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Elder and Special Needs Law Journal

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

Inside

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- Disciplinary Issues Facing Students with Special Needs
- Violations of Medical Privacy in Article 81 Guardianship Cases
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- Expanded Medicaid Estate Recovery Repealed
- Proposed Amendment to the Health Care Proxy Law
- Ethics Poll
- Recent New York Cases
- HECM Trusts

Estate Planning and Will Drafting in New York

Editor-in-Chief

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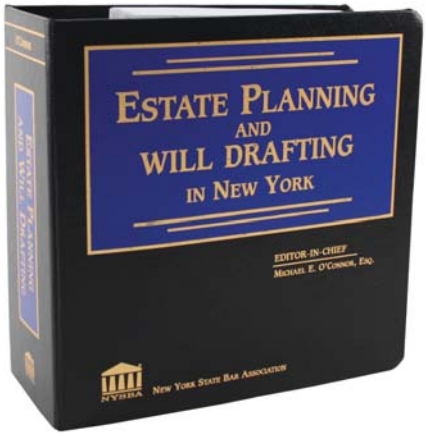

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Message from the Outgoing Chair

"It is a far, far better thing I have done, than I have ever done before…"

I started my first Message as Chair with the opening quote of Charles Dickens' "A Tale of Two Cities"; therefore, it seems only appropriate to start my final Message at the end of my term with a slight paraphrase of the quote that ends that classic. It also, coincidentally, was spoken by an attorney. Thankfully, that's where the similarity ends, I hope.

Looking back on the privilege of serving as your Chair, it has truly been the highest honor I have experienced in my professional life. My term as Chair has been so personally rewarding and fulfilling, thanks to the support and encouragement tendered by my fellow Officers, the Executive Committee, and members of the Section. You were always there, ready to serve during what was a most challenging and yet successful time. I owe you all an enormous debt of gratitude.

My predecessor, **Sharon Gruer**, handed me the torch of leadership over a Section that enjoyed a great reputation, not just within the Bar Association, but across our country. We are often the standard against which other sections are measured and a resource to which other sections turn for guidance. I truly felt the heavy responsibility of maintaining that high level of prominence and respect. With the critical assistance of our Officers and Executive Committee, I believe that standard has remained intact. Allow me to identify just a few of our Section achievements during this exciting and challenging year.

a. Foremost among them was the successful repeal of the Expanded Estate Recovery legislation, passed by the legislature just prior to the start of my term. Needless to say, this project was all-consuming for ten (10) tumultuous months, but the monumental effort by so many members of our Executive Committee was rewarded by repeal on March 30th. Our achievement was declared an epic victory by our professional lobbyists, and one of the most significant in the history of our Bar Association.

b. We have also accomplished the launching of a Mentoring Program, which has been met with great excitement and appreciation. Any attorney who has been enrolled in our Section for five (5) years or less is eligible to participate as a Mentee. As you might expect, at this point we have more Mentee requests than Mentors, so please consider volunteering for this program.

c. We are also working on a Mediation initiative, which will promote the use of Mediation as an additional and effective tool in resolving client disputes. You will be hearing more about this in the near future, as we will begin setting up educational programs to allow you the ability to become certified as a mediator.

d. Our Section also has taken the initiative in revising and promoting the adoption of the Uniform Adult Guardianship and Protective Proceedings Jurisdiction Act by New York State. It was approved by our Executive Committee at the Winter Meeting, and has now received approval by the Bar Association's Executive Committee, allowing it to become part of the Bar's legislative agenda. As an indication of its significance, legislators in Albany are already poised to introduce this legislation in the next session.

e. We have also developed a mechanism for monitoring and reacting, if necessary, to the unauthorized practice of law, which has been making incursions into the practice of Elder Law. This will be a continuing trend, and we need to be continuously vigilant in protecting the elderly, the infirm, and their loved ones from being victimized by the unscrupulous.

As a result of the successes of the past year, I have been the beneficiary of many favorable comments on our achievements. I have been quick to point out that those achievements have come as a result of the efforts of a great many people. My role, and my privilege, has been to be the conductor of a magnificently talented symphony orchestra during this opus. It is to that orchestra that our Section owes its gratitude. Those not intimately involved in the workings of our Section would find it hard to imagine the amount of time that our Executive Committee members devote to the success of our Section. To them, I am deeply grateful.

I ceremoniously passed the torch to **Anthony Enea** at the end of the Spring Executive Committee Meeting, and he is ready to begin his term with a seamless transition. Anthony has been actively and significantly involved in all that has been undertaken by the Section

throughout his years as an officer. I have greatly appreciated his invaluable assistance and counsel in all aspects of Section matters. Anthony will be a creative and dynamic Chair and, together with **Fran Pantaleo** as Chair-elect, **Richard Weinblatt** as Vice-Chair, **JulieAnn Calareso** as Secretary, **David Goldfarb** as Treasurer, and **Marty Finn** as Financial Officer, will continue to enhance the growth and eminence of this Section.

I would also be remiss if I did not credit the role played by **Lisa Bataille** and **Kathy Heider** in the success we enjoyed this year. As I have told them personally, they have been my personal guardian angels, watching over and guiding me through all the administrative issues that come with serving as Chair. They are a wonderful team, and have always been available to answer my many inquiries and assist in their solution. They will be relieved to know that I will remove their numbers from the "favorites" tab of my phone.

To all of you, my sincere thank you for allowing me the privilege of serving as your Chair for this past year. It has been such an honor to say that I represent the members of this great Section, for whom I have such admiration and affection.

As they say in the theater: **"The songs may be over, but the melodies linger on."** Thanks for the melodies.

T. David Stapleton

Message from the Incoming Chair

Our Section's Achievements Are the Result of the Combined Efforts of Each Member

As I began writing my inaugural message as Chair, my thoughts kept returning to how much this Section has meant to my development and success as an Elder Law Attorney, and to the many friendships I have made because of my involvement with the Section. I am truly honored and privileged to have the opportunity to serve as Chair of our esteemed Section.

Following in the footsteps of immediate Past Chair, T. David Stapleton, is no small task. In a year where our Section and the public faced the threat of onerous Estate Recovery regulations, David led our Section with grace and aplomb. His wisdom and leadership, along with the efforts of our Legislation Committee led by Amy O'Connor and David Goldfarb, played a significant role in the repeal of the Estate Recovery regulations. An achievement, which I believe has never before been accomplished in the history of our Section. We truly owe David a debt of gratitude for his service and leadership.

Over the last two decades, I have had the pleasure of working with so many of our Past Chairs, who have created the foundation for our Section's success and have inspired me. I am also honored to have the opportunity to work with my fellow officers, Fran Pantaleo, Richard Weinblatt, JulieAnn Calareso and David Goldfarb. Each of the aforementioned, as well as the members of our Executive Committee, bring a wealth of talents and energy to our Section. I am confident that through our collaboration we will be able to continue our success.

As I have expressed in the title of this message, our success is the result of the totality of each of our individual efforts and hard work. The hard work and efforts of each of our Officers, Committee Chairs, Vice-Chairs, Liaisons, Delegates, and each and every active member significantly contribute to the success of our Section. Whether it be a large significant legislative achievement, or an obscure achievement that does not make the headlines, all of our achievements, large and small, significantly contribute to our overall success. I urge all that have assumed a position of responsibility to treat that position with the respect, attention and effort that it deserves. In the next few months, I will be conferring with each Committee to insure that they have developed an agenda of goals and initiatives for the upcoming year, and that they are taking all of the necessary steps to implement their initiatives. Through all of our combined efforts will we be able to ensure the continued viability and importance of our Section.

At our Annual Meeting in January, I outlined for the Section my hopes and aspirations for the upcoming year. I also discussed how Chair-Elect, Fran Pantaleo, and all of our Officers, had been working to coordinate our common goals to insure they would be implemented

as expeditiously as possible and with an eye towards the future.

While I am cognizant of the fact that priorities may often be re-arranged due to legislative and regulatory initiatives that are beyond our control, I can assure you that our attention will not be diverted from our goal of ensuring that we consistently provide our members with the programs and services they deserve and need to be highly skilled, proficient and successful Elder Law attorneys.

The following are some of the initiatives (not in any specific order) that we believe will help ensure the future success of our membership and the Section:

A. Consistently provide CLE programs that provide a significant comprehensive focus on the Practice Management needs of our members. Our membership has regularly requested and positively responded to CLE programs that have placed an emphasis on Practice Management. Whether it be developments in technology, social media or the more mundane topic of organizing one's workload, consistently providing our membership with the Practice Management tools is imperative. It is our goal to utilize traditional CLE programs, telephonic seminars and webinars to provide our membership with this valuable knowledge. If you are interested in participating in our Practice Management and Technology Committee, please feel free to call Robert Kurre or Ronald Fatoullah;

B. In keeping with our goal of assisting our members with the development of their skills as Elder Law attorneys, we are in the process of creating a Study Group Database. The goal is to encourage our members, particularly our newly admitted members, to join and help form study groups. We are hopeful that this will allow our members to freely interact and discuss legal matters and issues with seasoned practitioners. I believe this initiative will work hand in hand with, and help strengthen the efforts of, our Mentoring Committee, which is chaired by Past Section Chairs Joan Robert and Tim Casserly;

C. As you may be aware, there has been significant concern over the last few years as to non-attorneys providing legal advice within the realm of Elder Law. I have chaired our Unauthorized Practice of Law Task Force, which has researched

this issue in great detail. A survey was sent to our members requesting their input and information concerning specific cases where the unauthorized practice of law has financially damaged a member of the public. The work of this Task Force will be a continuing objective of our Section in the months to come. The response of our membership will be critical to our development of a strategy to address this growing problem;

D. As in the past, our Section will proactively continue to monitor and promote legislative initiatives. We have truly been blessed with a Legislation Committee that has consistently been at the forefront of all State Bar legislative initiatives. This year our Legislation Committee will be chaired by Amy O'Connor and Ira Salzman;

E. In keeping with the challenge of immediate past NYSBA President, Vincent Doyle, and the current initiative of current State Bar President, Seymour James, our Diversity Committee, created by past Chair Sharon Gruer, will continue its work to make our Section as inclusive and diverse as possible. To that end, the Committee will be challenged to develop specific ascertainable standards to measure the level and extent of the diversity within our Section and what steps we can take to increase that diversity;

F. Attracting new members to our Section is of critical importance to our continued success. Like our clients, the membership of our Section is aging. Yes, we are wiser; however, the statistics show the members of our Section are getting older. Our Membership Services Committee and our Liaison to Law Schools Committee will be called upon to coordinate a comprehensive plan to attract younger attorneys to our Section and to the practice of Elder Law. New members are the lifeblood of our Section and we will make a significant effort to cultivate them.

As your Chair, I am always available to address any questions, concerns and suggestions you have about our Section. I encourage you to call me or email me with any questions, and to express any interest you have in becoming an active member of our Section. There is room in every Committee and Task Force for your involvement. For those of you who aspire to become Section leaders, I have two words for you: "Get Involved." Once you do, your hard work, initiative and contributions will be recognized.

In conclusion, for differing reasons each of us became attracted to the practice of Elder Law. However, one common reason for this attraction is our passion and core belief that devoting our life's work to the rights of seniors and the incapacitated is a noble and just cause.

Thank you for your confidence.

I can be reached at 914-948-1500 or Aenea@aol.com.

Anthony J. Enea

Message from the Co-Editors in Chief

The "lazy hazy" days of summer are upon us. Hazy perhaps, but as practitioners we would be hard-pressed to call this time of the year lazy. Our Section remains busy, dedicated to advocating for our clients' needs in the area of elder law and special needs planning.

The past months have been busy ones. We held a spectacular "UnProgram" in beautiful Saratoga Springs, New York. Our co-chairs, Shari Hubner and Jeffrey Goldstein provided participants with several important topics to choose from. It was an incredible opportunity for practitioners to collaborate on important issues, sharing ideas and concerns. We believe that the participants left with a renewed sense of appreciation for the important work of the Section. In this issue Moira S. Laidlaw explores the highlights of the "UnProgram," reinforcing pertinent topics and providing a basis for future discussions.

Several of our Section members work closely with personal injury and medical malpractice attorneys in the area of settling lawsuits on behalf of minors. Robert Mascali and Kathryn Jerian provide the first part of a two-part article on important issues to consider when settling these actions.

Many children with special education needs also face disciplinary sanctions because of a disability. As we continue to include articles that provide practitioners with information on assisting families of children with special education needs, Lauren Mechaly presents an overview of this important area of representation.

Privacy issues have become an increasing concern in our practices and violations of medical privacy continue to exist especially in the area of Article 81 Guardianships. Joseph A., Rosenberg provides us with a detailed overview of the issues and a framework for possible solutions to violations of medical privacy in this area. We also include a case study of a contested guardianship from our regular contributor, Robert Kruger.

Joseph Gruner provides important and very timely information on preparing and supervising estate planning documents when there might be a question of capacity. We continue to recognize the potential for liability in this area and this article offers crucial guidance.

Given the recent repeal of the expanded Medicaid estate recovery initiative, Diane Lynne Butler and Vincent W. Ansanelli provide very pertinent information on Medicaid Qualifying Trusts and a discussion of "Use" and "Occupancy." In addition, David Goldfarb summarizes the repeal process over the past few months.

We continue to be indebted to our regular contributors. In this issue, Ellen G. Makofsky keeps us posted on the proposed amendment to the Health Care Proxy Law, by the Elder Law Section of the NYSBA. Judith B. Raskin and Natalie J. Kaplan remind us of the proper protocol regarding the safekeeping of wills, with their report of Poll #4, by the *Elder and Special Needs Law Journal*. And Judith B. Raskin's article entitled "Recent New York Decisions" continues to keep us well informed.

Again, in the spirit of providing information on planning tools available to practitioners, Wayne R. Bodow provides an in-depth discussion of using Home Equity Conversion Mortgages.

We again thank our past Chair, T. David Stapleton, for his excellent stewardship of our Section during this most eventful year and congratulate our incoming Chair, Anthony Enea and wish him the best of luck and success. As always, we thank our production editors, student editors, our editorial board and everyone involved in this publication. It is a complete team effort.

We truly hope that you enjoy this "summer" reading list. We wish you a productive (and restful) summer. We await submission of articles for upcoming issues and welcome your ideas for future issues.

David and Adrienne

Best of 2012 Unprogram

By Moira S. Laidlaw

Once again, the Elder Law Section of the New York State Bar Association proved itself to be one of the most collegial and generous sections of the bar at this year's UnProgram. From April 26-27, 2012, Shari Hubner and Jeffrey Goldstein co-chaired the UnProgram, which is run as a series of contemporaneous discussion groups. Over two days, there were nine different sessions with five to ten topics to choose from at every session. Popular topics repeat throughout the program so that participants did not have to choose among really important topics. Shari and Jeff added topics to the program in "real time" based upon attendee requests. The subjects covered Annuities/IRAs, Promissory Notes, Long Term Care Waiver Programs, Home Care, Tax Issues relating to Income Only Irrevocable Trusts, Fair Hearings, Spousal Refusal and Alternative Planning Strategies, Employment Tax Issues and Law Practice Technology.

The UnProgram was like eight months of study group meetings condensed into a two-day program. It was an incredible opportunity to meet with other practitioners and hear how they are handling their elder law issues. There were several practice tips that I learned during the program that I wanted to share with the Section. Here are what I have been referring to as the Top Ten of the 2012 UnProgram:

1. **Irrevocable Trust and Completed Gift Issues:** The IRS has issued new guidance relating to its enforcement position on when it considers transfers to a trust to be completed gifts. It is now the IRS's position that a transfer to an irrevocable trust—even where the grantor retains a limited power of appointment—will be deemed to be a completed gift upon transfer to the trust if the trustee has discretionary authority to distribute the trust asset to beneficiaries. A few planning options were brainstormed that could defeat this presumption of a deemed completed gift. One option would be to have the grantor retain a right to reject any proposed trust distribution. Another option would be to limit distributions to an ascertainable standard. Please note that this is the IRS's enforcement position and not judicial precedent.

2. **Alternatives to Spousal Refusal:** The state recently contracted with a collection agency based out of Texas to assist with estate recovery. It may only be a matter of time before DSS starts support proceedings against every refusing spouse. One attorney recounted a case where a client who executed a spousal refusal in 2005 received a demand for payment of $250,000 in 2010. For this reason, we need to be able to offer alternative planning solutions to our married clients. One such solution would be to retitle all assets to the community spouse, and then have the community spouse loan all the assets in a promissory note to a trustworthy person. It would be a short term promissory note, ranging from one to two years. The interest would be payable to the community spouse, and 25% of it would have to be contributed toward share of care if the community spouse is over MMMNA. When the note comes due in one year, the community spouse can then engage in Medicaid asset protection planning with respect to those assets by transferring them to an irrevocable trust. That transfer would not need to be disclosed on recertification of the SNF spouse.

3. **Gifts for Purposes Other Than to Qualify for Medicaid:** There is a growing body of Fair Hearing decisions that have overturned penalties by DOH relating to gifts within the look-back period for purposes other than qualifying for Medicaid. Generally, an applicant has to prove three things: 1) his or her health was stable at the time of the gift (physician's affidavit recommended); 2) applicant continued to be self-supporting (bank statements showing resources retained at time of transfer are helpful); and 3) there was a history of gift giving by applicant.

4. **Home Care:**

    i. **"Unscheduled" Needs vs. "Needs Which Are Not Predictable":** DSS is reducing the hours in its authorizations for home care recipients. One basis that it is using to reduce an authorization from two 12-hour split shifts to one 24 hour care shift (where the aide gets paid one hour for "overnight" 12 hours) is to claim that the recipient's needs are predictable and thus can be prescheduled at convenient intervals. It is very important to show that the needs

cannot be prescheduled and that they remain unpredictable. Further, if you can show that the same aide would have to be up three or four times in the night, every night, and that doing so is unsustainable for one person, it can help make your case for split-shift care.

ii. **Family Member Able to Be Employed as CDPAP Aide:** One practitioner advised that there was a law enacted in the last year that allows a family member to be compensated through the CDPAP program, but the state has not issued a GIS on the issue, so it seems that the counties are refusing to follow this new law. We need to lobby for direction from the state to the counties on this issue so that our clients can benefit from this new law.

iii. **Managed Long Term Care:** Information is available through Valerie Bogart and Self-Help on the transition to managed long term care.

5. **Waiver Programs:** There was much discussion of the Nursing Home Transition and Diversion Medicaid Waiver Program (NHTD Waiver). Unlike the Lombardi Waiver, there is no cap at 75% of the regional cost of nursing home care; the proposed care has to be cost neutral. The NHTD Waiver also makes a certain amount of annual funds available for environmental modifications. Practitioners noted that it can take some time to get an approval of the NHTD Waiver and advised that home care or the Lombardi Waiver first be obtained before applying for the NHTD Waiver. Practitioners in counties with very low home care hour authorizations might find this waiver to be a much more effective way of obtaining home care for their clients.

6. **Promissory Notes:**

i. **Receipt of Funds:** One attorney reported a situation where the borrower under a Promissory Note did not receive the funds but rather let them pass directly to his or her children and DSS penalized the Medicaid recipient for the loan. Be sure that the person signing the note is the one who actually receives the funds. In addition, make sure that the loaned funds do not relate back to funds that were previously gifted. The funds have to be received by the borrower at the same time or immediately after the parties sign the note.

ii. **Equal Payments on Promissory Notes**: Several practitioners schedule promissory note payments to be due in 45-day intervals, rather than 30-day intervals. This helps avoid situations where the applicant could be over-resourced in the first month of applying because of income payments due under the promissory note combined with other income sources.

7. **Collateral Investigation:** Be sure to authorize DSS to collaterally investigate financial matters if you are having difficulty obtaining certain financial records for a Medicaid application. If DSS fails to collaterally investigate, then it will be a defense that you can raise at a Fair Hearing. You have to be able to demonstrate, though, that a good faith attempt was made to procure the records yourself.

8. **Over-Resourced Spouse:** Some practitioners reported that their local counties are only letting the community spouse keep resources over the resource allowance amount that are needed to purchase an annuity that would generate enough income to bring the community spouse up to the full amount of the MMMNA.

9. **Reimbursement to Family from Applicant:** Some counties are requiring a lawsuit by the family for any claimed reimbursement owed by the applicant to a family member.

10. **Documentation:** For practitioners in New York City, it is recommended that the Medicaid application be submitted in person at HRA's 34th Street office and that practitioners obtain a stamped receipt on an extra copy of the cover letter noting the enclosures.

This list is not exhaustive and I welcome any continued discussion on the Elder Law Listserv. The Elder Law Section offers this program annually. I highly recommend it to all Section members. Thanks again to this year's program chairs, Shari Hubner and Jeffrey Goldstein. It would not have been such a success without them.

Moira Laidlaw is the principal lawyer at Laidlaw Firm, Attorneys at Law, PLLC located in Bedford Hills, New York. Moira's areas of practice include Elder Law, Special Needs Planning, Trusts and Estates, and Guardianship. She is a member of the New York State Bar Association, the Westchester County Bar Association, the Westchester Women's Bar Association, and the Estate Planning Council of Putnam County. Moira regularly lectures to senior groups on elder law, asset protection and estate tax issues.

Balancing the Interests of a Minor and a Parent Where the Minor Is the Injured Party in a Personal Injury Action

Part One: Preliminary Issues for the Attorney to Consider

By Kathryn E. Jerian and Robert P. Mascali

Introduction

An attorney who represents an injured infant and ultimately obtains a monetary award for personal injuries, either through immediate settlement or litigation, faces a second phase in finally resolving the case, which can be fraught with as many complications and obstacles as the primary litigation. As discussed in this article, the infant's financial and medical needs at the time of the award, as well as many years into the future, must be considered in order to assist the family in making the best decision about how to structure the award for the best interests of the infant. Those considerations are additionally limited by the parental obligation to provide the necessary support during infancy and, finally, by what the particular judge[1] presiding over the settlement may or may not approve now and going forward. This article will deal with the preliminary considerations for an attorney, and a later article will delve more deeply into some of the problems that can arise during the period of infancy.

A. Initial Discussion with Your Client Following Settlement

Attorneys have several options to present to the parent or guardian of an infant for whom they have settled or obtained a personal injury award, with the caveat that any settlement proposal, even one agreed upon between the parents and the child's attorney to be in the best interest of the child, *must be approved by the court*.[2] A primary question to initially direct the attorney's advice relates to what public benefits, if any, the child is currently receiving, or may receive in the future either on the child's own account or derivative through their parents. Public benefits that are related to income level, such as Medicaid and Supplemental Security Income[3] (SSI), must be ascertained from the client in order to assist in planning a settlement. Since these benefits are means-tested, receipt of a monthly check or lump payment (outside of a trust) will affect the infant's eligibility for these benefits.

Attorneys handling these types of settlements should generally be familiar with the income levels for Medicaid eligibility[4] and the fact that the more income an individual receives, the less he or she will receive in SSI.[5] Furthermore, the attorney needs to discuss with the parents the legal obligation that they have to support their child during infancy and that the funds from the injury cannot be used to underwrite that obligation or to improperly collaterally benefit themselves or other family members. In that regard, it is necessary for the attorney to ascertain the overall financial situation of the parents and the overall dynamics of the family's living situation.

B. Four Options

As a general proposition, there are four possible alternatives for use where the injured party is a minor: (1) guardianship under Articles 17 or 17-A of the Surrogate's Court Procedure Act;[6] (2) guardianship under Mental Hygiene Law Article 81;[7] (3) the establishment of a supplemental needs trust, alone or in conjunction with guardianship; and (4) a proceeding under CPLR Article 12. A detailed review of each of these procedural options is beyond the scope of this article but suffice to say that with respect to each of these options the basic issue remains the same—to safeguard the funds of the injured party during infancy while at the same time allowing for the possible utilization of these funds for the ultimate benefit of the infant.

1. Surrogate's Court Procedure Act — Article 17 (17-A)

If desired, an application can be made to the local Surrogate's Court for appointment of a guardian of the person and property of an infant as a way to manage personal injury settlement funds. The Surrogate's Court Procedure Act governs applications to become guardian of an infant's person and/or property under Article 17[8] as well as guardianships of individuals with intellectual disabilities, whether an infant or not.[9] Guardianships provide for oversight of infant funds as the Court granting such guardianship retains control over the arrangement by means such as requiring a bond,[10] accounting of funds,[11] general approval by order necessary for expenditures,[12] and additionally imposing conditions which the Court deems necessary to safeguard the infant's funds.[13] It should be noted

that, to the extent that Article 17-A is silent on a matter, the provisions of Article 17 apply.[14]

2. Mental Hygiene Law—Article 81

Unlike guardianships under Articles 17 and 17-A of the Surrogate's Court Procedure Act, a proceeding to establish guardianship under Article 81 of the Mental Hygiene Law is available only to individuals consenting to such a guardianship or to "incapacitated persons."[15] The infant's incapacity must be determined by clear and convincing evidence that the infant is likely to suffer harm because of his or her inability to provide for his or her personal needs and/or property management *and* he or she does not adequately understand and appreciate the nature and consequences of his or her inabilities.[16] Given the more stringent requirements of Article 81, your infant client may not qualify for this type of guardianship and it would not likely be appropriate in any event.[17] In addition to the red tape required to obtain a guardianship under Article 81, more "red tape" is also required to maintain such a guardianship. All of these considerations, again, must be reviewed in detail with your client prior to choosing this option.

3. Supplemental Needs Trust (SNT)

In the instance where the client receives SSI[18] and/or Medicaid, a SNT may be the best vehicle for the infant's funds. SNTs are specially designed for individuals with qualifying disabilities and are specifically provided for under both federal and New York State Law and can either be privately administered or administered within a pooled trust that must be run by a non-profit organization.[19] SNTs allow disabled individuals to retain their public benefits while still receiving access to proceeds from personal injury settlements. A trustee or administrator coordinates the disbursement of funds from the trust so that the individual's public assistance will not be jeopardized by receipt of conflicting items, such as cash payments or payment for items for which SSI is meant to be used. Although the SNT is a special vehicle not available to all plaintiffs, depending on their level of disability, its terms should be carefully reviewed with the parent or guardian of the infant. Many clients balk at the restrictions placed on "their money" so a detailed discussion, perhaps to include the potential trust company, should be held to avoid confusion, manage expectations, and explain fully the advantages of a SNT.

4. Civil Practice Law and Rules—Article 12

If the infant receives no public assistance, Medicaid, or SSI, and is not sufficiently disabled to qualify for the use of a SNT, the remaining option consists of using Article 12 to possibly structure a settlement through use of an annuity, or by depositing the funds into a restricted bank account under joint control with the Court. The restricted bank account is generally not recommended[20] as it is quite restrictive as to access of funds that may be necessary and is often not favored by the Courts, especially if the terms of the Order allow the infant to gain full access to all funds at age 18. If after consultation with the client the decision is to structure the settlement through the use of an annuity, the main point to emphasize is that, once a structure has been chosen and "locked in," and later ordered by the Court, the client may not accelerate the payments without a subsequent court order[21] and significant financial penalty. Given the current glut of advertising by structured settlement factoring companies,[22] it is particularly important to explain to your clients the danger in factoring their settlement in the future.

Given that any of the above proposals must be ultimately approved by a judge, attorneys should advise their clients that these decisions are subject to change if the Court sees fit.

C. Resolution of Liens

If the infant received Medicaid benefits relating to treatment of the litigated condition, the county Medicaid office which provided that assistance will likely have a lien against the settlement proceeds. The attorney should notify the Medicaid office(s) where the infant currently resides as well as where he or she resided in the past, particularly at the time the injury occurred, to determine whether any liens exist.[23] Attorneys should request a detail of Medicaid benefits provided and amounts charged so that they are in the best position to negotiate with the corresponding county regarding what the lien relating to their particular injury claim may be.

In limited instances, an infant may also be a Medicare beneficiary.[24] Handling the resolution of Medicare liens is beyond the scope of this article but it is an issue of which practitioners should be well aware.

Conclusion

One thing that is clear is just how complicated the choices are facing infant clients, and their legal representative, following the settlement of a personal injury claim. Attorneys must be familiar with the intricacies of these various settlement vehicles and the legal routes to their establishment. Part II of this series will discuss in more depth the additional problems that may follow once the settlement has been confirmed by a Court and the vehicle for the funds has been established.

Endnotes

1. Article 12 of the C.P.L.R. outlines the procedures required when the action of an infant has been settled.
2. *See id.*
3. Generally, children under 18 with low income and who are "disabled" under the law can qualify for these monthly benefits. *See* http://www.ssa.gov/ssi/text-eligibility-ussi.htm for SSI eligibility requirements (last visited Apr. 17, 2012).
4. 2012 Medicaid eligibility requirements can be found here: http://www.health.ny.gov/health_care/medicaid/#qualify (last visited Apr. 17, 2012).

5. *See* "Understanding Supplemental Security Income: 2011 Edition," http://www.ssa.gov/ssi/text-income-ussi.htm (last visited Apr.17, 2012).
6. *See* N.Y. Surr. Ct. Proc. Act Arts. 17 and 17-A (McKinney 2012).
7. *See* N.Y. Mental Hyg. Law Art. 81 (McKinney 2012).
8. N.Y. Surr. Ct. Proc. Act. §§ 1701-1726 (McKinney 2012).
9. Article 17-A guardianships are only available to individuals who have been classified as "mentally retarded" or "developmentally disabled." *See* N.Y. Surr. Ct. Proc. Act §§ 1750-1761 (McKinney 2012).
10. N.Y. Surr. Ct. Proc. Act § 1708 (McKinney 2012).
11. N.Y. Surr. Ct. Proc. Act §§ 1719, 1721 (McKinney 2012).
12. N.Y. Surr. Ct. Proc. Act § 1713 (McKinney 2012).
13. *See* N.Y. Surr. Ct. Proc. Act § 702 (McKinney 2012).
14. N.Y. Surr. Ct. Proc. Act § 1761 (McKinney 2012).
15. N.Y. Mental Hyg. Law § 81.02(a) (McKinney 2012).
16. N.Y. Mental Hyg. Law § 81.02(b) (McKinney 2012).
17. There are several cases dealing with the propriety of Article 81 versus Article 17-A guardianships. *See Matter of Barbara Kobloth*, No. 10236/10 (Sup. Ct. Westchester Co., July 7, 2010); *Matter of Phillip Morris*, No. 10236/10 (Sup. Ct. Westchester Co., July 7, 2010); *Matter of John J.H.*, 27 Misc. 3d 705 (Sup. Ct. N.Y. Co. 2010); *Matter of Joyce G.S.*, 30 Misc. 3d 765 (Surr. Ct., Bronx Co. 2010); *Matter of Chaim A.K.*, 26 Misc. 3d 837 (Surr. Ct. N.Y. Co. 2009).
18. Even where a child does not receive SSI either because the parent never applied or applied but was rejected, a Court may still order that a child qualifies for the use of a SNT. This is an option to discuss with the parent.
19. N.Y. E.P.T.L. 7-1.12 (McKinney 2012); 42 U.S.C. § 1396p(d)(4)(A); 42 U.S.C. § 1396p(d)(4)(C).
20. However, if the net settlement proceeds to the infant are relatively small, such that an annuity's costs are prohibitive, a bank deposit may make sense.
21. Fortunately, the New York Structured Settlement Protection Act provides some barrier between settlement factoring companies and your client. *See* N.Y. Gen. Ob. L. §§ 5-1701, et seq. *See In the Matter of the Petition of J.G. Wentworth Originations, LLC v. Maurello, et al.*, 2012 N.Y. Misc. LEXIS 678 (Sup. Ct. N.Y. Co. Jan. 24, 2012) (holding that a proposal that the annuitant receive $19,600 in a lump payment in exchange for future payments presently valued at $35,289.87 was excessive and not fair or reasonable); *In the Matter of Benes v. American General Annuity Service Corp., et al.* 2011 N.Y. Misc. LEXIS 6174 (Sup. Ct. Nassau Co. Dec. 12, 2011) (denying request for transfer, holding that although transfer was fair and reasonable, it was not in the "best interest" of the annuitant).
22. Some of these companies are famous for slogans such as "Need Cash Now? Why Wait?" and "I Want My Money and I Want It Now!".
23. Soc. Serv. L. § 104-b requires that this notice be provided.
24. Children who have end-stage renal disease or Lou Gehrig's disease may be eligible. "Benefits for Children with Disabilities," http://www.ssa.gov/pubs/10026.html#a0=4 (last visited April 20, 2012).

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Disciplinary Issues Facing Students with Special Needs

By Lauren I. Mechaly

Danielle is a student with a disability and is enrolled in a local public school operated by the New York City Department of Education. She is twelve years old. When Danielle turned five, the Committee on Special Education (CSE) classified her as a student with a learning disability. Danielle was placed in a general education classroom, but she received speech and language therapy and special education services to address her delays. As a result of her disability, Danielle is easily frustrated and has difficulty with attention to task. The classroom teacher, Mr. Frank, is aware that she is a student with a disability, and does his best to provide additional help to Danielle on a regular basis. She sits at the front of the room to minimize the distractions, and Mr. Frank often repeats instructions to her so that she can complete classroom assignments. Danielle's previous teachers advised Mr. Frank that without these interventions, Danielle has the potential to act out in the classroom, thereby impeding her ability to learn, and also disturbing the other students in the class. This "acting out" behavior may be exhibited in the home as well, affecting the student's ability to complete homework assignments, study for tests, or relate appropriately with his or her siblings and peers. Such behaviors must be addressed by the CSE, and memorialized on the student's Individualized Education Program (IEP).

Unfortunately, a student's behaviors are not always appropriately addressed, and maladaptive behavior can result in disciplinary action against the student. When a student with a disability is removed from his or her current educational program for disciplinary reasons, he or she is placed in a temporary educational placement, or interim alternative educational setting (IAES). While placed in this interim program, the student continues to receive educational services pursuant to his or her IEP.[1] The parent must be notified of any change in placement, including placement in an IAES or a disciplinary change in placement due to a suspension.[2]

A. Suspensions and Disciplinary Changes in Placement

In February, Danielle was involved in an altercation with a boy in her math class. Specifically, this boy was assigned to work with Danielle on an in-class project. Danielle was on a lower math level than this boy, and her skills were not as advanced as his. The boy started getting impatient, and told Danielle that he wanted a new partner because he did not like to work with stupid people. Offended by his comments, Danielle stood up and hit the boy, and then ran out of the room. The math teacher witnessed the incident and contacted the school's principal. Danielle was found in the bathroom with a torn math book, and was brought to the principal's office, where her parents were contacted. Danielle was subsequently suspended for ten days for her violent and disruptive behavior. On the same date, a letter was sent home to Danielle's parents, advising them of the Manifestation Determination Review.

Often a student who is the subject of a disciplinary action is removed from his or her current educational placement. If a student "is insubordinate or disorderly or violent or disruptive, or [his or her] conduct otherwise endangers the safety, morals, health or welfare of others," he or she may be suspended.[3]

A student may be suspended for five school days either by the trustees or board of education, a district superintendent, or a building principal with authority to suspend.[4] During the suspension, the student shall be placed in an appropriate IAES. The length of the suspension may not exceed the length of suspension that would be imposed on a non-disabled student for the same behavior. In the event that a suspension of more than five days is imposed, a superintendent's hearing must be conducted, either by a superintendent of schools or by a hearing officer so designated, to determine whether the student shall be suspended for an extended period of time.[5]

A student's removal from his or her educational setting is considered a "disciplinary change in placement" if the suspension or removal is for more than 10 consecutive school days, or the student is subject to a series of suspensions or removals that constitutes a pattern. Such a pattern is established when the suspensions or removals accumulate to more than 10 days in a school year, and the student's behavior that precipitates that suspension or removal is substantially similar to the behavior which precipitated the previous suspension or removal. The school district shall consider the length and proximity of each suspension or removal in determining whether this pattern warrants a change in placement. If such a pattern is established, a student with a disability may not be removed for a suspension if such a suspension would result in this disciplinary change in placement. An exception to this rule is if the manifestation team has determined that the behavior is not, in fact, a manifestation of the student's disability, as discussed below.

B. Manifestation Determination

If a student with a disability is subject to a disciplinary action, a manifestation review must be conducted to determine whether the conduct is a manifestation of the student's disability.[6] Such review shall be conducted no later than 10 days following: 1) a superintendent's decision to change the student's placement to an IAES; 2) an Impartial Hearing Officer's decision to place a student in an IAES; or 3) the imposition of a suspension that constitutes a disciplinary change in placement.[7] The parent has an absolute right to attend the manifestation determination review, and should be invited to the meeting in writing on the day of the decision to change the student's placement to an IAES.[8]

The manifestation review meeting will consider the student's file, and will determine whether the student's behavior was "caused by or had a direct and substantial relationship to the student's disability; or…was the direct result of the school district's failure to implement the IEP."[9] Under either circumstance, the student's behavior is deemed a manifestation of his or her disability, and the CSE must conduct a functional behavioral assessment, implement a behavioral intervention plan (or modify the existing plan) (*see* Section C below), and, except under limited circumstances, return the student to his or her original placement (unless otherwise agreed).[10] Further, if any deficiencies in the IEP were discovered as a result of this review, said deficiencies must be remedied.[11]

The team conducting Danielle's Manifestation Determination included a district representative, Danielle's classroom teacher, the school psychologist, and Danielle's parents. Danielle also participated. The team determined that Danielle's behavior had a direct relationship to her disability. A Functional Behavioral Assessment was scheduled, and the team recommended that a Behavioral Intervention Plan be developed and implemented. The school psychologist also suggested adding one session per week of counseling to Danielle's IEP.

If a parent disagrees with the school district's decision regarding the placement, such as placement in an IAES, or with the determination of the manifestation team, the parent may request an expedited impartial hearing.[12] Parents should keep in mind that a procedural violation for disciplining a student with a disability will not automatically invalidate the determination of a manifestation team,[13] while a failure to produce evidence regarding the district's compliance with the procedures for conducting a manifestation determination review may not uphold the determination of the team.[14]

C. Behavior Intervention Plan

A student's IEP should be reasonably calculated to ensure educational benefit.[15] An IEP shall "consider the use of positive behavioral interventions and supports, and other strategies, to address that behavior" if the child's behavior impedes his or her learning or that of others.[16]

A behavioral intervention plan (BIP) is developed based upon the results of a functional behavioral assessment (FBA). The FBA is conducted in order to identify the student's "problem behavior" as well as the "contextual factors that contribute to the behavior."[17] The BIP that is developed as a result includes "a description of the problem behavior…hypotheses as to why the problem behavior occurs and intervention strategies that include positive behavioral supports and services to address the behaviors."[18]

Following the FBA, the CSE convened to develop Danielle's BIP and to amend her IEP. The BIP noted Danielle's difficulty with attention to task, and memorialized the interventions already in place, albeit informally, such as her need for the teacher to repeat directions. Preferential seating was also added to Danielle's IEP. Counseling was added to Danielle's IEP for one group session per week for thirty minutes per session, to assist Danielle in her socialization and communication skills.

D. Students Not Yet Identified (201.5)

If the student charged with a violation of the school district's code of conduct had not yet been identified by the CSE as a student with a disability, the parent may request a manifestation determination review, a functional behavioral assessment, or any other protection set forth under the law. However, the school district must have had knowledge that the student was a student with a disability before the behavior occurred. This "basis of knowledge" can be determined through prior writings from the parent to the school expressing a concern for the student's education, a previous request for an evaluation, or the classroom teacher's concern regarding a pattern of behavior exhibited in the classroom.[19] If, however, the parent had previously refused an evaluation, refused services, or it was determined that the student was not disabled, the student will not be considered a student with a disability for purposes of the pending disciplinary action.

If there is no basis for knowledge of the student's disability, the same disciplinary measures will be imposed on the student as on any student not classified with a disability.

E. Conclusion

Parents of children with special needs should be aware of their rights under the law so that they can effectively advocate for their children. Students with disabilities are entitled to certain rights under both federal and state law, and there are considerable safeguards in place to ensure that a student with a disability receives

a free appropriate public education, as is his or her right under the law.

Endnotes

1. 34 C.F.R. § 300.530(d).
2. 8 NYCRR 201.7.
3. NY Educ. L. 3214(3)(a).
4. 8 NYCRR 201.7(b); N.Y. Educ. L. 3214(3).
5. 8 NYCRR 201.2(q).
6. 8 NYCRR 201.4(a); 30 C.F.R. § 300.530(e); 20 U.S.C.S. § 1415(k)(1)(E).
7. *Id*.
8. 8 NYCRR 201.4(b); 20 U.S.C.S. § 1415(k)(1)(H).
9. 8 NYCRR 201.4(c).
10. 8 NYCRR 201.4(d); 34 C.F.R. § 300.530(f).
11. 8 NYCRR 201.4(e).
12. 20 U.S.C. § 1415(k)(3)(A); 34 C.F.R. § 300.532(c); 8 NYCRR 201.11(3)-(4); *see also* Coleman v. Newburgh Enlarged City Sch. Dist., 503 F.3d 198, 201-02 (2d Cir. 2007) *and Application of a Student with a Disability*, Appeal No. 11-034, at 8.
13. Fitzgerald v. Fairfax County Sch. Bd., 556 F. Supp. 2d 543, 551 (E.D.Va. 2008); Farrin v. Maine Sch. Admin. Dist. No. 59, 165 F. Supp. 2d 37, 51 (D. Me. 2001); A.C. v. Bd. of Educ., 553 F.3d 165, 172 (2d Cir. 2009); Matrejek v. Brewster Cent. Sch. Dist., 471 F. Supp. 2d 415, 419 (S.D.N.Y. 2007) aff'd, 2008 WL 3852180 (2d Cir. Aug. 19, 2008); Appeal No. 11-034, at 9.
14. *Application of the Bd. of Educ*., Appeal No. 10-028; Appeal No. 11-034.
15. 20 U.S.C. 1400 et. seq.
16. 20 U.S.C. 1414 (3)(B)(i) (2012).
17. 8 NYCRR 200.1(r).
18. 8 NYCRR 201.2(a).
19. 8 NYCRR 201.5(b).

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Routine Violations of Medical Privacy in Article 81 Guardianship Cases: So What or Now What?

By Joseph A. Rosenberg

Introduction

Each day in courtrooms throughout New York State, and indeed the United States, judges are asked to decide whether to appoint a guardian for an alleged incapacitated person ("AIP") with the power to make decisions about property management and personal needs.[1] In New York, the standard for appointing a guardian under Article 81 of the Mental Hygiene Law requires clear and convincing evidence of two main elements: that a guardianship is necessary to provide for a person's personal needs and property management, and the person either consents to the appointment or is found to be incapacitated.[2] Medical evidence is not necessary to prove that a person is incapacitated and needs a guardian.[3] Although medical information can be an important piece of the guardianship "puzzle," it may be prejudicial and obscure the primary inquiry under Article 81: what are the functional capacities of the person alleged to need a guardian, and does the person have functional limitations that she does not fully understand or appreciate, and as a result place her at risk of harm?[4]

Anecdotal evidence suggests that many, if not most, guardianships are resolved in a generally decent manner, with genuine care and concern for the person who is alleged to be incapacitated and in need of a guardian. However, the "loose use" of medical information creates the risk that medical privacy rights are routinely violated. This is not only a cause for concern in that unauthorized disclosure of private health related information is unlawful and damaging to a person, but it also may shift the predominant frame of a guardianship from a functional assessment to a medical diagnosis. Excessive reliance on medical evidence can result in a court order that appoints a guardian without a full exploration of less restrictive alternatives that may be available and sufficient. Consider the following scenarios:[5]

- Adult Protective Services ("APS") filed a petition to appoint a guardian for a single woman in her mid-80s based on an investigation conducted by an APS psychiatrist. The petition alleged that the woman could not make decisions about her property or personal needs, including health care decisions. At the beginning of each visit, the APS psychiatrist allegedly obtained the woman's consent to meet. The discussion leading to the patient's "consent" was brief and the psychiatrist did not advise her that the information he was gathering might be used in a guardianship petition and at a hearing. Although the APS psychiatrist testified that the person was incapacitated and needed a guardian, the petition was dismissed because the court found that the person had the capacity to execute advance directives and had an adequate informal support system. The testimony of the psychiatrist was permitted and the psychiatric affidavit remained part of the public record.
- A hospital filed a petition for a guardian to be appointed for a man in his 60s who was brought to the hospital by his family when he became disoriented while shopping at a local supermarket. The hospital included medical information relating to alleged psychiatric issues and substance abuse in support of the petition. The hospital also alleged that the person could not be safely discharged to his home and asked for a guardian with the power to sell his residence in the community and place him permanently in a nursing home. The court found the person had the capacity to consent to the appointment of a guardian, but only with limited powers for a limited period of time, and required that the guardian facilitate a discharge back to his home in the community with appropriate home care and case management.
- A nursing home filed a petition to have a guardian appointed for a woman in her 80s who had been living at home in an apartment. After a mild stroke required the woman's hospitalization, and rehabilitation in a nursing home, the petitioner alleged that the woman needed a guardian due to her dementia and psychiatric issues. The petition asked that the guardian be granted the power to relinquish the AIP's apartment and keep her in the nursing home. The court appointed a guardian with the power to release the person's apartment and place her permanently in the nursing home.
- A parent filed a petition to be appointed guardian for his 21-year-old daughter, whose struggles with psychiatric issues required her to reside in a residential school. The school provided medical information that was used to support the peti-

tion, and the daughter's psychiatrist submitted an affidavit that was attached to the petition. The petition requested a guardianship with full powers and for an unlimited duration. Although the daughter's functional capacity was relatively high and she may have been able to function independently over time, the court appointed the parent as guardian with broad powers for an unlimited duration.

These cases represent a microcosm of cases decided pursuant to Article 81 of the New York Mental Hygiene Law. This statute, which was enacted in 1983, has been justifiably lauded as a pioneering piece of legislation because it moved the focus of the need for a guardian from a medical model to a functional model and looks at the capacity of the person to make decisions and perform activities of daily living.[6]

The adult guardianship population in New York and the United States is rapidly becoming more diverse, and demographic patterns point to substantial increases in the number of people who may need a guardian due to mental health issues, age-related diseases that affect cognition (e.g., Alzheimer's disease and other dementia-related conditions), mental illness, and/or developmental disabilities.[7] The case vignettes described above reflect this diversity. The petitioners can include a government agency, hospital, nursing home, or a family member—and the statute also authorizes any other person or entity concerned with the welfare of the person alleged to need a guardian to file a petition. Those people alleged to need a guardian represent a diverse group, including the elderly woman, who becomes the subject of an APS investigation, who has an adequate support system in place; the older person who had a history of financial problems and substance abuse being forced out of his residence and into a nursing home; the elderly woman whose guardian was authorized to release her apartment and place her in a nursing home, and the young adult, suffering from a lack of maturity and mental disease. The reasons for bringing a guardianship proceeding are also illustrative: protection against possible financial exploitation, discharge to a nursing home; sale of a residence in the community and permanent placement in a nursing home, and assurance that a parent would have legal authority to make all major decisions for a child reaching the 21 years of age. Despite their variety, the cases described above have two commonalities: 1) medical information was included as part of the petition and used in ways that violated the medical privacy of the person alleged to need a guardian, and 2) all of the cases could have been resolved without filing a petition for guardianship.

In recent years, a great deal of attention has been paid to the "back end" of guardianships.[8] This phase of a guardianship relates primarily to the duties of a guardian, the duration of the guardianship, the filing of initial, annual and final reports which are reviewed by court examiners and approved by the guardianship part or court. In addition, this judicial oversight is crucial to assure that the powers being exercised remain appropriate and necessary, and that the person is residing in the least restrictive setting that is reasonable under the circumstances.[9]

However, relatively less attention has been paid to issues at the "front end" of guardianships, which is the point at which unnecessary guardianships can be avoided.[10] These issues include the standard for appointing a guardian, pleading requirements, possible alternatives to a guardianship, the nature and quality of notice to the AIP and interested parties, circumstances under which an attorney must be appointed, the scope of the court evaluator's role, and the use of medical information to support a petition to appoint a guardian, whether in the form of medical affidavits, records, or testimony.

Article 81 is a functional statute that includes important components of due process. The standard for the appointment of a guardian is clear and convincing evidence. The pleadings must include a plain English notice to the AIP. The court must hold a hearing at which the AIP must be present, unless the court dispenses with this requirement. The court must appoint a court evaluator or an attorney for the AIP. The rules of evidence apply in contested hearings, courts are required to consider alternatives to a guardianship before appointing a guardian, the statute requires particular findings of fact, and provides for a variety of arrangements that include limited guardianships both in scope and duration.[11]

Yet, even under Article 81, routine disclosures of medical information create a dual risk. One risk is that a person's medical privacy will be violated, and the other is that the statutory mandate to view the case through a functional and least restrictive means framework will be subordinated a medical diagnosis. These violations may occur throughout the various phases of a guardianship case, including the "front end" in pleadings, during the pre-hearing investigation stage when the parties prepare their evidence, and while the neutral court evaluator assesses the allegations and prepares recommendations to the court. These violations may continue at the hearing, and (if a guardian is appointed) throughout the "back end" of the guardianship in the guardian's initial and annual reports. These violations may be relatively benign and in reality few people may see, know, or care about the private medical information that remains in court files and digital records for many years. But the failure to adequately safeguard and protect private medical and health care related information might not only violate the dignity and privacy rights of the AIP person, but also result in a guardianship that is unnecessary.

The question I explore in this article is not whether medical evidence should ever be part of a guardianship case. Indeed, if it is relevant, probative, material, and admissible, then it may very well help a judge, and possibly a jury, make a decision. Rather, the real questions are whether there are sufficient safeguards to prevent violations of a person's medical privacy rights and under what circumstances, if any, should medical information be disclosed and admitted into evidence during the various phases of an Article 81 guardianship. In addition to violating a person's medical privacy rights, the loose use of medical information may help perpetuate vestiges of the *medical* model of guardianship, which has been repudiated over the course of the last quarter century in numerous reports and studies.[12] Medical information and diagnosis may potentially be detrimental to the person alleged to need a guardian in that it may enable a petitioner (and court) to relegate a *functional* assessment and potential alternatives to a guardianship[13] to a secondary consideration. Thus, health care facilities (i.e., hospitals and nursing homes) and government agencies (i.e., APS) may file a guardianship proceeding instead of exploring meaningful support services, such as case management and discharge planning, resulting in unnecessary guardianships that further strain the resources of the guardianship system.[14]

In addition, and perhaps more importantly, to have a guardian appointed to make decisions is to experience a "civil death." It deprives a person of the fundamental rights that define our personhood. It deprives a person of the right to forge an individual path in the world, however flawed and imperfect, as part of a larger community. It is those precious and fundamental rights that are essential to nurture human growth and development.

A. The Tension Between Functional and Medical Evidence to Prove the Need for a Guardian and Incapacity

Guardianships involve the deprivation of a person's fundamental liberty rights that are protected by the Due Process Clause of the Fourteenth Amendment to the U.S. Constitution.[15] The United Nations Convention and Optional Protocol on the Rights of Persons With Disabilities ("UN Convention") also includes far reaching provisions and a framework for protecting fundamental human rights for people with disabilities.[16] A guardianship should only be used as a last resort when less restrictive alternatives have been exhausted. If a court decides that a guardian is necessary, the U.S. Constitution and Article 81 require that the guardian only be granted the minimum powers that are necessary. Article 81 provides for an array of due process protections, including:

- Detailed notice and pleading requirements;
- A functional framework that does not require medical information;
- The appointment of a neutral court evaluator or attorney for the person in every case;
- Consideration of less restrictive alternatives to a guardianship;
- A mandatory hearing;
- The right to invoke the Fifth Amendment protection against self-incrimination;[17]
- Clear and convincing evidence of the need for a guardian and the person's consent or incapacity;
- Required findings of fact; and
- Tailored guardianships that are monitored after 90 days and annually.

The concept of the least restrictive alternative is central to the rights of people who are subjected to guardianship proceedings and is codified in the opening legislative findings and purpose section of Article 81:

> The legislature finds that it is desirable for and beneficial to persons with incapacities to make available to them the least restrictive form of intervention which assists them in meeting their needs but, at the same time, permits them to exercise the independence and self-determination of which they are capable…in a manner tailored to the individual needs of that person, which takes in account the personal wishes, preferences and desires of the person, and which affords the person the greatest amount of independence and self-determination and participation in all the decisions affecting such person's life.[18]

The stakes of a guardianship proceeding are extremely high. The outcome of a guardianship directly affects the AIP's right to make decisions about fundamental aspects of life such as where to live,[19] health care and medical treatment,[20] social environment,[21] and management of finances and property.[22] The right to live independently, with appropriate support, is an essential component for a person to be fully recognized under the law. In Article 81 cases, the question often arises whether a person should continue living at home in the community, return to a community residence from a hospital or nursing facility, or continue to reside in a health care facility or other institutional setting. Article 81 mandates that a person under a guardianship

be given the opportunity to remain living in, or return to, the community provided it is reasonable.[23]

The right of people with disabilities to live independently in the community was recognized by the U.S. Supreme Court in *Olmstead v. L.C. by Zimring*.[24] In *Olmstead*, the U.S. Supreme Court held that under the Americans with Disabilities Act (ADA), individuals with disabilities had a right to "the benefits of community living" if the placement was appropriate, it was not opposed by the "affected" individual, and the placement could be reasonably accommodated without a fundamental altering of the program providing the services.[25] The court held that under the ADA, the segregation of individuals with disabilities within institutions constitutes discrimination, and the ADA's "integration regulation" requires reasonable accommodations in a community based setting.[26]

The right to independent living under Article 19 ("Independent Living and Being Included in the Community") is also a key provision of the UN Convention. The UN Convention focuses on a person's legal capacity and rejects substitute decision-making and guardianship in favor of a support model of decision-making.[27] There is a symbiotic relationship under the UN Convention between the Article 19 mandate for independent living and Article 12, which provides that persons with disabilities shall have equal recognition before the law and be entitled to the support necessary to "exercise their legal capacity."[28]

The standard for appointing a guardian has evolved along with societal notions of incapacity, the understanding that disability is as much a social construct as a personal challenge, our knowledge that the capacity to make decisions is local and not global, and the value we place on autonomy over protection. The concept of disability has, and continues to be, defined under a variety of rubrics, not all of which are mutually exclusive. Medical, legal, and functional needs are all accepted "prisms" through which a person's capabilities can be assessed. The "support of legal capacity" model under Article 12 of the UN Convention situates all people along a continuum of support.[29]

The medical evidence dilemma reflects the tension between autonomy and protection that is at the core of guardianship cases and also illuminates the larger, evolving movement away from a medical model to a functional framework, which may ultimately culminate in the support model envisioned by Article 12 of the UN Convention. A requirement that medical evidence must be offered to establish incapacity or disability may violate a person's civil rights and result in an erroneous determination that does not reflect the functional ability and capacity of the person. In contrast, appointing a guardian merely based on factual evidence that is anecdotal, may risk ignoring or minimizing medical conditions that are causing the person's limitations and that might be temporary or responsive to treatment.[30]

When the evidence presented to prove the need for a guardian involves both a person's psychiatric condition and history, two main problems arise. First, admission of this evidence "[p]oses a significant risk of unfair prejudice to the plaintiff in light of the persistent and evasive stigmatizing effects of psychiatric diagnoses."[31] Second, "[f]act finders are likely to misuse psychiatric evidence, particularly when offered through expert witnesses, because they have few tools to independently evaluate such evidence and thus may overvalue the significance of psychiatric diagnoses for the resolution of factual questions."[32]

The functional capacity framework of Article 81 looks primarily at the person's capacity to manage activities of daily living, including decisions about finances and health care. The standard for appointing a guardian under Article 81 has two essential components. The guardianship must be necessary and, the person must either consent or found to be "incapacitated."[33] A court must not appoint a guardian if there are adequate alternatives that are less restrictive and adequately meet the person's needs, which would make the guardianship unnecessary.[34] The term incapacitated under the statute means the person has: a) limitations that interfere with activities and decisions of daily living; b) the person does not understand the nature and consequences of her limitations; and is c) therefore at risk of harm.

Although Article 81 has many of the positive attributes of the functional approach, the inappropriate use of medical evidence creates the risk of violating the medical privacy rights of the person alleged to need a guardian. The consequences of these violations may depend in large part on the context of the case and the circumstances of the person. Greater awareness of medical privacy would help Article 81 fully realize its stated intent to base guardianship on a person's functional capacity and reinforce respect for the complete legal recognition of each person's rights, dignity, and legal capacity.

B. Protections Against Disclosure of Medical Information that Affect the Guardianship Population

Privacy is of great value in our society, and medical privacy in particular enjoys multi-layered levels of protection under various laws that govern disclosure by health care entities and individual providers. These include the right to medical privacy, protection against disclosures by entities under the federal Health Insurance Portability and Accountability Act (HIPAA) and the New York Mental Hygiene Law, as well as evidentiary privileges such as the physician-patient privilege.[35]

1. Medical Privacy Rights under the U.S. Constitution and State Constitution Apply to Individuals Alleged to Need a Guardian

The U.S. Supreme Court has recognized a right of informational privacy under the Due Process Clause of the Fourteenth Amendment to the U.S. Constitution.[36] There are two broad categories recognized within the right to privacy: the right to autonomy, which protects personal choices from unwarranted interference from the government, and the right to maintain the confidentiality of private information.[37] In *Whalen v. Roe*,[38] the court held that although there was a constitutional right of privacy, a computerized record of prescriptions for controlled substances maintained by the State of New York did not violate those rights, as it contained adequate protection against disclosure and did not affect an individual's decision to obtain a prescription.

Federal courts in the Second Circuit have held that this constitutional right "[i]n avoiding disclosure of personal matters" applies to the medical information of a person with HIV,[39] a prisoner with HIV who is a transsexual,[40] and a person with sickle-cell anemia.[41] Although courts agree that determining if a person's medical privacy rights have been violated under the Constitution requires a case-by-case analysis, in *Matson v. Bd. of Educ. of the City Sch. Dist. of N.Y.*,[42] the Second Circuit held that the standard requires that the person have a serious medical condition that, if disclosed, would bring "opprobrium," such as disgrace, discrimination, and intolerance.[43] *Matson* involved a music teacher with fibromyalgia who was investigated by the City of New York Board of Education ("BOE") for potential abuse of its sick leave policy. In the course of its investigation, the BOE posted her condition on its website, and the *New York Times* ran an article about her situation. The court held that her privacy rights were not violated in that fibromyalgia was not fatal, did not involve a psychiatric disorder, was not the kind of condition that if disclosed would result in societal stigma and discrimination, and that any adverse consequences the teacher suffered were due to her abuse of the sick leave policy, not her medical condition. The dissent in *Matson* criticized the majority for imposing an unduly restrictive standard, particularly in the procedural posture of deciding a motion to dismiss the complaint.[44]

Assuming a particular medical condition is sufficiently serious and subject to societal discrimination, the question of whether disclosure is reasonable requires analysis of the government's interest in public health and whether action was taken to minimize the disclosure of private information.

Although not specifically mentioned in the N.Y. Constitution, New York courts have held that the scope of the right to privacy protected under the N.Y. Constitution is broader than the U.S. Constitution.[45] The N.Y. Court of Appeals has not specifically ruled on the question of disclosure of medical records, although it has upheld the requirement under New York City law that the name and address of a person obtaining an abortion be included on the pregnancy termination document filed with the Department of Health, as it furthered a governmental interest in maternal health and made it easier for government officials to retrieve a person's health records.[46]

Applying these standards to guardianship cases, the requirement that a condition be "serious" would appear to be satisfied if a case involved the disclosure of medical information supporting a finding of incapacity and that a guardianship was necessary. To the extent that particular medical conditions relate to a person's mental capacity to make decisions, disclosure could trigger the required level of disgrace, discrimination, and intolerance required by *Matson*. For example, if a medical affidavit accompanies a guardianship petition and includes information related to a condition such as Alzheimer's disease, Parkinson's disease, or a history of substance abuse, a person suffering from these potentially disabling conditions is protected from discrimination under the ADA. Each of these are serious, potentially fatal, and if revealed could subject a person to discrimination and intolerance. A person's reasonable expectation of privacy should not diminish or disappear merely because a government agency or health care facility files a petition for guardianship, or a court decides the person is incapacitated and appoints a guardian.

2. HIPAA and the New York Mental Hygiene Law Limit the Circumstances Under Which Covered Entities May Disclose Protected Health Care Information in Guardianship Proceedings

The release of medical records is subject to the requirements of the Health Insurance Portability and Accountability Act (HIPAA).[47] HIPAA preempts state law unless the state law provides greater privacy protection to health-related information than HIPAA. For example, prior to HIPAA, a person who brought a medical malpractice action was deemed to have placed his or her medical condition at issue, and therefore impliedly consented to the disclosure of medical information to the defendant's attorney. However, HIPAA's provisions require separate authorization by the plaintiff before a defendant's attorney is permitted to obtain protected health related information. Otherwise, the information is not admissible.

A patient or her authorized representative (for example, a person named in a HIPAA release, a court appointed guardian with the power to access health care information, or an agent under a health care proxy) must consent prior to the disclosure of medical records by a covered entity under HIPAA.[48] Exceptions to these requirements include a disclosure required by law, which include but are not limited to requests made in

the course of a judicial proceeding. The disclosure may be in response to a subpoena, court order, or other process related to the proceeding.[49]

Although HIPAA includes a number of exceptions to its general rule of non-disclosure, the failure to follow the HIPAA procedures will result in the exclusion of the medical records or information, and potentially a fine. The N.Y. Court of Appeals has held that a hospital's release of medical records to a state agency in an Assisted Outpatient Treatment (AOT) proceeding pursuant to N.Y. Mental Hygiene Law § 9.60 (a.k.a Kendra's Law) violated HIPAA, as the disclosure was not authorized by the person who was the subject of the proceeding and there was no judicial process in the form of a court order or subpoena.[50] In *Miguel M.*, the records provided to the AOT administrator did not meet any of the exceptions recognized under HIPAA: for purposes of treatment, or pursuant to a court order or other judicial or administrative process. The court also held that the AOT program did not fall within the public health exception under HIPAA and the Privacy Rule. Moreover, the court held that the records were not admissible, and distinguished the AOT context from a criminal context in which courts have admitted medical records to prove that a crime has been committed. In a subsequent case with virtually identical facts, a lower court held that *Miguel M.* applied retroactively and ruled that the medical records at issue were not admissible since they were disclosed without the patient's consent and without a court order or subpoena.[51]

Under Article 81, health care facilities that initiate guardianship proceedings routinely disclose medical information without the consent of the patient or an authorized representative. This disclosure of medical information may be at the very beginning stage of a guardianship proceeding, with the filing of the petition. The disclosure often continues throughout all stages of the guardianship. All the while, sensitive health care information is disclosed freely, without the AIP's consent or a court order.

3. Evidentiary Privileges Protect Disclosure and Admission of Medical Evidence in Guardianship Proceedings

Evidentiary privileges govern the relationship between a health care professional (and other disciplines such as social workers) and a patient/client/consumer.[52] The physician-patient privilege did not exist at common law and New York was the first jurisdiction to enact a physician-patient statutory privilege in 1828. Although subject to some criticism, this privilege is firmly embedded in the public policy of New York.[53] The privilege safeguards disclosures by individual providers and entities under the theory that "privilege in the courtroom will encourage disclosure in the sickroom."[54] The physician-patient privilege protects information obtained by a physician who attends to a person in her professional capacity, whether the information is communicated to the physician or based on the physician's observations.[55] A physician-patient relationship is created when "professional services are rendered and accepted by the patient pursuant to an express or implied contract."[56] The privilege applies regardless of whether the information is in the form of testimony or record.[57] The privilege is construed broadly, although there are exceptions for review of records by a court evaluator in an Article 81 case,[58] examinations related to employment (unless the physician affirmatively treats or recommends treatment),[59] cases involving guardianship or custody of abused or destitute children, reports made in concerning suspected abuse and neglect of children, where the physical and mental condition of a decedent is at issue, and for certain public health purposes.[60]

The privilege is not waived merely because a person has to defend against an action that places her medical or psychiatric condition at issue, even if the plaintiff or petitioner claims that the person's medical condition is "in controversy" and subject to discovery.[61] This applies directly to Article 81 guardianships, where a person who is alleged to need a guardian is not making a claim, or putting her medical condition at issue (at least initially), but is defending allegations made in the petition by a government agency, health care facility, person, or other entity.

Typically, a person who is alleged to need a guardian may interact with a variety of physicians and other health care professionals who initiate contact with the person in a therapeutic context and may be subject to an evidentiary privilege. This sort of involuntary physician-patient relationship can pose special challenges in a guardianship, as they may not fit neatly within the traditional conception of a treating physician.

C. The Use and Abuse of Medical Information in Guardianship Proceedings: A Double-Edged Sword Along a Fine Line

The disclosure of medical information in a guardianship case creates a risk that the person's medical privacy rights will be violated and health-related information will be admitted into evidence that may not be causally connected to the person's functional capacity and might distort the need for a guardian based on a medical diagnosis. Conversely, the use of medical evidence and testimony in guardianships may be necessary to assure that any possible determination of incapacity is not the result of side effects from medication, depression, or other conditions that if properly treated will resolve the problems causing the person's incapacity.[62]

Under Article 81, a guardian can only be appointed if it is necessary and the person consents or is found to be incapacitated.[63] The element of necessity requires a finding that the person is at risk of harm if a guardian is

not appointed. If alternatives to a guardian are available and sufficient, the guardianship may not be necessary, and the petition must be dismissed.[64] The secondary element of either consent or a finding of incapacity requires that the person either have the capacity to make an informed decision about the nature and consequences of having a guardian appointed or be found incapacitated. Incapacity is defined as a person's lack of awareness and understanding of how limitations that interfere with decisions about property and personal needs may put the person at risk of harm.[65] Notably, a finding of incapacity cannot be based, for instance, on inability to pay rent or provide for one's needs, nor the questionable wisdom or even self-destructive nature of "bad" decisions. Rather, it must be based on the absence of a knowing or informed choice about the decisions that may lead to harmful consequences.[66] If a court finds that a guardianship is not necessary, for example if adequate alternatives exist or the person is not at risk of harm, the petition must be dismissed, even if the person is found to be incapacitated.

Article 81 requires that certain information be included in the petition, including a "description of the AIP's functional level, including the AIP's ability to manage the activities of daily living, behavior, and understanding and appreciation of the nature and consequences of any inability to manage the activities of daily living."[67] Witnesses may be family members or friends, professionals that have come into contact with the person or health care personnel who may base their assessment on a medical diagnosis. Although this evidence can and should be primarily factual and anecdotal, medical information and diagnoses continue to have a significant, if not primary, role in Article 81 cases. However, medical evidence is not required, either as part of the petition or at the hearing.[68]

The use of medical evidence depends in large part on the context, the reasons for its use, and the role of the person requesting access to those records. In an uncontested proceeding, courts may have the discretion to relax evidentiary rules, although that may still be problematic in that the privacy rights of a person may be violated. In a contested guardianship hearing, the full panoply of objections and evidentiary requirements apply, and courts will deny motions to admit medical records and testimony into evidence.[69] In some cases, a court will order the hearing be closed to the public and the case record sealed.[70]

1. Using Protected Medical Information in Support of the Petition May Violate HIPAA, the Physician-Patient Privilege, and Distort the Focus on Functional Capacity and the Least Restrictive Alternative

There is risk that the privacy rights of the AIP may be violated when the order to show cause and petition are filed. The petitioner may be a hospital or nursing home, and the petition may contain the AIP's medical information obtained from the facility's medical records or records of treating physicians at the facility. Although Article 81 explicitly states that medical information is not required to be included in the petition, the order to show cause must inform the person that the court evaluator may request a court order to inspect medical or psychiatric records and that the AIP has the right to object to this request.[71] In this very common scenario, a court may strike a medical affidavit attached to the petition because it violates a person's medical privacy rights under HIPAA, the physician-patient privilege, or other applicable privacy laws.

When the petitioner is a hospital, nursing home, or other covered entity, the practice of including medical information as part of the petition violates HIPAA.[72] In *Matter of Derek*,[73] a case decided under Article 17-A of the Surrogate's Court Procedure Act but directly applicable to Article 81, a court removed medical affidavits that were attached to the petition, which is required by the statute. The court held that the affidavits violated HIPAA, but denied the motion to dismiss as there was sufficient non-privileged information to state a cause of action.

If medical information from a treating physician is included as part of the petition, it may also violate the physician-patient privilege.[74] Even when the purpose of the petition is to secure an appropriate placement for a patient in a facility, medical records and the testimony of treating physicians are not admissible.[75] In the illustrative case of *Tara X*,[76] a contested adversarial proceeding in which the privilege had been asserted, a daughter alleged in the Article 81 petition that her mother had various psychiatric conditions that made her incapacitated. The daughter attached affidavits from a physician who treated the mother during a prior hospitalization, and reports of "medical personnel" who "attended" to the mother prior to that hospitalization. The court evaluator requested access to the AIP's medical records, and permission to retain an independent physician to consult. The respondent AIP asked the court for a protective order to prevent admission of the medical records, and also opposed the request of the court evaluator.

The court began its analysis by referring to the strong public policy in New York which supports the physician-patient privilege. The court noted that its purpose was "[t]o encourage its citizenry to seek medical treatment for any physical or mental condition without fear of the public ridicule or disgrace that might result from a disclosure of any such condition."[77] The court stated that, although the privilege was not absolute, there were very limited exceptions, including the use of medical records by a court evaluator in guardian-

ship matters to assist in the investigation of the case as well as potential disclosure under some circumstances.

The court in *Tara X* denied a motion by the court evaluator to discover medical records because the court held that it would reduce the level of due process protection for the AIP to one below other civil litigants. The court ordered that medical information attached to the petition be removed and sealed. The holding in *Tara X* affirmed the vitality of the physician-patient privilege and the duty of the court to honor the privilege.

A petitioner who seeks disclosure of medical records by subpoena subsequent to filing the petition implicates a variety of protections against disclosure of medical information. In granting a motion to quash the subpoena served on a local agency of NYSARC Inc., the court noted that this was a case of first impression. As the New York State Office of People with Developmental Disabilities certified the local agency, the records were protected under N.Y. Mental Hygiene Law § 33.13. As a covered entity, the local ARC agency was subject to the requirements of HIPAA, which requires that medical records be held confidential without the consent of the patient or a court order. The court also held that the records were protected under the physician-patient privilege. Notably, the court emphasized that medical evidence is not required in an Article 81 proceeding, and there was ample non-privileged information to prove the need for a guardian.[78]

Using medical information in the petition potentially violates laws protecting medical privacy. The practice may also have the effect of allowing the petitioner to minimize or ignore the statutory requirement to provide information about the person's functional capacity and fully explore whether alternatives to a guardianship are available.[79] This has the effect of framing the guardianship in terms of medical diagnosis, and enables the petitioner to avoid taking responsibility for meaningful discharge planning or case management that meets the needs of the person without the appointment of a guardian. Even if a guardianship is necessary, medical information substitutes for a description of the person's capacity to perform activities of daily living and make decisions. Instead of guardianship being a last resort, it becomes a means for providing case management and discharge planning, often to the detriment of the person.

2. Disclosure of Medical Records to the Neutral Court Appointed Investigator: A Sound Practice That Balances the Need for Relevant Information and Privacy Concerns

Under Article 81, the court evaluator plays a pivotal role in the proceeding and has broad-ranging powers, including the duty to protect the property and interests of the person alleged to need a guardian.[80] As the neutral "eyes and ears" of the court, the court evaluator is in a unique position to shape how the case unfolds. It is critical that the court evaluator attempt to limit unnecessary disclosures of medical information, fully explore the availability of less restrictive alternatives, promote the use of evidence related to functional capacity, and if it is necessary to appoint a guardian, recommend that the court only grant those powers that are necessary and appropriate.

Article 81 strikes a balance between the court evaluator's possible need to review medical records, and the importance of protecting the medical privacy rights of the person alleged to need a guardian.[81] A court evaluator may request a court order to review medical records, and if the court issues an order, it is only for the limited purpose of assisting the court evaluator in her investigation.[82] The court may order the disclosure of these records to the court evaluator, notwithstanding the physician-patient privilege, the psychologist-patient privilege, or the social worker-client privilege provisions of the CPLR.[83] However, the authority of the court may be limited by federal and state laws that impose different standards for the disclosure of particular kinds of records including, but not limited to, records of patients in alcoholism and substance abuse facilities, HIV-related information, and records of patients in mental hygiene facilities.

Article 81 draws an important distinction between the use of medical records to assist the court evaluator and their admissibility as evidence in court.[84] This framework recognizes that while medical records might be helpful in a court evaluator's assessment, they are not always essential and should not be disclosed unnecessarily or automatically be deemed admissible. The court evaluator should initially only disclose relevant records to the court in-camera. Unless the court directs otherwise, the court evaluator should only discuss medical specific diagnoses and medications in a separate addendum to the court evaluator report.

If the court orders that medical records be disclosed to the court evaluator, the court may also direct such further disclosure of those records upon the request of the petitioner, or attorney for the person alleged to need a guardian.[85] This disclosure may be limited to pre-hearing discovery, as with Article 31 of the CPLR, or extend to admission as evidence at the hearing.[86] Although the court evaluator's report may be admitted into evidence if the court evaluator is subject to cross examination, that does not mean medical records and information obtained by the court evaluator are similarly admissible.[87] The court evaluator can also apply to the court to retain an independent medical expert where it is necessary and appropriate.[88] An independent medical expert may be necessary in order to avoid a breach of the AIP's physician-patient privilege. If there is insufficient medical information available and the court evaluator needs that information, an indepen-

dent medical expert may help determine if the AIP is incapacitated. A court may deny a request by the court evaluator for an order that grants access to medical records on the basis that it would deny the person alleged to need a guardian constitutionally protected due process rights.[89]

The court is also authorized, in uncontested proceedings and for good cause shown, to relax the rules of evidence. This discretion, as noted by the court in *Tara X*, reflects the balance between the more traditional "best interests" approach to guardianship and the "adversarial" approach embodied in modern guardianship statutes that provide enhanced protection of the rights of the person alleged to be incapacitated. However, relaxing the rules of evidence may create a potential problem for a person who needs, and does not object to, a guardian. If the person has the capacity to consent to the appointment of a guardian, a court may appoint based on a finding of necessity and consent. This makes a finding of incapacity unnecessary and medical evidence and testimony would not be required. Concerns about medical privacy are equally present in an uncontested proceeding, if private medical information is part of the proceeding and remains in the court file as a public record.

3. Testimony by Physicians and Other Health Care Professionals to Support the Appointment of a Guardian

The physician-patient privilege and other similar evidentiary privileges apply in contested Article 81 cases.[90] Under Article 81, medical testimony is not required in all cases and may not be admissible unless the person waives the physician-patient privilege or she places her medical condition at issue in the hearing.[91] A person placed her mental condition at issue when she included a doctor's report in her motion to dismiss the Article 81 petition, notwithstanding her assertion that the sole purpose of the report was to rebut the allegations of her examining physician.[92] A person does not waive the physician-patient privilege by failing to object to the testimony of a physician who treated the person in the hospital if the physician relies on her notes and not the person's medical records.[93]

If the privilege has not been waived, the testimony of a treating physician should be excluded.[94] Functional evidence alone can be sufficient to establish to meet the statutory standard for appointing a guardian. Even if the testimony of the treating physician is not admissible, the court may appoint a guardian based on the testimony of the person's children that she could not manage her medical, personal, and financial needs.[95]

The traditional confines of the physician-patient privilege may not adequately protect disclosures of private medical information when the person alleged to need a guardian has interacted with physicians and other health care professionals who serve in a variety of roles. The testimony of a non-treating physician is not subject to the privilege and is admissible provided it is material, relevant, and probative and not excludable on other grounds. In a case involving a psychiatrist who was part of a mobile emergency response team, the AIP moved to strike the testimony of the psychiatrist on the basis of the physician-patient privilege.[96] The psychiatrist was acting pursuant to a statutory "Comprehensive Psychiatric Emergency Program." This program authorized participating psychiatrists to involuntarily commit a person who was found to need immediate care and treatment and posed a danger to her or others due to a psychiatric condition. The court in *Marie H.* analyzed the nature and responsibilities of the psychiatrist's role and found that it was closer to that of a police officer making an arrest than a treating physician. The decision in *Marie H.* was supported by statutes that created a relatively well-defined role for the psychiatrist acting within the scope of emergency circumstances with specific protocols and remedies. The court noted that the psychiatrist was acting to protect the safety and well-being of the person, and served as part of the rescue component of a structured response that included treatment by other psychiatrists and providers at the institution to which the person was taken.

4. The Special Case of the APS Psychiatrist as Investigator and Witness: A Treating Physician Subject to Evidentiary Privilege or a "Guardianship Specialist" Fulfilling the Agency's Protective Function?

Federal law requires states to provide Adult Protective Services ("APS").[97] The protective services agency is generally responsible for providing information, referrals, and assurance that services are available to individuals who are unable to manage their property or personal care. The agency works to provide for vulnerable individual's personal needs and protect them from dangerous circumstances arising from neglect or abuse, particularly for those who have no one able or willing to provide needed assistance.[98] Adult protective services have a legal duty to provide necessary care and services to eligible adults.[99]

APS must provide an array of support services designed to assist vulnerable adults who are at risk of harm to remain in the community and avoid institutionalization. Additionally, APS is required to prevent or resolve cases of neglect, exploitation or abuse by enhancing the person's capacity to function independently. APS may investigate allegations or provide services to a vulnerable person,[100] and decide that it is necessary to file a guardianship petition. When a psychiatrist employed by APS is part of the investigation, roles may be blurred. Information gathered from the AIP in an arguably therapeutic context may later be used as evidence in a guardianship proceeding. The

methods by which APS obtains this information, and its use in guardianship cases, raises issues related to medical privacy and the scope and application of the physician-patient privilege.

There are two significant practices involving APS that raise serious concerns as to violations of the liberty interests and medical privacy rights of vulnerable elders. The first scenario occurs when APS is unable to gain access to a person, perhaps because the person does not want to cooperate for fear of being placed in an institution or having a guardian appointed. Under these circumstances, APS may utilize an *ex parte* process that culminates in an order granting access to the vulnerable elder's residence. The limited purpose of this visit is ostensibly to assure that the person is not in danger.

It is improper for APS to use evidence obtained as part of this *ex parte* process in a guardianship case. *Matter of Eugenia M.*[101] involved a 95-year-old woman whose landlord contacted APS and reported *inter alia* that her cooperative apartment was in need of repairs. A psychiatrist for APS met with Ms. M in March 2007. In early 2008, the City of New York Department of Social Services, the parent agency of APS, initiated an Article 81 guardianship proceeding and a hearing was scheduled for February 8, 2008. Ms. M thought the hearing was scheduled for February 6, in part because the return date was "faint" on the order to show cause, and traveled to the courtroom alone by public transportation, despite the winter cold.

After several months, during which the hearing was adjourned, the petitioner requested that the matter be further adjourned as Ms. M refused to allow the APS caseworker into her home. The petitioner suggested that an additional adjournment would allow APS to obtain an "Order to Gain Access" to Ms. M's apartment, which in turn would allow the APS psychiatrist to evaluate Ms. M. The court denied the request by APS because the Order to Gain Access is only intended to be used to assess a person's need for protective services—which APS had already done—and is also only appropriate if there is no other opportunity to observe and evaluate the person. In this instance, Ms. M left her apartment on a daily basis to shop, which would afford APS a sufficient opportunity to interact with her.

Ms. M's court-appointed attorney argued that APS was using the adjournment and possible Order to Gain Access as a pretext to gather additional evidence to support its guardianship petition since the nine-month delay had rendered APS's evidence stale. The court held that it was improper for APS to use the Order to Gain Access for this purpose and denied the motion for an adjournment. The petitioner then commenced its case with one witness, the APS psychiatrist, who testified based on the single meeting with Ms. M. The psychiatrist testified that Ms. M's apartment needed some repairs, some of which had not been done because Ms. M reported that she had previously been overcharged for the repairs. The psychiatrist further testified that Ms. M had food in the refrigerator, her grooming was "passable," told him that she paid her own bills, did her own banking, shopping, cooking, and had health insurance. The court dismissed the petition, finding that the evidence established that Ms. M's only functional limitation was an unsteady gait, and that the threat of a future eviction did not support the appointment of a guardian. The court saw the APS conduct for what it was: an abuse of a practice that is designed to be used in rare circumstances and only for the person's protection.

Outside the *ex parte* context, a similar practice that raises medical privacy and evidentiary privilege concerns is the use of APS psychiatrists to obtain information that is used in a guardianship petition. In these scenarios, the APS caseworker is usually familiar with the AIP, having worked on his or her case. Next the APS psychiatrist becomes the primary investigator, assesses the person's need for guardianship, and ultimately becomes the primary witness for the petitioner. The APS petition routinely recites that the person voluntarily consented to be interviewed by the psychiatrist. Ironically, the information obtained during that process becomes the basis of the psychiatrist's testimony that the very person who provided "informed consent" actually needed a guardian with broad powers, including those related to medical and health care decisions. Although it is possible that a person may have the capacity to consent to a meeting with the APS psychiatrist but not have the capacity to make decisions about property management and personal care, the nature of the consent is actually fairly complex and casts doubt as to whether it is truly informed, knowing, and voluntary.

As a threshold matter, it is doubtful that the psychiatrist provides sufficient information to the AIP for the AIP to form the predicate for an informed decision. The psychiatrist is employed by APS, and APS is charged with protecting those in need, including diagnosing and improving their circumstances. The psychiatrist will not only perform assessment and evaluation for those purposes, but the information obtained may also be the basis for bringing a guardianship proceeding, in part for precisely those decisions relating to the informed consent that the APS psychiatrist is trying to obtain. Even if the APS psychiatrist does provide that information, a truly informed consent would require that the person understands the role of the psychiatrist within APS, the mandate of APS, and the nature and scope of a guardianship proceeding.[102]

The extent to which the APS practice of using a psychiatrist as a "guardianship specialist" violates medical privacy depends, at least in part, on a number of fac-

tors. Assuming there is a constitutional right of medical privacy, does the person have a reasonable expectation of privacy when meeting with an APS psychiatrist in an arguably therapeutic context? Can the APS psychiatrist be characterized as a "treating physician" subject to the physician-patient evidentiary privilege, or alternatively, does the psychiatrist owe a duty of confidentiality to the person?

Generally, the existence of a privilege favors the "exclusion of the evidence."[103] "[T]he decision as to what values to recognize through the law of privileges is a difficult one."[104] Conventional wisdom holds that due to the narrow scope of the physician-patient privilege, the APS psychiatrist is an "examining" physician to whom the privilege does not apply. However, a closer examination of the APS mandate suggests that the role of the APS psychiatrist may be within the scope of the evidentiary privilege that attaches to treating physicians. Consider the following characterization of the APS role:

> The Commissioner is likewise charged with arranging for medical and psychiatric services to evaluate and whenever possible to safeguard and improve the circumstances of adults with *serious impairments* (See Social Services Law § 473(1)(b)) (*emphasis added*).[105]

The psychiatrist "visiting" Ms. M on behalf of APS was charged with carrying out the APS mandate to evaluate, safeguard, and improve Ms. M's circumstances. A treating physician is defined as one who provides diagnosis or medical treatment pursuant to an explicit or implicit agreement.[106] Although the APS psychiatrist is not providing services under a standing order from a physician, pursuant to the agency's statutory mandate, the psychiatrist is both diagnosing and attempting to remediate the person's medical condition. Although APS is required to conduct an investigation when a report is made of a vulnerable person at risk, in the guardianship context, the psychiatrist often, if not always, seeks to obtain consent to meet with the person.

It is therefore arguable that the APS psychiatrist should honor the person's expectations of privacy and also be subject to the physician-patient privilege, at least to the extent that the psychiatrist is involved in diagnosis and any kind of therapeutic relationship. Unlike a personal injury case, in the context of a guardianship proceeding, the person alleged to be incapacitated is not placing her own medical condition at issue. The case is brought "against" the person, and the petitioning party in New York has the burden of proving that the guardianship is necessary and the person either consents or is incapacitated as defined by the statute. A distinction between the APS psychiatrist's interaction with a potential AIP and a more conventional relationship between a psychotherapist and patient is that, typically, a conventional patient consults the psychotherapist for diagnosis and treatment, whereas APS initiates contact with an AIP pursuant to a statutory mandate.[107]

The privilege that attaches to communications between a patient and her physician or psychiatrist is subject to a number of exceptions, including when it occurs for reasons other than treatment.[108] The intended protective function of APS may require that a petition for guardianship be filed if the person is having difficulty providing for her needs, although guardianship should only be a last resort after sufficient efforts have been made to provide necessary services to the person. The purpose of the guardianship would ostensibly be to prevent harm to the vulnerable person and assure that she receives and maintains sufficient services. Assuming that alternatives to a guardianship have been fully explored to no avail, these arguments would support the view that the APS psychiatrist is not subject to the physician-patient privilege.

Yet there remains something quite troubling about this relationship and the medical professional's use of information obtained during the course of the APS investigation. Under Article 81, medical evidence is not necessary and non-privileged evidence that is relevant and material to a person's functional capacity and the standard for appointing a guardian is sufficient and favored by the statute. The rationale for using a psychiatrist to obtain information for APS is therefore weaker, and at least requires that diagnostic and other medical information obtained by the psychiatrist be excluded. A better alternative would be to rely on testimony from the APS caseworker regarding the AIP's functional capacity.

D. Recommendations to Prevent, Manage, and Resolve Violations of Medical Privacy Article 81 Guardianships

Although Article 81 is a "functional capacity" statute, it falls short of the emerging support model envisioned by Article 12 of the UN Convention that recognizes a person's full legal capacity regardless of disability. The support model would replace the guardianship incapacity framework with a "co" or "facilitated" structure for supportive decision-making. Article 81 includes many provisions that respect a person's autonomy and protects due process, privacy, and liberty interests that are at stake for individuals who are alleged to need a guardian. However, the permissive use of medical information perpetuates the medical model of guardianship, and creates the risk that medical privacy rights are routinely violated. Consequently, it may also impede a full exploration of functional capacity and alternatives to guardianship.

The following recommendations are intended to improve Article 81 through a combination of proposed

amendments and suggested "best practices." The ultimate goal of these recommendations is to move Article 81 closer towards a completely functional framework that utilizes a support model that will ultimately replace the notion of incapacity and guardianship with the model of "partnered" or "facilitated" decision-making required under Article 12 of the U.N. Convention.

1. Prior to filing an Order to Show Cause and Petition, attorneys for petitioners should conduct a complete investigation in order to fully assess the person's functional capacity, and determine whether alternatives to a guardianship are available and sufficient. Attorneys for petitioners should thoroughly assess the need for a guardian and determine to the greatest extent possible if the person has the capacity to make decisions. This assessment should focus on the statutory standard, explore potential alternatives to a guardianship, highlight the person's functional abilities rather than medical diagnosis, and use the statutory powers as a checklist.[109]

2. When drafting the petition, the attorney for the petitioner should include as much of the statutorily required information as possible. Under § 81.08(a), the petition is supposed to include specific information, including the following most relevant to these recommendations:

    - Describe the person's functional capacity based on her ability to manage activities of daily living.
    - Include specific information about events, actions, or occurrences that create a risk of harm, and indicate that the person does not appreciate or understand the limitations that interfere with her ability to provide for her personal needs or property management.[110]
    - Explicitly connect the person's needs and functional capacities to the powers sought.[111]
    - Identify and describe resources that may be available as alternatives to the guardianship.[112] If none exist, describe specific actions taken by the petitioner that would constitute due diligence in exploring these potential alternatives.
    - Include any other information that would help the court evaluator.[113] This existing statutory requirement implicitly requires that the petitioner view the petition from the perspective of the court evaluator, at least with respect to making sure that a guardianship is necessary and there are not sufficiently reliable alternatives that are available.
    - Do not include medical information without a court order. Medical information is not required to be included with the petition. The statute's emphasis on functional capacity and medical privacy protections suggest, and may require, that medical information not be included with the petition.

3. Suggested "best practices" for judges:

    - Do not sign the Order to Show Cause if the petition does not include the required elements described above.
    - Prior to accepting a petition that includes protected or privileged medical information, require the petitioner's attorney to submit an affirmation explaining the need for medical information, why evidence of functional capacity is not available or sufficient, and formally request a court order to include medical information with the petition.
    - As part of an order granting the request to use medical information (whether made by the petitioner or the court evaluator), require the protected or privileged information to be in a separate document, perhaps as a "medical information rider" to the petition, or an addendum to the court evaluator report, so that it may easily be separated and sealed from the publicly available case documents.
    - Exclude medical information and evidence from the hearing, unless there is insufficient evidence related to the person's functional capacity, or the medical information is necessary and appropriate in order to make the required findings and decisions, assure that the person's medical diagnosis and medication regimen is accurate and therapeutic, or for any other reason that would be helpful to the court or to the person. The goal is to more sharply focus the hearing on the person's functional capacity, potential alternatives to a guardianship, and the least restrictive alternative.
    - Disseminate rules for court evaluators regarding the use of medical information. These rules would emphasize that the assessment is a functional one and not a medical diagnosis. The rules would also require a court order for the court evaluator to obtain medical information and disclose it to other parties. In addition, the court evaluator would only be permitted to include medical diagnoses, medications, treatment, and other protected information in a separate addendum to the court evaluator report, unless otherwise

ordered by the court or the court record is sealed.

4. A party seeking to introduce medical evidence that may infringe on a person's medical privacy rights should be required to make a proffer of necessity. The court may either rule on the proffer as part of pre-hearing written motion or hear oral argument on the issue prior to the hearing or on the hearing date.

5. Require APS to focus more on functional capacity in its guardianship assessment and petition process, rather than basing its assessment, petition, and testimony too much on medical diagnosis.

   - Clarify the role of physicians, psychiatrists, psychologists, and social workers employed by APS who provide services to a person, and when they are acting in their professional capacity as an APS service provider, subject them to their profession's evidentiary privileges. Prior to a decision to file a petition for guardianship by the Department of Social Services or other "parent" agency of APS, these professionals should follow a protocol to obtain informed consent, which specifically states the purpose of the meeting (i.e., is it a therapeutic relationship that gives rise to an evidentiary privilege or is the purpose to assess the person's capacity to determine whether a guardianship is warranted). If the purpose is assessing the need for a guardian, and the person does not fully understand the nature and consequences of the consent, the APS professional must terminate the meeting and not gather information that may be used "against" the person in a guardianship proceeding. The goal would be to encourage these professionals to work with the person to achieve the statutory goals of APS, rather than gather evidence for a guardianship case from an unsuspecting person who is vulnerable and may not understand the nature and consequences of the APS employee's role. If the professional who may be subject to an evidentiary privilege is assessing the need for a guardian (i.e., acting as a "guardianship specialist" rather than a medical, psychological, or social work professional), the person should only be permitted to testify in that capacity, rather than as a professional who can diagnose and opine as to appropriate treatment of the person.

   - When an APS investigation involves an APS-employed psychiatrist or other professional who may potentially infringe on the person's medical privacy or be subject to evidentiary privileges, the professional must obtain meaningful informed consent from the person. If the professional does not believe that the person has the capacity to understand the potential consequences of providing information to the professional, no further discussion should be allowed. If the psychiatrist or health care professional is truly acting as a "guardianship specialist" for APS rather than in her capacity as a medical professional, that person should be precluded from testifying as a medical expert or about medical information at the hearing. A better alternative would be to have APS fully explore services that may avoid the need for a guardianship. If a guardianship petition is filed as a last resort, APS should have a caseworker, not a psychiatrist, testify about the AIP's functional capacity.

6. Amend the last clause of § 81.07(b)(3), by replacing "the court shall not require that supporting papers contain medical information" with "the petition, and any supporting papers, shall not include medical information without a court order."

7. Amend Article 81 terminology generally to more precisely reflect a focus on a person's legal capacity, rather than her incapacity or deficiency.[114] Throughout the statute, replace the term "alleged incapacitated person" with "person alleged to need a guardian" and replace the term "incapacitated person" with "person with a guardian."

Conclusion

Article 81 should continue moving toward becoming a fully functional capacity statute that emphasizes functional capacity, requires that alternatives to a guardianship be fully explored prior to appointing a guardian, and raises the threshold for including medical information with the petition and at the hearing. If a court determines that medical evidence is necessary, there should be uniform procedures to ensure that a person's medical privacy rights are protected. Ultimately, both the medical and functional models of guardianship based on a person's incapacity should be replaced by a support model that recognizes the full legal capacity of the person, and identifies areas in which assistance is needed without a finding of incapacity.

Endnotes

1. Under Article 81 of the N.Y. Mental Hygiene Law, the person is initially referred to as an "Alleged Incapacitated Person" (AIP) and if a guardian is appointed, an "Incapacitated Person" (IP). If the person consents to the guardianship, the court order will

generally refer to the person as a "person in need of a guardian" (PING).

2. N.Y Mental Hyg. Law § 81.02(a)(2).

3. *See, e.g.*, *In re* Ardelia R., 28 A.D.3d 485, 812 N.Y.S.2d 140 (2d Dep't 2006) (testimony established that frail 82-year-old woman did not understand or appreciate the consequences of her limitations where APS found her at her home without running water, food, electricity, or heat, she was diagnosed with dementia, hypertension, and coronary artery disease, could not cook, wandered from home, did not know her income, where she banked, and despite substantial savings, was behind on her utility bills).

4. The statute states that "[f]unctional level means the ability to provide for personal needs and/or the ability with respect to property management." N.Y. Mental Hyg. Law § 81.03(b).

5. The facts have been altered in these composite cases to protect privacy, although all of the facts and documents in these and virtually all Article 81 cases are matters of public record, available for anybody to see, unless the case file is sealed under N.Y. Mental Hyg. Law § 81.14.

6. Although Article 81 can be used to appoint a guardian for any person who is found to need a guardian, regardless of his or her particular functional capacity or medical condition, Article 17-A of the N.Y. Surrogate's Court Procedure Act is an alternative guardianship statute that follows a medical model and is limited to people with developmental disabilities, autism, traumatic brain injuries, and other enumerated conditions. N.Y. SCPA 1750-A. Article 17-A was initially enacted in 1969 primarily for parents of children with developmental disabilities who were reaching the age of majority, and has not been amended in any significant way. Article 17-A lacks most, if not all, of the due process protections of Article 81, as well as its flexibility, powers, and nuances. Courts have borrowed from the framework of Article 81 to fashion remedies that would pass constitutional muster or that are otherwise permitted under Article 81. *See, e.g.*, *In re* Mark C.H., 28 Misc. 3d 765, 906 N.Y.S.2d 419 (Sur. Ct. N.Y. Cnty. 2010) (in a case involving guardianship for person whose medical diagnosis was belied by his functional capabilities, court discussed history of Article 17-A within constitutional and international human rights framework, and imposed monitoring requirements to assure that the person's needs were being met by a guardian and by a substantial trust established for his benefit); *In re* Yvette A., 27 Misc. 3d 945, 898 N.Y.S.2d 420 (Sur. Ct. N.Y. Cnty. 2010) (court held that under Article 17-A terms and restrictions in best interests of person can be imposed on guardian and imposed initial and annual reporting requirements on guardian of the person). Although the focus of this article is on Article 81, my analysis applies with equal force to Article 17-A.

7. Naomi Karp & Erica F. Wood, *Guardianship Monitoring: A National Survey of Court Practices*, 37 Stetson L. Rev. 143, 150 (2007) (noting that guardianship population will grow and be more diversified, and that approximately 7-8 million individuals have intellectual disabilities, affecting 10% of families).

8. *See, e.g.,* Naomi Karp & Erica Wood, *Guarding the Guardians: Promising Practices for Court Monitoring* (AARP 2007); Pamela B. Teaster et al., *Wards of the State: A National Study of Public Guardianship* (ABA Comm. L. & Aging 2005), available at http://www.abanet.org/aging/publications/docs/wardofstatefinal.pdf; Sally Balch Hurme & Erica Wood, *Guardian Accountability Then and Now: Tracing Tenets for An Active Court Role*, 31 Stetson L. Rev. 867 (2002).

9. A guardian appointed under Article 81 must complete and file an initial 90-day report and subsequent annual reports, which are reviewed by a court examiner and approved by a judge. N.Y. Mental Hyg. Law §§ 81.30, 81.31. If the guardian is a family member or "lay" guardian, it is likely that an attorney will be required to assist with reporting, or the court examiner will have to provide assistance or at least review corrected reports. If the guardian is a "professional" appointed from the Part 36 fiduciary list of appointees, that person may not be available for another case that may involve greater need. Finally, when a guardian is appointed, payment for the petitioner's attorney, the court evaluator, the attorney for the person under the guardianship (if any), and the court examiner must be made from the assets of the person.

10. There have been three major guardianship "summits" in the United States, each resulting in findings and recommendations. The 1988 and 2001 Wingspan Conferences gathered together a multi-disciplinary group of experts and produced comprehensive recommendations. *See* Comm'ns on the Mentally Disabled & Legal Problems of the Elderly, Am. Bar Ass'n, *Guardianship: An Agenda for Reform*, 13 Mental & Physical Disability L. Rep. 274 (1989) (summarizing substance and recommendations of Wingspread Conference); Frank Johns & Charles P. Sabatino, *Introduction: Wingspan—The Second National Guardianship Conference*, 31 Stetson L. Rev. 573 (2002); *Wingspan—The Second National Guardianship Conference, Recommendations*, 31 Stetson L. Rev. 595 (2002); Marshall B. Kapp, *Reforming Guardianship Reform: Reflections On Disagreements, Deficits, And Responsibilities*, 31 Stetson L. Rev. 1047 (2002) (noting the presence of widespread disagreement among Wingspan participants, mostly revolving around the tension between adversarial and therapeutic approaches). The National Guardianship Network organized the "Third National Guardianship Summit: Standards of Excellence" at the University of Utah S.J. Quinney College of Law in Salt Lake City on October 12–15, 2011. The conference focused on "post-appointment guardian performance and decision-making." *See* http://www.guardianshipsummit.org (last visited April 9, 2012).

11. The functional model represents an improvement over the traditional status based medical model, which relied primarily on medical diagnosis as the basis for appointing a guardian. Although it has many positive aspects, to the extent that a functional model of guardianship requires a finding of incapacity, promotes the role of courts, and focuses on limitations and deficits, it falls short of the nondiscriminatory aspirations of the support model of the United Nations Convention and Optional Protocol on the Rights of Persons with Disabilities. 46 ILM 443 (2007), available at http://www.un.org/disabilities/convention/conventionfull.shtml (last visited Apr. 9, 2012) (hereafter "UN Convention"). The UN Convention was signed by President Barack Obama on July 24, 2009, 74 Fed. Reg. 37923 (July 29, 2009), but has not yet been ratified by the U.S. Senate. Nevertheless, the UN Convention and other international treaties and documents are relevant when analyzing potential human rights violations that may arise in guardianship cases. For a fuller discussion of the international framework within the context of an SCPA Article 17-A case, *see In re* Mark C.H., 28 Misc. 3d 765, 783–88, 906 N.Y.S.2d 419, 432–36 (Sur. Ct. N.Y. Cnty. 2010).

12. *See, e.g.*, A.B.A. Comm'n on Law and Aging, *Guardianship Law & Practice*, available at http://www.americanbar.org/groups/law_aging/resources/guardianship_law_practice.html (last visited Apr. 9, 2012).

13. Alternatives to guardianships include various supports such as home health aides, visiting nurses, adult day care, and senior centers and advance directives such as a power of attorney for property decisions, a health care proxy or living will for health care decisions. N.Y. Mental Hyg. Law § 81.03(e).

14. Guardianship courts play an important and largely constructive role in assuring that vulnerable individuals brought before them, and their constitutional rights, are protected. Occasionally, the protective function of the court comes at the expense of the person's rights of self-determination and autonomy. A guardianship can be expensive and utilizes scarce judicial resources. Guardianships also provide a source of compensation for court appointed guardians and court examiners, and fees are generally paid from the assets of the person for whom a guardian has been appointed. Compensation and appointments

are governed by "Part 36 Rules," N.Y. Comp. Codes R. & Regs. Tit. 22 pt. 36, which became effective on June 1, 2003 and were enacted in response to two reports issued by the Office of Court Administration in 2001 that verified the need for reform (the Inspector General's Report on Fiduciary Appointments in New York and the Report of the Commission on Fiduciary, referred to as the "Birnbaum Commission"). Another report that described the impact of the new appointment regime under Part 36, Development of a New Fiduciary Appointment System, was issued on February 9, 2004 by the Office of Court Administration, Guardian and Fiduciary Services. The text of the rules and reports are available at http://www.nycourts.gov/ip/gfs (last visited Apr. 10, 2012).

15. *See, e.g.*, *In re* Grinker, 77 N.Y.2d 703, 573 N.E.2d 536, 570 N.Y.S.2d 448 (1991) (holding that predecessor statutes to Article 81 lacked protection for fundamental liberty interests protected under the U.S. Constitution); *In re* Fisher, 147 Misc.2d 329, 552 N.Y.S.2d 807 (Sup. Ct. N.Y. Cnty. 1989) (describing constitutional infirmities of conservator and committee statutes that preceded Article 81); *In re* Doe, 181 Misc. 2d 787, 696 N.Y.S.2d 384 (Sup. Ct. Nassau Cnty. 1999).
16. 46 ILM 443 (2007), available at http://www.un.org/disabilities/convention/conventionfull.shtml (last visited Apr. 9, 2012). Among the key provisions in the UN Convention are Article 12, "Equal recognition before the law," Article 19, "Living independently and being included in the community," and Article 22, "Respect for privacy."
17. *In re* A.G., 6 Misc. 3d 447, 785 N.Y.S.2d 313 (Sup. Ct. Broome Cnty. 2004).
18. N.Y. Mental Hyg. Law § 81.01.
19. *See* N.Y. Mental Hyg. Law § 81.22(a)(9).
20. *See* N.Y. Mental Hyg. Law § 81.22(a)(8). *See also* N.Y. Pub. Health Law Article CC (authorizing guardian to make health care decisions as surrogate with power to make decisions to refuse or withdraw life-sustaining treatment).
21. N.Y. Mental Hyg. Law § 81.22(a)(2).
22. *See* N.Y. Mental Hyg. Law § 81.21 (authorizing a wide array of property management powers, including the power to make transfers, gifts, and establish trusts). *See also* Helen Hayes Hosp. v. DeBuono (*In re* Shah), 95 N.Y.2d 148, 711 N.Y.S.2d 824 (2000) (Article 81 guardian has power to engage in Medicaid planning, including transfers of assets to herself).
23. N.Y. Mental Hyg. Law § 81.22(a)(9).
24. Olmstead v. L. C. by Zimring, 527 U.S. 581, 119 S. Ct. 2176, 144 L. Ed. 2d 540 (1999).
25. *Olmstead*, 527 U.S. 581, 599, 119 S. Ct. 2176, 144 L. Ed. 2d 540 (1999).
26. 28 C.F.R. § 35.130(d) (1998).
27. UN Convention, available at http://www.un.org/disabilities/convention/conventionfull.shtml (last visited April 9, 2012). The U.S. Department of Justice is actively seeking to enforce the requirements of *Olmstead*. *See* http://www.ada.gov/olmstead/index.htm (last visited Apr. 2, 2012). *See also* Disability Advocates, Inc. v. New York Coalition for Quality Assisted Living, Inc., 2012 U.S. App. LEXIS 6984 (2d Cir. 2012) (holding that plaintiff lacked standing to bring action under the "integration mandate" of the ADA to challenge failure of New York State officials to place residents of adult homes who had serious mental illnesses in the community).
28. UN Convention.
29. Under Article 12 of the UN Convention, the person retains capacity as a legal matter and the support structure is designed, as is Article 81, to promote decisions by the person. Any "co" or "facilitated" decision would be based on the person's preferences, wishes, and values. Article 81 comes close to Article 12 in its functional approach, mandate to explore alternatives to a guardianship, and requirement that the guardian make decisions based on a subjective understanding of the person's wishes, and only utilize a best interests approach if the person's wishes are not known or ascertainable.
30. *See, e.g.,* Robert P. Roca, *Determining Decisional Capacity: A Medical Perspective*, 62 Fordham L. Rev. 1177 (1994) (explaining the critical role a psychiatrist can play in identifying the existence of a medical condition that may be causing cognitive impairment and recognizing when interventions such as adjusting medication may alleviate problems, for example when depression is an underlying cause). The assessment of incapacity by judges, lawyers, and health care professionals may be unreliable due to pretext and "sanism." *See* Michael L. Perlin, *"Half-Wracked Prejudice Leaped Forth": Sanism, Pretextuality, and Why and How Mental Disability Law Developed as It Did*, 10 J. Contemp. Legal Issues 3 (1999).
31. Deirdre M. Smith, *The Disordered and Discredited Plaintiff: Psychiatric Evidence in Civil Litigation*, 31 Cardozo L. Rev. 749, 753 (2010).
32. *Id.*
33. 33. N.Y. Mental Hyg. Law § 81.02(a)(1), (2).
34. 34. N.Y. Mental Hyg. Law § 81.02(a)(2). *See, e.g.*, *In re* May Far C., 61 A.D.3d 680, 877 N.Y.S.2d 367 (2d Dep't 2009) (appointment of guardian reversed where person made sufficient arrangements for meeting her needs, including executing a power of attorney).
35. Liability under tort law for invasion of privacy is another layer of potential protection, but beyond the scope of this article. These "privacy torts" include intrusion upon another's seclusion and public disclosure of private facts. A physician or other health care professional in a confidential relationship may incur tort liability through an unauthorized disclosure of confidential information.
36. *See, e.g.*, Whalen v. Roe, 429 U.S. 589, 599–600, 97 S. Ct. 869, 51 L. Ed. 2d 64 (1977) (computer record of prescriptions for controlled substances); Nixon v. Admin. of Gen. Serv., 433 U.S. 425, 457, 97 S. Ct. 2777, 53 L. Ed. 2d 867 (1977) (presidential papers). The U.S. Supreme Court has also found a broader right to privacy in a variety of other contexts. *See, e.g.*, Lawrence v. Texas, 539 U.S. 558, 123 S. Ct. 2472, 156 L. Ed. 2d 508 (2003) (right to consensual sexual contact between people of the same sex); Roe v. Wade, 410 U.S. 113, 35 L. Ed. 2d 147, 93 S. Ct. 705 (1973) (right to choose abortion); Griswold v. Connecticut, 381 U.S. 479, 85 S. Ct. 1678, 14 L. Ed. 2d 510 (1965) (right to obtain contraception).
37. O'Connor v. Pierson, 426 F.3d 187 (2d Cir. 2005) (holding that Board of Education did not have legitimate interest in demanding private medical records from teacher with a serious illness in matter involving sick leave, explaining that when a "legislative burden" infringes on privacy rights, the court will apply intermediate scrutiny and only permit it when the government has a substantial interest that outweighs the privacy interest).
38. 429 U.S. 589, 97 S. Ct. 869, 51 L. Ed. 2d 64 (1977).
39. Doe v. City of New York, 15 F.3d 264, 267 (2d Cir. 1994).
40. Powell v. Schriver, 175 F.3d 107, 110 (2d Cir. 1999).
41. Fleming v. State Univ. of N.Y., 502 F. Supp. 2d 324 (E.D.N.Y. 2007).
42. 631 F.3d 57 (2d Cir. 2011).
43. *Matson*, 631 F.3d 57, 66 (2d Cir. 2011). Prior to *Matson*, the standard for finding a right of medical privacy had only required a "serious medical condition." *See* O'Connor v. Pierson, *supra* note 37.
44. *Matson*, 631 F.3d at 72–73.
45. *See e.g.*, Rivers v. Katz, 67 N.Y.2d 485, 504 N.Y.S.2d 74, 495 N.E.2d 337 (1986); 1-12 New Appleman New York Insurance Law § 12.06.
46. Schulman v. New York City Health and Hosps. Corp., 38 N.Y.2d 234, 379 N.Y.S.2d 702, 342 N.E.2d 501 (1975).

47. 42 U.S.C. § 1320d; 45 C.F.R. §§ 160–164 (the entire privacy rule is available at http://www.hhs.gov/ocr/hipaa). Under HIPAA, the release of medical records and information is authorized, inter alia, pursuant to a court order or to a personal representative who is defined as a person with the legal authority to make health care decisions. For a summary of HIPAA, see U.S. Dep't of Health & Human Services Office of Civil Rights Privacy Brief, *Summary of the HIPAA Privacy Rule, available at* www.hhs.gov/ocr/privacysummary.pdf). Note that other federal statutes govern matters related to medical privacy, including the Privacy Act, 5 U.S.C. § 552a (federal agencies); *see* FAA v. Cooper, 2012 U.S. LEXIS 2539 (2012) (holding that definition of "actual damages" under the act is limited to pecuniary damages), and the Americans with Disabilities Act, 42 U.S.C. §§ 12101 et seq. (non-federal employers).

48. *See, e.g., In re* Mougiannis, 25 A.D.3d 230, 806 N.Y.S.2d 623 (2d Dep't 2006) (court held that court appointed guardian was a qualified person under HIPAA, but that health care agent was only authorized to obtain records related to duties as agent).

49. 45 C.F.R. 164.508, 164.512 (e).

50. *In re* Miguel M., 17 N.Y.3d 37, 926 N.Y.S.2d 371 (2011). Protections similar to HIPAA that apply to facilities operated by the Office of Mental Health and the Office of People with Developmental Disabilities can be found at N.Y. MENT. HYG. LAW § 33.13.

51. *In re* Dolan (Lisa O.), 33 Misc. 3d 870, 930 N.Y.S.2d 425 (Sup. Ct. Nassau Cnty. 2011).

52. *See, e.g.*, N.Y. C.P.L.R. 4504 (physician, nurse); 4507 (psychologist); 4508 (social worker).

53. Dillenbeck v. Hess, 73 N.Y.2d 278, 539 N.Y.S.2d 707 (1989).

54. People v. Sinski, 88 N.Y.2d 487, 646 N.Y.S.2d 651 (1996) (in criminal prosecution against person involving prescription drugs, court discussed purposes and exceptions to physician-patient privilege and held that it excluded information from doctors who provided the prescriptions to the defendant).

55. People v. Sinski, 88 N.Y.2d 487, 491, 646 N.Y.S.2d 651 (1996) (citing Alexander, Practice Commentaries, McKinney's Cons Laws of NY, Book 7B, CPLR C4504:1, at 628 (1992)).

56. Heller v. Peekskill Cmty. Hosp., 198 A.D.2d 265, 603 N.Y.S.2d 548 (2d Dep't 1993).

57. Dillenbeck v. Hess, 73 N.Y.2d 278, 284, 539 N.Y.S.2d 707, 711 (1989).

58. N.Y. MENTAL HYG. Law § 81.09(d).

59. Heller v. Peekskill Community Hosp., 198 A.D.2d 265, 603 N.Y.S.2d 548 (2d Dep't 1993).

60. *See* People v. Sinski, 88 N.Y.2d 487, 669 N.E.2d 809, 646 N.Y.S.2d 651 (1996).

61. Dillenbeck v. Hess, 73 N.Y.2d 278, 280-281, 539 N.Y.S.2d 707, 709 (1989) (plaintiff in personal injury case sought medical records of defendant from hospitalization on day of car accident to determine blood alcohol level, but court held protected by physician-patient privilege).

62. *See* Roca, *supra* note 30, at 1177.

63. N.Y. MENTAL HYG. LAW § 81.02(a).

64. *See, e.g., In re* May Far C., 61 A.D.3d 680, 877 N.Y.S.2d 367 (2d Dep't 2009) (reversing appointment of guardian where AIP made adequate arrangements for her affairs, including executing a power of attorney when she had sufficient capacity); *In re* Nellie G., 38 A.D.3d 547, 831 N.Y.S.2d 473 (2d Dep't 2007) (reversing appointment of independent guardian where daughter was agent under springing power of attorney, which was available resource rendering appointment of a guardian unnecessary, and allegation that daughter had engaged in questionable transaction involving AIP's real property was unfounded where daughter did not benefit and transaction did not adversely affect AIP's interests); *In re* Mildred M.J., 43 A.D.3d 1391, 844 N.Y.S.2d 539 (4th Dep't 2007) (petition dismissed where AIP had the capacity to execute advance directives and family relationship did not create presumption of undue influence nor a confidential relationship so as to shift burden of proof); *In re* Isadora R., 5 A.D.3d 494, 773 N.Y.S.2d 96 (2d Dep't 2004) (order appointing guardian reversed where agent appointed under health care proxy and power of attorney was properly carrying out plan for care of person and management of property); *In re* Albert S., 286 A.D.2d 684, 730 N.Y.S.2d 128 (2d Dep't 2001) (court refused to appoint guardian because health care proxy agents were acting consistently with provisions of living will, and court lacked authority to impose additional requirement for termination of life-sustaining treatment that was not contained in advance directives).

65. N.Y. MENTAL HYG. LAW § 81.02(b).

66. *See, e.g., In re* David C., 294 A.D.2d 433, 742 N.Y.S.2d 336 (2d Dep't 2002) (Commissioner of DSS petitioned for appointment of a guardian after an eviction proceeding initiated based on failure to pay rent and maintain the apartment properly, court reversed jury finding that person was incapacitated and held "[a] precarious housing situation and meager financial means do not, without more, constitute proof of incapacity…"); *In re* Tait, N.Y.L.J., May 31, 1994, at 28 (Sup. Ct. N.Y. Cnty.) (even if a person is mentally ill, eccentric, has poor personal hygiene and lives in squalor, there must be clear and convincing evidence that the person is incapacitated as defined in the statute); *In re* Presbyterian Hosp. (Early), N.Y.L.J., July 2, 1993, at 22 (Sup. Ct. N.Y. Cnty.) (guardian not appointed for elderly woman who recognized the potential for harm if she refused placement in a nursing home or did not allow home care attendants to assist her).

67. N.Y. MENTAL HYG. LAW § 81.08(a)(3).

68. *See, e.g.*, N.Y. MENTAL HYG. LAW § 81.07(b)(3); *In re* Bess Z., 2006 N.Y. Slip Op 1809, 2006 N.Y. App. Div. LEXIS 2858 (2d Dep't 2006); *In re* Q.E.J., 14 Misc.3d 448, 824 N.Y.S.2d 882 (Sup. Ct. Kings Cnty. 2006); *In re* Higgins (England), N.Y.L.J., Oct. 6, 1995, at 27 (Sup. Ct. Suffolk Cnty.).

69. *See, e.g., In re* Q.E.J., 14 Misc. 3d 448, 824 N.Y.S.2d 882 (Sup. Ct. Kings Cnty. 2006).

70. N.Y. MENTAL HYG. LAW § 81.14(b), (c); *See In re* Astor, 13 Misc. 3d 1203A, 824 N.Y.S.2d 755 (Sup. Ct. N.Y. Cnty. 2006) (court sealed medical, psychological, and nursing records, as well as court evaluator's reports, and documents that contained confidential information such as social security and financial account numbers; court proceedings concerning any confidential information would be closed to the public and press); *In re* A.J., 1 Misc. 3d 910A, 781 N.Y.S.2d 623 (Sup. Ct. Kings Cnty. 2004) (on motion of court evaluator, court closed courtroom and sealed the record where husband and wife who were alleged to be incapacitated feared their son who had physically and financially abused them).

71. N.Y. MENTAL HYG. LAW § 81.07(c).

72. *See In re* James B., 25 Misc. 3d 467, 881 N.Y.S.2d 837 (Sup. Ct. Delaware Cnty. 2009) (agency certified by state agency to provide services for people with developmental disabilities).

73. 12 Misc. 3d 1132, 821 N.Y.S.2d 387 (Sur. Ct. Broome Cnty. 2006).

74. *See, e.g., In re* Goldfarb, 160 Misc. 2d 1036, 1043, 612 N.Y.S.2d 788, 793 (Sup. Ct. Suffolk Cnty. 1994) (court held that affirmation of treating physician attached to petition would have violated physician-patient privilege, except that respondent placed her medical condition at issue).

75. *In re* Q.E.J., 14 Misc. 3d 448, 824 N.Y.S.2d 882 (Sup. Ct. Kings Cnty. 2006).

76. *In re* Tara X, N.Y.L.J., Sept. 18, 1996, at 27 (Sup. Ct. Suffolk Cnty).

77. *Id.*

78. *In re* James B., 25 Misc. 3d 467, 881 N.Y.S.2d 837 (Sup. Ct. Delaware Cnty. 2009).

79. N.Y. Mental Hyg. Law § 81.08(a)(3*); In re* Mary J., 290 A.D.2d 847, 736 N.Y.S.2d 542 (3d Dep't 2002) (allegations in petition were sufficient where they described the alleged incapacitated person's physical problems, memory impairment, need for assistance in performing activities of daily living, and lack of understanding of the nature and consequences of her inability and limitations).

80. N.Y. Mental Hyg. Law § 81.09.

81. The AIP must be advised in the "legend" of the order to show cause that the court evaluator may be granted permission to inspect medical records and of the right to object by telling the judge that the court evaluator should not be given permission. N.Y. Mental Hyg. Law § 81.07(c). This right to object may only be meaningful if the AIP has retained an attorney, or has the right to be appointed an attorney under N.Y. Mental Hyg. Law § 81.10.

82. *See, e.g., In re* Kufeld, 51 A.D.3d 483, 859 N.Y.S.2d 119 (1st Dep't 2008) (affirming court's decision to grant court evaluator's request for order to access medical records as they would assist in investigation, especially in light of allegations by AIP's nephew of duress and coercion against the AIP and AIP's allegations of incapacity in self-petition).

83. N.Y. Mental Hyg. Law § 81.09(d).

84. *Id.*

85. *Id*.

86. *In re* Goldfarb, 160 Misc. 2d 1036, 1041–42, 612 N.Y.S.2d 788, 792 (Sup. Ct. Suffolk Cnty. 1994).

87. N.Y. Mental Hyg. Law § 81.12(b); *Goldfarb*, 160 Misc. 2d at 1043, 612 N.Y.S.2d at 793.

88. N.Y. Mental Hyg. Law § 81.09(c)(7).

89. *In re* Tara X, N.Y.L.J., Sept. 18, 1996, at 27 (Sup. Ct. Suffolk Cnty.).

90. N.Y. Mental Hyg. Law § 81.09(d); *Goldfarb*, 160 Misc. 2d 1036, 612 N.Y.S.2d 788.

91. *In re* Rosa B.-S., 1 A.D.3d 355, 767 N.Y.S.2d 33 (2d Dep't 2003*); In re* Bess Z, 27 A.D.3d 568, 813 N.Y.S.2d 140 (2d Dep't 2006) (court excluded testimony of treating physician, but held that testimony established by clear and convincing evidence that the person was likely to suffer harm because she could not care for her medical, personal, and financial needs and did not understand the nature of her limitations).

92. *Goldfarb*, 160 Misc. 2d 1036, 612 N.Y.S.2d 788.

93. *In re* Maher, 207 A.D.2d 133, 143, 621 N.Y.S.2d 617, 623 (2d Dep't 1994).

94. *See, e.g., Bess Z.*, 27 A.D.3d at 568, 813 N.Y.S.2d at 140 (testimony of AIP's treating physician violated physician-patient privilege, but other evidence sufficiently clear and convincing to appoint guardian*); In re* Seidner, N.Y.L.J., Oct. 8, 1997, at 25, col. 3 (Sup. Ct. Nassau Cnty.) (excluding medical evidence to which AIP objected based on physician-patient privilege and dismissing petition for lack of evidence).

95. *Rosa B.-S.*, 1 A.D.3d at 355, 767 N.Y.S.2d at 33.

96. *In re* Marie H., 25 A.D.3d 704, 811 N.Y.S.2d 708 (2d Dep't 2006).

97. 42 U.S.C. §§ 1397-1397F.

98. N.Y. Soc. Serv. Law § 473(1); N.Y. Comp. Codes R. & Regs. Tit. 18 pt. 457; *see also* http://www.ocfs.state.ny.us/main/psa/; 97 ADM-2.

99. *See, e.g.*, Dan R. v. Bane, 199 A.D.2d 322, 606 N.Y.S.2d 1000 (2d Dep't 1993) (local commissioner of Department of Social Services required as part of protective services to serve as representative payee for persons receiving SSI who are unable to manage their own finances).

100. Adult protective services are available to all adults who meet the following non-financial eligibility criteria: unable to provide necessary food, clothing, or medical care, access public and private benefits, or protect herself from physical or mental injury, neglect, maltreatment, or financial exploitation. The person must be at risk and need protection from actual or potential harm. No other person or agency must be able or willing to provide the needed assistance. N.Y. Soc. Serv. Law § 473(1); 18 NYCRR § 457.1(c)(1), (2), (3); 90 ADM-40.

101. *In re* Eugenia M., 20 Misc. 3d 1110A, 867 N.Y.S.2d 373 (Sup. Ct. Kings Cnty. 2008).

102. One court has called the practice of trying to assess on a case by case basis the validity of a waiver in this context a practice "fraught with peril and fallibility." *In re* Goldfarb, 160 Misc. 2d 1036, 1040, 612 N.Y.S.2d 788, 791 (Sup. Ct. Suffolk Cnty. 1994).

103. Friedland et al., Evidence Law and Practice, p. 792 (3d ed. 2007).

104. *Id*. at 793.

105. *Eugenia M.*, 20 Misc. 3d at 1110A, 867 N.Y.S.2d at 373.

106. Heller v. Peekskill Cmty. Hosp., 198 A.D.2d 265, 603 N.Y.S.2d 548 (2d Dep't 1993).

107. *See, e.g.*, Jaffee v. Redmond, 518 U.S. 1, 116 S. Ct. 1923, 135 L. Ed. 2d 337 (1996) (upholding claim of psychotherapist-patient privilege where police officer sought services from a clinical social worker subsequent to shooting in which he was involved). The client or patient of a social worker may invoke an evidentiary privilege under N.Y. C.P.L.R. 4508.

108. *See* 4-12 Bender's New York Evidence § 12.04.

109. N.Y. Mental Hyg. Law §§ 81.02; § 81.02(a) (standard for appointing a guardian); § 81.03(e) (available resources that are alternatives to a guardianship); § 81.21 (property management) and § 81.22 (personal needs).

110. N.Y. Mental Hyg. Law § 81.04(a)(4), (5).

111. N.Y. Mental Hyg. Law § 81.04(a)(6).

112. N.Y. Mental Hyg. Law § 81.04(a)(14).

113. N.Y. Mental Hyg. Law § 81.04(a)(9).

114. Article 81 made great strides by using "incapacity" and "incapacitated person" instead of the labels "incompetency" and "incompetent" that was used in the predecessor Article 78 "Committee" statute. However, in the ensuing two decades, societal awareness of the importance of language has increased, and it is time to update the statute and use language that does not reflect negatively on the person or suggest that the person's legal capacity is not entitled to full recognition under the law. For example, New York has replaced the term "mental retardation" with "developmental disability" or "intellectual disability" in state agencies, statutes, and regulations.

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Guardianship News: Anatomy of a Guardianship, or "The $5,000,000 E-mail"

By Robert Kruger

My purpose in writing this article is to hopefully illustrate the internal dynamic of a contested guardianship. The roles of the various attorneys and their evolving positions, together with the sporadic involvement of the presiding judge, may tell us how a guardianship proceeding evolves when it works reasonably well.

The narrative starts with that e-mail. The 46-year-old lover of an 81-year-old woman is instructing her regarding her imminent visit to her attorney to make a new Will. Her status is this: she is totally smitten with him, she wants to marry him, and he, despite several intermittent affairs, is determined to marry her. He wrote her this e-mail because her short-term memory is in tatters. She could not possibly remember his instructions, assuming that she wanted to follow them.

Her estate, approximately $6,500,000, was inherited from her late husband. Very little of this estate was generated by her. She was an academic of some stature; her late husband was an academic of considerable stature. She had no children; he had two, one of whom, his daughter, was my client. It was she who found the e-mail while visiting her stepmother.

The e-mail, a lawyer's dream, contained the following statements:

> That is wonderful, sweetheart. First of all, make sure [attorney] does NOT come see you while _____ is staying with you; as I said, _____ will miss no opportunity to spread her usual lies about you being mentally incapable and me being some kind of predatory monster who is trying to trick you into not leaving her all the money she thinks she is entitled to. Instead, have [attorney] come after the weekend, after _____ has decamped.
>
> The key thing when you do meet with [attorney], I suppose, is the new will that you mailed her before I left. You remember that we wiped your letter off your computer to prevent it from falling into the hands of the house-guest who seems to enjoy poking around on your computer. However, I saved a printout so you can have one for your files once we get a safe place to store such sensitive documents.
>
> In that letter, as you'll remember, the key points you asked [attorney] to incorporate in the new will were: disinheriting _____ completely because of her attempts to manipulate and control you, and substituting your husband-to-be. You substituted me for _____ as your first executor…..
>
> I have been doing a little research and wondered whether it might be prudent not just to omit any mention of _____, but to specifically insert a clause explaining your desire to disinherit her completely, with the reasons why (her manipulation of you, attempts to influence you and bully you, and her long-standing—since at least 1977—machinations to get her hands on your money, to the extent that [late husband] wrote that with her greedy behavior she was "chipping away" at his feelings for her).
>
> The reason why it would be prudent to include such an explanation is that after you are gone, _____ will surely try to contest any will you make unless it is entirely favorable to her. To succeed at this she would have to prove that 1) you are now mentally incompetent; and/or 2) I am exerting undue influence on you. As you know, she has been trying to convince anyone who will listen that both these conditions prevail……..
>
> This is all good stuff to keep in mind when you talk to [attorney]. DON'T hold back from telling her about the emotional abuse by _____ that you have been telling me about….
>
> P.S. I don't need to tell you this, but you must NOT leave this e-mail lying around for _____ to see. PLEASE DO NOT EVEN PRINT IT. _____ has

been making your life hard enough, but if she sees this e-mail, she will go berserk and can make our lives a living hell.

Love you.

"Living hell," indeed!

After she found this e-mail, my client, the daughter of the alleged incapacitated person's (AIP) late husband, called and met me for the first time. She described her stepmother (the AIP) as extremely bright and as a woman who would make a very impressive appearance, even with a poor memory. From this, I assumed that at a guardianship hearing the AIP could very easily appear sufficiently intact so that a judge would deny the application.

That e-mail was all the "evidence" we had. So, a guardianship proceeding was commenced. The Order to Show Cause sought temporary restraining orders (TROs) on the marriage and on making a new Will. Incidentally, at this time I had not seen the AIP's last Will.

At a contested hearing on the TROs, contested by court-appointed counsel for the AIP, the Court denied the TRO on the marriage, but granted the TRO prohibiting a new Will. In broad strokes, if they married, her husband would be entitled to a marital share of almost $2.2 Million. Indeed, a wedding, scheduled for mid-September 2011, appeared unavoidable. Coincidentally, the AIP fell before the wedding date and fractured her collarbone. The wedding was postponed for that reason.

The judge, at the hearing on the TRO in June, had suggested that the parties consider a prenuptial agreement. While discussion of this idea was evolving, the fiancée retained counsel. The court evaluator, who was uneasy about the AIP's relationship with the fiancée (who wouldn't be?), was talking about applying to the Court for permission to have the AIP undergo a psychiatric evaluation, something the AIP and the fiancée most decidedly did not wish to undergo. The presence of counsel for all parties, plus the looming threat of a psychiatric evaluation, brought the parties to a point where the drafting of a prenup was agreed to. I was happy about this, because if we went to a hearing the petitioner could end up empty-handed.

The judge's suggestion meant that an expedited hearing would not take place; that took some pressure off. Perhaps as important, the AIP's court-appointed counsel, after immersing himself in this matter, reached a conclusion that my client was not simply out to protect her inheritance. Rather, he saw that there was a real and affectionate relationship between them. We were no longer the laughing heirs. Moreover, the fiancée's lack of restraint was turning the AIP's counsel against him and toward the petitioner.

The dynamic had shifted. Court-appointed counsel now saw the fiancée as entirely money-driven and he took the lead (no one else really could) in negotiating the size of the fiancée's right of election. As this negotiation was proceeding, counsel for the fiancée understood that it would now be foolhardy for the fiancée to rush off and get married without finishing the prenup. The September wedding was definitely a missed opportunity for the fiancée; by November, it was too late for the wedding to simply slide by. If they snuck off to be married now, there would have been a mighty uproar.

The negotiations on the prenup were helped immeasurably by the AIP's desire to limit the amount of her estate going to her fiancée under the prenup. Her counsel was taking instruction from her and was insulating her from pressure from the fiancée (whose job took him out of New York for several weeks at a time).

Therefore, while the AIP was angry with her stepdaughter for commencing the guardianship, she never sought to disinherit her or to unjustly enrich the fiancée. Had it been otherwise, he would have received a full share as he exercised his right of election against her estate (at best) or he would have inherited her estate if the TRO was lifted (at worst).

But in the beginning we could not know this. From our vantage point, she was the Renée Zellweger character in the movie *Chicago*, the puppet of her fiancée. We thought, therefore, that in the absence of a TRO prohibiting the marriage, there was nothing that could be done to thwart the fiancée's designs.

What I did not factor in was the revulsion most of the players had for the fiancée. His attorney aside, there was a universe of family and friends who were positively revolted by the fiancée. The person who mattered (the judge presiding), was not giving too much information away. She suggested the prenup, which turned out to be a sufficient indication of her thinking, but, early on, we were not certain of her leanings. We did know, however, that the judge would not enjoin the marriage. We wondered what would happen if the fiancé refused to abide by the prenup. Would the judge bow graciously and give him free rein? Of course it never came to that but we could not feel that we were on secure ground until the AIP repeatedly resisted giving him a full marital share of her estate. We thought she was a puppet; she turned out to be far tougher than that.

Do not discount the constructive role the AIP's attorney played in this. He took the lead in protecting the AIP from the predator. His firmness strengthened my negotiating position. Although we disagreed on several points, when he firmly decided on something I was not inclined to challenge him unless a point was quite

important. He was on my side, and I intended that he stay there.

The day came when we reported to the Court that we had reached an agreement on the prenup and the stipulation of discontinuance. We submitted these documents to the Court and the Court appointed an extremely fine matrimonial specialist to review the agreements. In doing so, he consulted with all counsel several times and he rewrote the agreements. He stated insistently that the Court instructed him to ensure that the agreements sufficiently protected the AIP and were not too generous. At last we knew how the Court was viewing the matter. Consequently, portions of the two agreements were tightened. The couple was put on a budget (a generous budget, but still a budget), and geriatric care management oversight was strengthened. The agreements were then signed and so ordered by the Court.

The happy couple married that very day. Most of us were resigned to this but were nevertheless appalled because of our distaste for the fiancée. Still, we protected the AIP (the proceeding was dismissed) to the extent we could. If the AIP dies within a few years, that notorious e-mail constituted a $5,000,000 blunder by the fiancée. If she survives a decade, the blunder would cost him at least $3,500,000, if not more. The spending—the budget—is generous; they travel widely, they live well; they are cultured people who attend concerts and opera often. The AIP's life is not all that circumscribed. However, she can make no new Will, the fiancée's right of election is defined and circumscribed, their budget is not wildly lavish, and we have preserved, depending on her life expectancy, the bulk of her estate. All in all, this is not too bad.

If there is a message here, it is that sometimes you have to let the Court appointees come to you. If they are good, they will usually find you.

Robert Kruger is an author of the chapter on guardianship judgments in Guardianship Practice in New York State (NYSBA 1997, Supp. 2004) and Vice President (four years) and a member of the Board of Directors (ten years) for the New York City Alzheimer's Association. He was the Coordinator of the Article 81 Guardianship training course from 1993 through 1997 at the Kings County Bar Association and has experience as a guardian, court evaluator, and court-appointed attorney in guardianship proceedings. Mr. Kruger is a member of the New York State Bar (1964) and the New Jersey Bar (1966). He graduated from the University of Pennsylvania Law School in 1963 and the University of Pennsylvania (Wharton School of Finance (B.S. 1960)).

The Dos and Don'ts of Preparing and Supervising the Signing of Wills for the Elderly, Impaired and Infirm

By Joseph H. Gruner

Ann Landers once wrote in her column, "Where there's a will, there's a lawsuit." Although that is not always the case, there is some truth to that statement.

The fundamental obligation of any attorney involved in preparing a will on any level, from the simple to the complex, and in supervising its execution, is to exercise independent professional judgment on behalf of the testator. At the same time, the attorney must at least consider the possibility of a will contest that could destroy the testator's estate plan. Even though a majority of will contests fail, the risk of a will contest increases when the testator was elderly, infirm or impaired. Fortunately, there are various important factors for the attorney to consider and steps the attorney can take during the initial meeting with the testator, the actual execution of the will, and the time between these events, to reduce the chance of a will contest in the first place.

For the purposes of this article, the term "elderly, infirm and impaired" is intended to describe a person who is suffering from some degree of deficiency or limitation involving eyesight, hearing, memory, reading, understanding, concentrating, or other mental or physical disability that may bring into question the issues of competence and undue influence. Obviously, the attorney preparing the will must know the criteria for determining whether the testator has the requisite testamentary capacity and is acting from his or her "free will." Before the will is prepared and signed, the attorney must firmly believe that the testator has a rational plan for the distribution of his or her property after death, knows the nature and extent of the assets and property in his or her estate, knows the natural objects of his or her bounty (including relatives, friends, caretakers, and may even be charities and other organizations), knows who will actually receive a bequest and who will receive nothing, and knows the significance of the will as governing the distribution of property after his or her death.[1]

The attorney preparing the testator's will has a duty to be reasonably alert to indications that the testator may not have testamentary capacity because he or she is elderly, infirm or impaired, or may be subject to undue influence. Where these issues are indicated, the attorney must make a reasonable inquiry and then make a reasonable determination based on the evidence. An attorney should not prepare or supervise the signing of a will unless the attorney reasonably believes that the testator is competent and free from undue influence. In making the required determination, the attorney must have undivided loyalty to the testator. The attorney should refuse to prepare the will if a reasonable inquiry discloses potential undue influence by someone to whom the lawyer also owes any obligation of loyalty, such as a friend or another client. It could be a conflict of interest for the lawyer to represent the testator in such circumstances. The lawyer should discuss with the testator measures that will reduce or eliminate the likelihood that the will may be contested. A will may be determined to be procured through undue influence because the will was prepared by the beneficiary's lawyer or a lawyer chosen by the beneficiary, which resulted in the testator acting without independent and disinterested advice. In fact, case law provides that even though a will execution was attended by an independent attorney, this does not automatically rule out that the plan was the product of undue influence.[2]

Undue influence can be defined as inappropriate manipulation, deception, intimidation or coercion intended to mold the mind of the testator to suit the beneficiary's purposes. To be "undue," the influence must amount to mental coercion that led the testator to carry out the wishes of another instead of his or her own because the testator was unable to refuse or was too weak to resist.[3]

When a claim of undue influence is raised in a will contest, the court, in order to refuse to grant probate of the will, must find that another person employed some relational leverage to obtain an unfair advantage over the natural objects of the testator's bounty, and the will's provisions constitute a marked departure in favor of the person charged with undue influence from a prior natural plan of disposition.[4]

Often times, it is difficult to find evidence of coercion, manipulation, deception, compulsion and intimidation since the perpetrator usually attempts to hide such conduct. But if the perpetrator succeeds the result is an impairment of the testator's ability to make free choices about the distribution of the testator's estate in his or her will.

There is a significant difference between someone encouraging a testator to remember him or her in the

testator's will, and someone using deceptive, manipulative and coercive actions to get named in the will. Mere advice or urging to make a will without more does not constitute undue influence.[5]

An inference of undue influence can arise when the beneficiary actively participated in the procurement, preparation and execution of the will and disproportionately benefits from it.[6]

Undue influence can even be exerted over a person who has testamentary capacity, and can result in the will being voided. However, there must be an element of coercion, compulsion, or restraint, so that the document does not represent the free will of the testator.[7]

Clues suggesting the possibility of undue influence may derive from an unusual amount of control, coercion and exclusion, such as when the alleged perpetrator keeps other family members and friends away from the testator, tells tales about other heirs to alienate them from the testator, and controls visits, mail, and telephone calls from friends and relatives to the testator. But the mere fact that the testator may have been vulnerable to undue influence does not mean that undue influence was exercised at the time the will was signed.[8]

The following suggestions focus on the initial meeting prior to preparing the will, when there are reasonable concerns regarding capacity and undue influence:

- Meet with the testator alone.
- Ask the testator probing questions regarding health (eyesight, hearing, reading ability, medications, hospital stays), relatives, friends, shopping, cooking, etc. Listen carefully to the answers and take notes of the answers given.
- Obtain information directly from the testator regarding names, addresses and telephone numbers of relatives and friends, bank accounts, brokerage accounts, pensions, Social Security payments, expenses, accountant, tax returns, cash, health insurance, life insurance, and long term care insurance.
- If the testator is not ambulatory, conduct the initial meeting at the testator's home so you can observe the testator's living conditions.

You should hear loud warning bells and see red flashing lights when:

- the person who refers you to the testator, or a friend or relative of the referring party, is to be named as a beneficiary under the testator's will;
- the testator either has no relatives or does not stay in contact with relatives;
- the testator wants to disinherit a relative without a specific reason or cause;
- the testator lives alone; or
- the proposed beneficiary is the person the testator is dependent upon for companionship, shopping and care, or is an unusual choice of beneficiary based on the circumstances—such as a healthcare aide, a hairdresser, a caregiver, a distant cousin, a neighbor, or a "friend" who has had the opportunity to unduly influence the testator.

Be especially vigilant and exercise caution when confronted with any of the above circumstances.

Let some time pass between the initial meeting and the signing. It's a good idea to deliver a draft of the will to the testator at least a few days prior to the signing so that the testator has an opportunity to review the will and digest its provisions in private, even if the testator does not take that opportunity.

The following suggestions focus on the actual execution of the will, and are just a few steps that will douse some of the fuel from the dispute fire:

- Will Execution Ceremony: One of the best ways to avoid a will contest related to the execution of the will is to have the will executed properly. It helps to have a "will signing ceremony" that has become your regular custom and practice. Years and hundreds of wills later, when you may have trouble even remembering the testator's name, you can at least testify that you know you took certain steps in that testator's ceremony, asked certain specific questions, and followed certain specific procedures because you always do it in every will signing you supervise.
- Attesting Witnesses: If there is a reason to suspect the possibility of a will contest, you may want to consider using friends, relatives or neighbors of the testator who have known the testator for a number of years, are not named in the will, and who will be able to testify if the situation arises. Obviously, do not use the beneficiaries or anyone closely associated with the beneficiaries as witnesses. If there are no such witnesses available, use office staff to witness will signings.
- Contemporaneous Affidavits: If there is a reason to suspect the possibility of a will contest, you may want to consider obtaining affidavits from the testator's close family and friends including, if possible, his or her attending physician(s), prepared at or near the time of will execution, as contemporaneous expressions by people who knew the testator well over a long period of

time, were aware of the testator's condition on or about the day the will was signed, and can effectively testify about how the testator's condition that day compares to the affiant's perception of testator's condition for periods of time prior to the execution.

- Discussions Prior to Execution: In the presence of the attesting witnesses, some of whom may be meeting the testator for the first time at the will execution, have discussions with the testator and have the testator read something aloud, so that the witnesses can truthfully sign the affidavits.
- Self-Proving Affidavit: Consider expanding your self-proving affidavit or even drafting a separate one for witnesses to sign contemporaneously which will outline and preserve the witnesses' observations of the testator's state of mind and expressed intent.
- Formality: Don't overlook the formality of the will signing. Make sure you are alone with the testator and witnesses. Never allow any other relatives or friends (particularly those who are beneficiaries) in the room when the will is being executed. Go over the contents of the will again and make certain that the testator expresses his or her understanding of its contents to the witnesses. Make sure witnesses are comfortable with the competence of the testator before the will is executed.
- Videotaping: If poorly done, it could do more harm than good. However, if the stakes are high, you can hire a professional to create a video of the testator on the day of the will execution to demonstrate to the world the testator's competence and freedom from undue influence.
- Serial Re-Execution of Estate Documents: If you suspect that a will might be challenged based on incompetence or undue influence grounds, consider having the testator come back to your office and republish or re-execute the same will a number of times over the course of a few months or a year. It will strengthen the case that the testator was competent and acting without undue influence, and will, for obvious reasons, make the caveator's task of setting the will aside difficult and expensive.

If you keep in mind the things you will likely have to prove in order to make out a *prima facia* case of a valid will execution,[9] how that proof might be perceived by perfect strangers years down the road, and act accordingly, you will have gone a long way towards discouraging questionable will contests.

Endnotes

1. *See* Matter of Kumstar, 66 N.Y.2d 691 (1985).
2. *See* In re Kaufmann's Will, 20 A.D.2d 464 (1st Dep't 1964); In re Delmar's Will, 243 N.Y. 7 (1926).
3. *See* In re Walther's Will, 6 N.Y.2d 49 (1959); Rollwagen v. Rollwagen, 63 N.Y.2d 504 (1876).
4. *See* In re Kruszelnicki's Will, 23 A.D.2d 622 (4th Dep't 1965).
5. *See* Matter of Knight, 87 Misc. 577 (Sur. Ct. New York County 1914).
6. *See, e.g.*, Matter of Kryk, 18 Misc. 3d 1105A (Sur. Ct. Monroe County 2007); Matter of Kindberg, 207 N.Y. 220 (1912).
7. *See* Matter of Walther, 6 N.Y.2d 49 (1959).
8. *See* Children's Aid Society v. Loveridge, 70 N.Y. 387 (1877).
9. SCPA § 1408.

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Your Client's Home in the Irrevocable Medicaid Qualifying Trust: To "Use" and to "Occupy"

By Diane Lynne Butler and Vincent W. Ansanelli

The expanded Medicaid estate recovery provisions enacted as part of the 2011 New York State Budget legislation set off a firestorm of analysis and best-educated guesses regarding the fate of homes of clients who engaged in Medicaid planning. Practitioners initially focused their concern on clients who retained life estates in deeds. This concern expanded to clients who retained beneficial interests in primary residences that had been transferred to Irrevocable Medicaid Qualifying Trusts. Specifically, Section 369(6) of the New York Social Services Law, as amended, provided that a Medicaid recipient's "estate" for purposes of Medicaid estate recovery included property "in which the individual has any legal title or interest at the time of death, including…retained life estates, and interests in trusts, to the extent of such interests…."[1] With regard to primary residences, the meaning of terms commonly found in Medicaid Qualifying Trusts, in particular the retention in the grantor of the right to "use" and to "occupancy" of the residence, became more relevant and important to understand. The question arose whether "use" and "occupancy" rights to a residence could be construed as creating a "constructive" life estate that would be subject to estate recovery.

The New York Department of Health subsequently issued temporary emergency regulations (now lapsed due to regulatory inaction) that broadened the definition of "estate" by reaching real property in which a deceased Medicaid recipient "had any legal title or interest at the time of death, including such assets conveyed to a survivor, heir, or assign of the decedent through… life estate…or other similar arrangement, *to the extent of the decedent's interest in the property immediately prior to death.*"[2] A deceased Medicaid recipient's interest in property "immediately prior to death" would include the value of a "retained life estate" created by the Medicaid recipient in real property, in which he or she held any interest at the time the life estate was created, based on the actuarial life expectancy of the life tenant at the time of death.[3]

The spotlight on "use" and "occupancy" rights in Medicaid Qualifying Trusts faded somewhat as official assurances were received that the Department of Health did not intend to reach interests that were retained by clients in residences transferred to Medicaid Qualifying Trusts. However, Section 369(6) of the New York Social Services Law was quite clear on its face, leaving practitioners uneasy with even the future possibility of estate recovery against beneficial, "constructive" life estates in such residences. The Department of Health was expected to issue final regulations for public comment that would not change the treatment of life estates and would take effect for dates of death occurring on or after July 1, 2012. However, at the time of this writing, Section 369(6) was repealed by the New York State Legislature in response to the successful lobbying efforts of the Elder Law bar.[4]

The original purpose of this article was to explore whether a client for whom a Medicaid Qualifying Trust is appropriate would be best served by reserving the rights to "use" and to "occupy" the primary residence, or whether "use" alone would suffice and avoid any risk of estate recovery. While this comparison now may be deemed academic from the perspective of estate recovery, practitioners should find it helpful to review the interplay of "use" and "occupancy" rights with the laws governing property tax exemptions, federal income and estate taxes, and other common provisions of Medicaid Qualifying Trusts, to gain a deeper understanding of how they interact. The prospect of a future "revival" of estate recovery against life estates always exists, which by itself warrants keeping this article close at hand.

A. What Do "Use" and "Occupancy" Mean?

Under New York common law, there is a clear distinction in the beneficial rights arising from a grant of "use" versus "occupancy" of real property in a trust. The term "use" gives the beneficiary the absolute right to rents and income arising from real property and, accordingly, is essential to vesting the beneficiary with a life estate in real property.[5] Therefore, the life tenant is "the exclusive owner of the land so held by him, with the exclusive right to its possession, control and enjoyment, subject only to certain well-defined limitations or duties; the owner of the reversion or remainder in fee has no present right of enjoyment, no tangible and physical ownership of the land, but has a future incorporeal interest or estate in the land which will ripen into ownership of the land itself on the death of the life tenant."[6] In contrast, a right to occupancy entitles the beneficiary to nothing more than occupancy of the premises.[7]

The beneficiary's right to "use" real property encompasses both the right to occupy and receive income and the obligation to pay expenses. Concomitant with the grant of a life estate is the obligation to pay taxes, interest, insurance premiums and ordinary repairs, which are "so wrapped up in a life tenancy as to be, practically speaking, part of the estate itself; the life tenant really has no 'property' for his own absolute use and enjoyment until these obligations are discharged."[8] Unless the trust granting the right to "use" real property provides otherwise, the general rule is that the life tenant is responsible for paying these expenses in order to preserve the value thereof for the remaindermen.[9]

B. "Use" and "Occupancy" Under Medicaid Rules

In the Medicaid context, there are significant advantages to a life estate compared to outright ownership of the homestead. The prospect for institutionalization of a Medicaid recipient who owns a homestead is of concern, because Medicaid may impose a lien on the homestead if he or she is permanently absent and cannot reasonably be expected to be discharged and, further, the homestead becomes a countable resource if the Medicaid recipient does not have a subjective intent to return home.[10] If the homestead is rented upon the Medicaid recipient's institutionalization, the rental payments would be treated as countable income to be surrendered as Net Available Monthly Income (NAMI) to the nursing home (net of ordinary and necessary expenses).[11]

In contrast, a life estate is not a countable resource for Medicaid purposes, and a Medicaid lien may not be placed on a life estate after a Medicaid recipient has been institutionalized. Further, a Medicaid recipient cannot be compelled to liquidate or rent the life estate, although any net rental income from the life estate will be countable income surrendered as NAMI to the nursing home.[12] Accordingly, it is important to ensure that the Medicaid Qualifying Trust indeed reserves to the Medicaid recipient a life estate in the homestead. Administrative guidance provides that a life estate holder "does not have full title to the property, *but has the use of the property* for his or her lifetime, or for a specified period. Generally, life estates are in the form of a life lease on property that the person is using, or has used, for a homestead."[13] This definition notably is consistent with New York common law in specifying that a life estate holder has "use" of property for his or her lifetime, which as discussed above confers broader rights than mere "occupancy."

It has been suggested that additional flexibility to deal with a Medicaid recipient's institutionalization is obtained by providing the trustee of a Medicaid Qualifying Trust discretion to "sprinkle" income to the Medicaid recipient and other beneficiaries. That is, any rental income arising from the homestead could be retained in the Trust or distributed, for example, to the children of the Medicaid recipient, thereby avoiding both a forced sale of the homestead and the attribution of rental income to the Medicaid recipient. However, payments which may be made to or for the benefit of the Medicaid recipient (as grantor of the Medicaid Qualifying Trust) are deemed to be an available resource.[14] Further, the Department of Social Services may maintain an action against a trustee to collect any beneficial interest of a Medicaid recipient in an inter vivos trust to reimburse the costs of medical assistance, assuming the full exercise of trustee discretion for maximum distribution to the Medicaid recipient.[15] These provisions should limit the practical benefits from a discretionary sprinkling income provision in a Medicaid Qualifying Trust as applied to the homestead. In addition, stripping the grantor's absolute, exclusive right to income from property out of the right to "use" such property may render the grantor's beneficial interest one of mere "occupancy" of such property under New York common law.[16] This is not just a theoretical concern, as will be explained further below with respect to the STAR and other real property tax exemptions.

C. "Use" and "Occupancy" under Real Property Tax Law

Ownership of a primary residence by an eligible person is a basic requirement for claiming a real estate tax exemption, be it enhanced STAR, the senior citizens' exemption, or the veteran's exemption. If the residence is held by a trust, whether revocable or irrevocable, the tax exemption applies if the beneficial owner of the residence is an eligible person.[17] The New York Department of Taxation and Finance has taken the legal position that a primary residence will qualify for a tax exemption only if the "instrument creating the interest" has granted a life estate in the residence to an eligible person, and, further, that the grant of the right to "use" of the residence—that is, a right to "rents and profits"—is critical to the creation of a life estate.[18] A mere right to "occupy" the residence will not suffice. In addition, a residence held in trust must be held solely for the benefit of the person who qualifies for the exemption, and granting other beneficiaries a right to present enjoyment is inconsistent therewith.[19]

One may question whether the requirement of a life estate applies only when the homeowner has conveyed his or her interest in the residence by deed, as opposed to retaining a beneficial interest in the residence. The statutes governing the exemptions distinguish between a life estate and a beneficial interest granted in trust, and do not require that a beneficial interest granted in trust be the equivalent of a life estate. The statutes merely require that the homeowner claiming the exemption be the sole beneficiary of the primary residence held in trust. However, the legal opinions of the Department of Taxation and Finance do not make this distinction,[20] and in practice, local tax assessors may raise issue with the reporting of a client's interest in the home as anything other than a life estate.

Accordingly, when developing a Medicaid Qualifying Trust, the practitioner should exercise caution in reserving to the client anything less than "use" and "occupancy" of the primary residence if he or she hopes to qualify for a property tax exemption. It also should be carefully considered whether providing the trustee discretion to sprinkle income from the primary residence to beneficiaries other than the client is consistent with the requirement that the client be the sole beneficial owner of the residence for purposes of the property tax exemptions. Our firm has taken the approach of permitting the trustee to sprinkle income to beneficiaries other than the client only with respect to financial assets held by the trust, but requiring the trustee to distribute income arising from the primary residence to the client. However, the potential for attribution of income to the client after he or she has applied for Medicaid arises regardless of whether distribution of income to the client is required or within the trustee's discretion, as previously discussed.

It also is worth noting that requiring the trustee to sell the residence within a certain period of time after the client enters a nursing home, in itself, will not disqualify the client from claiming a property tax exemption for which he or she otherwise is eligible.[21] Further, the property tax exemptions still should be made available to individuals who reside in nursing homes, subject to the important exception that any occupants of the primary residence must be co-owners or a surviving spouse.[22] However, as a practical matter, local assessors may have their own requirements and seek to disqualify permanently institutionalized individuals from claiming property tax exemptions.

D. "Use" and "Occupancy" and Federal Income and Estate Taxes

Medicaid Qualifying Trusts that hold primary residences typically are developed with the goal of qualifying the trusts as grantor trusts for federal income tax purposes. A trust is treated as a grantor trust when a grantor (or another person) is treated as the owner of the trust income or principal (or both) for federal income tax purposes. Sections 673 to 679 of the Internal Revenue Code set forth the rules for determining whether a trust qualifies as a grantor trust.[23] Income from a Medicaid Qualifying Trust that qualifies as a grantor trust is taxable to the grantor at the grantor's tax rate, even if not distributed to the grantor. This can be advantageous because the individual income tax rate often is lower than the compressed income tax rate applicable to trusts. If the grantor's primary residence held by the Medicaid Qualifying Trust is sold during his or her lifetime, the grantor also will be liable for the capital gains tax.[24] Importantly, the Section 121 capital gains tax exemption of $250,000 will apply regardless of how long ago the residence was transferred to the Medicaid Qualifying Trust, so long as the grantor lived there for at least two out of the five years preceding the date of sale.[25]

Section 677(a)(1) of the Internal Revenue Code provides that the grantor will be treated as the owner of trust income if a nonadverse party (such as a non-beneficiary trustee) has the discretion to distribute (or actually does distribute) trust income to the grantor (or the grantor's spouse).[26] A Medicaid Qualifying Trust that reserves to the grantor a right to "use" real property in the Trust is consistent with grantor trust treatment because such right entitles the grantor to "rents and profits" deriving from the property. An additional provision requiring the Trustee to distribute income from the real property to the grantor (or permitting the Trustee to do so, provided the Trustee is a nonadverse party) should provide grounds for treating the Medicaid Qualifying Trust as a grantor trust under Section 677(a)(1). Medicaid Qualifying Trusts containing other provisions, such as limited powers of appointment and powers of substitution, that allow them to qualify as grantor trusts for federal income tax purposes.

Reservation in the grantor of a right to "use" and "occupy" the primary residence also would constitute a legally enforceable right to "possession or enjoyment" of the residence that qualifies it for estate tax inclusion under Section 2036(a)(1) of the Internal Revenue Code, with the accompanying step-up in basis. If expanded estate recovery ever rears its ugly head again, and concern arises with the prospects for recovery against "constructive" life estates in residences held by Medicaid Qualifying Trusts, case law suggests that there is an estate tax inclusion under Section 2036(a)(1) of the Internal Revenue Code based on the grant of an "occupancy" right.[27] However, as previously discussed, this inclusion could be at the cost of depriving the client of real property tax exemptions and preferential Medicaid treatment of the life estate.

In conclusion, when developing a Medicaid Qualifying Trust to shelter a client's primary residence, the practitioner should ensure that all provisions of the Trust are consistent with those granting the client a right to "use" and to "occupy" the home. Ancillary issues relating to property, income, and estate tax treatment of the residence and the Trust also should be considered. A coherent Medicaid Qualifying Trust that achieves the client's goals while satisfying all statutory and regulatory requirements produces an optimal outcome for both the client and the practitioner.

Endnotes

1. 2011 New York Laws Ch. 59, Section 1, Part H, Section 53, at 155.
2. 18 N.Y.C.R.R. § 360-7.11(a)(1)(ii) (emphasis added). The emergency regulations were issued effective September 8, 2011, but lapsed on December 6, 2011, because the Department of Health did not issue a notice of proposed rulemaking within the required time frame.
3. 18 N.Y.C.R.R. §§ 360-7.11(a)(2)(ii), (a)(3)(i). The value of the life estate interest would be computed by (i) using an IRS Code 7520 Interest Rate applicable to Medicaid recipient's date of death, (ii) determining a life estate factor from IRS Table S, Single Life Factor based on the applicable IRS Code 7520 Interest Rate and

age at time of death, and (iii) multiplying the home's value by this life estate factor. N.Y. Dep't of Health, Expanded Definition of 'Estate' for Medicaid Recoveries, 11 OHIP/ADM-8 at 11 (Sept. 26, 2011). Although expanded estate recovery was repealed, the new procedure for valuing life estates was preserved. *See* N.Y. Dep't of Health, Required Tables/Method for Valuing Life Estate Interest, GIS 12/MA 001 (Jan. 28, 2012).

4. N.Y.S. Senate, S.6256D-2011 §56 (2012), *available at* http://open.nysenate.gov/legislation/calendar/floor-03-30-2012 (repealing Section 369(6) of N.Y. Social Services Law).
5. *In re* Fike's Estate, 59 Misc. 2d 1047, 1049, 301 N.Y.S.2d 394, 396 (Sur. Ct. 1969); *In re* Gaffers' Estate, 254 A.D. 448, 451, 5 N.Y.S.2d 671, 677 (App. Div. 3d Dep't 1938) ("A bequest or devise of the use of a piece of property during the natural life of a person gives to that person a life estate in the property and not merely the right to occupy it.").
6. *In re* McCarty's Estate, 158 Misc. 287, 288, 285 N.Y.S. 641, 642 (Sur. Ct. 1936).
7. *See* Carpenter v. Carpenter, 131 N.Y. 101, 29 N.E. 1013 (1892); Bartholomew v. Horan, 37 A.D.2d 643, 644, 322 N.Y.S.2d 401, 403 (App. Div. 3d Dep't 1971).
8. *McCarty's Estate*, 158 Misc. at 289, 285 N.Y.S. at 643.
9. *Gaffners' Estate*, 254 A.D. at 451-52, 5 N.Y.S.2d at 677.
10. N.Y. Soc. Serv. Law § 369(2)(a)(ii); 18 N.Y.C.R.R. § 360-7.11(a)(3)(ii). *See generally* David Goldfarb, *The Homestead and Medicaid Planning*, *available at* www.seniorlaw.com/homestead-medicaid.htm.
11. Medicaid Reference Guide, *Rental Income*, at p. 144 (Aug. 1999).
12. N.Y. Dep't of Health, OBRA '93 Provisions on Transfers and Trusts, 96 ADM-8 at 19 (Mar. 29, 1996).
13. *Id.* (emphasis added).
14. 18 N.Y.C.R.R. § 360-4.5(b)(1)(ii)-(iii).
15. N.Y. Soc. Serv. Law § 369(3).
16. *In re* Fike's Estate, 59 Misc.2d 1047, 301 N.Y.S.2d 392 (Surr. Ct., 1969) (holding that deceased husband's Will failed to provide widow with legal life estate on grounds that rental income was directed to be paid to her son). At least one authoritative source states that the life tenant is entitled to rents unless the granting document says otherwise. Robert F. Dolan & Joseph Rasch, New York Law and Practice of Real Property § 6:15 (2d. ed. 2011) (citing *In re* Thomson's Will, 43 N.Y.S.2d 392 (Surr. Ct. 1943)). However, the case cited by Rasch does not provide direct support for the proposition that a life estate in real property can be retained even if the grantor does not have a right to receive rental income from the real property, and many cases have been decided to the contrary.
17. 17. N.Y. Real Prop. Tax Law § 425(3)(c) ("If legal title to the property is held by one or more trustees, the beneficial owner or owners shall be deemed to own the property" for purposes of STAR exemption); *Id.* §§ 458(7), 458-a(5) ("[T]he provisions of this section shall apply to any real property held in trust solely for the benefit of a person or persons who would otherwise be eligible for a [Veterans/alternative Veterans] real property tax exemption…were such person or persons the owner or owners of such real property."); *Id.* § 467(10) ("[T]he provisions of this section shall apply to real property in which a person or persons hold a legal life estate or which is held in trust solely for the benefit of a person or persons if such person or persons would otherwise be eligible for a [Senior Citizen] real property tax exemption…were such person or persons the owner or owners of such real property.").
18. N.Y. Dep't of Taxation and Finance, Vol. 9: Opinions of Counsel SBEA No. 41 (Nov. 12, 1991) (grant of "exclusive life use" of property is sufficient to claim property tax exemption); Vol. 5: Opinions of Counsel SBEA No. 12 (June 9, 1975) (grant of right to occupy first floor of premises is not sufficient to create life estate or claim property tax exemption).
19. Vol. 10: Opinions of Counsel SBRPS No. 25 (Mar. 19, 1996).
20. *Cf.* Vol. 10: Opinions of Counsel SBRPS No. 55 (Feb. 26, 1998) (a life estate may be created or reserved by an unrecorded instrument in writing, so long as the instrument satisfies all requisites of a conveyance).
21. Vol. 11: Opinions of Counsel SBRPS No. 44 (Nov. 25, 2002).
22. N.Y. Real Prop. Tax Law § 467(3)(d) (senior citizens exemption), § 425(4)(c) (STAR exemption). *See also* Vol. 10: Opinions of Counsel SBRPS No. 69 (Oct. 2011) (when applicant for STAR or senior citizens exemption is absent from home while in residential health care facility, statutory residency requirement is satisfied, but assessor has discretion to determine residency when applicant is cared for in any place other than residential health care facility); Vol. 11: Opinions of Counsel SBRPS No. 12 (June 2001) (when a life tenant is confined to nursing home, occupancy of residence by non-spouse remainderman disqualifies residence from eligibility for STAR and senior citizens exemption).
23. 26 U.S.C. §§ 673-679 (2012).
24. 26 U.S.C. § 671 (2012).
25. 26 C.F.R. § 1.121-1(c)(3) (2010).
26. A "nonadverse" party is a person who does not have a substantial beneficial interest in the trust which would be adversely affected by the exercise or nonexercise of the power which he possesses respecting the trust. A person having a general power of appointment over trust property will be deemed to have a beneficial interest in the trust. 26 U.S.C. § 672 (2012).
27. Estate of Stewart v. Commissioner, 617 F.3d 148, 157 (2d Cir. 2010) (holding that continued exclusive possession of residence by donor and exclusion of donee from residence results in estate tax inclusion under case law).

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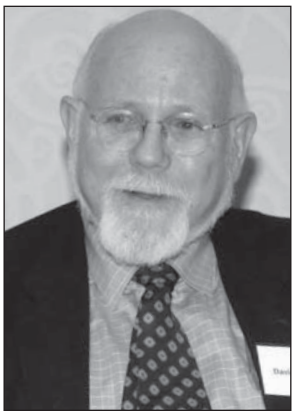
Back to the Future: Expanded Medicaid Estate Recovery Repealed

By David Goldfarb



As most of you know, this year as part of the annual New York State budget process the expanded Medicaid estate recovery enacted in 2011 was repealed.[1]

Federal law gives states the option to define the term "estate" broadly or narrowly.[2] In 2011, New York as part of its budget bill enacted enhanced Medicaid estate recovery whereby an individual's "estate" included all of the individual's real and personal property and other assets passing under the terms of a valid will or by intestacy and also included any other property in which the individual had any legal title or interest at the time of death, including jointly held property, retained life estates, and interests in trusts, to the extent of such interests.[3]

The enhanced recovery of assets passing outside probate or intestacy was subject to two very important limitations:

1. It was to be effective only pursuant to regulations adopted by the Department of Health commissioner, which could be promulgated on an emergency basis, and
2. the effective date of the provision in the 2011 budget bill stated, "this act shall not be construed to alter, change, affect, impair or defeat any rights, obligations, duties or interests accrued, incurred or conferred prior to the effective date of this act,…."[4]

The Department of Health promulgated an emergency regulation[5] in September 2011, which in many respects went beyond the bounds of the statute. In particular with regard to "life estates" not only did it conflict with existing New York Law,[6] but it also affected existing rights in apparent contradiction to the effective date provision cited above.

The emergency regulation expired on December 6, 2011, without a permanent regulation being promulgated.[7] However, the Department of Health had drafted and circulated a permanent regulation that in many ways was more Draconian than the emergency regulation. The proposal continued to affect vested interests despite the clear language of the enabling legislation prohibiting this. The proposed regulation confused estate recovery from a Medicaid recipient and from a legally responsible spouse of a Medicaid recipient. And the proposed regulation added estate recovery against "the amount the person could have withdrawn from an individual retirement account or other retirement fund,…." It also provided an enforcement scheme based on post-death liens, which were nowhere authorized by the statute.

It is interesting to note that Massachusetts went through a similar process of enactment and repeal in 2003 and 2004. In 2003 Massachusetts enacted an expanded definition of the word "estate" for Medicaid estate recovery purposes.[8] Legislation was subsequently submitted to repeal the expanded estate recovery provision but the proposed repeal was vetoed by the Governor. In July, 2004, the legislature overrode the Governor's veto and amended the Massachusetts General Laws to restore estate recovery only against the probate estate.

Although expanded estate recovery is no longer law in New York, there is one interesting remnant from the process. Along with the emergency regulation, the Department of Health had issued an Administrative Memo to implement the new law and regulation.[9] Part of the ADM included a revised methodology for calculating the value of a life estate and the transferred remainder interest. Instead of using CMS life expectancy tables imported into previous ADMs, the ADM instructed local districts to now use the Internal Revenue Service (IRS) actuarial table, "Table S, Single Life Factors," in accordance with the most recent mortality table, "Table 2000CM," and interest rates under IRS code 7520, "Section 7520 Interest Rates." Although the ADM became ineffective upon expiration of the emergency regulation, the policy guidance provided in the ADM regarding the method to use in evaluating life estate interests under the transfer of assets provisions continues to apply.[10]

Endnotes

1. Soc. Serv. Law § 369(6) as amended by 2012 N.Y. Laws 56.
2. 42 USC § 1396p(b)(4)(B).
3. Soc. Serv. Law § 369(6) as amended by 2011 N.Y. Laws 59.
4. 2011 NY Laws Ch. 59, Part H, § 111 (u).
5. Amending 18 NYCRR § 360-7.11, effective September 8, 2011.

6. See EPTL 6-4.7 and 6-5.1.
7. Technically expanded estate recovery was in effect for persons dying while the emergency regulation was in effect, however; because of all the legal problems with the statute and regulation it is doubtful that expanded estate recovery will be pursued for persons dying during this window.
8. Massachusetts General Laws, Chapter 118E § 31.
9. 11 OHIP/ADM-8 (September 26, 2011).
10. GIS 11 MA/028 (12/12/11).

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Update on Proposed Amendment to the Health Care Proxy Law

By Ellen G. Makofsky

In 2011 the Elder Law Section proposed an amendment to the Health Care Proxy Law that would permit an individual designated as a health care agent to make decisions about transporting a patient to a particular hospital, mental hygiene facility or residential health care facility when the patient is unconscious or unresponsive without a certification of incapacity.

Please note that this proposed amendment would not apply in cases involving major medical trauma, when a patient requires immediate medical treatment. The NYSBA made numerous attempts to move the proposed legislation forward, and finally, in June of 2012 Assemblyman Charles D. Lavine (D-Nassau County) and Senator John A. DeFrancisco (R-Onondaga County) introduced a bill (A-8389 and S-5014-A) reflecting the amendment proposed by the Elder Law Section.

The proposed legislation particularly addresses a 2009 federal court decision (*Stein v. County of Nassau, et al.)* that found—when outside of a hospital or other medical institution—a health care agent does not have the authority to direct where a patient is transported. The court said the state law requires that the agent must first consult a medical professional.

On June 21, 2012 the proposed amendment was passed by the New York State Legislature and now awaits the Governor's signature. The Elder Law Section worked very hard on the proposal and it is wonderful to see those efforts rewarded.

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Ethics Poll Conducted by the Elder Law Section Ethics Committee

By Judith B. Raskin and Natalie J. Kaplan

The Elder Law Section Ethics Committee e-mailed its Poll #4 on April 2, 2012 to all Section members. On April 5, 2012 the Committee e-mailed Poll #4 Results and Commentary.

We encourage you to participate in upcoming polls.

Judith B. Raskin

Poll #4: Results

Poll #4 asked the question:

> Client executed his will at his attorney's office. The attorney agreed to hold the client's original will for safekeeping and placed the will in a locked metal container in his office.
>
> Was the attorney in compliance with the Rules by placing the will in his locked container?

The poll offered three choices. The distribution below shows the results from 211 entries received:

Yes	73.6% (N = 215)
No	14.4% (N = 42)
Don't know	12.0% (N = 35)

Based on the authorities consulted, we conclude that the answer is "No."

Commentary

1.15(c)(2) directs that a lawyer shall "identify and label securities and properties of a client or third person promptly upon receipt and place them in a safe deposit box or other place of safekeeping as soon as practicable."

Comment [1] to Rule 1.15 states in part: "A lawyer should hold the funds and property of others using the care required of a professional fiduciary. Securities and other property should be kept in a safe deposit box, except when some other form of safekeeping is warranted by special circumstances."

Natalie J. Kaplan

Black's Law Dictionary, Fifth Edition, defines "safe deposit box" as a metal container kept by a customer in a bank in which he deposits papers, securities and other valuable items."

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Recent New York Decisions

By Judith B. Raskin

A. Medicaid Transfers Result in Denial of Application

On her attorney's advice, Petitioner made her friend joint owner of her accounts to avoid probate and a likely will contest. Over the next few years the friend withdrew funds from the accounts. Medicaid deemed these withdrawals uncompensated transfers when she applied for Medicaid to pay her nursing home costs. Her Medicaid application was denied and the denial was upheld at a Fair Hearing. On appeal, Petitioner argued that the transfers to her friend were not for the purpose of Medicaid eligibility, and that she was in good health and solvent prior to a fall, after which she was diagnosed with senile dementia.

The court upheld the denial. Petitioner failed to overcome the presumption that the transfers were made for the purpose of establishing Medicaid eligibility. She presented no evidence of her health prior to the fall, and her attorney's statement alone was insufficient to show the intent in making the gifts.[1]

B. Medicaid Lien on Award Upheld

Mr. and Mrs. Fried, Article 81 guardians for their disabled daughter, brought this personal injury action against several defendants for their part in causing the daughter's injuries. After a considerable jury award, the plaintiffs moved, *inter alia*, to bar the city's Human Resources Administration (HRA) from placing a lien on the proceeds due to HRA's failure to follow "strict statutory guidelines."

The court denied Plaintiffs' motion for failure to make a *prima facie* case. Plaintiffs failed to submit all documents they received from HRA regarding the lien and had not served notice to HRA regarding the commencement of their action. Although HRA did not strictly conform to the statutory requirements, their actions were sufficient to avoid prejudice to any party.[2]

C. Article 81 Guardian Appointed After Objections

After G.V.S. suffered a third stroke that left him in a vegetative state, his daughter, E.P., petitioned to be his Article 81 guardian. She had medical training and experience dealing with medical facilities, including billing matters. Several close family members objected to E.P.'s appointment. They testified she had not informed some of them of his last stroke, updated them on his condition, or given them any information about him. When asked why E.P.'s petition listed the incapacitated person's assets as $200,000, she stated that she was not aware of $1.3 million of additional funds. The court evaluator recommended that E.P. be appointed as co-guardian with an independent guardian to assure contact with and access by the family members.

The court appointed E.P. as sole Article 81 guardian with direction to keep the family apprised of all developments.[3]

D. Contested Accountant Fee in Article 81

The guardian in this Article 81 proceeding moved to settle her final account. The accounting included a fee to the accountant of $161,301.50 for 459 hours of work. This fee was based on hourly rates of $252 in 2008, $318 in 2009, and $343 in 2010. The court reduced the fee using an hourly rate of $150, with no explanation for the reduction in the hourly rate. The accountant appealed.

Before ruling on the matter, the Appellate Division sought an expedited explanation from the Supreme Court for the reduction in the hourly rate.[4]

E. Guardian Does Not Have to Pay Court Examiner's Fee

After parties agreed that the referee would determine all issues regarding the Article 81 guardian's final account, the guardian appealed the referee's determinations. The referee surcharged the guardian for unauthorized expenditures and additionally ordered the guardian to pay a court examiner's fee of $10,725.

The court upheld the surcharge but reversed on the court examiner's fee. There is no provision for a court to require a guardian to pay the court examiner's fee.[5]

F. Medicare and Medicaid Release in Personal Injury Action

Defendant in this personal injury action cross-moved for leave to pay proceeds to the court and to stay the plaintiff from entering judgment because the plaintiff failed to release the defendant from possible Medicaid and Medicare liens.

The court affirmed the lower court's order that Plaintiff provide Defendant with access to the plaintiff's Medicare and Medicaid records. It granted the

defendant's cross-motion to stay entry of the judgment until the plaintiff released the defendant from Medicare and Medicaid liens.[6]

G. Equipment Purchase Approved on Appeal

A seven-year old petitioner sought Medicaid approval of the purchase of a Bantam Stander standing device. Petitioner appealed the denial of this request from the agency at a Fair Hearing. She argued that this device was medically necessary and met the New York Department of Health regulation requiring that the device be "…necessary to prevent, diagnose, correct or cure a condition."

The Appellate Division, where this case was transferred, reversed. The court found that the petitioner met her burden of showing the Bantam Stander met the statutory requirements and was the best and least costly device to provide for her needs.[7]

Endnotes

1. *Mallery v. Shah*, No. 01542, 2012 N.Y. App. Div. LEXIS 513277 (3d Dep't. Mar. 1, 2012).
2. *Fried v. City of New York*, No. 28770/02, 2012 NY Slip Op. 22050 (Sup. Ct. Feb. 29, 2012).
3. *Matter of G.V.S.*, No. 9172X/11, NYLJ 1202538983666, at 1 (Sup. Ct. Bronx Co., Dec. 16, 2011).
4. *Matter of Doris J.*, 2012 N.Y. App. Div. LEXIS 1798; 2012 Slip Op. 1819 (App. Div., 2d Dep't., Mar. 13, 2012).
5. *Matter of Carl R.*, 2012 N.Y. App. Div. LEXIS 1809; 2012 Slip Op. 1822 (App. Div., 2d Dep't., Mar. 13, 2012).
6. *Torres v. Hirsch Park, LLC*, 2012 NY Slip Op. 00775 (App. Div., 2d Dep't., Jan. 31, 2012).
7. *Godfrey v. Shah*, 2012 NY Slip Op. 00564 (App. Div., 4th Dep't., Jan. 31, 2012).

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HECM Trusts: A Universal Planning Option for Cash Flow Management

By Wayne R. Bodow

Not all cars are Buicks. Not all reverse mortgages are Home Equity Conversion Mortgages (HECMs).[1] Not all mortgage originators seek the best interest of the borrowers. The first reverse mortgage products included: a balloon note, or an equity sharing concept and ultimate control of the real property, in exchange for no payment occupancy.

A. The HECM[2] Perspective

HECMs, by contrast, enable sophisticated options that include government guarantees such as: a line of credit that cannot be revoked that also accumulates growth at the same rate as the note interest rate, a guaranteed lifetime payment stream defined as "tenure"; or a combination of tenure and line of credit. Additionally, this mortgage is non-recourse. Like traditional mortgages, the HECM becomes due if the borrower fails to pay the real property taxes or assessments, fails to maintain property insurance and flood insurance where required, or fails to maintain the property in good repair. The loan will also become due upon death or transfer, or when the last surviving borrower no longer occupies the property as a principal residence for longer than one year. More often than not, there is equity to be recovered after the loan becomes due. The heirs have up to one year to pay back the loan, typically accomplished by selling the home to a third party.

There are numerous HECM products available to consumers. Not all lenders offer all products. Some only offer the fixed rate programs that require the borrower to take all the net proceeds available at closing, known as a fixed rate closed end loan. This can be predatory and abusive when it is the only choice offered. The lender earns a premium with this product because it has a more predictable outcome in the securitization marketplace compared to adjustable rate, open-ended HECM loans. The borrower often deposits a significant portion of the funds received from the closed end fixed rate loan in a bank account earning a lower interest than the cost of the fixed rate note. This product may be appropriate when the borrower is paying off liens and anticipates no proceeds, often the situation when the first lien holder accepts the proceeds in full satisfaction to avoid litigation. Bankruptcy attorneys prefer this product to settle "robo signing," rescission claims, and other predatory lien issues.[3] HECM product selection most appropriately is revisited after the last factor that determines the availability of funds is known, the property appraisal value. Only after all factors are known can the borrower select the best options to meet his or her needs. This reselection process defines the professional standards of the originator.

The HECM products that offer line of credit and tenure options are variable rate loans. Presently these loans are linked to the LIBOR (London Inter Bank Offered Rate) index, but such loans can also be linked to the U.S. treasuries. The LIBOR is the short-term lending rate between banks on the London Exchange. These variable rate loan products have fixed lender margins, as there are no teaser rate HECM programs. The teaser rate offer was a factor in the recent mortgage meltdown. A" teaser" rate offer allowed for the lenders margin to increase at specific time frames, subject to a loan rate cap.

There is a cap lending rate in the HECM products, but the only variable that adjusts the rate is the LIBOR index. By "googling" the term "LIBOR," you can discover the historic rate changes for this index. Today most mortgages worldwide are linked to this index. Presently, government policies across the world artificially support a low interest rate. This index has been stable at approximately one quarter to one half of one percent for the past several years. Currently, most mortgages offered in the United States are supported by government-sponsored entities such as Freddie Mac, Ginnie Mae, and Fannie Mae. Government-sponsored entities require Federal Housing Administration (FHA) insurance which is currently 1.25% of the monthly balance for all HECM programs. The rates change daily and are generally not locked until just prior to closing. When the rate is locked, the "fixed" margin rate becomes permanent. The total, including the index, the margin, and FHA insurance daily variable rates in late February 2012 for HECM products ranged from 3.746% to 5.75%. HECM rates should not be compared with rates available for a traditional mortgage that require current amortization.

HECM Mortgage vs. HELOC (Home Equity Line of Credit)

	HELOC	HECM
Line Growth?	No	Yes
Cancelable?	Yes	No
Requires repayment?	Yes	No
Age restriction?	None	62

The HECM rates are partially based on the long-term cost of funds. This is because each loan will not mature at any predicable point in time and there is no payment to the investor until the loan matures at an unknown future date. The metrics used to value the product on the secondary market consider the life expectancy tables.

There is significant competition among lenders in the HECM market. The program allows charges for monthly service fees, origination fees, and initial mortgage insurance fees that max out at $6,000. When state-required mortgage costs are added to the equation, the result is that some HECM products incur very high closing costs. Effective October 4, 2010, Saver HECM programs went into effect. This changed the landscape, creating an option to reduce the upfront mortgage insurance to a nominal sum. Some HECM loans are now available without any monthly servicing fee, origination charges, or up-front FHA insurance. It is now possible to close an HECM mortgage for only the state-related closing costs.

B. Professional Planners

Professional financial planners recently took notice. The *Journal of Financial Planning* featured an article by Barry H. Sacks, J.D., Ph.D. and Stephen R. Sacks, Ph.D., *Reversing the Conventional Wisdom: Using Home Equity to Supplement Retirement Income*.[4] Their model used historic rate growth for managed assets supplementing cash flow needs with a reverse mortgage line of credit during market lows. This enables professionals longer time periods to manage assets entrusted to their care. The authors concluded that when the withdrawal rates from the portfolio ranged between 4.5% and 7% there was a 67% to 75% probability that heirs would inherit more wealth. Another research team headed by Evensky and Katz Wealth Management concluded that "… using a reverse mortgage as a stand-by resource significantly improved the length of time that the investment portfolio lasted in retirement anywhere from 20 percent to 60 percent, depending on scenario specifics."[5] The full study is scheduled to be published in the August 2012 issue of the *Journal of Financial Planning*. This study was part of a Ph.D. thesis at Texas Tech University based on modeling assumptions that include the cost of the transactions, a more conservative approach than the historical assumptions. In the January 16, 2011 issue, *Investment News* suggested that "…reverse mortgages should be first resort for advisors…[to] stretch a retirement portfolio…allow[ing] people to stay in their homes and convert home equity to tax free income."[6] These strategies do not violate the investor notice from Financial Industry Regulatory Authority that strongly cautions investors against using home equity to purchase investments. The strategies suggest a timing approach as to what assets should be spent down first. Simply explained, these concepts improve cash flow management.

MetLife Mature Market Institute[7] has published two relevant studies: Tapping Home Equity in Retirement and The MetLife Report on Early Boomers. Both studies conclude that when employment income ends, there is an increased need for income security and financial resilience to meet unexpected contingencies. The early boomer study concluded that a "large portion [of the population]…can't retire at 65 or even 66…."[8] However, housing wealth may offer some relief. "Strategies need to shift to include home equity as an integral part of retirement security."[9] "In 2007, almost 80% of older households owned a home, including almost 78% of those 75 and older."[10] Anecdotal information suggests that this is the same market reached by attorneys for the Medicaid Shelter Trust. Although home equity may be needed to provide stay-at-home care, without a HECM mortgage and HECM qualified trust, the sheltered home equity is destined for the heirs or nursing home care providers and unavailable to the grantors. "Small amounts of home equity could also pay for early interventions that can reduce health problems."[11] The HECM trust design provides greater flexibility by providing an additional resource, home equity, to meet emergency or contingent planning needs. The small additional cost of obtaining an HECM mortgage to be used as a stand-by line of credit is insignificant when measured against the benefits of improved cash flow management that could extend wealth transfer and client security.

C. A Better Retirement Strategy

In order to maximize home equity, the consumer should plan ahead and apply for a HECM as soon as the youngest borrower reaches age 62. Once the loan is closed, the HECM should immediately be placed into an irrevocable trust. The trust design may have a wide variety of objectives ranging from Medicaid shelters to philanthropic gifts based on the needs and perspective of the grantors. This strategy assumes that the grantors have either decided to age in place or purchase a new residence with a HECM for purchase. The following is a list of the potential holistic objectives accomplished:

1. creating a source of emergency funds from the line of credit;
2. establishing cash flow investment strategies guided by professional financial advisors;
3. enabling flexibility of resource allocation;
4. protecting principal residence equity in a down market for the heirs, the equivalent of a "put";
5. establishing an inflation hedge, as the line of credit grows tax free and cannot be revoked;

6. balancing budgets with no mortgage payments;
7. controlling distributions to match property appreciation, which will preserve a fixed equity for heirs in the principal residence;
8. right sizing by moving and purchasing with a HECM for purchase, often freeing significant equity from the current home for a wide range of objectives;
9. utilizing the income stream from a HECM mortgage to defer receiving Social Security until age 70;[12]
10. preserving the spouse's ability to age in place;
11. protecting the assets from nursing home reach;
12. enhancing the probability that heirs will receive more assets by following the guidance of a financial professional;
13. enhancing the probability that the grantors will not outlive retirement assets when following the guidance of a financial professional;
14. funding gifts for education of grandchildren;
15. funding home improvements;
16. funding home care;
17. funding the cost of legal services.

Generally the strategy of obtaining a HECM at age 62 should not be deferred because the credit line growth is based on the variable rate of the loan, which is likely to be a faster growth rate on the funds available compared to the enhanced funds available at an older age. The strategy is appropriate when it matches a senior's objective of aging in place.

D. The HECM Trust Guidelines and Procedures[13]

Irrevocable trusts are eligible to hold a HECM mortgage[14] on an exception-only basis. The trust must pass two levels of review for MetLife Home Loans (MLHL) to allow the trustee to hold the HECM. First, special counsel must review the trust and issue an affirmative opinion letter. Second, house counsel must also approve the trust if the grantor only has the right to discretionary income. MLHL does not charge for this review service. If necessary, New York's Decanting Statute can be used to conform the trust to the HUD required standards.[15] The new or amended trust can be designed to protect against the inadvertent loss of effective date protection if the beneficial interest in the trust is not shifted as interpreted by Treasury Regulation §26.2601-1(b)(4)(i)(D).[16] The trust must include specific powers to enable the trustee to mortgage the property. The borrower/current beneficiary/grantor must either have a right to receive income or principal from the trust. All borrowers/current beneficiaries of the trust must be eligible HECM borrowers (age 62 and occupy the property as principal residence of an eligible property).[17] However, contingent or successor beneficiaries receiving no benefits from the trust, and who do not possess any control over the trust assets until the beneficiary is deceased, need not meet eligibility age and occupancy requirements. Every trust must be reviewed by legal counsel. The landscape often changes, and any new regulations must be considered.

E. Industry Reverberations

Shock waves are still resounding from the April 27, 2012 MetLife announcement to vacate the reverse mortgage market. Today no nationally recognizable brand offers the HECM products. Is the "HECM Trust" still viable? MetLife Bank was the only lender to have securitized an irrevocable trust holding a HECM mortgage. Viability requires legal authority, uniform underwriting and closing policies, and a funding source for the securitized product. The legal authority has been documented.[18] The funding source is still a government sponsored entity. I am certain that the marketplace will find a home for this elegant solution, the "HECM Trust," to be posted at my LinkedIn site.

Conclusion

The HECM trust that includes a funded HECM mortgage as part of a financial plan enables and enhances financial security for your clients. The language "reverse mortgage" implies a negative charged impression that should be avoided. Discuss with your clients, using a guided discovery approach, how they will meet the escalating cost of living. Both the Sacks and Evensky studies report that reverse dollar cost averaging as a distribution strategy is not the best solution because it is subject to a volatility drain and transaction costs. Ask your clients, "Would you like an option to access your home equity if needed?" Your clients will be required to have HECM-approved counseling[19] and will understand how they will benefit from a HECM option.

You now have the opportunity to orchestrate a value-added process that should include professional financial advisors. This team approach will enhance your reputation as an attorney, leading to more partnering opportunities and referrals from both financial planners and clients. All demographic studies indicate that HECM will soon be "mainstream." If you get ahead of the curve now, you can potentially grow your business, and serve your clients needs with prudent cash flow planning. It is not enough to just shelter assets. If the assets are not properly managed with good long-term planning that includes cash flow guidance and cash flow predictions, there is a greater probability that your clients will outlive their assets.

Endnotes

1. The legislative history on the origins of reverse mortgages can be found in The Housing and Community Development Act of 1987, Pub. L. No. 100-242, 101 Stat. 1860 (1987); See, e.g., 12 U.S.C.A. § 1715z-20 (West 2009); 24 C.F.R. § 206 (2012).
2. Download HUD Handbook 4235.1 from http://www.hud.gov/hudclips. Details the specific HECM standards.
3. Mortgagee letter 2003-17; *see* HUD form 2701 Part B (claims supported evidence). This is the basis for forcing settlements and or subordination agreements. Note that the mortgagee letters are searchable. Administrative guidance to specific issues can be accessed at http://portal.hud.gov/hudportal/HUD?src=/program_offices/administration/hudclips/letters/mortgagee/2008ml.
4. Barry H. Sacks & Stephen R. Sacks, *Reversing the Conventional Wisdom Using Home Equity to Supplement Retirement Income*, 25 J. Fin. Plan. 43-52 n.2 (2012).
5. Mark Miller, How Reverse Mortgages Can Help Your Older Clients, Registered Rep. The Source for Financial Advisors, Dec. 8, 2011, http://registeredrep.com/newsletters/retirement/how_reverse_mortgages_ can_help_your_older_clients _1208/.
6. Jeff Benjamin, *Reverse mortgages should be first resort for advisers: Vehicle may be the best way to Stretch a Retirement Portfolio*, Investment News, Jan. 16, 2011, http://www.investmentnews.com.
7. MMI is MetLife's research organization and a recognized thought leader on the multi-dimensional and multigenerational issues of aging and longevity. The reports are available at http://www.MatureMarketInstitute.com.
8. See generally, MetLife Mature Market Institute et al., The MetLife Report on Early Boomers (Sept. 2010), available at http://www.metlife.com/assets/cao/mmi/publications/studies/2010/ mmi-early-boomers.pdf.
9. See generally, MetLife Mature Market Institute et al., Tapping Home Equity in Retirement (June 2009), available at http://www.metlife.com/assets/cao/mmi/publications/studies/mmi-tapping-home-equity-retirement.pdf.
10. *Id.*; see also U.S. Census Bureau, American Housing Survey for the United States: 2007, Current Housing Reports, Series H150/07 (U.S. Government Printing Office) (Sept. 2008).
11. *Supra* no. 9.
12. Sass, S.A., Sun, W., and Webb, A. When Should Married Men Claim Social Security Benefits? Issue in Brief 326 (Center for Retirement Research at Boston College) (2008).
13. See generally, Wayne R. Bodow, *Can the Trustee of an Irrevocable Trust Obtain a Reverse Mortgage?* 22 Elder L. & Special Needs J. n.1 (Winter 2012).
14. See page 98 of this Handbook release 7610.1 (05/2010). "Properties held in trust….[do] not require a trust to be irrevocable for the property to be eligible for a HECM." HUD Handbook, http://www.hud.gov/offices/adm/hudclips/handbooks/hsgh/4060.1/index.cfm. Also see analysis of this statement *supra* n. 6.
15. N.Y. Est. Powers & Trusts Law 10-6.6(b) (McKinney 2011).
16. "Language to Protect Against the Inadvertent Loss of Effective Date Protection," as suggested by Carlyn S. McCaffrey, Trusts and Estates Law Section Newsletter, a publication of the Trusts and Estates Section of the NYS Bar Association, Winter 2011,Vol. 44, No. 4, p. 7. "…Notwithstanding anything in this trust agreement to the contrary, the trustees may not exercise their distribution powers in such a manner as to shift a beneficial interest in the property held in the Trust from the beneficiaries who held such interest under the [name of the original trust] to a beneficiary who occupies a lower generation than the such beneficiaries within the meaning of Treasury Regulation Section 26.2601-1(b)(4)(i)(D)."
17. 24 C.F.R §206.45 (2011) "eligible properties (a) Title. A mortgage must be on real estate held in fee simple, or a leasehold under a lease for not less than 999 years which is renewable, or under a lease having a remaining period of not less than 50 years beyond the date of the 100th birth date of the youngest mortgagor." *Id.*
18. *Supra* n. 13.
19. 24 C.F.R. 214 (2011).

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The views and opinions contained in this article are those of the author and do not necessarily represent the views or opinions of either MetLife Home Loans or iReverse Home Loans or their respective affiliates.

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