reaction time; and may contribute to automobile accidents.

Many elders medicate insomnia, restless leg syndrome, depression and chronic pain with alcohol. Alcohol and drug abuse ravages the mind and body with recurrent use. Over time, the cost-to-benefit ratio for using substances that can place a susceptible individual at risk for dependency shifts dramatically. Complications accumulate over time, especially if the abuse is on a daily basis. Elderly persons develop high blood levels per amount consumed because of age-related changes that alter absorption and distribution of alcohol, alter brain responses, and the liver's inability to metabolize alcohol. Kidney function also declines.

The difficulty with assessing alcohol abuse in the elderly is that many of the signs and symptoms are closely related to other medical and physiological processes. Some of the symptoms that we as professionals can be alert to are: abiding grief, inability to cope with daily life situations, family and social isolation, lack of adequate personal hygiene, insomnia or excessive sleeping, unexplained accidents or trauma, and destructive, sullen or boisterous behavior. Assessments that are frequently used as screening tools are—CAGE (Ewing 1984) and MAST G (Blow, et al., 1992). The client would be asked the following:

- C–Have you thought about cutting down?
- A–Are you ever annoyed by criticism about your drinking?
- G–Are you ever guilty about drinking?
- E–Do you ever need an eye-opener?

Two or more possible "yes" answers are an indicator for potential addiction.

The National Institute on Alcohol Abuse and Alcoholism recommends asking three questions:

- On an average, how many days per week do you drink alcohol?
- On a typical day when you drink, how many drinks do you have?
- What is the maximum number of drinks you had on any occasion in the past month?

Men who consume more than two drinks and women who consume more than one drink per day or anyone who consumes more than four drinks per day could be at risk. Elderly persons develop high alcohol blood levels per amount consumed because of age-related changes that alter absorption and distribution of alcohol.

Some research has shown that light to moderate drinking can improve health, but consuming more than two drinks per day increases the risk of adverse effects. The National Institute on Alcohol Abuse recommends a limit of one drink per day.

Alcoholism carries a stigma, threatens autonomy and negates the ability to realize consequences of admitting a substance abuse problem. Often the health care professional is hesitant to document the "problem," or service providers may be reluctant to provide services to the client.

We recently met with a client in our office who required assistance with nursing home placement. I discussed the procedures with the family, and since the client resided in the community, engaged a nurse screener to do an assessment of the client and do a PRI. The family had not shared the alcohol problem with me, but it was evident to the evaluator and was documented on the PRI. After completion and review of the PRI (for areas of concern, what NH would best serve the client's needs, etc.), the placement process began. Because the PRI screener had documented "history of alcoholism," many nursing homes were reluctant to consider the client. Finally, upon further evalu-

ation and screening we were able to recommend a facility that had a psychiatrist on staff and were able to successfully find placement.

The most helpful thing you can do for someone with a substance abuse problem is be supportive. Overcoming addiction and changing behaviors is difficult at any point in life, and very difficult for the elderly, but can be easier with the help of others. We should collaborate with other professionals to establish referral sources for clients and their families. Often family members may be out of touch with their loved one; denial, guilt, embarrassment and family dynamics can play a critical role in gathering information and defining appropriate planning. Cautiously confront the client's behaviors, trying not to enforce your values. Attempt to act as a mediator and try not to come across as an expert; encourage the client to seek positive actions such as reaching out to doctors and counselors.

Alcoholism can be a terminal disease, in which case we can assist with getting the client's affairs in order and helping the family make decisions about medical interventions that may need to be addressed. When meeting with the family and client we should discuss legal documents and recommend appropriate legal interventions and planning. Consider making a referral to an agency or organization that arranges transportation to AA meetings, evaluate living environments for safety, offer ongoing monitoring by primary care professionals, involving case managers as the situation warrants.

Some additional avenues that professionals can pursue to help serve the elderly and their families is to educate the community and explore ways to encourage prevention and link clients to appropriate professionals. Be aware of "risk triggers," such as loss of friends, family members and social status; loss of job; loss of independence; illness; or physical disabilities. Establish gateways where seniors can be offered assistance, live in safe environments and be offered quality care and dignity of life. Older patients are often more amenable to treatment and early diagnosis and rehabilitation can be lifesaving.

Relapse is high when community-based services are not coordinated and provided. No single treatment program can provide the necessary range of services and promote recovery. One of the many obstacles that need to be overcome is that there is no senior-service substance abuse single point of entry "model" available. The medical and geriatric communities have not clearly defined or identified links to the senior abuse epidemic. We as professionals lack training on what to look for and how to treat abuse in the elderly. We have an obligation to remain aware and educated to be able to convey information that is appropriate and accessible to our clients.

The elder law attorney and/or case manager may be helpful in recommending to the family a combination of resources through formal and informal referrals such as medical professionals, medical facilities for treatment of substance abuse, home health agencies, specialized housing services, in-home support, transportation services, senior centers, senior citizen groups and the faith community.

Addiction is a chronic illness that ebbs and flows. The needs of our clients will change over time and require different types and intensities of treatment. We must all be cognizant that older adults are susceptible and are vulnerable. If we do not, abuse will take a greater toll on one of the most susceptible and fastest-growing sectors of our population.

Sources for further information:

www.sambsa.gov—substance abuse among older adults

Project 2015, "Analysis and Summary" NYSOFA: http://www.aging.state. NY.US

NYS Office of Alcoholism and Substance Abuse Services: www.healthorg/gov pubs

National Council On Alcoholism: 800-NCA-CALL

The New York State Coalition for the Aging, in collaboration with geriatric professional organizations, offers Mental Health and Older Adult training programs. The goal of the training will be to provide information on a variety of mental health issues relating to older adults, and on mental health law, geriatric assessment scales, alcohol and drug use. The training will provide workable intervention strategies to the various senior providers who deal with seniors and their families. For further information contact Greg Olsen at (518) 465-0641.

Barbara Wolford is the Director of Elder Care Services for the Elder Law and Estate Planning firm of Davidow, Davidow, Siegel & Stern. She has been associated with the firm since 1996. Ms. Wolford is a Licensed Practical Nurse who concentrates in assisting families with the complex Medicaid process as well as the assessment procedure necessary for evaluating families' needs. Her background as a former Nursing Home Admissions Director lends itself well to her current position. In addition, she is very active in senior organizations and advocacy by serving as the co-director of the Council for the Suffolk Senior Umbrella Network, a board member of the New York State Coalition for the Aging, a member of the Long Island Coalition for the Aging, a member of the American Association on Aging, Nassau and Suffolk Geriatric Professionals of Long Island and Case Management Society of America.

Public Elder Law Attorney News

Tips for Solving a Common Problem for Medicaid Home Care Applicants Who Need Services Pending Approval of the Application

By Valerie Bogart

Because of the long delays in obtaining approval of applications for Medicaid personal care services,[1] known as home attendant services in New York City, arrangements must be made to provide home care for the client during the application period. Even when things go smoothly, the application takes at least 30–45 days. More often, the application may take several months until it is approved, and then several more months if a fair hearing is necessary. In some cases, families or their counsel might convince a home care agency to provide services without payment, on the assurance that the provider will ultimately be able to bill Medicaid retroactively. More often, clients or their families pay for services during this application or appeal period, planning to apply for reimbursement once services are finally approved. This article alerts practitioners to one type of problem that may arise in this pendency period—hiring an agency to provide services that is not permitted to bill Medicaid.

Arrangements can sometimes be made with a home care provider to provide services without collecting immediate payment, with the expectation that the provider will bill Medicaid directly at a later date, after Medicaid is approved. It is important to ensure that the home care provider is one that is permitted to bill Medicaid directly. Only certain types of providers may bill Medicaid directly. Certified home health agencies (CHHAs)[2] provide certified home health services[3] including home health aides, part-time or intermittent nursing (known as "visiting nurse"), physical or occupational therapy, and medical supplies. A CHHA may bill Medicaid directly.[4] Private-duty nursing agencies or individual nurses registered as Medicaid providers may bill also Medicaid.

Not all private agencies that provide home health aides, however, are CHHAs. An agency that a family may hire to provide aides is more likely to be a "licensed home care services agency" (LHCSA). A LHCSA is a home care services agency issued a license pursuant to Public Health Law section 3605.[5] CHHAs often subcontract with a LHCSA to provide the home health aide piece of the plan of care, which also includes nurses, therapists and social workers. These other personnel may be employed by the CHHA, or may also be or work for subcontractors. Under the contract between the CHHA and the LHCSA, the CHHA nurse develops and supervises the plan of care, and supervises the home health aides that are employed by the LHCSA.

In this common model, the CHHA is the participating Medicaid provider which bills Medicaid for the services. From this Medicaid payment, the CHHA then pays the LHCSA for the home health aide services provided. In fact, the Public Health Law specifically states that a LHCSA that is not "certified" as a CHHA under section 3608 "shall not be qualified to participate as a home health agency under the provisions of title XVIII or XIX of the federal Social Security Act,"[6] meaning that it may not bill Medicaid or Medicare. It is this prohibition that prevents a LHCSA from billing Medicaid directly for services rendered privately to a private client—when such services are not provided pursuant to a contract with a CHHA that may bill Medicaid.

"It is important to ensure that the home care provider is one that is permitted to bill Medicaid directly."

The Public Health Law does allow an exception, under which a LHCSA "may receive reimbursement under title XIX of the federal Social Security Act" where it "has a contract with a state agency or its locally designated office."[7] Most home health aide services, however, are not provided under a contract between the provider and the state or local Medicaid program. CHHAs, for example, do not have a contract—they are enrolled as a Medicaid provider and in that capacity may bill Medicaid directly. They have no contract with the state or local Medicaid programs. One type of home care service that is generally provided under a contract with a local Medicaid program is personal care services (home attendant services). Before 1986, these agencies did not need to be licensed.[8] In fact the exemption from the licensing

requirement continued for many more years. Thus, the dozens of home attendant vendor agencies in New York City formerly were exempt from licensing, and provided services exclusively under contact with the New York City Medicaid program. They were not permitted to provide home care services outside of that contract to private paying clients. In the 1990s all of these agencies became licensed, expanding their permissible services. Not only did they continue to provide services under their city contracts, but they could also be subcontracted by CHHAs and sell their home care services to privately paying clients. Under the terms of Public Health Law section 3605(8), however, they may only bill Medicaid for their "home attendant" services—the services provided under contract with the city. For their contracts with CHHAs or private home care services, they may not bill Medicaid.

The result of these rules is that clients and their counsel must be careful before hiring a private agency to provide home care pending acceptance of the application. The parties should not assume that the agency will ultimately be able to bill Medicaid. When services are provided by a LHCSA and not a CHHA, the only way to obtain payment is for the client or family to pay the agency or aides directly, and then seek reimbursement from Medicaid once the application is accepted and a satisfactory number of hours approved. In that context, it does matter if the home care provider is certified, licensed or even a private aide working on her own. There are many examples of disputes over tens of thousands of dollars of bills that arise because of these highly technical problems, which could have been prevented had the client's counsel ensured that the appropriate provider provided the home care services.

"When services are provided by a LHCSA and not a CHHA, the only way to obtain payment is for the client or family to pay the agency or aides directly, and then seek reimbursement from Medicaid once the application is accepted and a satisfactory number of hours approved."

Endnotes

1. N.Y. Social Services Law §§ 365-a(2)(e), 367-p, 365-f(2)(e) ("Soc. Servs. Law"); N.Y. Comp. Codes R. & Regs. tit. 18 § 505.14 ("N.Y.C.R.R.").
2. N. Y. Public Health Law §§ 3602(3), 3608, 3616 ("Pub. Health Law").
3. Soc. Servs. Law § 365-a(2)(d); 18 N.Y.C.R.R. § 505.23; 10 N.Y.C.R.R. § 763.5.
4. Pub. Health Law § 3614.
5. Pub. Health Law § 3602.
6. Pub. Health Law § 3605(8).
7. *Id.*
8. Pub. Health Law § 3605(1).

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The author gratefully acknowledges the contribution by Rodriguez counsel Leslie Salzman, Donna Dougherty, and Michael Scherz of pleadings and information used in this article.

Advance Directive News

End-of-Life Decision-Making as Media Fodder

By Ellen G. Makofsky

Most of our clients want to appoint a health care agent to make medical decisions if they are unable to make their own decisions. This said, many also fear that if they do appoint an agent, the agent will make a premature decision to remove needed life support. We as elder law attorneys know that there are many emotional components to end-of-life decision-making.

Newspaper editors look to report on issues that sell papers. Stories about disconnecting life support tug at the reader's emotions and increase readership. Sometimes, however, the reality of the situation does not mesh with what is reported in the newspaper. A recent case in Nassau County, New York, is illustrative. *Newsday*, the local paper, published several articles describing a guardianship proceeding which concerned right-to-die issues. Upon reading this series of articles several of my clients commented to me that they thought what had happened was horrible and unfair. When I looked into the matter I discovered that *Newsday*'s coverage was in sharp contrast to what actually happened.

Margaret Russell, an incapacitated person, was 92 years old, she never married and was without children. Ms. Russell was a resident at a Nassau County nursing home. She was diagnosed with breast cancer and suffered from Alzheimer's disease. She was also a stroke victim and the stroke impeded her ability to swallow. On or about January 2003 she suffered a second stroke that left her for the most part unresponsive.

In reporting what happened in this unreported right to die case, *In re Margaret Russell*, *Newsday* led with the line, "Deciding how to die turns out to be no easy task. . . ."[1] The story then went on to report that Ms. Russell lived for six weeks after a legal guardian instructed that the artificial nutrition cease based on the guardian's interpretation of documents signed by Ms. Russell. Russell's nephew disputed the guardian's instructions because he wanted to see if Ms. Russell could recover her health sufficiently to resume swallowing. The story then noted that the judge refused to intervene and consequently Russell died.[2] Another *Newsday* article which covered the case quoted Ms. Russell's nephew saying, "In this state, it is illegal to starve a dog to death. . . . Starving a human? My aunt? That's murder."[3] The stories failed, however, to report on the gravity of Ms. Russell's medical condition.

I subsequently reviewed the court record[4] and the report in the *New York Law Journal* and spoke with Tammy Lawlor, Esq., of Miller and Milone, P.C., who represented Ms. Russell's guardian. I came away with quite a different version of the story. According to these sources, in 1999 Ms. Russell designated her nephew, Roger Russell, as her health care agent to make medical decisions. In January 2000 the court in a guardianship proceeding revoked the health care proxy after an independent evaluator found that Mr. Russell was not acting in Ms. Russell's best interest. Previous to the revocation the court issued a restraining order against Mr. Russell for "financial and personal abuse."[5] The court subsequently appointed Family and Children's Association, a non-profit social services organization, as Ms. Russell's guardian.

"A guardian has a duty to make decisions in accordance with previously expressed health care wishes."

When Ms. Russell suffered a second stroke in January 2003 that left her for the most part unresponsive and her medical condition continued to deteriorate, Family and Children's Services applied to the court for expanded powers to make medical decisions for Margaret Russell, an incapacitated person. In order to evaluate possible actions, the guardian met with the nursing home's physician and as a consequence of the meeting determined to withdraw nutrition but to maintain hydration, as continued hydration would be consistent with Mrs. Russell's previously expressed wishes in regard to pain management.

A guardian has a duty to make decisions in accordance with previously expressed health care wishes.[6] Prior to her adjudication of incapacity Ms.

Russell executed numerous advance directives. She executed a health care proxy in 1991 that stated she did not want "heroic measures" to save her life and she specifically stated she did not want artificial nutrition or hydration administered. She further stated, "She intended no pre-conditions of irreversible brain damage or terminal cancer to preclude the withdrawal of life support."[7]

Ms. Russell executed a living will in 1995 which included a statement that she did not want cardiac resuscitation, tube feeding or antibiotics and that she wanted maximum pain relief.[8] The living will contained further language that indicated there were preconditions to her directions which included irreversible brain damage and terminal cancer.[9]

Ms. Russell executed a second health care proxy in 1999 authorizing a nephew, Roger Russell, to make medical decisions for her which was subsequently revoked by the court.

According to Tammy Lawlor, Esq., who represented Family and Children's Services, prior to the evidentiary hearing to determine whether the required clear and convincing evidence standard was met, there was an opportunity for nephew Russell to discuss his concerns with the nursing facility and Ms. Russell's doctors. Instead, Mr. Russell determined to go to the media with his story which resulted in the several emotionally charged newspaper articles.

Nephew Russell brought his own motion at the hearing and challenged the guardian's decision to withdraw nutrition on the basis that such withdrawal was creating pain. Justice Frank S. Rossetti determined that nephew Russell provided no additional credible evidence as to the pain argument and found that the guardian should "be given the additional and expanded power of making a determination as to whether or not Margaret Russell's life should be continued by the administration of artificial means. That decision lies solely with the guardian appointed herein."[10] According to the *New York Law Journal*, after the proceeding the judge stated, "It is not my decision, it is not the guardian's, not Roger Russell's. It was her decision as clearly expressed in 1981 and again in 1995 as to how she wants to be treated."[11]

The *Newsday* coverage was unfortunate because the true facts did not come out in the media. It appears from court records that the judge made a logical assessment based on the facts presented to the court and that the advance directives executed by Ms. Russell accomplished what she intended.

Endnotes

1. Talan, *When Death Needs a Plan,* Newsday, Mar. 11, 2003, at A33, col. 2.
2. Talan, *supra*, at A33, col. 2.
3. Talan, *Life in the Balance*, Newsday, Mar. 3, 2003, at A17, col. 3.
4. *In re Margaret Russell*, No. 2003-01184 (N.Y. Sup. Ct., Jan. 24, 2003).
5. Jones, *Judge Allows Feeding Tube To Be Removed,* N.Y.L.J., Mar. 4, 2003, at 1, col. 3.
6. N.Y. Mental Hygiene Law §§ 81.20, 81.22.
7. Jones, *supra*, at 2, col. 2.
8. Jones, *supra*, at 2, col. 2.
9. Jones, *supra*, at 2, col. 2.
10. *In re Margaret Russell*.
11. Jones, *supra*, at 2. col. 3.

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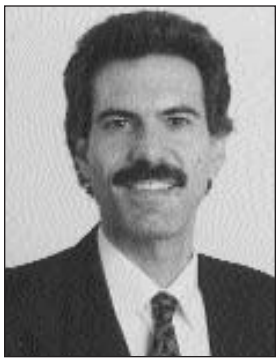
Ms. Makofsky is a member of the New York State Bar Association (NYSBA) and serves as Treasurer of its Elder Law Section Committee. She is also a member of the NYSBA's Trusts and Estates Law Section. Ms. Makofsky is a member of Nassau County Bar Association, Elder Law, Social Services and Health Advisory Committee and the Surrogate's Court Trusts and Estates Committee. She is a member of the National Academy of Elder Law Attorneys, Inc. (NAELA). Ms. Makofsky is also a member of the Estate Planning Council of Nassau County, Inc. Ms. Makofsky has been certified as an Elder Law Attorney by the National Elder Law Foundation.

Ms. Makofsky currently serves as co-chair of the Long Island Alzheimer's Foundation (LIAF) Legal Advisory Board and is the immediate past president of the Gerontology Professionals of Long Island, Nassau Chapter. She is the former co-chair of the Senior Umbrella Network of Nassau. She serves on the Board of Directors of Landmark on Main Street.

Public Policy News

Restructuring of the Liaison to Public Agency and Legislation Committee

By Ronald A. Fatoullah



I was recently named chair of the Liaison to Public Agency and Legislation Committee of the Elder Law Section (the "Committee"). My goal is to breathe new life into the Committee so that it will be responsive to the needs of Section members and our clients. I invite, and urge, each of you to become a member of this important committee.

As the saying goes, membership has its rewards. We have recently created a separate listserve for Committee members, so that members chat freely regarding public policy and legislative issues. Committee members will also receive information regarding proposed legislation in the New York State Assembly and Senate that is relevant to the elder law practitioner. But most of all, members of this Committee will have the opportunity to effect changes that could alter the lives of our clients and possibly, the way we practice elder law.

The main objectives of the Committee are to educate and influence. The Committee will create a legislative and issue "watchdog" in order to isolate relevant proposed legislation. Once important legislation and/or issues are identified, we intend to share what we have learned and to educate all Section members. The education process can be effectuated either (i) electronically on the Section's Web site or via the listserve; (ii) in print in this publication; or (iii) at one of the many educational CLE programs sponsored by NYSBA.

If there is a proposal and/or issue that is of special significance, the Committee will then determine whether it is prudent to have the Section take an official position on that legislation or issue. As chair of the Committee and a member of the Executive Committee of the Section, I intend to make a presentation of these important matters at one of our quarterly Executive Committee meetings. If the Section agrees to take a position on a particular law or issue, the Section can then attempt to seek a position from the New York State Bar itself.

Once our members are privy to new proposals and/or issues, they may want to influence their local representatives and lobby for a change. The world of politics and government is unfamiliar to many. The Committee, therefore, is currently exploring ways to educate members so that they may lobby effectively. This will likely be accomplished through the use of either written materials, a seminar, or possibly even a "hands-on" training session during a Section-sponsored "day in Albany."

". . . members of this Committee will have the opportunity to effect changes that could alter the lives of our clients and possibly, the way we practice elder law."

Recent Legislative Proposals

The following relevant bills have been proposed in either the New York State Senate or Assembly:

a. Senate Bill No. 04627, sponsored by Meier. This bill seeks to eliminate spousal refusals, increase the lookback period for *all* transfers to 60 months, impose a penalty period for transfers made by *community* Medicaid recipients, *and* start the period of ineligibility on the first day of the first month during or after which an application has been made. It appears that this legislation, if implemented, would conflict with federal law that has created a 36-month lookback period for all transfers (except for the 60-month lookback for transfers to or from certain trusts) *from the date of each transfer*, and the federal law which provides for spousal refusals.

b. Assembly Bill No. 00084, co-sponsored by Cymbrowitz, Levy, Markey, Dinowitz and Jacobs. This bill seeks to raise the personal incidence allowance for Medicaid recipients in a nursing home from $50 to $100 per month. The personal needs allowance is used for items such as clothing, toiletries, laundry supplies and personal luxuries such as cable television. The allowance has not been changed since 1981—the real dollar value of this allowance is therefore greatly diminished.

c. Senate Bill No. 00991, sponsored by Trunzo. This bill seeks to amend the Banking Law so

as to require all banking institutions in New York to accept a statutory short-form power of attorney. While New York's General Obligations Law already contains these provisions, the sponsors believe that direct amendment of the Banking Law will make bank institutions more aware of the power of attorney provisions, and therefore, have a greater impact.

d. Senate Bill No. 01167, co-sponsored by Stachowski, Rath and Volker. This bill would require that health insurance companies allow their senior citizen insureds to designate a third party for notification purposes. Bill S.01167 will bring regulations regarding health insurance in line with current regulations and safeguards regarding life, automobile and homeowners insurance. The sponsors state that "[b]y allowing an insured to designate a third party to receive copies of any premium notices or notices of cancellation, we can provide a vital protection to the elderly population."

e. Assembly Bill No. 04687, sponsored by Weinstein. This bill seeks to eliminate the harsh "exceptional circumstance" standard imposed on community spouses seeking to increase their minimum maintenance allowance at either a fair hearing or in Family Court. This standard was set forth by the New York State Court of Appeals in *Gomprecht v. Sabol*, 86 N.Y.2d 47, 629 N.Y.S.2d 190 (1995). Bill No. 04687 proposes that Family Court judges not be constrained by this standard, that they have greater discretion and that they make decisions with "due regard to the circumstances of the respective parties, including the fact that the institutionalized spouse may be receiving medical assistance."

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Capacity News

Capacity Required to Create a Trust

By Michael L. Pfeifer

What capacity is required for a grantor to validly execute a trust? Is it the standard of capacity required to draft a will?[1] Or is it the standard required to draft a contract?[2] Or perhaps we should look at the cases involving *inter vivos* gifts.[3]

There is very little case law on the subject of capacity to execute a trust in New York and the law is certainly unsettled. However, the case law that is available seems to hint that courts will look for analogous transactions and then apply the law that is used for that transaction.[4]

Surrogates Preminger and Roth in New York County looked at revocable trusts in the context of whether there was a right to a jury trial when the validity of the trust has been challenged. They came to different conclusions as to whether a jury trial should be permitted in such situations.[5] However, both Surrogates agreed that a revocable trust acts as a will substitute and indicated that the proper standard to determine capacity would be the same standard used to determine the capacity of a person executing a will. In *In re Tisdale*,[6] the court stated:

> Clearly, a revocable trust has little in common with instruments other than wills. Although such trust is established in the form of an "agreement," it is really unilateral in nature because the negotiation that characterizes bilateral instruments is totally absent. The trustee of a revocable trust (if not the settlor) simply acts at the behest of the settlor. If the settlor becomes dissatisfied with the trustee or with the terms of the trust, he or she simply amends the trust to suit his or her desires. There is no need to invoke the equitable powers of the court to relieve the settlor of a bilateral obligation because there is none.

In *In re Goldberg*,[7] the court discussed the reason why less capacity is required to execute a will:

> It is hornbook law that less mental capacity is required to execute a will than any other legal instrument. The reasons for this lower standard stem from the concept of a will as the testator's last act, and from considerations of fairness which militate against depriving elderly or infirm testators of the right to dispose of their property. (See, Radigan, Attorneys Are Alerted to Take Early Precautions To Avoid Will Contests in Sensitive Situations, NYLJ, Apr. 20, 1981, at 3, col 1; *Matter of Bossom*, 195 App. Div. 339, 343; *Matter of Seagrist*, 1 App. Div. 615, 620, aff'd 153 N.Y. 682.) Additionally a will is not the product of a bilateral transaction between putative antagonists and does not require the sharpness of mind of persons involved in a business transaction. (*Supra*.)

It seems as though the above reasoning would apply equally to most revocable trusts that are used as testamentary substitutes.

The issue in *Goldberg* involved the release of a spouse from her obligations concerning an antenuptial agreement. Here the court concluded that a contract standard of capacity was required. The court reasoned: "Such documents are clearly bilateral and in an important way, affect the parties' present rights. It is however true that these arguments relate only to inheritance rights and stem from a personal relationship where adequacy of consideration is not usually the issue."

A similar issue was presented in *In re ACN*,[8] which was the first New York case on the standard of capacity required to create an *inter vivos* trust. *ACN* applied the higher, contract standard of mental capacity, citing *Ortelere v. Teachers' Retirement Board*,[9] the leading case on the contract standard, relied upon by both parties here.

The traditional contract standard of capacity is a cognitive test, which focuses on whether the person was able to understand the nature and consequences of a transaction and make a rational judgment concerning it.[10] In *ACN* the decedent had executed a trust agreement creating a charitable remainder trust with himself and his wife as trustees of the bulk of his property. The spouses were to be life beneficiaries of an annual percentage of the value of the trust principal. The court relied on the bilateral character of the

transaction and the fact that a present property interest was surrendered in exchange for the annual interest under the trust, in invoking the contract standard.[11]

While the bilateral character of the trust in *ACN* could be viewed as largely a matter of form, Albert's revocation of the antenuptial agreement represented the surrender of his testamentary freedom in response to his wife's future needs. Since such a transaction requires sufficient mental capacity to evaluate another person's claims as well as one's own interests, and involves the making of an irrevocable decision, it calls for the degree of understanding required in the contract sphere. Accordingly, the court will apply the higher standard in evaluating Albert's capacity.

The court, in *In re ACN*,[12] summarized the capacity required to enter into a charitable remainder unitrust in this way:

> A will, by nature, is a unilateral disposition of property whose effect depends upon the happening of an event in futuro. A contract is a bilateral transaction in which an exchange of benefits, either present or deferred, is exchanged. A charitable remainder unitrust is a bilateral transaction between the settlor and trustee in which the settlor transfers a present interest in property in return for an annual fixed percentage of income based on the fair market value of the corpus (and a tax deduction). As such, it is more analogous to contract than to a will.[13]

In *Harrison v. Grobe*,[14] the court had an interesting way of resolving the capacity issue. The court concluded that the grantor had capacity to execute the trust whether the court applied the will standard or the contract standard of capacity. Therefore, without deciding which standard would apply to the particular trust at issue, the court applied the more stringent contract standard.

The Restatement Third of Trusts § 11 (Tentative Draft No. 1)[15] sets forth the following standards of capacity for the execution of trusts:

(1) A person has capacity to create a trust by will to the same extent that the person has capacity to devise or bequeath the property free of trust.

(2) A person has capacity to create a revocable *inter vivos* trust by transfer to another or by declaration to the same extent that the person has capacity to create a trust by will.

(3) A person has capacity to create an irrevocable *inter vivos* trust by transfer to another or by declaration to the same extent that the person has capacity to transfer the property *inter vivos* free of trust in similar circumstances.

(4) A person has capacity to create a trust by exercising a power of appointment to the same extent that the person has capacity to create a trust of his or her own property under subsection (1), (2), or (3) above, as appropriate to the type of transfer and trust being created.

(5) Under some circumstances, an agent under a durable power of attorney or the legal representative of a property owner who is under disability may create a trust on behalf of the property owner.

To put it another way, the court should first look at the nature of the transaction that the trust advances and then use the standard of capacity that would apply in circumstances where no trust is involved.

The Restatement also suggests that where a revocable trust presents issues beyond matters involved in making a testamentary disposition, the court may have to fashion appropriate remedies without jeopardizing the testamentary plan.[16]

Utilizing the above principles, it might be instructive to hypothesize a situation involving a revocable trust whereby the capacity of the grantor is challenged. Let us say that Jack has been recently diagnosed with Alzheimer's disease. Jack's spouse is deceased and he has a son with whom he is estranged. He has a nephew with whom he is close. Jack decides to set up a revocable trust and names his nephew as his trustee. The trust has detailed provisions for how Jack wants the trustee to care for him once he becomes disabled. The trust further provides for liberal compensation to the nephew beyond the statutory amounts. Furthermore, the nephew may make gifts to himself and his family while Jack is alive. Finally, upon Jack's death, the trust property passes to the nephew.

If the son were to challenge Jack's trust, what standard of capacity would a court use? The court may decide that different aspects of the trust require different capacities. The court may take a look at the aspects of the trust whereby the nephew, as trustee, takes care of Jack in return for compensation. This could be looked at, especially upon Jack's incapacity from Alzheimer's disease, as having the nature of a bilateral contract. Thus, with respect to this aspect of the trust, perhaps a contract standard of capacity should be used. The trust also allows the trustee to make *inter vivos* gifts to himself and his family. Perhaps, here the standard of capacity for *inter vivos* gift-giving should be used. Finally, upon Jack's death, the

trust estate passes to his nephew. Here the capacity necessary to execute a will might be used.

Alternatively, the court could look at the entire trust and decide that given its complexity, a higher standard of capacity is required regardless of the different transactions occurring within the trust.

In conclusion, the issue of capacity to enter into a trust is unsettled in New York. However, courts that have looked at the issue have indicated that they will apply the standard used in analogous transactions. Thus, we must look at the type of trust, its purposes and uses and how similar issues are resolved by courts looking at equivalent circumstances.

Endnotes

1. For the capacity necessary to execute a will, see *In re Kumstar*, 66 N.Y.2d 691 (1985).
2. For the capacity necessary to execute a contract, see *Ortelere v. Teachers' Ret. Bd.*, 25 N.Y.2d 196 (1969).
3. For the capacity necessary to make an *inter vivos* gift, see *In re Left*, 44 N.Y.2d 915 (1978).
4. *In re ACN*, 133 Misc. 2d 1043, 1046, 509 N.Y.S.2d 966 (Sur. Ct., N.Y. Co. 1986, Lambert, S.).
5. *In re Tisdale*, 171 Misc. 716, 655 N.Y.S.2d 809 (Sur. Ct., N.Y. Co. 1997, Roth, S.); *In re Aronoff*, 171 Misc. 2d 172, 653 N.Y.S.2d 844 (Sur. Ct., N.Y. Co. 1996, Preminger, S.).
6. 171 Misc. at 720.
7. 153 Misc. 2d 560, 582 N.Y.S.2d 617 (Sur. Ct., N.Y. Co. 1992, Preminger, S).
8. 133 Misc. 2d 1043.
9. 25 N.Y.2d 196 (1969).
10. *Id*.
11. *Goldberg*, 153 Misc. 2d at 565.
12. 133 Misc. 2d 1043, 509 N.Y.S.2d 966 (Sur. Ct., N.Y. Co. 1986, Lambert, S.).
13. *Id.* at 1047.
14. 790 F. Supp. 443 (S.D.N.Y. 1992, Carter, D.J.).
15. The author tried to get a copy of the finalized version of section 11 of the Restatement Third of Trusts but was unable to do so despite having visited three law libraries.
16. Restatement Third of Trusts § 11 (Tentative Draft No. 1), cmt. subsec. (2).

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National Case News

By Steven M. Ratner

This column addresses recent cases in jurisdictions other than New York. Questions or comments regarding this column should be sent to the author at smrlaw@yahoo.com

Brenda Martin, Executor of the Estate of Dewey O. Moore v. Jean Moore, Tennessee Court of Appeals, January 23, 2003.

In *Brenda Martin, Executor of the Estate of Dewey O. Moore v. Jean Moore*, Brenda Martin, the daughter of a deceased Alzheimer's patient, sued her stepmother, Jean Moore, for breach of fiduciary duty and asked for the return of assets to her father's estate. On appeal the Tennessee Court of Appeals affirmed the trial court's decision that Jean return a transferred bank account to the estate but allowed her to keep the proceeds from a sale of real property.

In 1997, Dewey Moore was diagnosed with Alzheimer's disease. Shortly after the diagnosis, Mr. Moore executed a power of attorney in favor of Jean, his wife of eighteen years. In 1996, Dewey had executed a will devising his residence to his wife and all remaining property to his grandsons.

Dewey died on December 30, 1997. His daughter, Brenda, brought suit on behalf of the estate, claiming that her father was not competent when he signed the power of attorney and that prior to his death, Jean had used the power to transfer a bank account and other property to herself, in violation of her fiduciary duty.

Two compelling allegations consisted of withdrawals by Jean totaling $66,076 from Dewey's separately owned checking account, and the use of the power of attorney to convey to herself her husband's interest in a land sales contract and promissory note related to real property in Kentucky.

The trial court declared that Dewey had signed the document by his own free will and that he was competent to do so. The court held, however, that Jean breached her fiduciary duty under the power of attorney when she transferred the separate account into her name. The evidence established that Jean used these funds to buy a chicken ranch for her brother in the Philippines. The property was jointly held between herself and her brother. She thus exchanged property held solely in Dewey's name for property in which he had no legal interest. This transaction was not reasonable under the circumstances and Jean failed to exercise good faith, honesty, and loyalty which were required under the power of attorney.

The court also held that Jean did not have to return the proceeds from the sale of real property made pursuant to the power of attorney. Before the power of attorney was executed, Dewey and Jean entered into a land sale contract that provided that the buyer make monthly payments of $600 for thirty months. The buyers defaulted and Dewey granted them additional time to pay. In 1997, Jean used her power of attorney to assign the contract into her name and collected the balance due under the note.

Brenda claimed that according to his will, her father wanted his real property to pass to his grandsons. The court noted, however, that Dewey had signed the land sale contract (in which Jean joined) while he was still capable and that he later affirmed the contract despite the buyer's default. The court went on to say that Jean's use of the power of attorney was consistent with Dewey's wishes.

Stella Thompson v. Department of Children and Families, Florida Court of Appeals, January 24, 2003

In *Thompson v. Department of Children and Families,* Stella Thompson, a Florida resident, appealed the decision by the Department of Children and Families (DCF) in denying her Medicaid benefits. Ms. Thompson was a 71-year-old nursing home resident who suffered from a leg infection and deteriorating health. Ms. Thompson's sister, Josephine, lived near the Florida nursing home and also cared for her sister. Three months after Ms. Thompson's arrival at the nursing home, Josephine used her power of attorney granted by her sister to purchase for Ms. Thompson a life estate in the condominium where Josephine lived. The life estate was purchased by a transfer of $18,250 from Ms. Thompson to Josephine and stated that the purpose of the transfer "was to ensure that Ms. Thompson would always have a place to live."

Josephine then applied for Medicaid on behalf of her sister. DCF denied the application and declared

that the $18,250 depletion of Ms. Thompson's assets was an improper transfer and was done only to meet the financial eligibility requirements for Medicaid. DCF also stated that Ms. Thompson failed to demonstrate that the fair market value of the life estate purchased in Josephine's condominium had a value of $18,250. The final order declared that there was insufficient proof that the transfer occurred for any other reason besides becoming eligible for Medicaid.

On appeal the court agreed with DCF and stated that the transfer of assets from Ms. Thompson to Josephine in return for a life estate was a sham to gain Medicaid. The court noted that no reasonable explanation for the transfer was set forth and that there was no competent evidence showing the market value of the transfer.

Attorney Grievance Commission of Maryland v. Charles F. Stein III, Maryland Court of Appeals, March 18, 2003

In *Attorney Grievance Commission of Maryland v. Stein*, the respondent, Charles F. Stein III, drafted a will for his client providing a substantial gift to himself. His client did not have independent counsel regarding the gift. Mr. Stein and the testatrix had been friends for many years. In the proceeding against Mr. Stein, the court determined that Mr. Stein violated Disciplinary Rule 1.8(c), which states that a lawyer shall not prepare a testamentary gift giving the lawyer any substantial gift from a client where the client is not represented by independent counsel.

The dispute in this case revolved around what sanction should be imposed upon Mr. Stein. Bar counsel recommended an indefinite suspension with the right to seek reinstatement conditioned upon Mr. Stein's renunciation of any interest he had in the residuary gift left to him in the will he prepared for his client. The court rejected this proposition and stated that there is no case law that requires an attorney to renounce a gift as a condition of reinstatement.

Attorney Grievance Commission of Maryland v. John A. Brooke, Maryland Court of Appeals, April 11, 2003

Similarly, in *Attorney Grievance Commission of Maryland v. John A. Brooke*, an attorney, Mr. Brooke, instructed his secretary to draft a will for his friend in which Mr. Brooke was named personal representative and sole legatee. In the proceeding against him, the court held that Mr. Brooke violated Rule 1.8(c). Here again, bar counsel recommended "that the right to seek reinstatement be expressly conditioned on the Respondent's renunciation of any interest in the bequest left to him by the Will." The court denied the recommendation and stated that a condition of renunciation fails to consider public policy. In this case, the statutory nine-month disclaimer period had elapsed. It would have been impossible for Mr. Brooke to be reinstated. The court sanctioned Mr. Brooke with an indefinite suspension not conditioned upon renunciation.

Steven M. Ratner is the founder of the Law Office of Steven M. Ratner, P.C., a firm committed to serving the needs of the elderly with offices in Manhattan and White Plains. Mr. Ratner is a frequent lecturer and author on issues within his practice areas and is the author of the Elder Law chapter in the *New York Lawyer's Deskbook*.

Steven M. Ratner graduated from the University of Oregon School of Law where he was first in his class, a member of the Order of the Coif, and an Associate Editor of the *Oregon Law Review*. Mr. Ratner received an L.L.M. in Taxation from New York University where he was a Student Editor of the *Tax Law Review* and the recipient of the Harry J. Rudnick Memorial Award.

Mr. Ratner's work experience includes a one-year clerkship with the Honorable Herbert Y.C. Choy of the United States Court of Appeals for the Ninth Circuit in Honolulu, Hawaii.

Mr. Ratner is admitted to practice law in New York and California. Mr. Ratner is a member of the National Academy of Elder Law Attorneys, the New York State Bar Association (Elder Law Section), and the Association of the Bar of the City of New York (Chair, Small Law Firm Management Committee; Member, Legal Problems of the Aging Committee).

Stacie Seewald, an Associate in Mr. Ratner's office, assisted with the preparation of this article.

Bonus News 1

The High Cost of Investing

By Stephen K. Davis

Stocks, bonds, mutual funds, managed separate accounts, wrap accounts, hedge funds, asset-based fees, performance-based fees, load funds, no-load funds, A, B, C, D shares, variable annuities, variable life, real estate investment trusts. The options seem endless, but one thing is certain. It costs money to make money. It even costs money to lose money!

Regardless of your preferences on how to invest your money, one thing is certain: *someone is getting paid*. Investment advice is getting expensive. Recent studies show that the average investor today is seeking advice and is willing to pay for it. However, the question begs to be asked: "Are you getting what you're paying for?" Even bad advice will cost you money.

What Factors Drive Costs?

The cause is rooted in the notion that by paying a professional stock picker or market timer you can "beat the market." However, studies have shown this to be a very difficult thing to do and that a very high percentage of money managers don't. Why? Because the market is largely composed of professional managers who are the majority of participants in today's securities market. Each one brings his years of experience and expertise to the marketplace. So, by default they have become the market, trading on all known information. Essentially, the managers are competing against each other and by definition cannot outperform themselves. The effect of this is high turnover of portfolio assets, which create increased trading costs and possibly higher taxes.

What's an Investor to Do?

The first step in learning how to reduce your investment expense and improve your odds of success is to accept the fact that "you can't beat the market!" The style of investing associated with the attempt to beat the market is called active management. Active management is what drives expenses. This is demonstrated by the various components and pricing of an actively managed mutual fund.

How Mutual Funds Are Priced

Mutual funds issue shares in different classes. The most popular classes are known as A shares. **A** shares, also referred to as "front-end load shares," charge you an up-front commission which is paid to a broker when you make your purchase of the fund. For the larger investor the load diminishes until you pay no load. In the universe of broker-sold mutual funds, the A shares will have the highest up-front costs but the lowest annual management fees.

However, in an effort to cater to those who object to paying an up-front commission, mutual fund companies have created other classes of shares which do not charge an up-front commission. These are called B shares and C shares. Each class charges fees to clients differently.

For example, **B** shares, a.k.a. "back end-load shares," charge nothing at the initial purchase but will penalize the investor for early withdrawal. For instance, a B share will charge 5% of the money invested if you withdraw from the fund within the first year of ownership. The charge will decline 1% each year until you can withdraw without penalty in the 5th year, at which time the B share will convert to an A share. B shares carry a higher 12b1 fee. **C** shares, often touted by brokers as "no-load shares," have hidden charges which make them **the most expensive share class**. Why are C shares so costly? The devil is in the 12b1 fee. Often overlooked, 12b1 fees were intended to reimburse funds for marketing expenses and therefore are technically not a load or management fee. The 12b1 fee can range from zero percent in many no load funds to 1.00% or more in a C share.

Let's take a close look at a C share mutual fund. In this example we have selected the popular PIMCO Total Return Fund C share (symbol: PTTCX). Here's how the expenses break out. This fund has a management fee of 1.65% and a 12b1 fee of 1% and an annual portfolio turnover of a whopping 445%. When added up it looks like this:

Management fee	0.68%
12 b1 fund distribution costs	1.05%
Transaction costs (calculated based on 445% turnover)	1.16%
Taxes paid	1.97%
Total 1-year cost of ownership	**4.86%**

As you can see the costs add up. Turnover is often overlooked when comparing mutual funds. Turnover is the buying and selling of securities in the fund. The greater the turnover the higher the fees.

Turnover affects taxes as well, which can also increase your costs. You've probably experienced the end-of-the-year distribution of capital gains even when

shares weren't sold. Mutual funds are required to distribute 95% of all dividends and capital gains. Which in turn increases your taxable income. This is, of course, out of your control. The following example shows how you might end up after making a $10,000 investment in the fund.

$10,000	investment
+ $700	capital appreciation estimated @ 7%
$10,700	current market value
($ 185)	fund charges
($ 124)	trading costs
($ 197)	short-term capital gain tax 37%
$ 194	net gain (This represents a 72% loss to fees, expenses and taxes)

(This example is strictly hypothetical and does not reflect the performance of any specific investment product. Costs were determined using the fund cost calculator at www.personalfund.com.)

The Passive Alternative

Instead of attempting to "beat" the market with costly actively managed funds, let's take a look at a different concept called "passive management." Simply stated, a passively managed fund maintains the same securities as the market segment it represents and makes no attempt to beat the market by trading or market timing and is essentially a buy-and-hold strategy.

A commonly known example is the Vanguard S&P 500 index fund.

For example, let's look at the same amount invested in an index fund:

$10,000	investment
+ $ 700	growth
($ 20)	fund fee (0.18%)
$10,680	net gain

0% Trading cost. 0% Taxes on capital gains. 0% Distribution.

As you can see the potential net annualized rate of return can be substantially greater in the index fund. Because of the diverse number of asset class-specific index funds available today it is possible to create an "efficiently optimized" (asset-allocated) portfolio with a substantially reduced cost. This gives you a higher probability of equaling market performance with less risk of underperformance due to fees, expenses, and taxes.

How Are Other Investment Products Priced?

This discussion opens the door to all types of investment-related services and the manner in which you are charged for them. Retirement plan sponsors that offer actively managed mutual funds in their 401(k) plans are adding additional layers of fees of as much as 2% on top of those already mentioned. Similarly annuity plan sponsors are adding mortality and expense charges of 1.5% or more. In an investment climate where returns are expected to be closer to the historical norm of plus or minus 10%, a 3% cost of doing business will be a substantial impediment to accumulating wealth.

Conclusion

Studies continue to show that actively managed funds underperform their requisite index, cost more to own and have style drift. The first study, known as the Fama French study, performed in 1965 and re-affirmed in 1989, determined that active management does not add value. The investment community has hotly debated this. However, numerous subsequent studies have reaffirmed those findings. Most recently a comprehensive study performed by Stefan Sharkansky and published on his Web site www.personalfund.com concluded that "One of the simplest ways for an investor to improve his or her odds of investment success was to invest in reasonable-cost low turnover, tax-efficient investment vehicles of the appropriate asset classes."

By switching from active management to passive management strategies you can achieve those objectives and be assured that your portfolio will achieve equivalent market performance while at the same time reducing your expenses and your taxes!

Does this suggest that no fund or manager can beat the market? Of course not, someone always will. The problem is identifying them in advance. Past performance is no guarantee of future similar results.

To improve your chances of investment success try to develop an asset allocation strategy based on modern portfolio theory. This can help mitigate volatility and improve your portfolio compound rate of return.

Mr. Davis began his career in the financial services industry in 1976 after leaving a successful commercial fishing business he founded in 1968. As a partner in the firm Employee Benefit Planners, Stephen helped educators plan for retirement through workshops and seminars.

In 1982 Stephen successfully passed the NASD Series #7 Licensing Exam (General Securities License). In 1989, Safe Harbor Asset Management was formed as a vehicle to provide fee-based planning and investment advice to clients needing more sophisticated services. Stephen is a noted speaker on the subjects of financial and estate planning, and has lectured on the application of modern portfolio theory and asset allocation to associations and trade groups. He is a recognized expert in college aid planning and has been quoted in the *New York Times* and *Wall Street Journal*.

Bonus News 2

Written Statement of Michael S. Kutzin

Before the United States Senate
Special Committee on Aging

February 11, 2003

Good morning, and thank you for inviting me to testify. My name is Michael Kutzin, and I am a partner in the New York law firm of Goldfarb & Abrandt.

The ordeal that my client, Jane Pollack, and her family has endured in carrying out the wishes of her aunt, Mollie Orshansky, demonstrates many of the problems that seniors and their families often face after falling into the guardianship whirlpool.

Guardianship statutes generally recite lofty principles of honoring the wishes of an incapacitated person where possible, and call for a myriad of protections of due process rights. This includes requiring the party who is petitioning for the appointment of a guardian to demonstrate, by the legal standard known as "clear and convincing evidence," that such a drastic step is required. While the "clear and convincing" standard is below the standard required for a criminal conviction, namely, "beyond a reasonable doubt," it is a significantly higher burden of proof than the usual standard of proof in civil cases, namely proof by a preponderance of the evidence.

So-called "modern" guardianship statutes, such as those found in New York, call for judges to provide flexible solutions to meet the needs of an incapacitated person, such as limited guardianships, and to honor the senior's wishes regarding who she wants to care for her.

In practice, however, once a guardianship proceeding is brought against someone, machinery begins that often presumes that a guardian is required, and runs roughshod over the wishes of the senior and his or her family.

This is particularly true where, as in the case of Mollie Orshansky and her family, the proceeding is commenced by a hospital or nursing home, and family members live in another state. A similar disregard for the wishes of the senior and her family often occurs where the senior has significant assets. Both of these factors were present in the Orshansky case.

The Mollie Orshansky Guardianship Proceedings

In this case, once the Washington, D.C., petition was filed by the hospital, the D.C. Judge sought to retain control over the case, even though (1) Mollie Orshansky's family all lived in New York, (2) Mollie Orshansky owned an apartment in New York City in the same building as her sister, (3) Mollie Orshansky had established, years before, a revocable trust naming her sister, Rose, as a trustee to handle her assets if she could not do so herself, (4) Ms. Orshansky had executed a health care proxy naming her niece, Jane Pollack, as the person to make medical decisions for her if she could not do so herself, and (5) Jane Pollack commenced a guardianship proceeding in New York to assure the D.C. Court that no one was attempting to avoid court scrutiny.

There was no need for a guardianship proceeding in the District of Columbia. Jane Pollack was Mollie Orshansky's duly appointed health care agent under both New York and D.C. law, and Ms. Orshansky's revocable trust was a functioning vehicle for the management of her assets. Moreover, Ms. Orshansky had purchased the New York City apartment not as an investment property to rent to others, but for her to reside in, near her family, in the event that she could not care for herself.

In other words, Mollie Orshansky had taken all of the appropriate legal and practical steps to avoid a guardianship proceeding—yet the hospital and the D.C. Superior Court insisted upon continuing down the guardianship path.

To make matters worse, the hospital refused to permit Mollie Orshansky to leave, even though Mollie Orshansky was not receiving medical care, but rather was receiving custodial care pending what the hospital anticipated to be Ms. Orshansky's placement in a nursing home.

In short, Mollie Orshansky was being held captive in the hospital pending an involuntary nursing home admission, despite the fact that her duly authorized health care agent, Jane Pollack, had requested her discharge.

As a result of Ms. Orshansky's status as a custodial care patient, she received inadequate care from the hospital. Jane Pollack was not going to permit her aunt to be treated in such a manner, so she transported Ms. Orshansky, at Ms. Orshanksy's request, from the hospital, to her New York City apartment. Ms. Pollack and her family immediately arranged for 24-hour home care for Ms. Orshansky, and for her medical needs.

Ms. Pollack notified the hospital that Ms. Orshansky was no longer present in the hospital, at which point the hospital's counsel informed the D.C. court. The judge responded by naming one lawyer as Ms. Orshansky's temporary guardian and appointed another attorney from a large firm as "Mollie's attorney." This judge also ordered the temporary guardian to take all steps necessary, including bringing in the police, to have Mollie Orshansky brought back to the District of Columbia.

In other words, the judge asserted that the mere fact that someone filed a guardianship petition presumptively made Ms. Orshansky incapacitated and made her a captive of the District of Columbia. Mollie Orshansky was not a criminal, and she, her family and her health care agent had the right to remove her from the hospital and transport her to her own apartment.

In addition to these infringements of Ms. Orshansky's due process rights, Mollie Orshansky's court-appointed attorney never bothered to visit or to speak with her, and even represented herself to me as representing the temporary guardian. It was in the temporary guardian's financial best interests to keep the guardianship in the District of Columbia in order to earn large fees from Mollie Orshansky's assets, and Ms. Orshansky's "lawyer" acted accordingly.

Fortunately for Ms. Orshansky and her family, the D.C. Court of Appeals, in a unanimous, 50-page decision, reversed the decision of the lower court. In that decision, the actions of the lower court and its appointed agents were sharply criticized.

The Need for Reform

The Orshansky matter and cases like it demonstrate dangers that seniors and their families face when family members live in another state or where courts are eager to assert control over seniors and the lucrative guardianship appointments that result.

Too often, the wishes of seniors, as manifested by their legal documents and their lifetime planning, are ignored by courts on the basis of being ill-advised. In a recent case in which I represented an incapacitated person with no living relatives, the court was unwilling to let my client name longtime, caring friends to supervise her finances on the grounds that my client was incapable of deciding who she could trust, even though there was absolutely no basis for such a conclusion. The stated rationale of the court, as well as the two attorneys who petitioned for the guardianship, was that when a person knows only a few people, the person will simply choose from among that limited group.

Instead, a lawyer "on the judge's list" in New York will be in charge of this client's finances.

The freedom to make choices, even "bad" ones, is what we as a society have always valued. It is what we fight for, and what our foes seek to take from us by force. Self-determination is at the heart of freedom, and the right to choose family and friends to care for us rather than an institution or a court must be jealously guarded. When people either plan in advance, as Mollie Orshanksy did, for her needs in the event of her incapacity, or, as the other person to whom I have alluded, expresses her wishes as to whom she wants to assist her, then, in the absence of compelling reasons to the contrary, these plans and wishes must be honored by our legal system.

Aside from the obvious emotional and financial turmoil that institutional disregard for individual rights causes for seniors and their families, there are other important issues that must be considered. Many seniors retire from their cold-weather homes to warm-weather states that are hundreds, or even thousands, of miles away from their families. It cannot and should not be used as an excuse by overreaching courts and their minions for the appointment of non-family guardians simply because family members live far away, or because the family is not immediately available when seniors require medical care.

Cases like that of Mollie Orshansky will, in the absence of reform, make seniors far more reluctant to move to states such as Arizona, Florida, or North Carolina if they fear that courts will ignore their wishes.

Proposed Legislative Remedies—Mollie's Law

I do not believe that it would be appropriate or helpful to take guardianships from the hands of state courts. Congress and the federal government, however, may properly impose conditions upon the receipt of Medicare or Medicaid funds on institutions. This provides an opportunity for Congress to require that hospitals and other institutions respect the wishes of seniors and their families.

I refer to these legislative proposals as "Mollie's Law," in honor of Mollie Orshansky and her family,

in the hope that no family in the future will have to endure the nightmare that Ms. Orshansky's family lived through.

There are two parts to my proposal. I propose that hospitals, adult protective services, and other recipients of federal funds must not be permitted to commence guardianship proceedings if there are properly executed advance directives (health care proxies, trusts or powers of attorney) unless there is a good-faith belief that (1) such documents were not duly executed, (2) there has been a breach a fiduciary responsibility, or (3) the advance directives do not give the donee of the power sufficient authority to act where necessary.

Moreover, even where the institution commences the guardianship case in good faith, the institution must be required to withdraw its action if and when it discovers that adequate advance directives are in place.

Violations of this standard must result in a sanction significant enough to deter such behavior, such as loss of federal Medicare and Medicaid funds.

The second part of my proposal is that, even where no advance directives exist, in the event that an institution brings a guardianship proceeding, federal law should require that such case be withdrawn or dismissed in the event that family members commence a guardianship proceeding in another jurisdiction. This would again place the preference where it belongs, namely with the family over an institution, and would recognize the fact that seniors and their families often reside in different jurisdictions—at least until a senior requires assistance.

There is a role for guardianship proceedings. To the extent possible, however, they should be avoided, as they result in extraordinary expenses in the form of legal fees and compensation paid to guardians (especially in states that do not use nonprofit organizations to serve in that capacity), as well as the trauma of court proceedings when seniors and their families are most vulnerable. Too often, the notion of self-determination gets lost in guardianship proceedings.

Mollie's Law will not solve all of the problems that occur in guardianship proceedings, but it will provide important safeguards to seniors that their wishes will be carried out.

Thank you.

Testimony of Jane M. Pollack

Before the United States Senate Special Committee on Aging

February 11, 2003

Good morning. Thank you for the opportunity to appear before this committee. I come here to testify today with the hope that no other family will have to endure the nightmare that we did on behalf of my elderly aunt, Mollie Orshansky.

Who Is Mollie Orshansky?

Mollie Orshansky is a national treasure. My Aunt Mollie is renowned in the areas of statistics and economics. She is best known for her genius in envisioning and developing the federal poverty line formula in 1963, which has enabled millions of the nation's poor to obtain the benefits and the means to sustain themselves and their families. Aunt Mollie has been sought out and mentioned by other authors and by Members of Congress. She has appeared on "Meet the Press" and been interviewed on National Public Radio. Most recently, we were surprised to hear her mentioned as the creator of the poverty line on the television program, "The West Wing." During her outstanding 46-year public service career, Aunt Mollie was the recipient of many prizes and honors, including the Distinguished Service Award, in 1976, the highest honor bestowed by what was then known as the Department of Health, Education and Welfare.

However, Mollie has said that her proudest accomplishment was her testimony in 1964, at the request of the Department of Justice, which helped to end the poll tax.

Mollie was always very strong-willed and fiercely independent. However, Aunt Mollie was a devoted, loving and affectionate sister and aunt, with a special fondness for children.

Mollie's Precautions

Aunt Mollie did everything possible to plan for her future. She executed a health care proxy, naming me as her agent. She also established a trust in 1981, which held all of her assets. Aunt Mollie designated her sister Rose as co-trustee, so that her money and assets could be used and administered for her in the event of incapacity. She purchased an apartment in the same building as Aunt Rose, which is also four blocks from her sister Sarah, my mother. Aunt Mollie planned to move there when the time was right. This planning was to ensure that she would be able to live at home, near her family, in the event of poor health or diminished capacity. They were designed to let her

family, not strangers, care for her and make the necessary health and financial decisions should she be unable to do so.

Aunt Mollie carefully planned for her future but she never anticipated that a hospital, court and lawyers could or would overturn all of her plans.

Mollie's Decline

Aunt Mollie's decline began gradually, in mid-2000. The family noticed she was having difficulty keeping track of her mail and paying bills on time, and we intervened. During frequent visits, family members noticed some decline in her personal care, and her apartment was no longer neat and organized. Despite this, Mollie stubbornly refused live-in or part-time assistance, and she did not feel the time was right to move to her apartment in New York City.

Because of her sometimes disheveled appearance and rambling conversations, her building management contacted Adult Protective Services. One day, without notifying the family, the caseworker ordered an ambulance and took Mollie, against her will, to the hospital. In her report, the caseworker stated that Mollie was alert and oriented, and that she did not want to go to the hospital. Although the caseworker and the hospital were aware that Mollie had interested family, the hospital instituted guardianship proceedings.

As her health care agent, I arrived in Washington a few days later and presented the proxy. I found Aunt Mollie sitting in the dark, forlornly staring into space, with a large contusion on her forehead, due to a fall in the hospital. Her hands and feet were strapped to her chair and a sheet wrapped around her waist tied her body to the chair. Her speech was slurred. She was disoriented and confused. I was told that she had to be restrained and was heavily medicated because she did not want to be in the hospital and kept making a fuss and trying to leave for home.

My requests to obtain Mollie's release into my care as her health care agent were denied because of the pending guardianship hearing. I was informed that she was not there for medical reasons, but for custodial reasons, until her scheduled hearing in late February. I was also told that they were waiting for an opening in a nursing home.

I informed the administrator and the social workers of Mollie's wishes, plans and arrangements. However, although the health care proxy gave me legal authority to direct that Mollie be released to me and Aunt Mollie had certainly not committed any crime, her release was denied and she was held against her will, a prisoner in the hospital.

Mollie's Incarceration and Escape

Each day of her incarceration in the hospital compromised Mollie's health. She received little attention. Mollie's physical and mental condition deteriorated. She fell twice, developed a bedsore, sustained two urinary tract infections, her appetite suffered and she became dehydrated. Mollie became incontinent. Her muscles atrophied and she could no longer stand or walk. In addition, when I was not there, Aunt Mollie was deprived of mental stimulation and social interaction.

One day, I arrived to find Aunt Mollie asleep in a private room that smelled of feces. When Mollie's dinner was served, I discovered that she was clutching feces in her hand. I later discovered that she was holding it for several hours.

I was incensed. I demanded that Mollie be released to me. However, this was again denied.

The next afternoon, I arrived to find Aunt Mollie lying in a dark room, eyes open, with her full breakfast and lunch trays sitting untouched next to her bed. Again, I was quite disturbed by the lack of care and attention afforded Aunt Mollie.

That evening, at 7:40 p.m., I rescued Aunt Mollie. With a lump in my throat and my heart pounding furiously, I pushed Mollie out of her room, past the nurse's station to the elevator and down to the lobby. I avoided the security desk and prayed the guard would not notice. I took Mollie to a side exit and pushed the door open to freedom. At 10:15 p.m. I called the nurse's station to advise them that Mollie was all right and they need not worry. However, 2½ hours later after Mollie left the hospital, they had not even realized that she was gone.

Elian Gonzalez Revisited

I was fearful of how the D.C. court would react—and my fears were justified. I retained New York counsel, and upon the advice of both my New York and D.C. attorneys, informed the D.C. court through my attorneys that I would commence a guardianship proceeding in New York. We did this so that the D.C. court could be assured that the New York courts would ensure Aunt Mollie's well-being.

However, before my attorneys could file the guardianship petition in New York, I was informed that the D.C. court appointed "Mollie's attorney" as her temporary guardian (he volunteered to serve), appointed another person as "Mollie's attorney," invalidated the health care proxy, and ordered the temporary guardian to enlist the New York City Police Department to have Aunt Mollie returned to the District of Columbia.

Needless to say, our whole family had visions of SWAT teams storming into Aunt Mollie's apartment in the middle of the night, as the pictures of heavily-armed law enforcement officials taking Elian Gonzalez away were fresh in our minds.

Fortunately, we were able to obtain an order from the New York court prohibiting Aunt Mollie's removal from the jurisdiction while the court cases were proceeding.

Even with the order in hand, we were so frightened that the temporary guardian and the police would storm into Aunt Mollie's apartment and take her before we, or our attorney, could show the police that a New York court forbade such action from being carried out. Our lawyer was on-call 24 hours a day those first few tense days to run to Aunt Mollie's apartment with the court order in hand.

The Court Case

I lost my bid for guardian/conservator at the February hearing in D.C., and strangers were appointed to represent Aunt Mollie. Incredibly, Aunt Mollie's court-appointed attorney has never met with her or even spoken to her on the phone. Her court-appointed guardian/conservator has done nothing for her. However, he diverted money from Aunt Mollie's trust and has run up astronomical fees, without benefiting her.

The guardian/conservator and the attorney have spent more time charging for their time than caring for their charge. They have hectored and harassed the family, especially Aunt Rose. Fortunately, the appeals court vacated all of the decisions of the lower court, and charged the judge with abuse of discretion. The judge's decision was so egregious and filled with folderol, rather than fairness, that the appeals court overturned every aspect of it in a fifty-page decision.

However, this is not over. A judge still must decide whether to dismiss the case and whether to grant requests for reimbursement of expenses and legal fees from the D.C. guardianship fund.

Our family (including Mollie) has, so far, incurred over $160,000 in expenses—and they are still mounting. The emotional and physical toll is incalculable.

Conclusion

My grandparents emigrated from Russia, where they faced poverty and persecution. They truly believed the words of the Declaration of Independence that all people have the "inalienable rights to life, liberty and the pursuit of happiness." Last year, on his trip to China, President Bush declared that, "All the world's people . . . should be free to choose how they live, . . . worship . . . and how they work." My grandparents would feel much deceived and dismayed by the trampling of Aunt Mollie's rights and disregard of her wishes and carefully made plans.

If you live long enough, infirmity will eventually catch up with you. It is ludicrous to think that any hard working American would want strangers to appropriate their savings or make decisions about their personal care. I am hopeful that Congress will enact legislation to guarantee that the wishes of seniors and their families are respected, so that no other family will suffer the travails that our family did.

Thank you.

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Bonus News 3

Advice and Direction Under SCPA 2107

By David Badanes

An executor seeks your opinion with respect to refinancing a mortgage. The executor's quandary was that although two out of the three co-executors wanted to proceed with the refinancing, the third co-executor preferred selling the property. Additionally, the proposed mortgage prohibited prepayment of the mortgage for five years and contained a clause for a prepayment penalty for three years thereafter. Although, EPTL 10-10.7 does confer that a majority of fiduciaries could vote to exercise the refinancing, your instincts detect a potential problem with the terms of the new mortgage. You counsel your client to petition the Surrogate's Court for advice and direction under Surrogate's Court Procedure Act section 2107 (SCPA). The court accepts the invitation and approves the refinancing.[1]

SCPA 2107 represents the exception to the rule that a court will not give advice and direction to a fiduciary. The statute defines the circumstances whereby a petitioner may ask for the court's advice. Whenever the value of the decedent's property is "uncertain or dependent upon the time and manner of [the] sale," a fiduciary may ask the court "for advice and direction as to the propriety, price, manner and time of [the] sale" of said property.[2] Additionally, a fiduciary may also petition the court "in other extraordinary circumstances."[3] A non-exhaustive list of extraordinary circumstances is defined in the statute as "complex valuation issues, or tax elections, or where there is conflict among interested parties."[4]

In general, if the petition for advice and direction portrays an unusual or peculiar situation that would make it inadvisable for the fiduciary to sell the estate's property, then the court will grant the petition.[5] This can be illustrated by the following example. An administrator is presented with two purchase offers for the decedent's real property. The administrator accepts both offers and is now faced with a potential legal problem. Although, usually a fiduciary can exercise discretion and accept the best purchase offer, the potential liability to the estate could warrant an application to the Surrogate for advice and direction on how to proceed.[6]

Although, the real estate market is currently robust, if a fiduciary has a worthless or severely devalued piece of property due to a depressed real estate market, they can ask the court for permission to delay the sale until a later date.[7] If the will prohibits the sale of property but the fiduciary believes it should be sold despite the will's language, it is proper for the fiduciary to seek advice and direction.[8] Other instances where fiduciaries have used SCPA 2107 include: when the fiduciary wants to purchase estate property for themselves;[9] when the fiduciary is an officer of the corporation of which the estate is a majority shareholder;[10] when an element of self-dealing is present;[11] how to allocate an extraordinary cash distribution to a trust from a subchapter S corporation;[12] or to alleviate any concerns about conflicts of interests when an executor was a limited partner and an attorney for the partnership.[13]

Some fiduciaries have placed the court's approval as a prerequisite to a sale.[14] The courts will usually accept the invitation for advice and direction in those cases.[15] However, if the parties are competent and there are no special circumstances warranting the court's intervention, the court will dismiss the petition.[16]

If a fiduciary substantially complies with the court's advice and direction they are relieved from "any objection that the estate suffered a loss on account of the action taken under [the court's] advice and direction."[17] Furthermore, if the Surrogate does not grant the fiduciary's application, then it has be suggested that it can be implied that the court has betokened the fiduciary to use his or her own business judgment in deciding how to handle the decedent's estate.[18] The fiduciary's petition for the court's advice and subsequently being denied that request may strengthen the appearance of good faith and reduce the possibility of a surcharge.[19] Therefore, it is recommended that if a fiduciary is unsure which course of action to take, they should file a petition for advice and direction, even with the assumption that the court will reject the petition.

The court, however, will not merely substitute its own business judgment for that of the fiduciary.[20] The Surrogate's Court is not to take the place of a fiduciary, and the court will not make managerial decisions. It is only in exceptional and rare circumstances that advice and direction is granted.[21] This reflects the reality that usually a fiduciary can settle the affairs of an estate using their own business judgment.[22] Therefore, a fiduciary's application for advice and direction will be denied unless the facts can demonstrate that it is not safe for the fiduciary to proceed in the usual business fashion.[23] It has been speculated that the Surrogate's Court may not want to encourage the use of section 2107, except in extraordinary situations, as this "may have a tendency to unduly create in the minds of some a limitation of the powers afforded to fiduciaries."[24]

The Surrogate's Court has declined advice and direction petitions in the following situations:

- Determining who is the real owner of a parcel of real estate.[25]
- If the letters of administration authorize the collection of assets less than what the administrators could obtain from a sale of estate property.[26]
- If the offered price for real estate is only slightly less than the appraised value of the property.[27]
- If the disposition of the assets are wholly a matter of business judgment.[28]

Procedural Aspects of SCPA 2107

A fiduciary applies to the court for advice and direction via a petition.[29] The Surrogate has discretion on whether or not to entertain the application.[30] If the application is to be entertained, then the Surrogate must direct the manner of giving notice to any interested parties.[31] Preferably, notice is given by a citation, but an order to show cause theoretically could also be used.[32] Service of the citation must be served in the manner prescribed for the service of citation generally.[33]

A SCPA 2107 proceeding can be brought independently or can be incorporated in another proceeding before the Surrogate.[34] If a fiduciary presents an independent proceeding under SCPA 2107, the court has the authority to decide other matters within its jurisdiction.[35] If the court is to grant advice and direction it will be as a result of a full proceeding.[36]

Conclusion

SCPA 2107 is a necessary and useful provision in those rare instances when a fiduciary needs the court's counsel in deciding how to proceed. The scope of SCPA 2107 explicitly confers to the Surrogate the power to advise and direct in situations other than the price, manner and time of a decedent's property. As demonstrated by the cases heard before the Surrogate's Court, sometimes there are special conditions surrounding a decedent's estate that would make it unwise for a fiduciary to undertake any action without first consulting the court. Commendably, the court has demonstrated that it will not substitute its own judgment when the facts do not justify the court's intervention.

Endnotes

1. *See* 2 Warren's Heaton on Surrogates' Courts § 67.10 (6th ed.) (Heaton), citing *In re Langfur*, N.Y.L.J., Feb. 23, 1994, at 26 col. 1 (Sur. Ct., Nassau Co.).
2. SCPA 2107(1).
3. SCPA 2107(2).
4. *Id.*
5. *See* Heaton, *supra* note 1, at sec. 67.10, citing *In re James*, 27 Misc. 2d 312, 208 N.Y.S.2d 303 (Sur. Ct., Orleans Co. 1960).
6. *See In re Peck*, 79 Misc. 2d 1053, 362 N.Y.S.2d 120 (Sur. Ct., Monroe Co. 1974).
7. *See In re Rosenbert*, 145 Misc. 581, 261 N.Y.S. 650 (Sur. Ct., Richmond Co. 1932).
8. *See In re Pulitzer*, 139 Misc. 575; 251 N.Y.S. 549 (Sur. Ct., New York Co. 1931).
9. *See* Turano & Radigan, New York Estate Administration (2002) sec. 12.06, citing *In re Kramer*, 101 Misc. 2d 782; 421 N.Y.S.2d 975 (Sur. Ct., Bronx Co. 1979).
10. *See* Turano & Radigan, *supra* note 9, at sec. 12.06, citing *In re Hubbel*, 302 N.Y. 246; 97 N.E.2d 888 (1951); *In re Durston*, 297 N.Y. 64, 74 N.E.2d 310 (1947); *In re Cohen*, 88 A.D.2d 290, 453 N.Y.S.2d 10 (1st Dep't 1982).
11. *See* N.Y.L.J., Oct. 9, 2001 at 28, col. 1 (Sur. Ct., Nassau Co.).
12. *See In re Davies*,148 Misc. 2d 37, 559 N.Y.S.2d 933 (Sur. Ct., N.Y. Co. 1990).
13. *See In re Gilbert*, N.Y.L.J., Apr. 19, 1990 at 26 col. 3 (Sur. Ct., N.Y. Co.).
14. *See* Turano & Radigan, *supra* note 9, at sec. 12.06.
15. *See id.* at sec. 12.06, citing *In re Peck*, 79 Misc. 2d 1053, 362 N.Y.S.2d 120 (Sur. Ct., Monroe Co. 1974).
16. *See id.* at sec. 12.06, citing *In re Leibu*, N.Y.L.J., Aug. 17, 1987, at 13, col. 2 (Sur. Ct., Nassau Co.).
17. SCPA 2107(3).
18. *See* Turano & Radigan, *supra* note 9, at sec. 12.06, Heaton, *supra* note 1, at sec. 68.01(2).
19. *See* Turano & Radigan, *supra* note 9, at sec. 12.06; *see also In re Lerner*, N.Y.L.J., Oct. 28, 1993, at 29, col. 4 (Sur. Ct., N.Y. Co.).
20. *See* Heaton, *supra* note 1, at § 67.10; *see also In re Goldstein*, N.Y.L.J., Mar. 23, 1999, at 29, col. 4 (Sur. Ct., N.Y. Co.).
21. *See In re Tannenbaum's Estate*, 20 A.D.2d 808; 248 N.Y.S.2d 749 (2d Dep't 1964), *aff'd*, 15 N.Y.2d 829; 257 N.Y.S.2d 943.
22. *See* Heaton, *supra* note 1, at sec. 67.10.
23. *See id.*; *see also In re Goldfarb*, 93 Misc. 401, 157 N.Y.S. 137 (Sur. Ct., N.Y. Co. 1916).
24. *See* Heaton, *supra* note 1, at § 68.01(2) citing *In re Osterndorf*, 75 Misc. 2d 730, 349 N.Y.S.2d 275 (Sur. Ct., Nassau Co. 1973).
25. *See In re Gerold*, N.Y.L.J., Oct. 29, 1999 at 30, col. 5 (Sur. Ct., Queens Co.).
26. *See In re Goldstein*, N.Y.L.J., Mar. 23, 1999 at 29, col. 3 (Sur. Ct., N.Y. Co.)
27. *See In re Leibu*, N.Y.L.J., Aug. 17, 1987 at 13, col. 2 (Sur. Ct., Nassau Co.).
28. *See In re Tannenbaum's Estate*, 20 A.D.2d 808; 248 N.Y.S.2d 749 (2d Dep't 1964), *aff'd*, 15 N.Y.2d 829; 257 N.Y.S.2d 943.
29. *See* Heaton, *supra* note 1, at sec. 67.10(3).
30. *See id.*; *see also* SCPA 2101, SCPA 202.
31. *See* Heaton, *supra* note 1, at sec. 67.10(3).
32. *See id.*
33. *See id.*
34. *See* Turano & Radigan, *supra* note 9, at sec. 12.06.
35. *See id.*
36. *See In re Levitt*, N.Y.L.J., May 28, 1987 at 14, col. 5 (Sur. Ct., Nassau Co.).

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