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Elder Law Attorney

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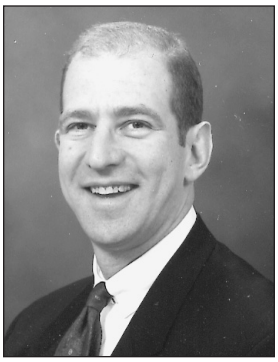
Chair to Chair



Bernard A. Krooks
Outgoing Chair

It has been a privilege for me to serve as Chair of the Elder Law Section of the New York State Bar Association during this past year. As you know, the Elder Law Section has a well deserved reputation, both locally and nationally, for being at the forefront of elder law issues. Our views and input are solicited by legislators and policy makers due to our broad-based experience and expertise on technical issues.

Moreover, I believe that the elder law bar offers collegiality, camaraderie and friendship that is unsurpassed in any other practice area. Elder Law attorneys are more than willing to share information, forms and case citations, etc., on a regular basis. Just peruse the messages on our listserve and you will surely see the support and guidance that our Section members give and receive from one another. It is this atmosphere of friendship and caring that initially attracted me to the practice of elder law and our Section. I am delighted to observe that this atmosphere continues to exist today despite our tremendous growth over the years.

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Louis W. Pierro
Incoming Chair

Ten years ago I attended my first elder law seminar, put on by a brand new Section of the New York State Bar Association. I listened intently as Robert Freedman chaired a panel of expert attorneys, each of whom had chosen to focus his or her practice on the legal issues involving seniors. The passion of the presenters, and their level of commitment, attracted me immediately—I was hooked.

As a trusts and estates attorney seeking to answer questions posed by a rapidly-expanding senior clientele, I discovered the new world of elder law, and the Elder Law Section. Knowing virtually no one, I quickly began to volunteer for committee assignments, drafted memoranda on legislation, and in 1993 became caught in the whirlwind of the Omnibus Budget Reconciliation Act. The pace was fast, the subject matter fascinating, and the people first-class.

Over the past ten years, our Section has been chaired by a number of brilliant leaders, and it is humbling to have been chosen to walk in their foot-

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Inside this Issue

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

Our Section meetings are fun to attend because all of the members go out of their way to greet first-time attendees, make friends and form lasting relationships, both personal and professional. In fact, many people who I have met through the Elder Law Section have become close personal friends. I will always cherish the memories of the meetings I have attended and I am grateful for the friendships I have made. The opportunity to serve as Chair of the Elder Law Section has truly been a once in a lifetime opportunity. I want to thank you all for making this possible and for your help and support during my years as a Section Officer.

I would like to express my thanks to the individuals who served as Officers of our Section during my tenure as Chair; Louis W. Pierro—Chair-Elect; Cora A. Alsante—Vice-Chair; Ira K. Miller—Secretary; Joan L. Robert—Treasurer; David R. Pfalzgraf—Financial Officer, for all their assistance and tremendous support they have given me over the years. In addition, I would also like to thank Beth Krueger for her invaluable assistance as my "right hand" during my term as Chair.

I am delighted to be succeeded as Chair by Louis W. Pierro. Lou is a dynamic and energetic leader who will do an outstanding job as Chair. Lou and our current Section Officers have my best wishes for the upcoming year.

Best regards,
Bernard A. Krooks

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

steps. From our founding father, Mortimer Goodstein, through our most recent Chair, Bernard Krooks, the Section has produced excellent leadership, and I pledge my dedicated effort to carry on the tradition.

We have witnessed many changes since we moved into the new millennium. The lights stayed on, but we now must fear blackouts not from some computer malfunction, but from a lack of energy. The estate tax which fuels many trusts and estates practices, and which has spawned cottage industries around it, is on the block, and the President is advocating for its repeal. The health care system has seen dramatic cuts in reimbursements, and many of our best providers are operating in the red, with some having gone out of business entirely.

In the wake of the rapid changes that occur almost daily as a routine part of modern life, elder law attorneys will continue to be a "life preserver" that our elderly, frail and disabled clients cling to. To meet the challenges facing our clients, the Elder Law Section must continually rededicate itself to educating its members, and providing them with the benefits necessary to maximize their efforts, and the value of their services.

One of the most daunting issues that faces the elder law bar, and society in general, is the financing of long-term care. To meet this challenge, we have convened a Task Force on Long-Term Care Reform, under the direction of Committee Chair Ellice Fatoullah, which will study long-term care issues in New York State, draft a report recommending change, and present the report at our Fall Meeting in Albany on October 10th and 11, 2001. As was done as part of the White House Conference on Aging under the direction of Chairs Robert Abrams and Walter Burke in 1995, we will invite other groups with a vested interest in long-term care reform, such as providers, insurers, consumers and the government, and seek to be proponents for change, rather than interpreters of misguided and ambiguous legislation.

I encourage each and every Elder Law Section member to become more involved, to serve on a committee, to volunteer to speak at local programs or at our Advance Directives Day, and to give back to the Section, your community and the clients we serve. The Section has over the last 11 years produced substantial benefits to its membership, recently exemplified by the creation of an elder law listserve, which has provided rank and file Section members with direct access to some of the top practitioners in the state, such as René Reixach, David Goldfarb and Joan Robert, who take the time to answer virtually all members' questions, and provide valuable information and advice to those seeking to hone their skills in this challenging field. The volume of activity on the listserve lets us know that the Section is alive and well, and I strongly encourage every member to also attend Section meetings, and to get more personally involved.

Our agenda for the coming year will include our Summer Meeting in Florence, Italy, chaired by Peggy Bomba, which for the first time will feature a joint meeting with the New York State Bar Association Trial Lawyers Section. This is an exciting event and an opportunity to network with our colleagues in the trial bar, to share ideas and explore common solu-

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Editor's Message

I am pleased to present to you the Summer 2001 edition of the *Elder Law Attorney*.

As the name of this journal suggests, we are a group of lawyers whose practices are focused on representing elder clients. But as many of you know, the issues that elderly incapacitated clients face are similar to the issues faced by the younger disabled client. Naturally, some of us have developed sub-specialties in the area of representing the younger disabled client. Others have looked at the issue but have not yet committed their time and practice to this area. With threats to our businesses coming from the reformation of the estate tax and/or future reformation of the Medicaid laws, we must always strive to find new practice areas, especially ones that fit well into what we are already undertaking. And what I like most about this area of practice is that it allows us to still do well by doing good.

It is with this all in mind that I dedicate this Summer 2001 edition of the *Elder Law Attorney* to representing the younger disabled client.

At this point I want to publicly thank Joan Robert who made my job of compiling authors and topics for this issue so easy. One call to Joan and I had an instant education on the topic and relief that this topic could be pulled together in time. Joan is a true professional and I am honored to call her a friend.

The theme is developed with five articles. The first article, written by Joan Robert and Charlie Robert, is an in-depth update on the topic of Supplemental Needs Trusts (SNTs) and Medicaid liens. Joan and Charlie articulate well the whole issue of Medicaid's right to reimbursement prior to the funding of an SNT, and the controversy surrounding the issue.

The second article, written by Beth Polner, a veteran of public benefit and guardianship law, discusses the proper forum to bring a guardianship over a younger disabled client: Article 81 or 17A? This article is an invaluable tool to point you in the right direction.

The third article, written by Candace Appleton of Nassau Suffolk Legal Services, helps us understand the SSI system and the SSDI system. Often confused, these two systems are the two main public benefits to which young disabled clients may be entitled. This article makes clear their purposes and their differences.

The fourth article, written by Allan Silver, concerns "Kendra's Law," which authorizes court-ordered assisted outpatient treatment for the mentally ill. Allan brings his vast experience in health law to this issue.

Finally, the last article is written by Peter Van Nuys, and concerns a listing of some selected private and public agencies for disabled persons. This listing is a good resource to help us help our clients get the right help at the right time.

Besides our THEME section, please also enjoy our NEWS section, which contains timely articles on the many aspects of our elder law practices.

I hope you enjoy reading this edition of our journal. It was fun to work on.

All my best! Keep smiling!

Lawrence Eric Davidow, CELA

Supplemental Needs Trust Funds and Medicaid Liens: 2001 Update

By Joan Lensky Robert and Charles Robert

I. Introduction: What Is a Supplemental Needs Trust (SNT) Fund?

An SNT fund is a principal planning tool to enable the disabled individual under the age of 65 to retain eligibility for government entitlements based upon need, notwithstanding families who wish to provide for their economic future and notwithstanding lawsuit recoveries. These trusts may either be funded with the disabled individual's own funds or with a third party's assets. Elder law attorneys rely upon *In re Escher*[1] and Estates, Powers & Trusts Law (EPTL) 7-1.12 to draft third-party trusts for families with disabled loved ones. For guidelines in drafting self-settled trusts, practitioners look to EPTL 7-1.12 as well as the federal[2] and New York State[3] laws authorizing these trusts. SNTs create a public/private partnership that enable our most vulnerable members of society to live as rich a life as possible.

II. SSI and Medicaid Rules Governing the Availability of Resources and Income and Transfer of Assets

A. Income and Resources

Disabled individuals under the age of 65 often rely upon the Supplemental Security Income (SSI) program[4] for a cash stipend and the Medicaid program[5] to pay for health care needs. To be eligible for SSI, an individual may have $2,000 in available resources. Available resources are liquid assets, i.e., cash or items that can be converted to cash within 20 days to be used for the support and maintenance of the SSI recipient, as well as real property or personal property that an individual could convert to cash to be used for his/her support and maintenance.[6] If the individual does not have the right, authority or power to liquidate the property, it is not a resource of the SSI recipient.

When computing the monthly SSI payment, the Social Security Administration (the "Agency") considers other income received by the SSI recipient. The Agency distinguishes between earned and unearned income, and between cash income and income received in kind. The Agency deducts earned income from the SSI stipend.[7] Unearned income, such as that provided by a trust, given *in cash* to the SSI recipient, will also be deducted from the SSI stipend.[8] However, bills paid directly to the supplier of services other than food, clothing and shelter will not result in a reduction of the SSI benefit.[9] This is noncountable income provided *in kind* to the SSI recipient. Bills paid directly to the supplier of food and clothing will result in a reduction of SSI benefits.[10] Bills paid directly for housing that does not result in an actual economic benefit for the SSI recipient will not result in a reduction of the monthly stipend so long as the person making the payment is not legally responsible for the SSI recipient and does not reside in his/her household.[11] For Medicaid, in kind income provided by a person not legally responsible for the support and maintenance of the Medicaid recipient is not countable income. Medicaid benefits are not reduced even if the trust income is used for food, clothing and shelter.[12]

B. Transfer of Asset Rules

1. Medicaid

If a Medicaid recipient receives assets and then transfers them for less than fair market value, there will be an ineligibility period for nursing home services and for waivered home care services. This ineligibility period is calculated by dividing the assets transferred by the average cost of a nursing facility in the county in which the Medicaid recipient resides.[13] For nonwaivered community Medicaid services there is no ineligibility period caused by the transfer of assets.[14] There is no ineligibility period for any Medicaid services if a disabled individual transfers assets into an SNT described in IV., *infra*.[15]

2. SSI

The SSI transfer rules mirror, to a large extent, the Medicaid rules. If an SSI recipient transfers resources there will be an ineligibility period calculated by dividing the amount of the resource transferred by the SSI monthly payment, approximately $600 in 2001, with no more than a 36-month ineligibility period.[16] As with Medicaid, if a disabled individual under the age of 65 transfers resources into a trust described below, there is no ineligibility period caused by this transfer.[17]

III. A History of Third-Party Discretionary SNT Funds: *In re Escher* and EPTL 7-1.12

When a person not legally responsible for the support of a Medicaid or SSI recipient wishes to provide for his or her needs, a trust fund is an appropriate vehicle to assure a lifetime of comforts not provided through government entitlements. The settlor should clearly state that the funds are to be used to supplement rather than supplant government entitlements. However, not all trust funds are artfully drawn; some testamentary trust funds are drafted in other states, while others are general support trusts that make vague references to the beneficiary's age or disability. Under what circumstances can the government compel the use of the trust corpus or income in a manner which supplants rather than supplements the entitlement program?

A. EPTL 7-1.6

Government agencies rely upon EPTL 7-1.6 in proceedings to declare the trust corpus of third-party trusts an available resource to a Medicaid or SSI recipient. New York law provides that a court having jurisdiction of a trust may direct that the principal be invaded for the benefit of an income beneficiary whose support or education is not sufficiently provided for.[18] For trusts created prior to 1966, the income beneficiary must have an indefeasible interest in the principal or the remaindermen must all consent.[19] For trusts created after 1966, the court may order such an invasion even without the remaindermen's consent if the court determines that the trust's original purpose cannot be accomplished without such invasion. This invasion may be made even if the income beneficiary is not entitled to any part of the principal, unless the trust fund explicitly limits the court's discretion.[20]

B. *In re Escher*

In 1981, the New York State Court of Appeals issued a landmark decision, *In re Escher.*[21] *Escher* involved an accounting proceeding to judicially settle the account of a testamentary trustee. The New York State Department of Mental Hygiene claimed reimbursement for the care it had provided to the testator's daughter, who had resided in a state psychiatric facility for approximately 30 years. The trustees had discretion to pay out such sums as necessary to provide for her maintenance and support incurred by reason of illness or accident or other emergency.[22]

Because the trust was created prior to 1966, only EPTL 7-1.6(a) applied. Hence the Court could not exercise its discretion to invade principal for the benefit of Marie Escher. Instead, the Court looked to the express terms of the trust to determine the testator's intent. The Court found that the testator knew of his daughter's condition, intended for there to be remaindermen, and intended that there be funds available for her lest she ever left the facility. The Court held that the trust intent directed that the State's claim be rejected.

The principles enunciated in *Escher* are those that underlie all third-party SNT funds. The desire to supplement the loved one's standard of living so that the vulnerable are not wholly dependent upon the benevolence of the law results in a third party's empowering the aged, blind and disabled. The government entitlement becomes a floor rather than a ceiling upon which they can attain a standard of living above the poverty level.

C. EPTL 7-1.12

Troubled by the absence of a statute that would protect their loved ones' trust assets, parents of the disabled, among others, sought the codification of the principles announced in *In re Escher.* Their efforts resulted in EPTL 7-1.12. This statute encouraged third parties to establish SNT funds for their disabled loved ones. Pursuant to the statute, assets in conforming trusts will not be considered available resources when computing eligibility of persons with severe and chronic or persistent disabilities for government benefits or assistance.[23]

SNT funds are trusts intended to supplement, rather than supplant, government entitlements. Supplemental needs that the draftsperson may provide include transportation, vocational training, insurance coverage, computers, specially-equipped vans, personal care givers, vacations, a home, and any luxury or need including health care not provided through government entitlements or private insurance. The legislature included drafting suggestions[24] as well as construction standards to be applied to a conforming SNT fund.[25]

These trust funds, when established by third parties, are not subject to any claim or lien upon the death of the Medicaid recipient.[26] For inter-vivos trusts, the creator can be a person or entity other than the beneficiary's spouse,[27] or a person with a legal obligation to support the beneficiary.[28] The assets will be protected so long as the beneficiary does not have the power to "assign, encumber, direct, distribute, or authorize distributions from the trust."[29] Family members or interested friends may provide for the disabled and then designate remaindermen who will

take accumulated assets upon the death of the disabled beneficiary.

IV. Self-Settled Payback Trusts for the Disabled Under the Age of 65

A. Statutory Authority for Payback Trusts

In August, 1993, as part of the Omnibus Budget Reconciliation Act (OBRA), the federal Medicaid program created harsher rules for the use of trust funds for Medicaid applicants.[30] The Congress carved out an exception to these rules for disabled individuals under the age of 65.[31] If a disabled individual under the age of 65 funds a trust established by his parent, grandparent, legal guardian or through court order, the transfer of assets into this trust will not result in any period of ineligibility for Medicaid for that individual.[32] Moreover, the corpus or income of such a complying trust will not be considered available to the disabled individual when computing his/her eligibility for Medicaid.[33] However, "upon the death of such individual, the state will receive all amounts remaining in the trust up to the total value of all medical assistance paid on behalf of such individual."[34] Hence the term "payback trusts."

OBRA '93 was implemented in New York State by amending EPTL 7-1.12. After OBRA '93, the New York State SNT statute, previously limited to third-party trusts, was amended[35] to provide that the creator of an SNT Fund may be the beneficiary so long as the trust provides a payback to the State upon the death of the beneficiary for the Medicaid services paid on his/her behalf.[36] Thus, guidelines for the drafting of payback SNTs may be found in EPTL 7-1.12. However, as federal law authorized these trusts, New York's own drafting suggestions need not necessarily be followed so long as the trust document provides for an independent trustee empowered to make discretionary trust distributions in kind for the benefit of the disabled beneficiary in such a manner as to supplement rather than supplant government entitlements.[37]

B. Drafting Payback Trusts

1. New York State Regulations

New York State has promulgated regulations to ensure that its remainder interest will be protected.[38] These regulations require that the trustee of an "exception" trust:

1. notify the social services district of the creation or funding of the trust;[39]
2. notify the social services district of the death of the beneficiary of the trust;[40]
3. notify the social services district in advance of any transactions tending to substantially deplete the principal of the trust whose corpus exceeds $100,000, i.e., 5% for trusts between $100,000 and $500,000; 10% for trusts between $500,000 and $1,000,000; and 15% for trusts over $1,000,000;[41]
4. notify the social services district in advance of any transactions involving transfers from the trust principal for less than fair market value;[42]
5. provide the social services district with proof of bonding if the assets exceed $1,000,000.[43]

2. Article 81 Court-Ordered SNTs

As the beneficiary of an SNT is often incapacitated, authority for the establishment of the trust may be sought in a proceeding for the appointment of a guardian pursuant to Article 81 of the Mental Hygiene Law or pursuant to SCPA 17-A. In *In re Morales*,[44] the court set forth requirements for a trust fund established by a guardian of an incapacitated person pursuant to Article 81 of the Mental Hygiene Law. The purpose of these provisions was to protect not only the State's remainder interest, but also the incapacitated person. Requirements such as accountings, the filing of a consent, designation and bond, and the oversight of the use of funds are included in this trust. This format was approved by the State and has been followed in many counties. *See also In re Julie Beth Goldblatt*,[45] for trust provisions required by one Surrogate's Court.

3. Request for Independent Trustee

The City of New York routinely requests that a person who is not a family member serve as trustee or co-trustee of the trust. This request is based on *DiGennaro v. Community Hospital of Glen Cove*,[46] in which the Appellate Division upheld the Supreme Court's denial of a pre-OBRA based, *inter alia*, upon the conflict of interest between the parent/trustee who might refuse to make disbursements for the benefit of the infant beneficiary in order to preserve trust assets that the parent would later inherit. As the application for this trust was made in 1992, prior to OBRA '93, the parents were the remaindermen listed in the trust. There was no payback to the State at that time and no invasion of principal allowed. *See In re Pace*,[47] setting forth court criteria for determining whether a parent/trustee should qualify as a fiduciary in a post-OBRA Guardianship setting.

4. Trusts Established Without Court Order

Not all disabled beneficiaries are mentally incapacitated. However, pursuant to OBRA '93, the payback trust must be established by a parent, grandparent, guardian, or pursuant to court order.[48] In cases in which a guardian is not needed and a parent is available, the parent can "establish" the trust fund. The payback provision remains unchanged, as is the requirement that the State regulations be followed. Annual accountings will most likely be required by the local social services agency and, if the beneficiary is an SSI recipient, by the Social Security Administration. In addition, the other Medicaid regulatory requirements of notification to the social services district also must be followed, as "a social services district or the department may commence a proceeding under section 63 of the Executive Law against the trustee of a . . . ("payback") trust if the district considers any acts, omissions, or failures of the trustee to be inconsistent with the terms of the trust, contrary to applicable laws or regulations . . . or contrary to the fiduciary obligations of the trustee."[49]

5. Drafting for Tax Planning

The *Morales* trust did not address income and estate taxation of the SNT.[50] As the income taxation of trusts is at a higher rate than that of individuals, taxation of income to the Medicaid recipient/trust beneficiary is almost always beneficial. If the trust is a grantor trust for income, all of the income, whether distributed or not, will be taxed to the grantor. If the trust is a grantor trust for principal, then capital gains will also be taxed to the grantor.

The grantor's retention of certain control over trust assets will render the trust a grantor trust for income taxation purposes so that the income is taxed to the grantor/beneficiary at his/her rate rather than at the trust's income taxation rate. Grantor Trust rules that should not affect Medicaid eligibility include the grantor's right to receive the income without the consent of an adverse party,[51] the grantor's retention of a Special Power of Appointment,[52] and the grantor's retention of the power, without the approval or consent of a person in a fiduciary capacity "to reacquire the trust corpus by substituting other property of an equivalent value."[53]

Although the Department of Social Services has challenged some of these provisions in irrevocable income only trusts for Medicaid recipients over the age of 65, no decisions to date have addressed these provisions in a payback trust. It is suggested that these provisions, when suitable, be included in the trust. If notice is given to the Department of Social Services through a guardianship proceeding that the proposed guardians seek the court's authority to establish a trust with the above provisions, and if the Department of Social Services does not oppose the trust, then the terms of the trust will be fixed by court order.

V. Pooled Income Trusts

OBRA '93 authorized a second kind of "exception" trust that protects the assets of disabled individuals. When assets of a disabled individual are held in a trust established and managed by a non-profit association which maintains separate accounts for the benefit of disabled individuals, but which pools the accounts for purposes of investment and management of the trust funds, the assets in the trust will not be considered available resources when applying for government entitlements.[54] Upon the death of the disabled individual, the remaining moneys in his/her own account may remain in a pool for other disabled individuals. Any funds not so retained will be used to pay back the State for Medicaid benefits. A not-for-profit corporation may, in furtherance of and as an adjunct to its corporate purposes, act as a trustee of this trust so long as a bank acts as co-trustee.[55]

This trust is particularly useful for the competent disabled individual without a parent, as the trust may be established by the disabled individual himself/herself, thereby eliminating the need for a guardianship proceeding when the disabled individual has capacity. Among the organizations that have established pooled trusts are UJA Federation, YAI, NYSARC and Lifetime Care Foundation for the Jewish Disabled. Each has different minimum requirements for funding and different services offered in conjunction with the trust management. These not-for-profit organizations offer an alternative to the payback to the State for the Medicaid program. They are a good choice for competent disabled individuals who have no close family members to serve as trustee and who wish to avoid a guardianship proceeding.

VI. Medicaid Budget With SNT

In general, a disabled individual who has income above the Medicaid allowance must spend down this excess income each month on medical expenses, as set forth in a Medicaid budget. Such an individual's income may be derived from Social Security Disability, private pension, or disability pension. Oftentimes this income cannot be assigned to another, or to a trust, without violating the anti-alienation provisions of the Social Security Act or of ERISA.

When this income is paid to the disabled individual, directly, but then placed each month into the SNT, the income will not be countable income for Medicaid purposes. Thus, when a disabled person has income of $2,000/month and receives home care benefits, all of that income may be placed monthly into the SNT. This income will not be subject to a spend down of all income above $600/month. It is a way to allow the disabled to remain in the community.[56]

Elder law attorneys must be vigilant in reviewing Medicaid budgets in which a disabled individual under the age of 65 has an SNT and will place all income above $600 into the trust. Whether in the community or in a nursing facility, the disabled beneficiary should have no excess income spend down. The accumulating trust income for a patient in the nursing home may allow him/her to leave on weekends, hire private aides, or obtain transportation. If the county refuses to establish the budget correctly, a Fair Hearing should resolve the situation. The Agency will likely seek proof that the income is, indeed, going into the trust each month.

VII. Medicaid Liens and Personal Injury Actions: The Court of Appeals Has Spoken

A. Introduction

When the OBRA 1993 legislation was enacted, the obstacles that had prevented disabled individuals from creating trusts while maintaining eligibility for government entitlements were removed. Only three legal issues remained. First, when a personal injury plaintiff had received Medicaid and a recovery was made, must the lien be satisfied prior to the establishment of a payback SNT? Secondly, if so, was the entire amount of an award, or only that portion intended to compensate the plaintiff for past medical expenses available to satisfy the lien? Lastly, how do the SNT lien rules apply to an infant?

B. Court of Appeals *Cricchio/Link* Decisions

The first question was answered by the Court of Appeals in *Cricchio v. Pennisi* and *Link v. Town of Smithtown*.[57] The Court determined that a lien must be satisfied prior to the establishment of a payback trust. Personal injury plaintiffs Christopher Cricchio and Patricia Link had argued that a deferral of the lien was consistent with the statute, as the statute called for a payback upon death from all remaining trust assets for an amount up to the total value of all medical assistance paid on behalf of the individual. The Court of Appeals held that the assignment statute, requiring that the Medicaid recipient assign to the State the rights against third parties, meant that the trust assets did not pass to the plaintiff and hence to the trust until the lien had been satisfied. Pursuant to this decision, when a plaintiff in a personal injury action received Medicaid benefits on account of the injury and a social services district imposed a lien against the lawsuit proceeds payable by a third-party tortfeasor, this lien had to be satisfied prior to the establishment of an SNT fund.[58]

The *Cricchio/Link* decision remitted the cases to the courts below to decide whether the entire amount of the personal injury settlement or only that portion attributable to past medical expenses is available to satisfy the lien. Plaintiffs argued that when a case settled, the settlement was comprised of many causes of action, such as pain and suffering, lost future earnings, lost past earnings and past and future medical bills. They argued that only that portion of the settlement intended to reimburse the plaintiff for the medical expenses incurred by the Department of Social Services should be available to reimburse the State. They argued that the court could and should allocate the damages and determine what percentage, if any, of the lawsuit recovery was properly attributable to past medical expenses. They further argued that a jury allocation explicitly finding percentages of a verdict attributable to past medical expenses should be followed in determining the extent that a lien must be satisfied prior to the establishment of a payback trust.

C. *Calvanese v. Calvanese* and *In Re Callahan*

In *Calvanese v. Calvanese* and *In re Callahan,* the New York State Court of Appeals decided that the Medicaid agencies had unreviewable discretion to determine the amount of settlement funds that were to be paid to satisfy a Medicaid lien prior to the establishment of an SNT.[59] Pursuant to this decision, the entire amount of a personal injury recovery is available to satisfy a Medicaid lien prior to any other damages being paid. A Medicaid lien must be satisfied prior to the establishment of an SNT and the amount of the Medicaid lien to be paid to satisfy the lien is at the discretion of the Medicaid agency. Plaintiffs could transfer the settlement proceeds into an SNT only after the liens are satisfied.

The Court of Appeals rejected the appellants' argument that the trial courts should make a factual determination as to the "allocation" of a settlement as and between pain and suffering, past medical expenses, loss of earnings, and future needs. The effect of the decision is to provide the Medicaid agencies with a priority claim for reimbursement for past

medical expenses from the proceeds of any settlement.

D. Even Infants Must Satisfy This Medicaid Lien

The plaintiffs in *Cricchio-Link* and C*alvanese-Callahan* were adults when their cases settled. Although Christopher Cricchio had received Medicaid benefits when he was under the age of 21, no lien had been placed against these proceeds. New York State statute[60] and case law[61] had prevented the imposition of liens against the lawsuit recovery of a recipient of public assistance under the age of 21 unless he/she had assets sufficient for his/her reasonable needs during the time that benefits had been provided.[62]

After the *Calvanese-Callahan* decision, the local Medicaid agencies argued that *Cricchio-Link* and *Calvanese-Callahan* had overruled *Baker v. Sterling*.[63] The agencies argued that because a Medicaid recipient assigned the cause of action to the agency as a condition of receiving benefits,[64] and that because the assignment statute did not limit the assignment requirement to adults,[65] that the decisions of *Cricchio-Link* and *Calvanese-Callahan* now required that even lawsuit recoveries of infants be subject to full reimbursement of a Medicaid lien.

The Court of Appeals has spoken and agreed with the agencies. In *Gold v. United Health Services Hospitals Inc.,* and *Santiago v. Craigbrand Realty*,[66] the Court determined that the full proceeds of an infant's tort recovery are available to satisfy a Medicaid lien. The Court found that the Medicaid agencies have broad powers to recoup payments from third parties legally liable for expenditures that have been paid by the Medicaid program. The Court found that this recoupment, required by federal law and implemented in New York State law,[67] superseded the specific language in § 104(2) that limited recovery against infants' lawsuits. The Court reiterated its findings in *Cricchio* and *Calvanese* that the assignment, subrogation and recoupment provisions of the federal Medicaid statute give rise to the Agency's right to recover payments from a third party who is responsible for the costs paid by Medicaid. The Court found that §§ 104(1) and (2) of the Social Services law remain applicable for other forms of public assistance, but not for Medicaid.

Kimberly Santiago had received $12,877 in Medicaid benefits. She must pay them back before establishing an SNT. Abraham Gold had received Medicaid benefits of $1,770,294. Abraham Gold's case did not involve a lawsuit settlement. Rather, the jury had reached a verdict in favor of the plaintiffs for close to $100,000,000. However, the plaintiffs and defendants had agreed, prior to the jury's decision, that should there be a plaintiff's verdict, it would be capped at $5,000,000. If there were a defendant's verdict, the plaintiffs would receive $450,000.

Upon issuing its verdict, the jury allocated a portion of the verdict for future needs, pain and suffering and past medical expenses. As only $5,000,000 would be paid, the plaintiffs sought to reduce the Medicaid lien to the proportionate share that it represented in a $100,000,000 verdict, or approximately 2% of the total recovery. The plaintiffs asked the trial court to fix the Medicaid lien at $103,000 instead of requiring that it be paid in full at $1,770,294, or approximately 1/3 of the recovery. They asked that after attorney's fees all remaining assets be placed into an SNT.

In addition to requiring that the Medicaid lien be paid in full, the trial court then denied the plaintiffs' request that the net recovery be placed into an SNT. The trial court found that as the jury had explicitly allocated funds for the future medical and custodial needs of the infant plaintiff, that these funds should not be placed in an SNT. Rather, they should remain outside of an SNT as an available resource to pay for the future medical and custodial needs of the infant plaintiff. The court held that these funds, $2,173,626, should be utilized for the medical and custodial needs of the plaintiff rather than having them fund an SNT for items of need that the government would not provide. By the court's refusing to fund an SNT, the plaintiff lost eligibility for ongoing Medicaid services. Only when the $2,173,626 has been consumed on medical and custodial needs will Abraham Gold be eligible once again for Medicaid services.

The Court of Appeals first found that the entire Medicaid lien must be paid, dollar for dollar, notwithstanding the 20-fold reduction between the jury's verdict and the agreed-upon settlement. Next, the Court of Appeals determined that the Supreme Court had used a mathematical formula and had not exercised its discretion in determining the amount that would fund an SNT. The Court then remanded *Gold* so that the trial court could articulate its use of discretion pursuant to CPLR 1206 as to the manner in which to invest or disburse the proceeds of an infant's recovery in order to best serve the infant's needs.

E. Medicaid Liens: Advocacy

The Court of Appeals' decisions have eviscerated the federal remedial statute enacted in 1993 to exempt disabled individuals under the age of 65

from the new, harsher rules for Medicaid eligibility and trusts. All Medicaid recipients must satisfy Medicaid liens imposed against lawsuit recoveries prior to retaining any proceeds of a lawsuit. However, practitioners should note the following:

1. Only Medicaid benefits causally related to the lawsuit should be subject to a lien, as the assignment, subrogation and recoupment rights are based upon the theory that the tortfeasor is legally responsible for the expenditures made by the Medicaid program and that the Agency has a duty to pursue third parties legally liable to pay for expenses paid by the Medicaid program, which is the payor of last resort.[68]

2. The lien that the agency must place against the lawsuit has strict procedural requirements. In order for a lien to be valid, the statutory requirements of Social Services Law § 104-b must be followed. No lien should be effective unless the procedures outlined in the statute have been met. A written notice containing the name and address of the injured recipient, the date and place of the accident, the name of the person alleged to be liable to the injured party together with a brief statement of the nature of the lien, the amount claimed, and that the lien is claimed against the suit must be served by registered mail upon the defendant and insurance carrier prior to the plaintiff's receiving any funds. A copy of the notice of lien must also be served by regular mail to the plaintiff and to the attorney for the plaintiff, if known.[69] The public welfare official must also file a true copy of the notice of lien in the office of the county clerk in which the public welfare official has an office.[70] *See, e.g.*, *In re Corine Gilbert*,[71] in which the Department of Social Services' failure to comply with these statutory requirements resulted in the court's vacating the lien.

3. The Medicaid liens attach only to a third party who is responsible for the costs paid by the Medicaid program. When a Medicaid recipient inherits assets or receives a windfall, there may be no recovery from these assets or from the Medicaid recipient during his lifetime.[72] Should a Medicaid recipient establish an SNT with this inheritance or other windfall, then recovery may be made upon his death from remaining trust assets. Should he choose not to continue eligibility for Medicaid services, and should he die without an estate passing through probate or intestacy,[73] then there would be no recoupment for the Medicaid program.

4. There is no payback to the government upon the death of an SSI recipient for SSI benefits paid.

VIII. Applicability of SNTs to Office of Mental Health Clients

When a person between the ages of 21 and 65 is an inpatient in a state psychiatric facility, that person's stay is not paid for by the federal Medicaid program. The Office of Mental Health has asserted that a payback SNT does not protect assets from being available to pay for room and board at facilities under the auspices of the Office of Mental Health.

Elder law practitioners should advocate that the EPTL 7-1.12 protects assets of third parties whose disabled loved ones reside in such facilities and need such care. "A 'beneficiary' [of a Supplemental Needs Trust] means a person with a severe and chronic or persistent disability who is a beneficiary of a supplemental needs trust."[74] "'Person with a severe and chronic or persistent disability' means a person (i) with mental illness. . . ."[75] "The trustee of the trust shall not be deemed to be holding assets for the benefit of the beneficiary for purposes of section 43.03 of the mental hygiene law or section one hundred four of the social services law."[76]

While EPTL 7-1.12 as originally enacted in July 1993 did not provide for self-settled trusts, it was amended in June 1994 to reflect the applicability of OBRA '93 and the federal payback trusts. The New York State SNT statute, with its OBRA '93 grafting of the payback provision, does not limit its protection of assets only for Medicaid eligibility. As enacted, it protects assets for any New York State program available to disabled individuals, specifically § 43.03 of the Mental Hygiene Law, which treats patients at state psychiatric facilities.

The government has argued that if an OMH patient inherits money or receives a lawsuit settlement, that it may place a lien against these funds prior to the establishment of a trust. In the context of an inheritance, when the person who died was not legally responsible for the cost of care of the disabled individual, advocates should argue that no lien can attach to the third party's estate, and that the mechanics necessary to establish a trust by court order should not affect the beneficiary's right to receive all assets and then place them in a payback trust.

Advocates should also argue that if the lawsuit is not causally related to the reason for the institutionalization, the recovery should not be subject to a lien and that the full recovery should be placed into an SNT. Mental Hygiene Law § 43.03(d) offers support for this proposition, though no courts have as yet determined this issue.

IX. The Death of the SNT Beneficiary

New York State regulations provide guidance to the trustee of the payback trust. Upon the death of the SNT beneficiary of a payback trust, the trustee has a duty to notify the Department of Social Services as to the death of the beneficiary.[77] At that time, the trustee should examine the Claim Detail Report for accuracy as to the benefits provided. The agencies often seek a Final Accounting of the trustee, which is also required in a guardianship proceeding.

Now that liens will be satisfied prior to the establishment of an SNT, the trust language must provide that payment shall be made only to the extent that a lien has not been satisfied prior to the establishment of the SNT. The claim detail report must then be reconciled with the previous lien satisfaction. Any income paid to offset the cost of care (NAMI) should also be reflected in the Claim Detail Report.

The following are unresolved issues concerning the payback upon the death of the Medicaid recipient:

1. If a Medicaid lien has been satisfied for less than the amount of Medicaid expended, must the unreimbursed Medicaid benefits be paid upon death? What if the lien has been vacated for an infant? Must there still be reimbursement?

2. If a structured settlement is owned by an insurance company, and if the beneficiary dies with future periodic payments to be made to the estate of the beneficiary, are all future periodic payments free of estate recovery and payback when the plaintiff/beneficiary dies prior to age 55? Advocates should argue that the statute provides for reimbursement only from trust assets upon the death of the disabled beneficiary.[78] For nontrust assets, estate recovery may be made only for Medicaid provided after age 55, and only from recipients who die with assets passing through testacy or intestacy.[79]

VII. Conclusion

SNTs remain a valuable planning tool for the disabled. For third-party trusts, there is no payback to the State upon the death of the disabled beneficiary. Trusts funded with the assets of the disabled beneficiary will require a payback upon death. When the plaintiff of a personal injury action establishes an SNT, the New York Court of Appeals has determined that a Medicaid lien must be satisfied prior to the transfer of a tort settlement into the trust. The entire amount of an award is available to satisfy this lien.

Once the trust has been established, the assets in the trust may then be used to supplement rather than supplant government entitlements. SNTs help further the mandate of the Supreme Court that the disabled remain in the least restrictive environment.[80]

Endnotes

1. 94 Misc. 2d 952, 407 N.Y.S.2d 106 (Sur. 1978), *aff'd mem.*, 75 A.D.2d 531 (1st Dep't 1980), *aff'd*, 52 N.Y. 1006, 438 N.Y.S.2d 293 (1981).
2. 42 U.S.C. § 1396p(d)(4)(A).
3. SSL § 366(2)(b)(2)(iii)(A).
4. 42 U.S.C. §§ 1381 *et seq.*
5. 42 U.S.C. §§ 1396 *et seq.*
6. 20 C.F.R. §§ 416.1201(a), (b).
7. *See* 20 C.F.R. § 416.1112 for the formula used when an SSI recipient works.
8. 20 C.F.R. § 416.1123.
9. 20 C.F.R. § 416.1103(g).
10. 20 C.F.R § 416.1130.
11. *See Ruppert v. Bowen*, 871 F.2d 1172 (2d Cir. 1989); *see* 20 C.F.R. §§ 416.1132, 1133, 1140, 1141.
12. 18 N.Y.C.R.R. § 360-4.3(e).
13. SSL § 366(5)(a)(d)(4).
14. SSL § 366(5)(a)(d)(3).
15. SSL § 366(5)(a)(d)(3)(ii)(D).
16. 42 U.S.C. § 1382b(c)(1)(A).
17. 42 U.S.C. § 1382b(e)(5).
18. EPTL 7-1.6.
19. EPTL 7-1.6(a).
20. EPTL 7-1.6(b).
21. 94 Misc. 2d 952, 407 N.Y.S.2d 106 (Sur. 1978), *aff'd mem.*, 75 A.D.2d 531 (1st Dep't 1980), *aff'd*, 52 N.Y. 1006, 438 N.Y.S.2d 293 (1981).
22. 407 N.Y.S.2d at 108.
23. EPTL 7-1.12(a).
24. EPTL 7-1.12(a)(5)(e).
25. *Id*. at (b).
26. SSL § 104(3).
27. EPTL 7-1.12(a)(5)(iv),
28. *Id*. at 7-1.12(c)(1)(i).
29. *Id*. at (a)(5)(iii).
30. *See, e.g.*, 42 U.S.C. § 1396p(c).

31. 42 U.S.C. §§ 1396p(d)(4)(A), (C); 42 U.S.C. § 1396p(c)(2)(B)(iv).
32. 42 U.S.C. § 1396p(c)(2)(B)(iv); SSL § 366(5)(d)(3)(ii)(D).
33. 42 U.S.C. § 1396p(d)(4)(A); SSL § 366(2)(b)(2)(iii)(A).
34. SSL § 366(2)(b)(2)(iii)(A).
35. EPTL 7-1.12(a)(5)(v).
36. *Id*.
37. In-kind disbursements of income are not countable for Medicaid, or for SSI if not for food, clothing, shelter. 18 N.Y.C.R.R. § 360-4.3(e); 20 C.F.R. § 416.1130(b).
38. 18 N.Y.C.R.R. § 360-4.5(b)(5)(iii).
39. *Id*. at (iii)(a).
40. *Id*. at (iii)(b).
41. *Id*. at (iii)(c).
42. *Id*. at (iii)(d).
43. *Id*. at (iii)(e).
44. N.Y.L.J., July 28, 1995 at 25, col. 1-5 (Sup. Ct., Kings Co.).
45. 618 N.Y.S.2d 959 (Sur. Ct., Nass. Co. 1994).
46. 611 N.Y.S.2d 59 (2d Dep't 1994).
47. 699 N.Y.S.2d 257 (Sup. Ct., Suff. Co. 1999).
48. 42 U.S.C. § 1396p(d)(4)(A); SSL § 366(2)(b)(2)(iii)(A).
49. 18 N.Y.C.R.R. § 360-4.5(b)(5)(iv).
50. Treas. Reg. § 671-3(b).
51. I.R.C. § 677.
52. I.R.C. § 674; Treas. Reg. 1.674(a)-1.
53. I.R.C. § 675(4).
54. 42 U.S.C. § 1396p(d)(4)(C); SSL § 366(2)(b)(2)(iii)(B).
55. SSL § 366(2)(b)(2)(iii)(B).
56. *See, e.g., Joseph R.K. v. DeBuono*, 97-CV-0948 (N.Y.N.D. 1998), stipulating that pursuant to 18 N.Y.C.R.R. § 360-4.5(b)(5), income diverted into the SNT or income received by the disabled individual and then placed into his SNT will not be countable income when preparing a Medicaid budget; *See also* 96 ADM-8, as Amended.
57. 90 N.Y.2d 296 (N.Y. 1997).
58. *Id*.
59. *Calvanese v. Calvanese*, *In re Callahan*, 93 N.Y.2d 111 (N.Y. 1999), *cert. denied, sub nom. Callahan v. Suffolk Co.*, 120 S. Ct. 323 (1999).
60. SSL § 104(2).
61. *Baker v. Sterling*, 39 N.Y.2d 397 (N.Y. 1976).
62. *Id*.
63. *Id*.
64. SSL § 366(4)(h)(i).
65. *Id*.
66. __ N.Y.2d __, __ N.Y.S.2d __ (Feb. 15, 2001).
67. 42 U.S.C. §§ 1396a(a)(25)(A),(B); 42 U.S.C. § 1396k(a)(1)(A); SSL § 366(4)(h)(1).
68. 42 U.S.C. §§ 1396a(a)(25)(A),(B); 42 U.S.C. § 1396k(a)(1)(A); SSL § 366(4)(h)(1).
69. SSL § 104-b(2).
70. *Id.* at § 104-b(3).
71. N.Y.L.J., July 24, 1998 at 25, col 1 & 2 (Sup. Ct., Kings Co.).
72. 42 U.S.C. § 1396p; SSL § 369.
73. SSL § 369(6).
74. EPTL 7-1.12(a)(6).
75. *Id*. at (a)(3).
76. *Id*.
77. 18 N.Y.C.R.R. § 360-4.5(b)(5)(iii)(b).
78. SSL § 366(2)(b)(2)(iii)(A).
79. SSL § 369.
80. *Olmstead v. L.C.*, 119 S. Ct. 2176 (1999).

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The Right Guardianship Forum: Article 81 vs. 17-A

By Beth Polner

The wide array of permanently disabling physical and/or mental disorders which may affect our clients, whether due to accident (personal injury), birth defect, medical malpractice, or simply aging, may require the appointment of a guardian for health care decision making and/or financial management. The selection of the proper forum for the appointment of a guardian is made easier by laws which have been implemented in New York State in the last decade. In 1989, the Surrogate Court Procedure's Act added Article 17-A to permit the appointment of guardians for mentally retarded and developmentally disabled persons. In April, 1993, New York overhauled its conservator and committee statutes under Mental Hygiene Law (MHL) (former Articles 77 and 78), eliminating a finding of incompetence, and implementing Article 81, "Proceedings for Appointment of a Guardian for Personal Needs or Property Management." This article will outline some of the procedural and substantive differences between the two statutes and issues related to those differences.[1]

As a starting point, SCPA Article 17-A is limited to the appointment of a guardian for a person who is either mentally retarded or developmentally disabled. For persons who are developmentally disabled,[2] the statute requires medical certification that the person is incapable of managing himself/herself and/or their affairs, that the condition is permanent in nature, and that the disability is attributable to either cerebral palsy, autism, traumatic head injury, epilepsy, or neurological impairment. The disability may also be attributable to "any other condition of a person found to be closely related to mental retardation," or to dyslexia when taken in combination with either mental retardation or developmental disabilities. With the exception of traumatic head injury, the onset of developmental disability must have been before age 22.

By contrast, no specific medical diagnosis is required to establish incapacity under Article 81 of the Mental Hygiene Law. That statute, as discussed below, relies on findings related to the "functional limitations" of the person alleged to be incapacitated.[3]

Procedural Differences

The Petition and Supporting Documents

Preparation of the Article 17-A is eased by the use of Surrogate Court forms, which may be obtained from the court itself. The individual(s) seeking to be appointed guardians must check on the form itself, which powers they are requesting—i.e., guardian of the property, guardian of the person, or guardian of the person *and* property.[4] No delineation of specific powers is required by the statute. In addition to the court's forms, the petitioner must submit an original birth certificate, and in some counties, proof of fingerprinting.

Article 81 places the burden on the drafter/attorney to meet the *prima facie* elements for the petition and those elements are set forth in the statute. No medical documentation is required to be submitted with the petition. In fact, medical proof of functional limitations from a treating physician may raise issues of doctor/patient privilege and the proper waiver of that privilege. Rather, the petitioner must establish by clear and convincing evidence that functional limitations impair the alleged incapacitated person's ability to provide for personal needs and/or property management.[5]

In addition, in most counties, the Article 81 petitioner is required to specify the powers he or she is seeking in the petition. This is because the powers given to an Article 81 guardian must be "tailored specifically to the particular needs of a person with respect to personal care, property management, or both."[6] The Article 81 Order to Show Cause, although not a pre-printed form, must contain certain statutory language and information, and the style of the Order to Show Cause is mandated in the statute. The font size must be 12 point, bold, and double spaced.[7]

The Petitioner

Article 17-A sets forth a priority for eligible petitioners for the appointment of a guardian.[8] Those persons, in order of priority, are: a parent; interested persons over the age of 18; a nonprofit corporation

authorized to act on behalf of retarded or developmentally disabled persons; or the retarded/developmentally disabled person himself/herself, if over the age of 22. If both parents are deceased, grandparents have priority as petitioners.

There is no specific priority of petitioners under Article 81 and a broader class of persons under § 81.06 may commence the proceeding, including the person alleged to be incapacitated (in a self-petition). Some of the possible petitioners are presumptive distributees under the Surrogate's Court Procedure Act, an executor or administrator of an estate when the alleged incapacitated person (AIP) is a beneficiary under that estate, a trustee of trust when the AIP is a beneficiary, or a person concerned with the welfare of the AIP. This latter group may include a non-relative, neighbor, the Department of Social Services or Adult Protective Services, or the director of a nursing home, hospital, school, or alcoholism facility.

Commencing the Proceeding

No index number is required to be purchased but there is a filing fee of $15 in Article 17-A proceedings. Article 81 proceedings require the purchase of both an index number and RJI.

Unless the appropriate parties under Article 17-A execute the waivers of process and consent to the appointment of a guardian, service of the citation in the manner set forth in SCPA §§ 305, *et seq*., will be required.[9] The statute requires that the retarded or developmentally disabled person be personally served (if age 14 or older), and that the person having the care and custody of the disabled person be personally served if the disabled person does not reside with the parents. Additionally, notice of the petition is required to be mailed by certified mail to the local office of Mental Hygiene Legal Service if the disabled person resides in a facility, and to the director of that facility.

Article 81 requires personal service on the AIP unless a court directs otherwise. All other persons ordered to be served in the Order to Show Cause may be served by regular mail.[10]

Hearing, Findings and Orders

SCPA § 1754 provides for a hearing and there is a right to a jury trial. However, that section permits, in the court's discretion, a hearing to be dispensed with, and the court may appoint a *guardian ad litem* or Mental Hygiene Legal Service to prepare a written report of its recommendations regarding the request for the appointment of a guardian. Practice varies in each county as to when hearings will be dispensed with and the practitioner should check with the particular Surrogate Court. In some counties, when the petitioner is one or both parents, the hearing may be dispensed with; the statute provides for other circumstances.

If a hearing is held, the disabled person must be present unless the certifying physician has indicated on the medical form that the person is "medically incapable of being present to the extent that attendance is likely to result in physical harm" or as the court may determine would be in the best interest of the disabled person.

The appointment of a 17-A guardian is based upon a medical diagnosis of either mental retardation or developmental disability, that the disabled person is incapable of managing his/her affairs due to the particular diagnosis, and that it is in the best interest of the disabled person for the guardian to be appointed.

The Article 81 hearing is the hallmark of the statute. The hearing is mandated under § 81.11 and cannot be waived or dispensed with. In addition, a Court Evaluator is required to be appointed by the court (and the appointment is made in the Order to Show Cause). The Court Evaluator is required to prepare a written report of his/her findings, and to appear and testify at the hearing.[11]

The AIP is required to appear at the hearing unless it has been determined (usually by the Court Evaluator) that the person cannot physically come to the courthouse for the hearing. The statute states that if the AIP cannot attend the hearing, there must be proof as to whether any "meaningful participation would result from the person's presence at the hearing." So important is the AIP's presence at the hearing, that if meaningful participation and testimony would result from the AIP's presence at the hearing, the court must conduct the hearing where the AIP resides "so as to permit the court to obtain its own impression of the person's capacity."[12]

Under Article 81, the determination of incapacity and that a guardian will be appointed must be based upon clear and convincing evidence that the IP's functional limitations impair the ability to provide for his/her personal and/or property management and that the IP cannot understand the nature of that inability.[13] The statute makes clear that the guardian's powers must be the least restrictive form of intervention.

The order and judgment is prepared by the drafter/attorney and the order must set forth the court's findings and specific powers. Generally, a transcript of the court's decision must be ordered and an original filed with the clerk's office. Each guardianship judge may have a different format or style preference for orders. After the order has been signed, entered and served, the guardian must file a designation of clerk to receive process and consent to act as guardian[14]; shortly thereafter, the guardian will receive a commission issued by the clerk.[15]

As in most Surrogate Court proceedings, the Article 17-A proceeding results in a decree, rather than an order and judgment, which names the guardian(s) and standby and/or alternate guardian(s). There will not be a list of specific powers for the guardian. In some jurisdictions, the court includes a proposed decree in its form packet. After the decree is entered, the guardian will receive Letters of Guardianship indicating that they are the guardian of the person, property, or both. In cases where there is property, a bond may be required by the Surrogate's Court.

There are no educational requirements for a 17-A guardian. However, Article 81 requires appointed guardians to attend an educational training program[16] (for which they receive a certificate of attendance); these programs are usually offered by local bar associations.

Annual Accounts and Reports

An Article 81 guardian is required to file an annual report summarizing the changes, if any, in the physical or mental condition of their incapacitated ward, their visits with the IP (four are required per year at a minimum), and an overview of the plan of care.[17] The guardian of the property is also required to submit an annual accounting of assets, income, and expenditures. The format of the accounting is similar to SCPA § 1719. Accountings are reviewed by court appointed Court Examiners.

Unlike personal needs guardians under Article 81, a 17-A guardian of the person is not required to file an annual report. Where property or a trust is involved in a 17-A guardianship, an annual accounting is required and most Surrogate's Courts have preprinted forms available for use in the accountings.

Overview of Substantive Differences

In addition to some of the procedural differences outlined, the heart of the difference between the appointment of a 17-A guardian and an Article 81 guardian lies in the consequence for the disabled person. The appointment of a guardian under 17-A continues a relationship between the guardian and the ward similar to a parent/child relationship. The guardian has unlimited powers over the disabled person[18] (as guardian of the person) and the Surrogate's Court will determine the limitations for the guardian of the property.

Under Article 81, the determination of incapacity and the appointment of a guardian does not mean a loss of rights.[19] The statute, itself, also specifies that in keeping with the functional limitations, the incapacitated person may continue to participate in decision making for medical determinations and/or finances.

The requirements for Supplemental Needs Trusts (SNTs) are beyond the scope of this article, however the use of SNTs continues to grow and evolve under both Article 81 and 17-A proceedings. The practitioner should note that in some jurisdictions, there may be different requirements between SNTs submitted to Surrogate's Court and those submitted under Article 81 in Supreme Court. There may also be differences among what individual judges may require. Some differences may include the selection of the trustee[20] (where the proposed trustee will also be a named remainder beneficiary upon the death of the disabled trust beneficiary after Medicaid has been paid back), and the manner of accountings for SNTs.

The Article 81 petitioner may request permission to establish an SNT as part of the proceeding to appoint a property management guardian. Under Mental Hygiene Law § 81.36 a court may modify an existing guardian's powers under certain circumstances. The procedures for modification of powers, for example, to establish the SNT, are similar to commencing an original Article 81 proceeding, with a hearing on notice as set forth in other sections of the statute.[21]

Where a guardian of the person has already been appointed for a mentally retarded or developmentally disabled person under 17-A and an SNT now needs to be established, the guardian will need to resubmit the guardianship packet of forms requesting that Letters be amended to now appoint the guardian as guardian of the person *and* property. If the original Letters were issued before 1997, the petitioner/guardian may need to re-submit an original birth certificate and copies of medical reports. The practitioner should check with the local Surrogate's Court. Once Letters have been amended, an application to establish the SNT is usually submitted to the miscel-

laneous department of the Surrogate's Court. Again, local custom may vary in a particular county.

Familiarity with Article 17-A and Article 81 enables the practitioner to empower both the disabled client and their families, and to knowledgeably guide them in selecting the proper forum based upon the disabled person's present and future needs.

Endnotes

1. For an excellent in-depth discussion of Article 17-A proceedings, see *Distinguishing Article 81 and Article 17-A Proceedings*, Lawrence R. Faulkner and Lisa Klee Friedman, Guardianship Practice In New York State, Robert Abrams, editor, N.Y.S. Bar Association, 1997.
2. SCPA § 1750-a.
3. MHL § 81.02.
4. Although there may be variations by county, the forms generally consist of a pre-printed Petition for Appointment of Guardian; Waiver of Process Renunciation and Consent to Appointment of a Guardian; Consent, Oath and Designation of Standby Guardian; Affidavit of Proposed Guardian; Notice of Petition; Affirmation (Certification) of Examining Physician or Psychologist; Citation; Request for Information Guardianship Form; and an instruction sheet.
5. MHL § 81.15 sets forth the specific findings for a court, including the IP's (incapacitated person's) lack of understanding of the consequences of his/her functional limitations, the likelihood that harm will occur, the necessity of a guardian to prevent that harm, the specific powers of the guardian and the duration of the appointment.
6. Law Revision Commentary, MHL § 81.02.
7. MHL § 81.07(a).
8. SCPA § 1751.
9. The practitioner should read SCPA §§ 1753 and 305-309.
10. MHL § 81.07(d)(2).
11. MHL § 81.09 sets forth in detail the court evaluator's duties, which include interviewing the AIP, explaining the proceeding to the AIP, determining whether the AIP wishes legal counsel (MHL § 81.10), interviewing the petitioner and other family members, and making specific recommendations to the court in a written report.
12. MHL § 81.11. This section also sets forth other exceptions which permit the absence of the AIP from the hearing and the findings required by the judge on the record when the AIP is present, or not present, at the hearing.
13. MHL § 81.02, 81.15.
14. MHL § 81.26.
15. MHL § 81.27. In some cases, the guardian will be bonded and that bond will have to be filed with the court. In addition, most drafters must prepare the written commission for submission to the clerk and it will be stamped as a certified original.
16. MHL § 81.39. There are also educational requirements for court evaluators and court examiners. *See* §§ 81.40, 81.41.
17. MHL § 81.31. A medical report or summary from a treating practitioner (for example, physician, psychologist, neurologist, social worker) must be attached to the report and that medical report must be based upon an examination within 90 days of filing the annual report. Practitioners should check with local practice to determine if there are any variations particularly where an IP may be only examined annually by a neurologist or other specialist.
18. Interestingly, § 2963 (Article 29-B) of Public Health Law (with respect to Do Not Resuscitate (DNR) orders) provides that an adult shall be presumed to have capacity to make a decision regarding a DNR unless determined to lack capacity by a court. The statute states that lack of capacity shall not be presumed from the fact that a 17-A guardian, committee, or other guardian (presumably under Article 81 as Articles 77 and 78 have been repealed) may have been appointed.
19. For example, § 81.29, "Effect of the appointment on the incapacitated person" specifies that the IP retains all rights and powers except those which the guardian has been granted; that the appointment of a guardian is not conclusive evidence that the person lacks capacity for any other purpose, including making a will, and title to real property remains in the IP's name.
20. Some courts under Article 81, including Judge H. Patrick Leis, III of the Supreme Court, Suffolk County, have held that a parent/guardian may act as trustee of an SNT even if the parent will be a remainder beneficiary of the SNT. This decision, *In re Pace*, 669 N.Y.S.2d 257 (Sup. Ct., Suffolk Co. 1999) sets forth criteria for inquiry by the court to determine the suitability of parents as trustees and does not reject parents as trustees based upon a presumed "conflict of interest," e.g., *DiGennaro v. Community Hospital of Glen Cove*, 611 N.Y.S.2d 591 (2nd Dep't 1994). *In re Goldblatt*, 618 N.Y.S2d 959 (Surrogate's Court, Nassau Co. 1994) also relied on *DiGennaro*. However, both cases are based upon pre-OBRA changes to the Medicaid statutes in 1993 and pre-date current case law regarding satisfaction of Medicaid liens before an SNT is funded.
21. MHL § 81.31(e) also requires that the guardian submit proposed changes to his or her powers in the annual report.

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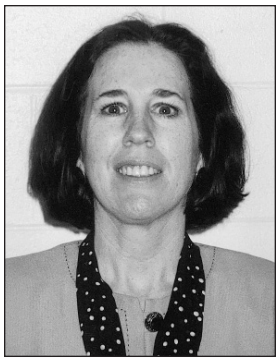
Entitlement Overview: SSI and SSDI

By Candace Appleton



Although we seem to be living longer, healthier lives, there are still many younger Americans who find themselves disabled and unable to work. The search for a steady stream of income becomes essential, and an attorney can play an important role in achieving this goal. This article deals with two such disability programs administered by the Social Security Administration (SSA).[1] I will discuss their differences and similarities as well as the legal criteria for obtaining them.

SSD vs. SSI

The two programs are known as Old Age, Survivors and Disability Insurance ("Social Security Disability," "SSD" or "Title II") and Supplemental Security Income ("SSI," or "Title XVI"). Both are primarily administered by the SSA which was separated from the Department of Health and Human Services and became an autonomous federal agency in 1994.[2] The State is involved somewhat, though, as the federal government has contracted with the New York State Office of Temporary and Disability Assistance's Office of Disability Determinations (ODD) to "work up" the disability applications. ODD collects and reviews medical documents and is the agency that sets up consultative appointments. Also, the SSI program is funded by both federal and state dollars.

SSD entitlement is based on the individual's work record and is *not* a needs-based program. Therefore, resources and unearned income are irrelevant. The level of payment received is computed based on length of time worked and the amount paid into the account.[3] Generally, applicants must prove that their disability commenced within five years after they stopped working. Finally, SSD is insurance for wage earners *and* their dependents. Both can receive a monthly allotment. However, an SSD applicant will not receive any benefit payment for the first five months the disability existed but can receive benefits for a period of one year prior to the date of the application.

SSI, on the other hand, is a needs-based benefits program for the blind and disabled who have not worked and paid Social Security taxes or accumulated insufficient quarters of coverage.[4] There are strict limits on resources and unearned income. Earned income and resources from financially responsible parents or spouses are "deemed" available and might lower the SSI benefit. The disabled individual only (not their dependents) receive monthly cash benefits that vary in amount from state to state and depend on living situation. Some disabled younger individuals are covered by both disability programs. SSD recipients whose entitlement is lower than the established SSI rate can also receive SSI to bring them up to that minimum amount. Finally, SSI applicants will only be paid from the first day of the month following their date of application, no matter how long their disabling condition has existed.

Corollary Medical Benefits

Most importantly, medical insurance comes along with the Social Security benefits. After 24 months of eligibility, SSD recipients receive Medicare for which a premium of approximately $50 per month is deducted. SSI recipients, on the other hand, receive immediate eligibility for Medicaid. SSD recipients who receive a low monthly benefit amount (roughly equivalent to those on SSI) and are resource/income eligible can also receive Medicaid. Those with higher SSD income could obtain eligibility by "spending down" that excess money on medical needs. For those receiving both forms of medical coverage, Medicaid will pay the Medicare premium.

Proving Disability

Many younger Americans are challenged with a "disability" yet are still gainfully employed. However, those who find themselves unable to work and desiring SSD or SSI benefits must meet the strict legal definition of "disabled."

Under both programs, the burden is on a claimant to show "the inability to engage in any substantial gainful activity (SGA) by reason of any medically determinable physical or mental impairment which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than twelve months."[5]

The procedures for determining whether a claimant is disabled under the law are specified in Title 20 of the Social Security regulations. It is a five-step evaluation process[6] where the claimant carries the burden of proof at the first four, and SSA the fifth. The claimant must meet each threshold requirement in sequence, otherwise the evaluation stops at that stage and further review is precluded. Generally, the five-step analysis is as follows:

1. **Is the claimant working?** The claimant must not be engaged in Substantial Gainful Activity (SGA). Beginning January 1, 2001, SSA presumes that an applicant earning over $740 per month is gainfully employed and will deny him/her at this step. However, the earnings level set forth in the regulations merely creates a "rebuttable presumption." The SSA could make a case that a lower earnings amount is SGA, or the claimant could argue that a higher amount is not SGA.

2. **Does the claimant have a severe impairment?** The claimant must have an impairment "which significantly limits [his or her] physical or mental ability to do basic work activities." and which disabled him from doing his/her previous work or any other SGA that exists in the national economy. If not, the application will be denied.[7]

3. **Does the claimant suffer from one or more of the disabilities outlined in the SSA's Listing of Impairments?** The Listing of Impairments is found in an appendix to the federal regulations (20 C.F.R.). It is divided into two parts: Part A deals with those impairments which affect adults and children in the same manner; Part B deals with impairments which only affect children.[8] Medical criteria is set out for every possible physical or mental diagnosis. Impairments are looked at individually or in combination. If the claimant meets the requirements set forth in these listings, a finding of "disabled" will issue immediately without further consideration.

4. **Can the claimant resume his/her past work?** This analytical step requires a medical-vocational determination of whether the claimant is prevented from performing any relevant work he performed over the past 15 years. The mental and exertional demands of the past work must be fully explored as well as the limitations resulting from the impairment or combination of impairments. If claimant's disability does not prevent him from performing past work, he is considered not disabled.

5. **Is there any other work in the national economy that the claimant can do?** The final question presented in the sequential evaluation process is whether, considering the claimant's residual functional capacity, age, education, and prior work experience, he/she can perform other substantial gainful work which is available in significant numbers in the national economy. The burden of proof lies with SSA here. The agency predominantly relies on a series of tables (known as "the grids")[9] to determine whether a physical impairment renders a claimant disabled. Work is characterized by its exertional requirements. Jobs can be heavy, medium, light or sedentary and each level is also characterized by the number of hours the worker would be expected to sit, stand and walk and what weight would frequently have to be carried. SSA cannot meet its burden by utilizing the grid with non-exertional impairments. (i.e., mental, visual). A vocational expert can also be called when the claim reaches the hearing stage. If other work is available, the claimant is not disabled.

The Appeal Process

The pursuit of Social Security benefits involves an unfortunately lengthy, but challenging, federal administrative process. Applicants must fill out reams of forms and will probably have to subject themselves to one or more consultative examinations. They can submit medical evidence that they have. If an initial application is denied, and it frequently is,[10] the claimant has 60 days to request reconsideration.[11] Once that is denied, a hearing before an Administrative Law Judge (ALJ) must be requested within 60 days. This appeal stage offers the best opportunity for success. The hearings are informal and essentially "non-adversarial." The ALJ, unlike a judge in a trial, must affirmatively develop the record even if an attorney is present for the claimant. The claimant can submit evidence, present witnesses, and cross examine SSA's consultative experts, if any were called. A claimant who is unsuccessful at a hearing can ask for administrative review by the Appeals Counsel, located in Falls Church, Virginia. Again, this must be done within 60 days. This is basically a paper review where evidence (relating to the time period prior to the date of the hearing decision) can be submitted along with a legal argument. If unsuccessful, an

action can be commenced in the federal district court within 60 days.

Attorneys' Fees

There are several sources of attorneys' fees in Social Security cases. Most awards are paid out of the claimant's back benefits.[12] The Administration will withhold up to 25% of past-due benefits or $4,000, whichever is less, for direct payment to attorneys in SSD cases for agency-level representation. There is no authority for withholding benefits for fees in SSI cases. Another source of fees when federal litigation is involved is the Equal Access to Justice Act.[13] SSA carefully regulates all requests for fees.

Work Incentives

Ironically, SSA actually encourages recipients (not applicants) of SSD and SSI to test their ability to work, earn wages, yet still maintain their monthly benefits. New "work incentive" legislation seems to be introduced in Washington every week.[14] The existing programs differ for SSD and SSI, though. SSD beneficiaries are entitled to a nine-month "trial work period" during which they may earn any amount and receive full benefits. Earnings of less than $530[15] per month will not trigger the "trial work" provision. After completion of nine trial work months, SSD benefits are suspended while medical benefits continue. However, if earnings fall below the $740 substantial gainful activity level, full benefits generally continue.

On the other hand, SSI recipients, who receive the highest monthly rate, can earn up to $1,282.99 per month and continue to receive some amount of SSI and Medicaid. A mathematical formula is applied utilizing a $20 standard disregard and an earned income disregard of $65. Once this $85 is subtracted from the gross earnings, the remainder is divided by two. That amount is then subtracted from the SSI entitlement amount to arrive at the adjusted SSI benefit. The recipient retains his/her full wages and a small amount of SSI for an indefinite amount of time.

Continuing Disability Review

Once entitlement to SSD or SSI benefits is established, it is not guaranteed for life. Recipients are subject to periodic review and benefit payment may be terminated at the occurrence of any of several events: a) resumption of work; b) medical improvement; and c) resources exceeding the $2000 limit. Most cases are subject to review every three years. Others, where medical improvement is expected, will occur every year. Grave disabilities will be scheduled only every seven years.

Most terminations are based on allegations of medical improvement.[16] The Social Security Act provides that disability benefits may be terminated on a finding that the physical or mental impairment has ceased, does not exit, or is no longer disabling. The SSA must establish this by substantial evidence prior to termination, and notice must be given of the "Continuing Disability Review." Appeals rights similar to those above are provided. For benefits to continue, though, appeal must be sought within ten days rather than 60.

Conclusion

This has been just a brief glimpse into Social Security's two major disability programs. Over 12 million disabled Americans rely on them for their survival. The legal arena involved is complex and changing almost daily it seems. However, it is a most challenging and rewarding practice to pursue. The impact on the quality of your client's life is always immense.

Endnotes

1. This article only pertains to Social Security benefits available for disabled individuals age 18 and over. (Disabled children of low income/resource families also have an entitlement to SSI on their own right, but their eligibility will not be explored here.) Keep in mind other possible sources of income for younger disabled individuals: workers' compensation, unemployment, state disability payments, public assistance or benefits from a private work, union or insurance plan. This article is also only a *brief* summary of two legally complex federal programs which undergo revision constantly. This information should not replace legal research into the pertinent areas when representing a client.
2. SSA has a very informative Web site at www.ssa.gov.
3. Annually, all wage earners should be receiving a statement from SSA of what their current estimated disability benefit would be.
4. SSI also provides "retirement" benefits to those 65 or over, regardless of disability, who have no work record.
5. 42 U.S.C. § 423(d)(1)(A); 20 C.F.R. §§ 404.1501-1587; 20 C.F.R. §§ 416.901-986.
6. *See* 20 C.F.R. §§ 404.1520, 416.920.
7. Only two prevalent impairments are excluded altogether by SSA. In 1996 the law changed and drug addiction and alcoholism were no longer recognized as disabilities under the Social Security programs. Advocates must now prove that drug addiction and/or alcoholism are not a contributing factor "material" to the finding of disability. Individuals must now prove total disability based on other physical or mental grounds.
8. Again, this article deals only with disabled individuals over age 18. Disabled children of low income/resource families

might be eligible for SSI on their own right. The legal analysis of their case, though, is quite different and has undergone very recent changes.

9. These are found in Subpt. P, Appendix 2 of 20 C.F.R.

10. In fiscal year 2000, only 38% of all applications were allowed; 16% of all reconsiderations; 59% of all ALJ dispositions; 24% at the Appeals Council; and 54% at federal court.

11. SSA is undergoing constant "redesign." In certain areas of the country (New York State included) the "reconsideration" stage has been eliminated. There is also talk of doing away with the Appeals Council.

12. 20 C.F.R. §§ 404.1720 *et seq*.

13. 28 U.S.C.A. § 2412.

14. The "Ticket to Work and Work Incentives Improvement Act of 1999" began implementation in Spring 2001. SSD and SSI recipients will be mailed a "ticket" entitling them to obtain employment services, vocational rehabilitation services, or other supportive services in a community program. Certain enticements come with the ticket. Participation is strictly voluntary.

15. This amount, like the $740 for substantial gainful activity, will be adjusted annually to increases in the national average wage index.

16. 20 C.F.R. §§ 1594, 416.994.

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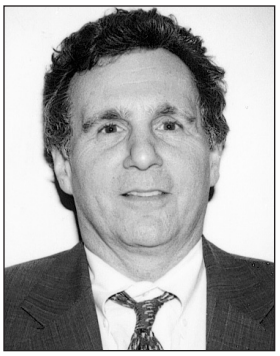
Ms. Appleton specializes in federal court litigation including a major Social Security impact case, *De Leon v. HHS*, 734 F.2d 930 (2d Cir. 1984). She also pursues legislative advocacy: drafting, lobbying for and seeing through to passage: RPAPL § 711 (amendment giving due process rights to rooming-house residents) and SSL § 461-a(3) (giving lawyers access to their clients residing in adult homes). She has testified before congressional and N.Y.S. Assembly committees, contributed articles to *Newsday* and other periodicals, and done extensive writing and training on many poverty law areas.

Kendra's Law Authorizes Court-Ordered Assisted Outpatient Treatment for Mentally Ill

By Allan E. Silver

Background



On August 9, 1999, Governor Pataki signed legislation which created assisted outpatient treatment programs and authorized certain individuals to seek court orders requiring persons with severe mental illness to obtain such assisted outpatient treatment.[1] Kendra's Law was enacted largely in response to the death of Kendra Webdale, a woman allegedly killed at the hands of a diagnosed schizophrenic who pushed her in front of an oncoming subway train in Manhattan in January 1999. The law was intended to provide the severely mentally ill with essential services and monitoring to promote continuity of care and the ability to live safely in the community. It is an important change in the state's mental health law and the Legislature hoped that it would benefit the lives of all New Yorkers.

The term "assisted outpatient treatment" refers to categories of outpatient services which a court may order to "treat a person's mental illness and to assist the person in living and functioning in the community, or to attempt to prevent a relapse or deterioration that may reasonably be predicted to result in suicide or the need for hospitalization." Assisted outpatient treatment must include either case management or assertive community treatment team services to enable frequent contact with the subject. It may also include the following categories of service (among others): medication, periodic blood tests or urinalysis, individual or group therapy, day or partial day programming activities, educational and vocational training or activities, alcohol or substance abuse treatment and counseling, and supervision of living arrangements.

The creation of assisted outpatient treatment programs through Kendra's Law was intended to enable care givers to coordinate the delivery of assisted outpatient treatment services to severely mentally ill persons, and to allow for their continuous evaluation and monitoring. Under the new law, a person with severe mental illness who is believed to be a risk to self or to others in the community and who meets all of the statutorily-defined criteria for assisted outpatient treatment may become the subject of an order requiring his/her participation in an assisted outpatient treatment program.

Oversight

Because of the importance of ensuring a subject's compliance with court-ordered treatment, Kendra's Law authorizes local directors of community services to receive and investigate reports of persons alleged to be in need of assisted outpatient treatment, and to file, when necessary, a petition for an order authorizing court-ordered treatment. Thereafter, a director of community services must ensure timely delivery of court-ordered assisted outpatient treatment, and must monitor and enforce a subject's compliance with any such treatment.

To monitor the effectiveness of assisted outpatient treatment programs, Kendra's Law also requires the directors of such programs to submit periodic reports to regional program coordinators appointed by the Commissioner of Mental Health. Such reports include quarterly reports, as well as reports for each occasion on which a person is ordered to participate in assisted outpatient treatment. Additionally, if a program coordinator determines or receives notice that a subject is not receiving timely and adequate assisted outpatient treatment services, the program coordinator must require the program director to immediately commence corrective action, including, if necessary, involuntary hospitalization of the subject. If the program director fails to take corrective action, the director's failure will be reported to the program coordinator, who, in turn, must notify the Commissioner of Mental Health and the court.

Protective Provisions

Due to the obvious restrictive nature of assisted outpatient treatment, Kendra's Law also contains provisions to protect persons who may become the subject of a petition for assisted outpatient treatment. Petitions for an order to participate in assisted outpatient treatment may be filed by specified individuals only. As noted above, a director of community services may file a petition. Other individuals who may file a petition include any adult who resides with the subject, a relative (such as a parent, spouse, or adult sibling or child), certain mental health care providers (including a psychiatrist who is treating or supervising treatment of the subject, the director of a hospital in which the person is hospitalized, or the director of a public or charitable institution in which the person resides), a social services official in the city or county in which the person is present, or a

parole or probation officer assigned to supervise the subject.

All petitions—regardless of by whom they are filed—must be accompanied by a physician's affirmation. The physician's affirmation must indicate that the physician examined the person (or attempted to examine the person) within 10 days prior to the filing of the petition, recommends assisted outpatient treatment, and is willing and able to testify at a hearing. At the time of the hearing, the physician must explain why the subject requires assisted outpatient treatment and why assisted outpatient treatment represents the least restrictive alternative for the subject. The physician must also explain the recommended treatment plan and its rationale. This treatment plan must be in writing and developed in conjunction with input from the subject, the subject's treating physician and, upon the subject's request, a relative or close friend.

As a further precaution, the court may not order an individual to participate in assisted outpatient treatment unless it finds by clear and convincing evidence that the subject meets *all* of the statutory criteria set forth in the law. For instance, the court must find that, among other things, the person is unlikely to survive safely in the community without supervision, and is unlikely to voluntarily participate in the recommended treatment. The evidence at the hearing must also demonstrate that the person has a history of lack of compliance with treatment for mental illness, and that such noncompliance has been a significant factor in necessitating hospitalization at least twice in the past 36 months or has resulted in one or more acts of serious violent behavior toward self or others (including threats of or attempts at serious physical harm) in the last 48 months. The court must also find that the person needs assisted outpatient treatment to prevent a relapse or deterioration which would likely result in serious harm to self or others, and that the person is likely to benefit from assisted outpatient treatment.

An initial order for assisted outpatient treatment may not extend for a period longer than six months. No material changes may be made to the terms of the order without prior court approval.

If the petitioner is the director of a hospital that operates an assisted outpatient treatment program, the court order must require the hospital director to provide or arrange for all categories of assisted outpatient treatment for the subject. For all other persons, the court order must require the director of community services of the appropriate local governmental unit to provide or arrange for all categories of assisted outpatient treatment for the subject.

Conclusion

According to the Office of Mental Health, between November 1999 (the statute's effective date) and February 2001, the courts have issued 684 orders for assisted outpatient treatment. During this time frame, the constitutionality of the statute has been upheld,[2] and it has been determined that it was the legislature's intent to waive the physician-patient privilege by permitting the treating psychiatrist to either file the petition or to actually participate in the formulation of the treatment plan.[3]

While the statute has been interpreted and upheld by the courts, the effectiveness of the law is still debated. The statute's proponents point to the increase of case management services and to the careful formulation of treatment plans for patients who are at risk in the community due to noncompliance. On the other hand, the statute's critics, such as Mental Hygiene Legal Service (MHLS),[4] are appalled that an individual subject to an assisted outpatient treatment order can be hospitalized for up to 72 hours on a physician's order. To MHLS, a significant liberty interest has been placed at risk.

Only time will tell if Kendra's Law can provide continuity of care and allow the severely mentally ill to reside safely in the community without an undue threat of re-hospitalization.

Endnotes

1. Chapter 408 of the Session Laws of 1999 created New York Mental Hygiene Law § 9.60, entitled "Assisted Outpatient Treatment."
2. *In re Urcuyo*, 185 Misc. 2d 836, 714 N.Y.S.2d 862 (Supreme Ct., Kings Co. 2000); *In re Martin*, N.Y.L.J., Jan. 9, 2001, p. 31, col. 6.
3. *Amin v. Rose F.*, N.Y.L.J., Dec. 7, 2000, p. 31, col. 1.
4. Article 47 of the New York Mental Hygiene Law establishes MHLS in each judicial department to provide legal assistance to patients or residents of facilities for the mentally disabled.

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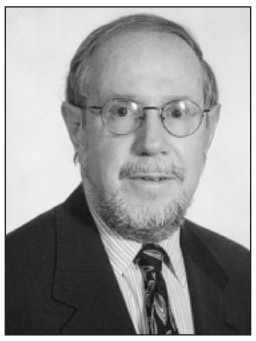
Private and Public Agencies for Disabled Persons

By Peter Van Nuys



Trying to locate services available for persons with disabilities can be a difficult and frustrating endeavor at best. No one seems to have all of the necessary information for any community, let alone an entire county or the entire state. With that in mind, New York State set out a few years ago to establish a central clearinghouse for such information. With the aid of Senator Nick Span, funding was obtained from the State to start a pilot project. Unfortunately, as is usual with state-funded operations, the project lasted only about two years before closing. It appears that the agency chosen to handle the clearinghouse lost interest and failed to seek continuing funding for the project.

The author strongly urges the New York State Bar Association or the Elder Law Section thereof to either (a) start and maintain a central clearinghouse of information about services available in New York State for various disabled populations; or (b) become involved in such a project in conjunction with other not-for-profit organizations within the State. There are several such organizations which have expressed an interest in maintaining or helping to maintain such a clearinghouse.

This article will attempt to list some of the services available in New York State and to list some sources where information about services can be obtained. The unfortunate reality in New York State is that, while there are a few organizations which provide services to, and information about services for, a broad range of individuals, most of the organizations provide services to, and have information about services for, only the particular disabled population which the organization serves. Furthermore, the population afflicted with mental illness seems to have fewer services and less information available to it than other populations with disabilities. While some organizations have a great deal of knowledge about housing programs available in their area, no one seems to know which programs actually have openings in their housing programs at any one time.

The balance of this article will attempt to provide certain basic information about some of the services available in New York State and sources for obtaining more detailed information about available programs. Some of the programs are statewide, while others are limited to a small area or small population within a small area.

1. Broad Range of Services

The services vary, but often include: provision of a case manager or service coordinator; housing; transition planning; job training; sheltered workshops; help in obtaining jobs in the community; provision of a job coach; various habilitation services; day programs; and information about other services available in the area, including lists of lawyers, financial planners or other "experts" familiar with the needs of the disabled. Some also provide future care planning advice to the families of the disabled, have pooled SNTs and/or corporate guardianship programs and/or operate camps or other summer programs for the disabled. Many have respite services.

a. **Community Living Corporation**—600 Bedford Road, Mount Kisco, N.Y. 10549 (914) 241-0032. This organization serves the higher functioning mentally retarded and developmentally disabled in Westchester County. It provides housing and employment and has two pooled Supplemental Needs Trusts (SNTs).

b. **F.E.G.S.**— 315 Hudson Street, New York, N.Y. 10013-1009 (212) 366-8400 or Web site at www.fegs.org. Provides a broad array of services to the mentally retarded, developmentally disabled and mentally ill in New York City and on Long Island. Large array of employment services. Has two pooled SNTs (called "Community Trusts") which are available for persons with any disability and which also fund advocacy services for the trust beneficiaries. Operates the old "PLAN" Trust, which provides lifetime advocacy services to the mentally ill. Also operates an Assisted Outpatient Treatment (AOT) clinic in coordination with Kendra's Law. Does not operate a corporate guardianship program, but will help with the guardianship process. Affiliated with UJA/Federation of Jewish Philanthropies.

c. **Lifetime Care Foundation for the Jewish Disabled**—4510 16th Avenue, Brooklyn, N.Y. 11204 (718) 686-3275—Contact Rabbi Simch Seuerman. This organization provides a broad array of services for Jewish mentally retarded,

developmentally disabled, mentally ill and seniors in Brooklyn and Queens. It also has a corporate guardianship program and two pooled Supplemental Needs (or community) Trusts.

d. **Mental Health Associations in Various Counties**—These organizations provide a broad array of services for the mentally ill. One with which the author has had good experience is the **Mental Health Association of Westchester County, Inc.**, 2269 Saw Mill River Road, Bldg. A, Elmsford, N.Y. 10523 (914) 345-0700. They should be able to give you information on Mental Health Associations in other counties.

e. **New York City Office of Mental Health-Mental Retardation and Alcoholism Services**—93 Worth Street, New York, N.Y. 10013-3412. General Information and Referral number is (212) 219-5599. **Mental Retardation & Developmental Disability Bureau** (212) 219-5213. Mental Health has separate Borough offices for all boroughs other than Staten Island. The numbers are: Manhattan office (212) 442-5000; Bronx office (212) 219-5500; Queens office (212) 219-5514; Brooklyn Office, 16 Court Street, Brooklyn, N.Y. 11241-0102 (718) 643-4620.

f. **New York State Alliance for the Mentally Ill** (AMI)—This a state-wide organization which provides advocacy, support and information for the mentally ill and friends and relatives of the mentally ill. There are member groups in most counties. One of the larger more active chapters is **AMI/FAMI**, 432 Park Avenue South, New York, N.Y. 10016-8013 (212) 684-3264.

g. **NYSARC, Inc.** (formerly New York State Association for Retarded Citizens, Inc.)—393 Delaware Avenue, Delmar, N.Y. 12054 (518) 439-8311. Operates chapters in every county except Tompkins County. Usually listed as "(name of county) ARC" or "ARC of (Name of County)," but in New York City is "AHRC" or "Association for Help of Retarded Children." Provides a broad range of services for the mentally retarded and developmentally disabled. It has two pooled SNTs, a corporate guardianship program and provides information.

h. **OMH (Office of Mental Health)**—44 Holland Avenue, Albany, N.Y. 12229 (800) 597-8481 (Customer Relations Service). Runs psychiatric hospitals, outpatient clinics and housing, among other services.

i. **OMRDD (Office of Mental Retardation and Developmental Disabilities)**—44 Holland Avenue, Albany, N.Y. 12229 (518) 473-1973, TDD (528) 474-3694. Services are provided through regional Developmental Disability Service Offices (DDSOs).

j. **YAI (Young Adult Institute) National Institute for People With Disabilities**—460 West 34th Street, 11th floor, New York, N.Y. 10001-2320. Contact Raul Fuentes at (212) 273-6542 or YAI Link at (212) 273-6182 (information on all YAI programs and referral to other programs in English, Spanish and Russian) or TDD (212) 290-2787. Its Web site is www.yai.org. Has a broad array of programs for the mentally retarded and developmentally disabled in the downstate area (Long Island, New York City (except Staten Island), Westchester and Dutchess Counties). Also has a vocational program in the Bronx for the mentally ill called Capable (contact Louis Lazarides at (718) 239-1790, ext. 233) and a program for the learning disabled in Rockland County (YAI RCALD). It also has two pooled SNTs.

k. Organizations aimed at specific disabilities, such as **United Cerebral Palsy (UCP)** and the **National Multiple Sclerosis Society** (800) 344-4867, usually offer a broad array of services for their targeted populations.

2. Corporate Guardianship Programs

Several organizations have corporate guardianship programs for those disabled individuals who have no one else to act as guardian of the person (a charitable organization cannot act as guardian of the property). The following are some of the organizations with which the author is familiar. The list does not include those programs aimed primarily at the elderly.

a. **Continuing Development Services**—650 Blossom Road, Rochester, N.Y. 14610 (716) 224-9880. Contact either Carrie Carra or Erin Bostian.

b. **Lifetime Care Foundation for the Jewish Disabled**—4510 16th Avenue, Brooklyn, N.Y. 11204 (718) 686-3275. Contact Rabbi Simch Seuerman. This organization has a corporate guardianship program for Jewish mentally retarded, developmentally disabled, mentally ill and seniors in Brooklyn and Queens.

c. **NYSARC, Inc.**—393 Delaware Avenue, Delmar, N.Y. 12054 (518) 439-8311. Contact Erica F. Berman, the Associate Executive Director for Guardianship Services. This organization runs a

state-wide guardianship program for the mentally retarded and developmentally disabled. It is administered through the local chapters. Erica Berman is also a good source for information on all types of corporate guardianship programs throughout New York State.

d. **UCP of Nassau County**—380 Washington Avenue, Roosevelt, N.Y. 11575 (516) 378-2000. Contact Shelley Seindenberg, Director of Social Work at extension 290.

3. Financial Planning and/or Future Care Planning

a. **Community Living Corporation**—600 Bedford Road, Mount Kisco, N.Y. 10549 (914) 241-0032. Provides future care planning.

b. **Disabled and Alone/Life Services for the Handicapped**—352 Park Avenue South, 11th Floor, New York, N.Y. 10010 (212) 532-6740. Contact either Leslie Park or Roz Brilliant. This organization provides future care planning and annual or lifetime advocacy for the disabled and helps a family fill out a book containing all known information about the disabled individual and the family's and disabled person's wishes for the disabled person's future. It also has a third-party pooled SNT and is in the process of adopting a self-settled pooled SNT. It is a national organization, but concentrates primarily on New York State, and the rest of the east coast.

c. **NYSARC, Inc.**—393 Delaware Avenue, Delmar, N.Y. 12054 (518) 439-8311. Some of its chapters, such as Westchester ARC, 121 Westmoreland Avenue, White Plains, N.Y. 10606 (914) 949-9300, provide future care planning and also maintain lists of financial planners who are familiar with the needs of the disabled.

d. For profit organizations which provide financial planning and future care planning for families of the disabled:

(1) **METDESK**—One Madison Avenue, New York, N.Y. 10010-3690. Contact David M. Harmon at (212) 578-8532. It is a division of Metropolitan Life which provides free financial and future care planning for the disabled. All employees either are parents or relatives of a disabled person or have received special training in the field.

(2) **Solomon Smith Barney**—a division of CitiGroup. There are financial planners with knowledge of the special needs of the disabled. Contact Bruce Scharf at (516) 684-2705. He is in charge of the Long Island and Westchester offices and can put one in contact with his counterparts in other parts of the state. Citi Fiduciary Trust Company and other CitiGroup banks are affiliated with Solomon Smith Barney, will act as trustee of SNTs and have much lower minimums than many other banks.

4. Housing

a. Substantially all of the organizations listed under the heading "Broad Range of Services" provide housing.

b. **OMH**—Contact the Customer Relations Service at (800) 597-8481 and ask for housing services.

c. **OMRDD**—Contact either DiAnn L. Baxley or Rob Davies at (518) 473-1973, TDD (518) 374-3694. Rob is the Assistant Director for Housing & Employment Initiatives at OMRDD. Both are familiar with many housing programs for the MR/DD population (including funding and other help for home of your own programs) throughout the state. OMRDD services are provided through regional Developmental Disability Service Offices.

5. Pooled SNTs

a. **Community Living Corporation**—600 Bedford Road, Mount Kisco, N.Y. 10549 (914) 241-0032. It has two pooled SNTs for the mentally retarded and developmentally disabled.

b. **Disabled and Alone/Life Services for the Handicapped**—352 Park Avenue South, 11th Floor, New York, N.Y. 10010 (212) 532-6740. Contact either Leslie Park or Roz Brilliant. It has a third-party pooled SNT and is in the process of adopting a self-settled pooled SNT for the mentally retarded and developmentally disabled. State-wide.

c. **Lifetime Care Foundation for the Jewish Disabled**—4510 16th Avenue, Brooklyn, N.Y. 11204 (718) 686-3275. Contact Rabbi Simch Seuerman. It has two pooled SNTs for mentally retarded, developmentally disabled, mentally ill and seniors in Brooklyn and Queens.

d. **NYSARC, Inc.**—393 Delaware Avenue, Delmar, N.Y. 12054 (518) 439-8311. It has two pooled SNTs which it has recently revised. Unlike most other pooled SNTs, there is no minimum contribution required. State-wide.

e. **UJA/Federation of Jewish Philanthropies and F.E.G.S.** It has two pooled SNTs called "community trusts." While the trusts are administered through UJA/Federation of Jewish Philanthropies, Dept. of Planned Giving & Endowments, 130 East 59th Street, New York,

N.Y. 10022 (contact Morton Asch at (212) 836-1339), the services under the trust are provided through F.E.G.S. (contact Ellen Pepperberg Millman at (212) 366-8030). Serves any disabled person in New York City, Long Island and Westchester County.

f. **YAI (Young Adult Institute) National Institute for People With Disabilities**—460 West 34th Street, 11th floor, New York, N.Y. 10001-2320. Contact Raul Fuentes at (212) 273-6542 or YAI Link at (212) 273-6182. It has two pooled SNTs. Downstate New York area.

6. Sources for Information

a. **Disabled and Alone/Life Services for the Handicapped**—352 Park Avenue South, 11th Floor, New York, N.Y. 10010 (212) 532-6740. Contact either Leslie Park or Roz Brilliant.

b. **Jewish Information Referral Services (JIRS)**—a part of UJA-Federation of Jewish philanthropies. Contact Jane Abraham at (212) 836-1427. Has information on both Jewish and non-Jewish services in New York City, Long Island and Westchester County.

c. **Mental Health Information and Referral**—(800) LIFENET.

d. **New York City Office of Mental Health-Mental Retardation and Alcoholism Services—Information and Referral Services**—93 Worth Street, New York, N.Y. 10013-3412 (212) 219-5599.

e. **OMH**—44 Holland Avenue, Albany, N.Y. 12229 (800) 597-8481 (Customer Relations Service).

f. **OMRDD**—Contact either DiAnn L. Baxley or Rob Davies at (518) 473-1973 (TDD (518) 374-3694). Rob is the Assistant Director for Housing & Employment Initiatives at OMRDD. Both of them are familiar with many housing programs for the MR/DD population (including funding and other help for home of your own programs) throughout the entire state. In addition, OMRDD provides training programs for future care service coordinators and family members, publishes a *Parents Planning Journal* and a *Future Care Planning Manual*, provides information on SNTs and provide answers to frequently asked questions (FAQs).

g. **Resources for Children With Special Needs, Inc.**—200 Park Avenue South, Suite 816, New York, N.Y. 10003 (212) 677-4650. Provides information, referral, advocacy training and support for New York City parents and professionals seeking programs and services for children from birth to age 21, with learning, developmental, emotional or physical disabilities.

h. **Various County Governments**—Some county governments have substantial information available on services within the county. For example, Westchester County has a substantial amount of information available on its Web site at westchestergov.com and through the Westchester Department of Community Mental Health, which has two subdivisions—Mental Health Services (914) 995-5245—and Mental Retardation and Developmental Disabilities—(914) 995-5244.

i. **Local VESID and BOCES programs** also have substantial information, especially regarding pre-school, school aged and transition (to work and life in the community) programs.

Peter Van Nuys is a partner in the New York City law firm of Becker, Glynn, Melamed & Muffly LLP, a small full service firm. He concentrates his practice in the areas of domestic and international estate planning and administration, domestic and international tax planning and estate planning and future care planning for families with relatives with disabilities.

Mr. Van Nuys has lectured extensively in the New York metropolitan area on estate planning and future care planning for families with relatives with disabilities, has given college courses on that subject, has taken part in seminars on that subject at the Government Law Center at Albany Law School, has lectured and presented papers on international tax issues at banks throughout Europe and has lectured on the use of offshore trusts and corporations at a seminar for international banks in the Cayman Islands. He has also appeared as an expert witness on international estate planning and international taxes in the U.S. District Court for the Southern District of New York.

Mr. Van Nuys is on the board of directors of Disabled and Alone/Life Services for the Handicapped, Inc., a charitable organization that acts as an advocate and case manager for disabled individuals, was a member of the board of directors of Westchester ARC for six years, was a member of the Residential Services Committee and Home of Your Own Committee of Westchester ARC (which helped to develop models for disabled individuals to use in acquiring their own homes), and still is a member of the Guardianship Committee of Westchester ARC. He was a founder, director and secretary of Planned Lifetime Assistance Network (PLAN) of New York, Inc., a charitable organization that acted as an advocate and case manager for mentally ill individuals until it was taken over by F.E.G.S. He is a member of the Future Care Planning Committee, a working group of state officials, charities and professionals in the field of disabilities who work to develop state laws and public/private initiatives to better provide for the needs of those with disabilities.

ELDER LAW NEWS

REGULAR COLUMNS

Case News

By Judith B. Raskin

Medicaid

DDS appealed from an order to reinstate the monthly personal needs allowance for a married person in the Lombardi program to $550, up from the revised $50 allowance. Remitted for determination of reasonable allowance. *Evans v. Wing*, __ A.D.2d __ (4th Dep't 2000).

In this class action, petitioners challenged the 1995 change in the personal needs allowance for a married person in the Long Term Home Health Care Program from $550 to $50. The Supreme Court, Erie County, held that the $50 allowance was unreasonable and not in compliance with federal law. The court ordered DSS to grant the $550 allowance and rebudget all class members from August 21, 1996.

The Appellate Division agreed that the $50 allowance was unreasonable but remitted the matter back to DSS to determine a reasonable allowance. $550 is the allowance granted to a single person in the program. The question to be determined is what is reasonable for a married person in the community.

The court gave several reasons for upholding the lower court's annulment of the $50 allowance:

1. The $50 does not cover the costs of a person residing in the community with a spouse. The spouse will be required to use a portion of her income allowance to make up the difference, thereby reducing the benefits of the community spouse income allowance to which the community spouse is entitled.
2. It is not reasonable to allot the same $50 allowance to a person living at home with a spouse and a person residing in a nursing facility. The expenses of the person in the facility are substantially lower and put a lesser burden on the spouse at home.
3. Prior to 1995, DSS did recognize the need to give the person in the community a larger allowance of $550.
4. Federal statute does not mandate a specific allowance but HCFA opinion letters, while granting that the allowance may be the same, state that the allowance must be an amount reasonable to cover costs in the community.

A Medicaid recipient appealed from a decision dismissing her appeal of a DSS denial of her transportation costs for her visits to Medicaid providers. Reversed. *Sharp v. De Buono*, __ A.D.2d __ (4th Dep't 2000).

DSS denied Ada Sharp's request for payment of her transportation costs incurred in traveling to her Medicaid providers. The Supreme Court, Erie County, dismissed her appeal.

On further appeal, the Appellate Division reversed. The court held that DSS can consider financial ability to pay but DSS must develop standards to apply to the determination of whether a recipient has the ability to pay. DSS determinations in this area are currently arbitrary and capricious and contrary to the State Administrative Procedure Act.

The petitioner had argued that DSS was in violation of federal law in considering her financial status in determining her eligibility for the transportation costs. The court found that the DSS decision to consider financial ability to pay was a reasonable interpretation of the regulations and therefore entitled to deference. Section 431.53 of 42 C.F.R., stating Medicaid will ensure all necessary transportation, has been held to mean that although transportation is ensured, payment is not required. Section 505.10(a) of 18 N.Y.C.R.R. states that payment will be made "only when payment for transportation expenses is essential in order for an eligible . . . recipient to obtain necessary medical care and services which may be paid for under the . . . program." The HCFA Manual says that if payment is made, it is to be for the least expensive suitable method.

DSS argued that its policy of considering essential expenditures of a recipient was a valid policy. The court disagreed, stating that DSS has not developed standards to determine which expenditures are essential and it has not filed its rules in this regard with the State as required under 18 N.Y.C.R.R. § 300.6.

Medicaid Recovery

The executor for the estate of a deceased Medicaid recipient's spouse appealed from an order to reimburse Medicaid. DSS cross-appealed for greater interest on the claim amount. *In re Klink*, __ A.D.2d __ (4th Dep't 2000).

Lois Klink was a responsible relative with "sufficient income and resources to provide medical assistance for" her husband while he was receiving Medicaid benefits. On her death, DSS sought reimbursement from her estate. The Surrogate's Court, Cattaraugus County, granted the claim and 6% interest from the date of the hearing. The executor appealed the order to reimburse Medicaid. DSS appealed the interest calculation.

The Appellate Division upheld the Medicaid claim for reimbursement. Mrs. Klink had sufficient resources and/or income at the time care was provided to her husband and had entered into an implied contract for reimbursement. The court held that the 6% interest rate from the date of the hearing was incorrect. The statutory interest rate is 9% and because the claim was based upon an implied contract, DSS was entitled to predecision interest. The matter was remitted to the Surrogate's Court to consider a proper calculation of interest at the 9% rate. The court suggested that the interest be calculated from each individual payment by Medicaid, or the recipient's death or some other reasonable date at which damages would be deemed to have occurred.

DSS appealed a decision that it could not recover from a refusing spouse because it did not have evidence of her ability to pay when the care was provided. Reversed. *Commissioner v. Fishman*, __ A.D.2d __ (1st Dep't 2001).

At the time her husband's application for medical assistance was approved, Mrs. Fishman had income exceeding the MMMNA by $537.48 and resources exceeding the CSRA by $421,807.59. DSS sent Mrs. Fishman letters requesting reimbursement with no response. Two months after Mr. Fishman died, DSS commenced an action for reimbursement. The Supreme Court, New York County, dismissed the complaint because DSS failed to state a valid cause of action. DSS did not plead the conditions precedent to the formation of an implied contract. Mrs. Fishman had successfully argued that, although DSS had her resource and income information at the time the application was approved, DSS had no evidence that she had excess income and or resources at the times that care was actually being provided. DSS appealed.

The Appellate Division reversed. Mrs. Fishman entered into an implied contract at the time that her husband's application was approved. She never responded to the letters sent by DSS to refute its claim for reimbursement. The holding in *In re Estate of Craig* was that DSS cannot recover if the spouse had insufficient means at the time care was provided. This does not require DSS to monitor resources and income beyond the application date.

Judith B. Raskin is a member of the law firm of Raskin & Makofsky, a firm devoted to providing competent and caring legal services in the areas of Elder Law, Trusts and Estates and Estate Administration.

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

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

Fair Hearing News

By Ellice Fatoullah and René H. Reixach

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

Copies of the Fair Hearing decisions analyzed above may be obtained by visiting the Web site of the Western New York Law Center, wnylc.com/Fair Hearing Database. The "keyword" for all of the decisions cited is "Trusts and Medicaid eligibility."

In re Appeal of K. M.

Holding

Ellice Fatoullah

Where the local agency determined a period of ineligibility for nursing facility services based on a transfer of assets, but the determination was made in conjunction with an application for coverage for services to which the transfer of assets rules do not apply, when the applicant subsequently seeks coverage for nursing facility services more than 36 months after the date of the transfer, the agency may not deny coverage for the nursing facility services.

Facts

In October, 1996, the appellant applied for personal care services. In conjunction with that application, the appellant disclosed that a transfer of assets had been made in March, 1996. The agency then requested documentation of the assets which had been transferred, and this was submitted. Later in October the appellant signed and submitted a Request for a Simplified Asset Review for Medicaid Eligibility. That Request indicated that with that review the appellant would not be eligible for nursing home services, and that if and when such services were applied for the appellant would then have to submit information about her assets for a period of up to 36 months.

The agency did not conduct a simplified asset review, but it issued a notice of decision dated March 12, 1997, which determined to provide personal care services at home, effective October 1, 1996, and to impose a penalty period of more than four years with respect to any services provided in a nursing facility. No fair hearing was requested with respect to that notice.

René H. Reixach

The appellant received Medicaid coverage for personal care services until she entered a nursing home in February, 2000. By notice dated March 27, 2000, the agency determined to discontinue Medicaid coverage based on its March, 1997 decision that she was ineligible to receive nursing home coverage for a period of several years which had yet to expire.

The appellant requested a fair hearing to review the March 27, 2000 decision.

Applicable Law

Section 366.5(d) of the Social Services Law and Section 360-4.4(c)(2) of 18 N.Y.C.R.R. (the "Regulations") govern transfers of assets made by an applicant or recipient on or after August 11, 1993. Generally a transfer of assets for less than fair market value made within or after the "look-back period" will render the person ineligible for nursing facility services. The "look-back period" is the 36-month period immediately preceding the date that a person receiving nursing facility services is both institutionalized and has applied for Medicaid. A person is institutionalized if a patient in a nursing facility, or in a medical facility receiving the level of care provided in a nursing facility, or if the person is receiving waivered services.

A transfer for less than fair market value, unless it meets an exception in the Regulations, will cause an applicant or recipient to be ineligible for nursing facility services for a period of months equal to the total cumulative uncompensated value of all assets transferred during or after the look-back period, divided by the average cost of care to a private

patient for nursing facility services in the region in which such person seeks or receives nursing facility services, on the date the person first applies or recertifies for Medicaid as an institutionalized person.

Fair Hearing Decision

The agency's determination to discontinue the appellant's Medicaid upon her request for Medicaid services in a nursing facility because a previously determined ineligibility period was still in effect is not correct and is reversed. The agency is directed to reevaluate the appellant's eligibility for Medicaid as of February, 2000, and if otherwise eligible, is to provide Medicaid in accordance with verified medical need.

Discussion

The record establishes that pursuant to the October, 1996 application, the agency determined a period of ineligibility based upon a transfer of assets, which it seeks to apply at this time as the appellant requests Medicaid while institutionalized. The record shows that when the agency originally determined a period of ineligibility, it had done so despite the fact that the appellant was not institutionalized at that time and had requested a simplified asset review, which specified that with said review the applicant would not be eligible for nursing home services, and that if and when nursing home services were applied for, the applicant must then submit information about her assets for a period of up to 36 months.

The agency acknowledged that despite appellant's written and submitted request, a full, rather than a simplified, asset review was conducted. The agency stated that this was done because information regarding the asset transfer was submitted. The record shows that this information was submitted because the agency requested it, after noting that the application provided information about a transfer. The agency explained that it actually only needed the information to ensure that the appellant did not own excess resources at the time of application.

The appellant contended that a period of ineligibility should not have been determined previously. The appellant contended that it is only at the time of institutionalization, as it coincides with an application for assistance, that a 36-month look-back period should be evaluated. The record shows that the appellant was institutionalized in February 2000 and that it was at that time that the appellant's daughter asked the agency to provide nursing home assistance. It is noted that a new application was not filed at that time as the appellant already had an open case.

The appellant's position is correct. The agency is to reevaluate appellant's request for assistance as of February, 2000, i.e., the date of institutionalization, and is to begin its look-back period then, without regard for any previously determined period of ineligibility.

Editor's Comment

This decision demonstrates that a substantial transfer of assets may result in an adverse decision by a local agency, even if there are no legitimate grounds for the decision. The mistake made by the applicant here was answering the questions on the application form about transfers of assets. Such questions are not relevant to the determination of coverage for non-waivered home care services such as those initially sought by the appellant in 1997.

The decision is clearly correct. The agency should not have made any determination about a period of ineligibility in 1997 since the application only concerned home care services. When the agency redetermined the appellant's eligibility in 2000 for nursing home services, that determination should only have considered transfers within 36 months prior to the date of institutionalization, i.e., back to February 1997. The 1996 transfers in question should not have been considered.

The appellant at this fair hearing was represent by Joan Robert, Esq., of Rockville Centre, New York.

In re Appeal of H. S.

Holding

Where funds are transferred from an IRA account owned solely by the institutionalized spouse to a joint bank account opened in the name of the community spouse and one child, a transfer of assets penalty may be imposed based on the value of the transferred account.

Facts

The appellant had been residing in a nursing home since April, 1999. The appellant and his community spouse had various bank and investment accounts owned in each of their names and jointly with a total value of $143,397.08. $30,312.68 was in accounts in the name of the appellant, $69,274.66 was in accounts in the name of the community spouse, and $43,809.74 was in their joint accounts. In September, 1999, the appellant's community spouse opened a joint checking account with their daughter. On September 30, 1999, $23,692.58 from the appellant's IRA was distributed and the check was deposited into the

new checking account owned by the community spouse and daughter on October 6, 1999. On October 13, 1999, $23,427.96 from a joint investment account owned by the appellant and his community spouse was transferred to an investment account which the agency determined to be owned jointly by the community spouse and their daughter.

A Medicaid application was submitted on November 10, 1999 seeking coverage back to August 1, 1999. On February 14, 2000, the agency determined to accept the application for Medicaid for August and September with a zero contribution; to deny coverage for the period from October 1, 1999 through January 31, 2000 for 4.47 months, or until February 1, 2000 with an excess of $2,500.58 for February 2000 on the grounds that there had been an uncompensated transfer of $23,692.58 on October 6, 1999. The notice further advised that the case would be reopened with a zero contribution effective March 1, 2000.

On February 29, 2000 a fair hearing was requested, and the only issue at that hearing was whether the agency had correctly determined that assets transferred to the community spouse were subject to a transfer penalty. By decision dated April 24, 2000 the agency was directed to redetermine eligibility. The decision advised that while transfers to the community spouse were not subject to a transfer penalty, transfers to joint accounts with the daughter had to be reviewed separately. That decision also found that the agency had failed to make a complete review of all resources and income of the couple in determining eligibility.

By notice dated May 17, 2000 the agency redetermined eligibility and advised the appellant that the three transfers totaling $62,734.92 made in October, 1999 to joint accounts listing the community spouse and daughter as joint owners were subject to a transfer penalty. Based on the daughter's share of the transfers, the agency determined that there had been an uncompensated transfer of $31,367.46 with a penalty period of 5.62 months effective November 1, 2000. The transferred amounts were determined to be the $23,692.58 from the appellant's IRA on October 6, plus transfers from a joint account of the appellant and community spouse to an account in the names of the community spouse and daughter on October 1 and October 20, 1999, totaling $16,454.95, and from a joint account of the appellant and community spouse on October 13, 1999 to an account in the name of the community spouse and daughter in the amount of $22,587.39. There was no explanation given for the inclusion of new transfers on October 1 and 20 or for the difference in the amounts stated for the October 13 transfer.

Another fair hearing was requested to review that determination, and at the hearing the appellant produced evidence showing that in July and August, 2000 the daughter's name had been removed from the accounts to which transfers had been made on October 1 and 20 and on October 13 (the accounts with initial deposits of $16,454.95 and $22,587.39). The agency agreed to reduce the penalty period to reflect an uncompensated transfer of $11,846.29 (1/2 of the $23,692.58 transfer from the IRA on October 6).

Applicable Law

18 N.Y.C.R.R. 360-4.10(c)(2) provides that resources held by the institutionalized spouse, the community spouse, or both, will be considered available to the institutionalized spouse to the extent that the value of the resource exceeds the maximum community spouse resource allowance. 18 N.Y.C.R.R. 360-4.10(c)(6) provides that after an institutionalized spouse is determined eligible for Medicaid, transfers by the institutionalized spouse to the community spouse will be permitted to the extent that the transfers are solely to or for the benefit of the community spouse and do not exceed the value of the community spouse resource allowance.

Administrative Directive 96 ADM-8 describes how to determine whether jointly held assets are considered available to an applicant or recipient on or after September 1, 1994. Section IV.1 of this Administrative Directive provides that the general rule is that joint property held by an applicant/recipient is considered available to the applicant recipient to the extent of his or her interest in the property. In the absence of documentation to the contrary, it is presumed that all joint owners possess equal shares. However, there are special rules for SSI-related applicants/recipients. In addition, with respect to an applicant/recipient who converts his or her assets into joint assets, OBRA '93 and Chapter 170 of the Laws of 1994 indicate when such a conversion constitutes a transfer of assets.

In accordance with SSI regulations (20 CFR 416.1208), as long as an SSI-related applicant/recipient is designated as the sole owner by the account title, the applicant/recipient is presumed to own all of the funds in the account, regardless of their source, and this presumption cannot be rebutted. If an SSI-related applicant/recipient is a joint owner, in the absence of evidence to the contrary, it is presumed that all of the funds in the account belong to the applicant/recipient. If there is more than one SSI-related applicant/recipient who is a holder of the joint account, it is presumed that the funds in the account belong to them in equal shares. To rebut this presumption, the SSI-related applicant/recipient

must submit a written statement, along with corroborating written statements from the other account holders regarding who owns the funds, why there is a joint account, who has made deposits and withdrawals, and how withdrawals have been spent. The applicant/recipient also must submit account records for the months for which ownership of funds is at issue and separate the funds owned by the SSI-related applicant/recipient from the funds of the other account holders.

Fair Hearing Decision

The agency's determination to limit Medicaid coverage, as modified at the hearing, due to a transfer of $11,631.29, is correct. The agency is directed to issue a modified notice reflecting the reduced penalty period based on the transfer of $11,631.29 in October, 1999.

Discussion

The only issue at the hearing is whether assets transferred from an account owned solely by the institutionalized spouse to a joint account opened in the name of the community spouse and one child was subject to a transfer penalty period based on 1/2 the value of the transferred asset. It was undisputed that on September 30, 1999, $23,692.58 was distributed from the appellant's IRA account and deposited to the joint checking account owned by the community spouse and daughter on October 6, 1999. The agency found that 1/2 of the assets in the account was presumed to be a gift to the daughter and imposed a transfer penalty.

At the hearing the appellant and the community spouse were not present; their appearances were waived by the attorney for the appellant. The appellant argued that the Banking Law and 96 ADM-8 create a presumption that the appellant intended to transfer the entire $23,262.58 to the community spouse. The agency determination is correct. Contrary to the argument made by the appellant, section 675 of the Banking Law creates a presumption that the opening of an account in the name of two persons, payable to either person or to the survivor, creates a joint tenancy. The joint tenancy vests each tenant with a present unconditional property interest in an undivided one-half of the money in the account.

While 96 ADM-8 at page 19 does indicate that there may be cases in which a joint tenancy is created for mere convenience, there is no evidence in this record to show that the joint account was created with this in mind. Absent such evidence, the legal presumption created by the Banking Law applies. In this case, the burden was on the appellant. His representative did not rebut the presumption that the institutionalized spouse transferred one-half of the $23,262.58 account to his daughter.

Editor's Comment

This case seems to be a case of the agency and the Department of Health having a double standard. Notwithstanding section 675 of the Banking Law, 96 ADM-8 sets forth a contrary rule that a joint account generally should be presumed to be an account of convenience, and cases computing the entire balance of such funds as resources of the applicant/recipient abound. 96 ADM-8 states at page 19, "Merely placing another person's name on an account or asset as a joint owner does not necessarily constitute a transfer of assets. The individual may still possess ownership rights to the account or asset and have the right to withdraw all of the funds in the account at any time."

Advocates should remember that there is now a statutory form for a joint account for convenience under section 678 of the Banking Law. Had this form of account been used in this case, the result should have been different.

The decision also points out the dangers of waiving any personal appearance, if not by the appellant or community spouse, at least by the daughter. While it is not discussed in the decision, the statement of facts and the Fair Hearing Summary submitted by the appellant indicate that in response to the May 17 decision that the October transfers from three accounts were uncompensated, the daughter's name was taken off two of the joint accounts with the community spouse to which the funds had been transferred. The failure of the appellant to present any evidence to explain why no change had been made to the third account could have been the basis for a finding that keeping the name of the daughter on one account was intended to vest one-half ownership of it in her.

What is not clear from the decision is why the appellant was ever eligible for Medicaid during the first few months for which coverage was granted. According to the decision, coverage was granted without dispute for August and September, and ultimately for October as well. Yet as of October 1, 1999 the appellant had the $23,692.58 proceeds from the IRA distribution and a share in the $23,427.96 joint account that was not transferred to the community spouse until October 13, plus a share in the $16,454.95 joint account that was not transferred to the community spouse until October 1 and 20. If one applies the presumption from the SSI rules relied on by the decision, at the very least the appellant had $43,634 of

resources on October 1. While post-eligibility transfers are permitted to bring the resources of the community spouse up to the community spouse resource allowance (here $74,820), the community spouse already had $69,274.66 in her own name on October 1, plus her share of $43,810 of joint accounts.

The appellant at this fair hearing was represented by David J. Starkey, Esq., of Lockport, New York.

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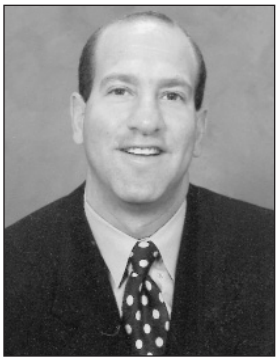
Legislative News

Update on Estate Tax Reform

By Howard S. Krooks and Steven H. Stern



Howard S. Krooks

There are now numerous proposals pending before the Congress to repeal or otherwise significantly alter the federal gift and estate tax. To date, only the House of Representatives has passed its version of reform. H.R. 8 provides for the ultimate repeal of the gift, estate and generation skipping taxes beginning the year 2010.[1] Until full repeal, the new law would be phased in over time as follows:

1. The Unified gift and estate tax exemption amount (currently the applicable credit) would be the same as it is today. That is, $675,000 is exempted for 2001. In the years 2002 and 2003, $700,000 is the exempt amount. In 2004, the exempt amount is $850,000 and $950,000 for the year 2005. In 2006, the amount would go to $1 million and would remain at that amount for the years 2007 through 2009.
2. At the same time, the gift and estate tax rates would be reduced. Under the new law, the top rate of 55% would be eliminated, as would the 5% surtax on large estates. The new top rate would be 53%. In the intervening years, the top rate would continue to decrease, to 53% for 2002, and then decreasing further every year by an additional 1% in 2003, 2004, 2005 and 2006. A 1.5% reduction would apply for each rate in 2007. Then, a 2% decrease would apply to rates in 2008 and 2009.
3. Under the proposal, a "carryover basis" would apply to estates after January 1, 2010. Some exceptions could apply:
   a. Income in respect of a decedent as defined in I.R.C. § 691.
   b. Property of the decedent to the extent that the aggregate adjusted fair market value of such property does not exceed $1,300,000 (this amount would be adjusted annually for inflation).
   c. Property passing to the surviving spouse that would have qualified for the marital deduction under I.R.C. § 2056 before enactment of the legislation to the extent such property passing to the surviving spouse does not exceed $3,000,000 (this amount would be adjusted annually for inflation).

Steven H. Stern

In February 2001, President Bush submitted his proposed budget, which provides for the repeal of the gift and estate tax. With the House on board, the issue will now be decided in the U.S. Senate. Some of the Senate proposals follow:

S.9—Working Family Tax Relief Act of 2001

This bill introduced by Senator Daschle, the Senate Minority Leader, increases the exemption amount of the unified credit:

2002-2006:	$1 million
2007-2008:	$1.125 million
2009:	$1.5 million
2010 and after:	$2 million

This bill would also increase the Qualified Family Owned Business deduction:[2]

2002-2006:	$1.375 million
2007-2008:	$1.625 million
2010 and after:	$2.375 million

The estate tax exemption amount and the QFOBI deduction would be coordinated as under the present system, and the surviving spouse could use any unused portion of the first spouse's QFOBI deduction.

S.31—Estate and Gift Tax Rate Reduction Act of 2001

Introduced by Senator Campbell, this proposal repeals the gift, estate and GST taxes for decedents dying after December 31, 2001 and all property would receive a step-up in tax basis.

S.35—Tax Cut With a Purpose Act of 2001

Senators Gramm, Kyl, Miller and others introduced this proposal which would repeal all estate, gift and GST taxes after 2009, and all property passing would continue to receive a step-up in tax basis. The applicable rates would decrease by five percentage points each year through 2006, and then by ten points in 2007 and 2008.

Senator Lugar of Indiana has certainly hedged his bets. He has three proposals as follows:

S.82—Estate and Gift Tax Repeal Act of 2001

This legislation would repeal all gift, estate and GST taxes as of the date of enactment, with a full step-up in tax basis for all property passing.

S.83—Estate and Gift Tax Phase-Out Act 2001

The gift, estate and GST tax would be eliminated by 2007 as follows:

2002:	$1 million
2003:	$1.5 million
2004:	$2 million
2005:	$2.5 million
2006:	$5 million
2007:	Elimination

S.84—Farmer and Entrepreneur Estate Tax Relief Act of 2001

This proposal retains the current tax system, but increases the unified credit exemption amount to $5 million in 2002 and thereafter.

S.179

Introduced by Senator Dorgan, this bill increases both the applicable exemption amount and the QFOBI as follows:

2001-2002:	$1 million
2003-2004:	$1.125 million
2005:	$1.5 million
2006 and after:	$2 million

The QFOBI would be increased significantly:

2001:	$2.375 million
2002:	$4.375 million
2003:	$6.375 million
2004:	$8.375 million
2005 and after:	$9.375 million

The applicable exemption amount and the QFOBI deduction would coordinate as under the present system until 2006. However, thereafter the exemption amount and the QFOBI would no longer be coordinated. Thus, an estate would have a separate deduction for qualified family-owned business interests as well as the maximum unified credit for the year of death. In addition, this proposal would allow the surviving spouse to use an unused portion of the first spouse's QFOBI deduction.

S.275—Estate Tax Elimination Act of 2001

This proposal, introduced by Senators Kyl, Breaux, Gramm, Lincoln and others repeals the gift, estate and GST tax system as of the date of enactment. A carry-over basis system would be created, except that an executor could step up the decedent's property by an amount not exceeding the greater of $2.8 million or the total fair market value of the decedent's property, adjusted annually for inflation. Also, property of the decedent that receives a carryover basis would be determined under the present gift tax system.

With so many different proposals in the Senate, it is still unclear whether the ultimate result will be repeal, or significant reform. However, it is clear that the U.S. Senate now controls the destiny of the gift and estate tax system. Elder law attorneys and our clients will have to wait a while longer to see what happens and how to proceed with planning.

Endnotes

1. *See* Death Tax Elimination Act of 2000.
2. I.R.C. § 2057.

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Regulatory News

Chapter Two: Social Security Administration Issues New Guidelines on Treatment of Trusts for SSI Recipients

By Louis W. Pierro and Edward V. Wilcenski

Louis W. Pierro

Edward V. Wilcenski

Readers may recall the Winter 2001 issue of the *Elder Law Attorney* wherein we wrote about the Social Security Administration (SSA) release of Transmittal No. 13 (SSA Pub. No. 68-0501150). The Transmittal was released shortly after the passage of the Foster Care Independence Act of 1999 (FCIA) which, in part, reinstated the transfer of the asset penalty for applicants and recipients of Supplemental Security Income (SSI) benefits. The new law is effective for gifts made on or after December 14, 1999, and for trusts "established" after January 1, 2000. "Uncompensated transfers" (a familiar term for elder law practitioners) had not been subject to penalty under the SSI program since 1988.

"The new rules also invite confusion because some of the terms contained in the new SSI rules are identical to those found in the Medicaid penalty provisions, but they are interpreted differently by the SSA."

The new transfer of asset rules were quite familiar to most elder law practitioners, as they incorporated many of the same rules and exceptions found in the transfer penalty provisions of the Medicaid program (for example, exceptions for transfers to or for the benefit of a disabled child, transfers of the homestead to selected individuals, etc.). Also included within the transfer penalty exception provisions were transfers to First-Party Supplemental or Special Needs Trusts (SNTs) established pursuant to 42 U.S.C. § 1396p(d)(4)(A) or (C). Practitioners had been waiting for the SSA to release more detailed instructions on how it would be reviewing these and other types of trusts within the framework of the new law. In February 2001, SSA released Transmittal No. 35 (SSA Pub. No. 68-0501120), which lays out the guidelines for SSI treatment of trusts that are "established" after January 1, 2000. The Transmittal obsoletes prior Emergency Transmittals EN-99143 and EN-00067, and affects subchapter 20 ("Identifying Resources") of chapter 011 ("Resources") of Part 05 of the Program Operations Manual System (POMS) governing the Supplemental Security Income program.

As a matter of general observation (or, more appropriately stated, in the writers' opinion), while the Transmittal does attempt to provide a working framework for the treatment of trusts under the new SSI rules, it also contains some ambiguities and other somewhat confusing cross references that will need to be clarified by the SSA or resolved through the appeals process. The new rules also invite confusion because some of the terms contained in the new SSI rules are identical to those found in the Medicaid penalty provisions, but they are interpreted differently by the SSA.

Note that the new rules only apply to trusts that are "established" (more on the term "established" in a moment) after January 1, 2000, and can be found in significant part at SI 01120.201-204; for trusts established prior to January 1, the former rules found at SI 01120.200 continue to apply. Following find what we believe to be some highlights (and some low points) in the new POMS. Citations beginning with the letters "SI" refer to the SSI section of the POMS:

1. "Medicaid Trust" Equals First-Party SNT

In SI 01120.203, the POMS use the term "Medicaid Trusts" to describe First-Party Supplemental or SNTs authorized under 42 U.S.C. §§ 1396p(d)(4)(A) and (C), otherwise known as "exception trusts" or "payback" trusts by those familiar with the Medicaid program rules governing exempt transfers of assets by applicants/recipients of institutional or waivered Medicaid services. Just as in the Medicaid program, the new SSI provisions exclude transfers to a Medicaid Trust from penalty as an uncompensated transfer. Later on in § 203(B), it clarifies that "although this exception is commonly referred to as the 'special needs' trust exception, the exception applies to any trust meeting [the requirements for a valid § (d)(4)(A)

or (C) trust]," and does not have to be an SNT. One is led to wonder how frequently the substantive elements of § (d)(4)(A) or (C) would be used in trusts that are *not* SNTs.

In any event, the SSA's use of the term "Medicaid Trust" may initially give rise to some confusion. In the parlance of the elder law practitioner, the Medicaid Trust most commonly refers to an irrevocable, income-only trust that is used as a means of preserving assets in anticipation of Medicaid coverage. The grantor reserves the right to receive all income from the trust, and in many cases a limited power to appoint the remainder, usually by will. The full value of assets transferred to this type of trust are subject to penalty, notwithstanding the fact that the grantor retains an interest in the transferred property that might otherwise warrant reducing the transfer value by the retained income interest. This treatment derives in part from HCFA State Medicaid Manual, Transfmittal 64, § 3259.6(C).

Under the new SSI rules, a transfer to an irrevocable, income-only trust (here we are referring to the elder law practitioner's Medicaid Trust, and *not* a traditional First-Party SNT) would similarly generate a period of ineligibility for SSI.[1] The POMS appear to adopt the HCFA position that in determining the fair market value of transfers to this type of trust, there should be no reduction for the present value of the retained income interest: "In determining the value of the transfer, do not subtract the value of any disbursements made after the date determined above."[2]

2. "Establishment" Breeds Confusion

One issue that has drawn the attention of practitioners reviewing the new POMS provisions is the apparent inconsistent use of the term "establish." In § SI 01120.201(B), "Definitions," the POMS state that "an individual is considered to have established a trust if any assets of the indiviudal (or spouse), regardless of how little, were transferred to a trust other than by will." Read plainly, the term "establish" is used to describe the act of transferring income or resources to a trust. In other words, "establishment" equals "*funding.*" The term "established" is used in this context in various subsections of the new rules.[3]

With this in mind, consider how the new POMS explain how a trust is to meet the criteria[4] regarding exception trusts "established" by a grandparent, parent, guardian or court:[5]

> Under the special needs trust exception, the trust must be established for the benefit of the disabled individual.[6]
>
> To qualify for the special needs trust exception, the trust have been established by the disabled individual's parent(s), grandparent(s), legal guardian(s), or a court. The special needs trust exception does not apply to a trust established by the individual himself/herself. The person establishing the trust must have legal authority to act with regard to the assets of the individual. An attempt to establish a trust by an individual without the legal right or authority to act with respect to the assets of the individual may result in an invalid trust. *Note: This requirement refers to the individual who physically took action to establish the trust even though the trust was established with the assets of the SSI claimant/recipient.* (emphasis added).[7]

We think it fair to say that in order to read these rules consistently with the accepted treatment of First-Party Supplemental or SNT under the Medicaid program, the term "establish" is being used to mean two different things: first, to describe the act of initiating the trust transaction and executing the trust instrument, and second, the act of funding the trust. Nonetheless, we're betting that this language will on occasion lead to much merriment at the application level. Our recommendation would be to adopt the practice and treatment of the Medicaid program when establishing and funding these trusts, at least until there is some further clarification on the matter.

3. Other Points of Interest

- Testamentary trusts are not affected by the new rules, although to the extent assets of the SSI recipient are added to a testamentary the trust established under someone else's will, a transfer penalty may apply.[8]
- The rules appear to foreclose using a First-Party SNT to exempt many different types of income when determining SSI eligibility, including Social Security Disability Insurance payments and certain pension payments.[9]
- In the Winter 2001 article, we anticipated the release of the new POMS regarding trusts to see how the SSA would define trusts established "for the sole benefit" of another. Our question concerned whether a transfer by an SSI recipient to a *Third-Party* SNT established for the lifetime benefit of a disabled individual *other than* the SSI recipient (and which did not

include a payment in favor of the State upon death) would be considered an exempt transfer under the SSI program rules. Apparently so, according to SI 01120.201(F)(2).

The rules are new and quite lengthy, and time will tell how some of the provisions mentioned above will be interpreted. It will be interesting to see how the new rules governing transfers and trusts will be implemented at the application level, especially now that the SSA must conduct the same three-year audit of financial records with which elder law practitioners are so familiar.

Endnotes

1. SI 01120.201(E).
2. SI 01120.201(E)(1)(a).
3. See, for example, SI 01120.201(E)(1)(a); 201(D)(2)(c) (example 3).
4. 42 U.S.C. § 1396p(d)(4)(A).
5. SI 01120.203(B)(1).
6. SI 01120.203(B)(1)(d).
7. SI 01120.203(B)(1)(e).
8. SI 01120.201(B)(6, 7); (C)(2)(a).
9. SI 01120.201(J)(1)(c).

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Practice News

Expanding the Elder Law Planning for Younger People with Disabilities

By Vincent J. Russo

Elder law, elder law and elder law—What does it mean to practice *elder law?* This is a question we raise today and it was a question raised by the founding members of the National Academy of Elder Law Attorneys (NAELA) in the mid-1980s. The NAELA pioneers raised that question in the context of identifying the field of practice—attorneys serving the needs of the elderly and *people with disabilities*. Well, we know the ending to that story, or do we? The identification issue continues to concern elder law attorneys as they expand their practices by serving people *as they age!* In my view, a wonderful progression!

Defining the Elder Law Practice

I agree with this latest thinking. This means that the practice is never constant because the needs of people as they age are changing and evolving. Let's look at one of the main ingredients of today's elder law practice: estate and long-term care planning. The practitioner must have a knowledge of trust and estate laws, tax law and guardianship law as well as a working knowledge of government benefits and housing options. As we gain additional knowledge as to the particular needs of younger people with disabilities (people under 65), we will be able to broaden our practices and services.

Special and Supplemental Needs Trusts (SNTs)

What will the elder law attorney need to know? First, the world of government benefits must include not only Medicare and Medicaid, but Supplemental Security Income (SSI)[1] and Social Security Disability Income (SSDI). This is not news to the elder law practitioner. In 1993, the federal government enacted OBRA '93[2] which included the advent of Special Needs Trusts.[3] With this enactment, elder law attorneys were ideally suited to represent people under 65 who are disabled.

Along with the establishment of these trusts, the elder law attorney must have an understanding and a working knowledge of SSI and SSDI. Depending upon the terms of the Special Needs Trust and, in particular, the discretion of the trustees to make payments to or for the beneficiary, SSI benefits could be affected.

This is not our first connection with younger people with disabilities. We must look to *In re Escher*[4] as to the right of an individual to set up a SNT for a beneficiary who is disabled. Yes, we relied on *Escher* as the basis for the establishment of a SNT under the will of one spouse, and for the benefit of a surviving spouse who was disabled. The use of Third-Party SNTs proliferated when New York legislated its use with the enactment of EPTL 7-1.12 in 1993.

Government Benefits

As elder law attorneys, we have been trained and have experience with Medicare and Medicaid benefits. Our approach to those laws and regulations can also be employed when dealing with SSI and SSDI. This is certainly true with the Medicaid law which is based upon Social Security law. We are in the best position to understand, analyze and advise our clients as to the new SSI rules, including Transfer of Assets and the Establishment of Special Needs Trusts. We have an advantage in advising our clients because we understand the interrelationship of SSI and Medicaid. For example, now that there are transfer penalty rules for SSI, we can use our working knowledge of the Medicaid laws and apply them to planning for SSI benefits.

When implementing Medicaid planning, seniors can take advantage of the exempt transfer provisions which allow transfers to a child with disabilities without incurring a penalty period for Medicaid nursing home care. At the same time, the transfer may disrupt the child's eligibility for SSI and Medicaid. A "Sole Benefit Trust" may offer a solution to the problem. Here's where the elder law attorney is in a position to use his/her experience and expertise in Medicaid planning. This benefits the family regarding the most protective plan for the needs of both the senior and the child with disabilities.

Guardianships

As elder law attorneys, we are experienced in dealing with capacity issues and Article 81 guardian-

ship proceedings. We deal with capacity issues all the time, and when an individual is incapacitated, we consider commencing an Article 81 for the appointment of a guardian of the person and of the property.

With younger people or children with disabilities, we need to familiarize ourselves with Article 17-A of the Surrogates Court Procedure Act[5] which allows for the appointment of a guardian for a person who is developmentally disabled, mentally retarded or suffering from a traumatic head injury.[6] Article 17-A is available for such individuals providing their disability began before such individual became 22 years of age, with the exception of those with traumatic brain injury for whom there is no age limitation. With our knowledge of Article 81, we are in the best position to advise our clients of the option between Articles 81 and 17-A proceedings.

Housing Options

When representing seniors, we are involved with advising seniors as to housing options. In the old days, there were simply two options—you lived at home or with your family or you were placed in a nursing home. Today, there are many choices and we have responded to the needs of seniors by advising them of new housing options. Younger people with disabilities have many housing options as well. For example, there are independent living arrangements, group homes and supportive living arrangements.

Estate Planning

Here, there are two levels of planning required. We must first implement an appropriate estate plan for the younger person with disabilities. If that individual has the requisite capacity, then durable powers of attorney, health care proxy, living will and a last will and testament are appropriate. If not, then a guardianship proceeding should be commenced for the younger person if he/she is 18 or older, or if he/she has his/her own assets, regardless of age.

The second level is implementing appropriate estate planning for the family of the younger person with disabilities, in particular the parents. The use of Third-Party SNTs is essential in providing for the younger person, while maximizing government benefits. This planning approach would be similar in concept to using a Third-Party SNT under a will for a surviving spouse, except that this trust can be set up as a living trust or under a will.

Practice Environment

As elder law practitioners, we have set up our offices with the goal of serving seniors with disabilities and their families. We have trained our staff to be sensitive to people with disabilities, and we have made ourselves available for home visits. Therefore, we are prepared to represent younger people with disabilities.

Expanding Our Elder Law Practices

We have all the tools we need to expand our services to *people as they age*. We have made a commitment to helping people in need. As elder law attorneys, we have perhaps put ourselves in a box—which may limit how people see our services. Elder law implies planning for older people. Yet, it often involves persons with disabilities *who happen to be elderly*. Take the next step: become familiar with the nuances of the laws which affect younger people with disabilities; understand their needs and represent them.

Endnotes

1. 42 U.S.C.A. §§ 1381, *et seq.*
2. Omnibus Budget Reconciliation Act of 1993, PL 103-66, August 10, 1993, 107 stat. 312.
3. 42 U.S.C.A. § 1396p(d)(4)(B)(ii).
4. 94 Misc. 2d 952, 407 N.Y.S.2d 106 (Sur. Ct., Bronx Co. 1978), *aff'd*, 75 A.D.2d 531, 426 N.Y.S.2d 1008 (1st Dep't 1980), *aff'd*, 52 N.Y.2d 1006, 438 N.Y.S.2d 293, 420 N.E.2d 91 (1981).
5. SCPA 1750, *et seq.*
6. SCPA 1750-a3.

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Tax News

Some Tax Issues Which Affect Disabled Persons and Their Families

By Ami S. Longstreet and Anne B. Ruffer

Introduction

Ami S. Longstreet

Numerous tax issues should be considered when counseling families of persons with disabilities. There are certain credits, deductions, and other beneficial treatment to which a disabled person or his/her family may be entitled for income tax purposes. Furthermore, certain informal care arrangements between family and non-family members of a disabled individual may trigger transfer tax consequences. Finally, the use of trusts, in order to benefit a disabled individual, particularly Supplemental Needs Trusts (SNTs), creates several income and transfer tax issues which will be examined below.

Favorable Exemptions and Deductions

A personal exemption deduction may be available for a taxpayer who supports a disabled person, even if the disabled person is not the taxpayer's child, and even if the disabled person is no longer a minor. However, the disabled person's income must not exceed the exemption amount, $2,900 in 2001 (up from $2,800 in 2000).[1] Furthermore, the taxpayer must be related to the disabled person in any one of the following categories: (1) son, daughter, stepchild, grandchild, or adopted child; (2) sibling, half-sibling, or step sibling; (3) parent, ancestor, or stepparent; (4) niece or nephew; (5) aunt or uncle; (6) certain in-laws; or (7) a non-spouse who lives in the taxpayer's home for the entire year and is a member of the taxpayer's household.[2]

Another form of tax assistance may be available to an unmarried taxpayer who houses a disabled individual (for more than half the year) in his/her home. More favorable "head-of-household" tax rates are available for a qualifying taxpayer if he/she is "related" to the disabled person under any of the above categories (1) through (6) required of a taxpayer claiming a dependent exemption for a disabled person of any age.[3] If the disabled person's relation to the taxpayer is only category (7) above, then the taxpayer cannot take advantage of the head-of-household tax rate status.[4] In other words, an unmarried parent or other relative who provides a home and substantial support for a disabled individual may qualify for head-of-household status.[5]

Furthermore, taxpayers who pay for the medical expenses of a disabled individual may be entitled to include those expense items in calculating their medical expense deductions. In general, a taxpayer who itemizes his/her deductions is entitled to a deduction for medical expenses exceeding 7.5% of the taxpayer's adjusted gross income. The medical expenses are those not only for the taxpayer and the taxpayer's spouse, but also for his/her dependents.[6] In addition to those "regular medical expenses" which may be used in aggregating expenses in order to utilize the medical expense deduction, those expenses which are incurred by a taxpayer who supports a dependent disabled person as mentioned above may also be deductible by the taxpayer who itemizes. Such deductible amounts incurred by or on behalf of a disabled individual may include costs for special schooling for a physically or mentally handicapped child, including those needing psychiatric treatment,[7] and may include amounts paid to acquire, train, and maintain guide dogs or other service animals for persons who are blind, deaf, or physically disabled.[8]

Anne B. Ruffer

Also, certain "qualified long-term care services" provided to a dependent with a disability may be considered "medical care" and may be taken into consideration by the taxpayer in calculating medical expenses.[9] Qualified long-term care services include necessary diagnostic, prevention, therapeutic, curing, treating, mitigating, and rehabilitative services and maintenance or personal care services, which are required by a "chronically ill individual" and are prescribed by a "licensed health care practitioner."[10]

Where an individual is not otherwise claiming the disabled individual as a dependent, as set forth above, nor mandated by a duty of support or court order to provide support to a disabled individual, the taxpayer paying such expenses may be subject to gift tax liability if the support provided exceeds the annual gift tax exclusion amount.[11] However, the taxpayer may pay certain medical and education expenses directly to the provider, with no gift tax consequences regardless of the amount.[12] An individual may pay unlimited amounts for doctors' bills, hospital and nursing bills, medical insurance, and other health care expenses for another individual regardless of the relationship between the payor and the recipient of the medical care, as long as (1) such payments would be deductible under the Internal Revenue Code (the "Code") § 213

(medical expense deductions) and are paid directly to the service provider and (2) the payments are not reimbursed by insurance.[13]

This same taxpayer may also pay for the tuition of a disabled individual by paying tuition directly to the provider in order to avoid gift tax consequences.[14] In the case of a disabled individual, the tuition payment exclusion may even include payments made to certain institutions, such as nursery, pre-school, or day-care providers that run specialized programs for disabled individuals. The institution must normally maintain a regular faculty and curriculum, have regularly enrolled pupils or students in attendance where the educational activities are regularly carried on, and its primary function must be formal instruction.[15] Unfortunately, other payments made to support the disabled individual by a taxpayer who has no legally enforceable obligation to support a disabled individual will be considered taxable gifts unless they fall within the annual gift tax exclusion.[16] It should be pointed out that in developing a plan for paying tuition, the taxpayer should keep in mind that if he/she transfers funds to a trust that authorizes the trustee to pay tuition expenses incurred by a trust beneficiary, the transfer is not a direct transfer to an educational organization and therefore will not qualify for the exclusion for the payment of educational expenses.[17]

Tax Issues Regarding SNTs

Individuals concerned with the care and well-being of a disabled person will frequently create a special type of trust referred to as a Supplemental or Special Needs Trust (SNT) for the benefit of a disabled individual. This type of trust is different from a support trust in which the trustee is to pay for the beneficiary's support. A support trust may jeopardize the disabled beneficiary's eligibility for need-based government benefits. An SNT, on the other hand, is meant to supplement, not supplant, governmental benefits otherwise available to a disabled beneficiary.

An SNT may be created with the disabled individual's own assets or assets from a third party. The former SNT is oftentimes referred to as a self-settled trust. The latter is a third-party SNT which is funded with the assets of someone other than the disabled individual. The self-settled SNT is also distinguishable from the third-party SNT in that any assets remaining in the trust upon the death of the disabled beneficiary will be used to pay back the state in an amount equal to the total medical assistance paid on the beneficiary's behalf.

There are several tax issues which arise when a disabled individual is a beneficiary of an SNT. SNTs, like other trusts, are subject to applicable income tax rules, as well as gift and estate tax rules. Who is taxed on the income of an SNT depends on whether the SNT is a grantor trust or not.

In general, when an SNT is drafted, the trust income and principal are restricted so that they are only available for use by the disabled trust beneficiary within the discretion of a trustee. This type of trust may be established either by a testamentary or *inter vivos* instrument. Either way, the trustee is directed to pay only for those items or services not otherwise available through governmental benefits. Once the SNT is funded, income will be earned by the trust through interest and dividends. The question becomes, who pays the tax? The trust or the disabled individual?

Tax rates applicable to trusts are far more compressed than those applicable to individuals.[18] Thus, if the income is taxed to the trust, the trust will be taxed at the highest tax bracket of 39.6% on taxable income of only $8,900 for the year 2001. But, the 39.6% rate does not apply to an individual until his/her income exceeds approximately $288,350.[19] Therefore, from a tax planning perspective it may be beneficial for the tax to be reported by the disabled individual, rather than the SNT itself.

In order to have the income earned in the self-settled SNT attributable to the disabled individual rather than the SNT, the trust must be considered a "grantor trust."[20] Generally, a grantor trust is a trust in which a person keeps some level of control or interest in the trust, thereby causing the grantor to be treated as the owner of the trust property.

Some ways in which to ensure that a self-settled SNT is considered a grantor trust would be to draft a clause which allows the disabled individual an unrestricted power to remove, substitute or add trustees and to designate any person as the replacement trustee.[21] Alternatively, if the trust provides that the disabled individual is able to reacquire some of the property of the SNT by substituting other property of equal value, the SNT income will be taxed to the disabled individual.[22] Additionally, the Internal Revenue Service applied grantor trust status to a trust funded with monies from a personal injury settlement for the benefit of a minor because the trustee had the authority to distribute or accumulate the income to the minor without the approval or consent of any adverse party.[23]

SNTs created by a third-party grantor are usually not grantor trusts. In other words, a third-party donor-grantor creates an *inter vivos* trust when he/she makes a completed gift of assets to an SNT and does not retain any grantor trust powers.[24] Therefore, the income earned in third-party SNT is taxed to the trust at the trust tax rates. However, if the grantor of a third party SNT desires grantor trust treatment, the same drafting provisions as set forth above would apply with respect to the third party. The donor, in that case, would be responsible for the trust's income tax obligations. Alternatively, an SNT third-party donor-grantor

may gift grantor trust powers to the SNT disabled beneficiary in order to tax the income to the disabled beneficiary. Under either circumstance, the planner will need to consider tax, as well as the non-tax consequences of bestowing grantor trust status on a third-party SNT.

A separate tax identification number (TIN) should be obtained for an SNT. In the case of a self-settled grantor SNT, the SNT should still obtain a separate TIN, even though the income is taxed at the disabled beneficiary's rates. In that case, the trustee files a Form 1041 informational return and then sends the necessary information to the disabled beneficiary for inclusion on the beneficiary's Form 1040. In the case of a non-grantor SNT, the trustee of an SNT is required to report income earned on Form 1041.

In the case of a third-party SNT with grantor trust status where the income is taxed to the third party, if the third party is in the highest tax bracket, whether or not the trust income is taxed to the grantor or the trust makes no difference. However, if the grantor's rate is lower than the trust tax rate, it may be beneficial for income tax purposes to try to establish grantor trust status. This type of trust would tax trust income at the grantor's income tax rate but the trust would still be excluded from the grantor's estate at death, assuming a completed gift was made upon funding of the trust. This type of trust is known as a "defective" grantor trust.[25]

Conclusion

It is clear that there are numerous unique tax issues applicable to a disabled individual. Will a taxpayer be able to take advantage of a personal exemption deduction for a disabled person? Can the taxpayer consider himself/herself eligible to receive "head-of-household" tax status? Are there expenses of the disabled individual paid for by a taxpayer which are expenses which may be specific to the disabled individual's care and which may be included in the "medical expense" deduction calculation? Will a taxpayer be subject to a gift tax for providing "too much support" to a disabled individual? Will it be most beneficial to have the income of the SNT taxed to the disabled person, third-party grantor, or the trust itself? Finally, what are the gift tax consequences of an *inter vivos* SNT? Hopefully this article has provided some insight into the answers to these questions.

Endnotes

1. *See* Internal Revenue Code of 1986 as amended (I.R.C.) § 151(c)(5). This section permits the exclusion of certain income of disabled individuals, such as income earned in certain types of sheltered workshops; *see also* CCH 2001 U.S. Master Tax Guide, paragraph 133.
2. I.R.C. § 152(a).
3. *See 2001 U.S. Master Tax Guide*, CCH for overview of 2001 tax rates.
4. I.R.C. § 2(b).
5. I.R.C. § 2(b); I.R.C. §152(b).
6. I.R.C. § 213(a).
7. Rev. Rul. 58-280 1958-1 CB 157.
8. PLR 8033038; *see* Rev. Rul. 68-295 1968-1 CB 92; Rev. Rul. 68-212, 1968-1 CB 91; Rev. Rul. 63-91, 1963-1 CB 54; Rev. Rule 58-280, 1958-1 CB 157; Rev. Rul. 57-461, 1957-2 CB 116; Rev. Rule 55-261, 1955-1 CB 307, *modified by* Rev. Rul. 58-8, 1958-1 C.B. 154.
9. I.R.C. § 213(d)(1)(c).
10. I.R.C. § 7702(B)(c)(1). A "chronically ill individual" includes persons who by reason by illness or disability cannot perform at least two activities of daily living without substantial assistance, e.g., eating, toileting, transferring, bathing, dressing and continents, or who require substantial supervision to protect them from threats to health and safety due to severe cognitive impairment.
11. I.R.C. § 7702(B)(c)(2). "Maintenance or personal care services" are defined as "any care the primary person of which is the provision of needed assistance with any of the disabilities" that make the individual "chronically ill individual."
12. I.R.C. § 2503(e).
13. I.R.C. § 2503(e)(2)(B).
14. I.R.C. § 2503(e)(2)(A).
15. Rev. Rul. 78-446, 1978-2 C.B. 257.
16. I.R.C. § 2503(b).
17. Regs. § 25.2 2503-6(b)(2); Regs. § 25.2503-6(c), example 2.
18. *Compare* I.R.C. §§ 1(a)-1(d) to I.R.C. § 1(e).
19. *Id.*
20. I.R.C. §§ 671-677.
21. I.R.C. § 674; 26 C.F.R. § 1.674(d)-2.
22. I.R.C. § 675.
23. I.R.C. § 677(a); Rev. Rul. 83-25, 1983-1 C.B. 116.
24. I.R.C. §§ 671-678.
25. I.R.C. §§ 671-677 and 679.

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Health Care Continuum News

Evaluating a Resident's Transfer or Discharge from a Nursing Home

By Ellyn Kravitz and Ari J. Markenson

Introduction

Ellyn Kravitz

On April 25, 2001, the New York State Department of Health (DOH) issued a "Dear Administrator" letter (DAL #01-02) to nursing home administrators regarding the applicable regulatory requirements for transferring or discharging residents. This letter seeks to remind nursing home administrators of a prior "Dear Administrator" letter which was issued on August 15, 1997, which changed the DOH's policy with regard to the requirements for nursing homes in transferring or discharging a resident.

The recent letter is important to elder law practitioners in that it reminds administrators of the applicability of the regulatory requirements to situations in which residents are admitted for short-term stays. The April 25 letter reiterates an interim policy for nursing homes and also specifically provides that a nursing home may not (1) enter into a discharge plan upon admission; (2) seek to specify a date of discharge based upon a third-party payer's liability for payment; or (3) seek to discharge a resident who has completed his/her rehabilitation but still needs nursing home care. While each of these issues has been covered by applicable regulation, residents admitted to nursing homes for short-term stays have received varying degrees of assistance and explanation with respect to potential discharge or transfer.

In order to advise clients, practitioners should be aware of resident right requirements set forth in 10 N.Y.C.R.R. §§ 415.3(h) and 415.11(d) and two "Dear Administrator" letters mentioned. The August 15, 1997 letter primarily revised the requirements of 10 N.Y.C.R.R. § 415.3(h). The changes in policy set forth in the letter became effective as of September 1, 1997 and continue to remain in effect until the Department revises the regulation.

The "Dear Administrator" letters and several sections of the N.Y.C.R.R. dictate the requirements for nursing homes in transferring or discharging a resident. A discharge summary is required to be prepared, by 10 N.Y.C.R.R. § 415.11(d), when a facility anticipates discharge. The August 15, 1997 letter and 10 N.Y.C.R.R. § 415.3(h) describe reasons for discharge and technical requirements to facilitate a transfer and discharge of a resident from a nursing home. However, none of these apply to an intra-facility room transfer.

In general, a facility must undertake a transfer or discharge "in recognition of the resident's rights to receive considerate and respectful care, to receive necessary care and services, and to participate in the development of the comprehensive care plan and in recognition of the rights of other residents in the facility."[1]

There are three major requirements that a facility must comply with when contemplating a transfer or discharge. The facility must prepare and retain the correct documentation, issue a discharge notice and transfer or discharge according to the permissible regulatory reasons.

Documentation Requirements in the New York State Regulations

According to 10 N.Y.C.R.R. § 415.11(d), a facility is required to prepare a discharge summary when it anticipates discharging a resident. The summary must contain:

1. A recapitulation of the residents stay.
2. A summary of the residents status which includes comprehensive assessment information described in 10 N.Y.C.R.R. § 415.11(a)(2).
3. A post discharge plan of care which will assist the resident in their new living environment and assure that needed medical and supportive services have been arranged and are available to meet the needs of the resident.

Additionally, the facility must "ensure complete documentation in the resident's clinical record when the facility transfers or discharges a resident" according to 10 N.Y.C.R.R. § 415.3(h)(1)(ii). The proper documentation required by this regulation must be made by:

1. The resident's physician and interdisciplinary care team, as appropriate, when transfer or discharge is necessary because of the following circumstances:
   a. the resident's needs cannot be met by the facility;
   b. the resident's health has improved so that he/she does not need nursing home services.
2. A physician when transfer or discharge is necessary due to the endangerment of the health of other individuals in the facility.

Reasons for Discharge in the New York State Regulations

According to 10 N.Y.C.R.R. §§ 415.3(h)(1)(i)(a)-(c) "the resident may be transferred only when the interdisciplinary care team, in consultation with the resident or the resident's designated representative" has determined that one of the following six reasons for transfer or discharge has been satisfied:

1. The resident's needs cannot be met by the facility.
2. The resident's health has improved so that he/she does not need nursing home services.
3. The safety of individuals in the facility is endangered.
4. The health of individuals in the facility is endangered.
5. The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid for by Medicaid, Medicare) his/her stay in the facility. Practitioners should note: a facility cannot discharge for this reason if the resident has a Medicaid appeal pending, or a charge is in dispute.
6. Closure of the facility.

Notice Requirements in the New York State Policy and Regulations

According to the August 15, 1997 DOH letter, if a facility can meet one of the articulated reasons for discharge, it can then only discharge or transfer a resident if it issues a valid discharge notice. The notice must be made to both the resident and resident's representative where applicable. In addition the notice must contain the following information:

1. Date of notice;
2. Resident's identity;
3. Effective date of proposed discharge or transfer which must be 30 days from date of notice unless:
   a. the safety of residents is endangered;
   b. the resident's health has improved such that he/she no longer needs services and a more immediate discharge is appropriate;
   c. the resident's urgent medical needs require an immediate transfer or discharge;
   d. the resident has not resided in the facility for at least 30 days.
4. Location where the resident is to be transferred or discharged to.
5. Reason for proposed discharge or transfer.
6. Statement, with address and phone number, that resident has the right to appeal to the Area/Regional office of the DOH.
7. Name, address, and phone number of New York State Long-Term Care Ombudsman.
8. For residents with developmental disabilities, or mental illness, addresses and phone numbers for the Agency responsible for protection and advocacy of these individuals.

Conclusion

Practitioners evaluating whether a resident's transfer or discharge is appropriate should pay close attention to the regulatory requirements mentioned and the DOH "Dear Administrator" letters. When a discharge notice has been issued, practitioners should review whether or not all the current requirements are included in the notice and the resident is given 30 days unless a circumstance as set out in the regulations dictate otherwise. An awareness of the applicable regulatory requirements will allow a practitioner to more appropriately advise a client with respect to whether or not a transfer or discharge is appropriate and to ensure that resident rights protections are met.

Endnote

1. 10 N.Y.C.R.R. § 415.3(h)(1)(i).

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Publication News

The Consumer's Guide to Long-Term Health Care—*Eldercare in New York*

By Friends and Relatives of Institutionalized Aged,
Jean Murphy, Jennifer Weiss and Lora Meyers, Editors

Reviewed by Daniel G. Fish

The greatest risk which we face as elder law attorneys is to forget just how illogical and overwhelming is our long-term care system. After years of practice, we can become inured to the complexity families face when the need for long-term care occurs. *Eldercare in New York* helps the professional avoid the trap of complacency. It is a constant reminder of the bewilderment felt by those when they are forced to deal with these issues for the first time. *Eldercare in New York* is not meant to be read in one sitting; it is written to be used and consulted when a specific question arises.

My copy of this book is tattered from constant use. It is a reference guide that I refer to on a daily basis. I frequently give a copy to clients as a Baedeker for the new territory they find themselves in. It should be on the desk or bookshelf and within easy reach of every practicing elder law attorney. It is required reading for all new attorneys and paralegals in this firm. It is also useful for family members who want information about the issues they are likely to face when someone is diagnosed with a long-term illness such as Alzheimers or Parkinson's disease.

The book deals in depth with home care, adult homes, assisted living and nursing homes. In addition, there are chapters on paying for long-term care, searching for quality care and developing problem-solving skills.

In a questions and answer format, the book explores the major issues faced by families when a person's ability to live independently begin to fail. You will find sophisticated answers to questions such as:

1. Can I keep my current home health aide if I apply for Medicaid under the consumer-directed "Concepts" program?
2. What are the exceptions to the transfer of assets rule?
3. How can I challenge a hospital discharge notice? I believe my relative is not medically ready to leave the hospital.
4. How can I tell if my relative is appropriate for a continuing care retirement community (CCRC)?
5. When can a nursing home use physical restraints?
6. How many beds does the Laconia Nursing Home have, and is the facility privately owned?

The most valuable parts of the book are the appendices. There is a list of every nursing home in New York City and the counties of Nassau, Suffolk and Westchester. Each listing gives the facility's address, phone number, number of beds and type of affiliation (proprietary or voluntary). There are separate lists of nursing homes with ventilator beds, traumatic brain injury beds, respite beds. There are lists of hospice programs, adult homes, assisted living programs, enriched housing programs, adult day care programs and certified home health agencies. In addition, there is a detailed check list to help evaluate a nursing home and a complete copy of the PRI (Patient Review Instruments) with an explanation of how it is scored.

Also included are listings of health department offices, area agencies on aging, county departments of social service, long-term care ombudsman programs, Medicaid fraud control unit regional offices and legal services programs.

The hallmark of elder law is the interdisciplinary nature of the practice. Our clients come to us overwhelmed by medical issues and their stress is compounded by confusing legal and financial issues. Our job is to explain the system in a logical and coherent way so that a plan can be formulated. *Eldercare in New York* is a way to start to get a handle on this topic. This book is a resource guide to many of the services which are available. This is the most comprehensive resource guide on long-term care in New York.

Daniel G. Fish is a partner in the law firm of Freedman and Fish, whose practice is devoted to the representation of the interests of the elderly. Mr. Fish is a Past President, founding member and Fellow of the National Academy of Elder Law Attorneys. He was a member of the Board of Directors of Friends and Relatives of the Institutionalized Aged and a Fellow of the Brookdale Center on Aging. He was a delegate to the 1995 White House Conference on Aging. Prior to forming the firm, Mr. Fish was the Senior Staff Attorney of the Institute on Law and Rights of Older Adults of the Brookdale Center on Aging of Hunter College. He has taught as an adjunct professor at Cardozo Law School, and Hunter College School of Social Work. He has authored several articles on the legal issues of elder law. He has been quoted in the *New York Times*, *Business Week*, *Fortune* and *Lawyers Weekly USA*.

Advance Directive News

Health Care Proxies Can Facilitate Organ Donation

By Ellen G. Makofsky

Organ and tissue transplants save and improve lives. The medical technology exists to do amazing things but a critical shortage of available organs and tissue limit the technological miracles. According to the calculations of Thinkquest, every 27 minutes someone in the world receives an organ transplant but every 2 hours 24 minutes someone else dies waiting for an organ to become available. [1] The actual numbers are astounding. The United Network for Organ Sharing, (UNOS) calculated that as of March 17, 2001 in the United States there were 48,245 patients waiting for kidney transplants, 17,286 patients waiting for liver transplants, 1,086 patients waiting for pancreas transplants, 170 patients waiting for intestine transplants, 4,271 patients waiting for heart transplants, and 3,724 patients waiting for lung transplants.[2] About 2,000 new names are added to the national waiting list for organ transplants monthly.[3] The critical shortage of organs exists because there are not enough donors. As elder law attorneys we can help by providing our clients with the legal documents to authorize organ and tissue donation and by fostering conversations between the potential donor and the donor's family.

Until recently, New York State law authorized organ and tissue donations only pursuant to a properly executed organ donor card, a driver's license which includes authorization to make an anatomical gift, last will and testament or other written authorization.[4] Although the law clearly provides that the authorization for donation can not be rescinded by an objection of a family member,[5] in practical terms, a potential donor's signature on a card or other document is usually not enough. The reason for this is that hospitals are generally very reluctant to contradict the wishes of living family members even though the law allows the harvest of organs or tissue to occur if the donor has indicated such wishes. This is why communication with family members is the single most important thing to be done to implement the potential donor's wishes. Inclusion of an individual's wishes in regard to organ donation in a health care proxy may be the way to encourage the necessary dialogue.

On October 4, 2000 Governor Pataki signed into law a bill which amends the New York health care proxy law.[6] The amendment, which adds subdivision (f) to § 2981, states that a health care proxy may include the principal's wishes or instructions regarding organ and tissue donation. The amendment further provides that the failure to state wishes or instructions shall not be construed to imply a wish not to donate.

The changes required on the standard health care proxy form are minimal in order to provide for organ and tissue donation. A statement should be included as to whether the principal does, or does not, wish to donate organs or tissues and whether any needed organs or tissues are to be donated or whether the principal wants to specify which organs or tissues should be donated. Another statement should be made to indicate for what purposes the donation might be used: transplants; therapy; research; and/or education.[7]

Pursuant to the health care proxy law the agent is required to act according to the principal's wishes. Where an agent is unaware of the principal's wishes he/she must act according to the best interest standard except in the case where the surrogate is making a decision in regard to artificial nutrition or hydration, where wishes must be known.[8] As knowledge of a person's wishes are such a critical part of having an effective health care proxy the elder law attorney must, as part of the legal consultation, advise and encourage the client to have a full discussion with the health care agent and substitute agent. What better time to include and foster a discussion of wishes in regard to organ donation? If the client were to have this family discussion and an organ donation were later to become a possibility, family members would be more likely to agree to the health care provider's request for the donation.

In light of the tremendous number of lives which could be saved if more organs and tissue were available for transplantation, we, as elder law attorneys, should make it a regular practice to ask clients whether the client is interested in providing for donation. If the answer is yes, the client's intent can easily be indicated on the newly authorized health care proxy form. Then, when we are all done serving our clients, each of us should sit back and evaluate our own thoughts regarding donation. Maybe it's

time to redraft your own health care proxy to authorize donation. Small acts can change the world.

Endnotes

1. http://library.thinkquest.org.
2. http://www.lifeconnectionofohio.org.
3. http://www.iaod.org/organ-donor-faq.htm.
4. N.Y. Health Law §§ 4301(1), (2).
5. N.Y. Health Law § 4301(1).
6. N.Y. Health Law § 2982(2).
7. A sample New York State health care proxy that includes provisions for organ and tissue donation may be found at www.partnershipforcaring.org. This document was prepared under the auspices of Carol E. Sieger, J.D., Director of Legal Affairs, Partnership for Caring: America's Voices for the Dying.
8. N.Y. Health Law § 2982 (2).

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Capacity News

A Few Interesting Cases

By Michael L. Pfeifer

In this column, we will discuss three recent cases involving the issue of capacity that had interesting facts or raised interesting issues.

* * *

In previous installments, we discussed capacity in the context of executing documents or giving gifts. The case of *In re the Estate of Arroyo*,[1] gives us an interesting departure from that theme. In *Arroyo* the issue was whether a parent, who abandoned or failed to support his child, could nevertheless inherit from her if he showed that his abandonment or failure to support was caused by mental incompetence.

EPTL 4-1.4(a) says in part:

> No distributive share in the estate of a deceased child shall be allowed to a parent who has failed or refused to provide for, or has abandoned such child while such child is under the age of twenty-one years, whether or not such child dies before having attained the age of twenty-one years, unless the parental relationship and duties are subsequently resumed and continue until the death of the child.

In interpreting this statute and its predecessor, courts have uniformly held that the abandonment or failure to support must be the result of a voluntary act.[2] Thus, if a parent abandoned or failed to support a child due to mental incapacity, he or she would not forfeit the right to inherit.

In *Arroyo*, the court acknowledged the aforesaid principal and found that the respondent was incompetent. However, notwithstanding its finding, the court held that the respondent was barred from inheriting from his child. The court said, "[c]ontrary to his contention, [he] was not incompetent to such a degree as to excuse his abandonment of his child and failure to support her."[3] Thus, mere proof of incompetence is not sufficient to overcome the statute; one must also prove a relationship between the lack of capacity and the abandonment or failure to support.

* * *

In *Terrell v. Terrell*,[4] plaintiff's mother (hereinafter "decedent") executed a will giving him her house. However, subsequently, decedent gifted her house, via a quitclaim deed, to her granddaughter. The plaintiff son claimed that decedent was not competent at the time that she executed the quitclaim deed. The issue before the court was whether plaintiff was entitled to a preliminary injunction that would prevent him from being evicted from the home.

The battle between the decedent's son and her granddaughter apparently began in Landlord/Tenant Court where her granddaughter brought an eviction proceeding against the son. That action was settled by giving the son a limited time to continue to reside in the disputed property while pursuing his claim in Supreme Court that his mother was incompetent at the time she deeded the property over to the granddaughter. The son did bring an action in Supreme Court, Bronx County and moved for a preliminary injunction that would allow him to remain in the residence until resolution of his action. In order to obtain a preliminary injunction, the son had to show 1) a likelihood of success on the merits; 2) irreparable harm; and 3) that the equities favored him.

Plaintiff's proof that he would likely succeed on the merits consisted of hospital records showing that over the course of almost a month the decedent had periodic confusion as to person, place and time and that she lacked understanding as to why she was in the hospital. The records also contained references to dementia, impaired memory, the onset of slurred speech and "mental status changes." The discharge notes showed that the defendant granddaughter was made aware of decedent's declining mental status.

In opposition, the defendant granddaughter claimed that decedent was fully competent and deeded the home to her because the plaintiff mistreated and stole from the decedent.

The Supreme Court denied the plaintiff's motion on the ground that he did not show a likelihood of success on the merits. (However, the court did find that the plaintiff succeeded in proving the other two grounds needed for preliminary injunction: namely that he would be irreparably harmed if the injunction were not granted and that a balancing of the equities favored him.) Plaintiff appealed.

The Appellate Court reversed. The court held that plaintiff had made a sufficient showing on the issue of a likelihood of success. "In support of his motion, plaintiff submitted medical records describing the decedent as confused, disoriented, and suffering from dementia during her hospitalization. She executed the quitclaim deed twelve days after her release from that hospitalization. While not conclusive, plaintiff's proof was sufficient for the purpose of obtaining provisional relief."

* * *

In *In re Rella*,[5] the proponent of a codicil moved for summary judgment dismissing objectant's claim of lack of testamentary capacity. Surrogate Holzman denied the motion and the Appellate Division, First Department affirmed. The proponent's motion was opposed by the affidavits of objectant and one of decedent's children, a doctor. Objectant's proof showed that when decedent executed the codicil disinheriting her the decedent was "in deteriorated physical, emotional and mental states, suffering from arteriosclerosis, often crying, depressed and forgetful, and was taking medications that have mind-altering side effects, including Valium, Darvon and Librax." There was also an issue of fact concerning undue influence in that objectant had a "vituperative argument" with her sister, one of the proponents of the will, in the presence of decedent, which resulted in objectant being banished from the house. This same sister subsequently prevented the objectant from having any further contact with decedent. The decedent had no reason to disinherit the objectant. On the basis of these facts, the Court found issues of fact concerning the questions of mental incapacity to execute the codicil and undue influence.

* * *

Each of the foregoing cases presented the issue of capacity in an interesting light. I hope you enjoyed reading about them.

Endnotes

1. 273 A.D.2d 820, 710 N.Y.S.2d 492 (4th Dep't, 2000) *aff'd*, 95 N.Y.2d 763 (2000).
2. *In re Barth*, 176 Misc. 310, 26 N.Y.S.2d 409 (Sur. Ct., Erie Co., 1941); *In re Zounek*, 143 Misc. 827, 258 N.Y.S. 665 (Sur. Ct., Queens Co., 1932); and *In re Musczak*, 196 Misc. 364, 92 N.Y.S.2d 97 (Sur. Ct., N.Y. Co., 1949).
3. *Supra*, at 820.
4. __ A.D.2d __, __ N.Y.S.2d __ (1st Dep't 2001).
5. __ A.D.2d __, __ N.Y.S.2d __ (1st Dep't 2000).

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GUARDIANSHIP NEWS

The *Gold* Decision and the Closing of the Circle

By Robert Kruger

Introduction

Applying Social Services Law § 104(2), the Court of Appeals in *Baker v. Sterling*[1] held that an infant who receives a tort recovery is obligated to repay only that portion of the corresponding Medicaid lien that is allocated for the infant's prior medical expenses. Any portion of the recovery which is allocated for pain and suffering is not recoverable by the Medicaid agency because same is "by definition" not in excess of the child's "reasonable requirements."[2]

Following upon recent Court of Appeals decisions in *Cricchio v. Pennisi*[3] and *Calvanese v. Calvanese*,[4] the Court of Appeals, on February 15, 2001 decided *Gold v. United Health Services Hosps.* and its companion case, *Santiago v. Craigbrand Realty Corp*., rejected *Baker v. Sterling* and ruled that no such allocations is required and that the Medicaid agency is entitled to be repaid its entire lien, dollar for dollar, in children's cases as well as adults' cases.

This article analyzes this Court of Appeals decision and focuses, as well, on issues left undecided by the Court of Appeals.

Cricchio v. Pennisi and *Calvanese v. Calvanese,* with some reference to *In re Costello v. Geiser*,[5] defined most of the parameters of recovery of Medicaid liens from personal injury awards. *Gold* dealt with, perhaps, the last frontier—recovery of Medicaid liens of infant plaintiffs.

Setting forth the parameters and quoting liberally from the three aforementioned Court of Appeals decisions in the process, we note that

> Medicaid is a jointly funded Federal and State medical assistance program, established by Title XIX of the Social Security Act. It pays for necessary medical care for qualifying indigent individuals, whose income and resources are insufficient to meet the costs of their medical care. . . . Participating States are mandated to establish a State Medicaid program in accordance with Federal statutory and regulatory requirements. To that end, States are required, among other things, to adopt procedures to prevent fraud, abuse, unnecessary or inappropriate use of Medicaid services and excess payments.[6]

To insure that the Medicaid program is (and remains) "the payor of last resort,"

> . . . as a condition of eligibility, an applicant must assign to DSS any rights he or she has to seek reimbursement from any third party up to the amount of medical assistance paid. . . . Additionally, a Medicaid recipient must "cooperate with the State in identifying, and providing information to assist the State in pursuing, any third party who may be liable to pay for care and services available under the plan.' . . ."[7]

In addition to this right of assignment the Court noted that the agency has a right of subrogation to the rights of the injured party, SSL § 367(a)(2)(b), as well as a right of recoupment.

> As an alternative to initiating legal action on its own, DSS may pursue its interests by placing a lien on the recovery SSL § 104(b). However, SSL §104(2) as aforesaid, limits DSS's right to recover from infants to the amount of the recovery allocated for medical expenses.

In *Cricchio v. Pennisi*,[8] (a case involving an adult plaintiff), the Court of Appeals ruled that the Medicaid liens must be fully satisfied before the proceeds of a personal injury settlement may be transferred to a supplemental needs trust, holding

> Because the injured Medicaid recipient has assigned its recovery rights to DSS, and DSS is subrogated to the rights of the beneficiary . . ., the settlement proceeds are resources of the third-party tortfeasor that are owed to DDS. Accordingly, the lien on the settlement proceeds attaches to the property of the third-party. . . .[9]

Answering the question left open in *Cricchio*, the Court in *Calvanese v. Calvanese*, held that a Medical lien attaches to the entire settlement amount and not just that portion allocated to prior medical expenses. The Court of Appeals in *Calvanese* distinguished the infant's case in *Baker v. Sterling* from the adult's case in *Calvanese*, stating in 93 N.Y.2d at 115:

> In *Baker*, the Department placed a lien on a personal injury suit brought by a plaintiff who received Medicaid assistance when she was under the age of 21. The department's right of recovery in such a situation is governed by Social Services Law § 104(2) . . .
>
> Here, however, "the right to recover from responsible third parties * * * is not derived from Section 104, but rather from the assignment, subrogation, and recoupment provisions created by 42 USC §§ 1396a and 1396k, and Social Services Law §366(4(h)(1) and §367-a(2)(b). Accordingly, any limitations found in Section 104 * * * are not relevant here.[10]

Baker v. Sterling had defined the lien recovery landscape for infants since it was written. The *Baker* Court said several things. First, it noted that § 104-b "is purely procedural" and that "the scope of the remedy is governed by the terms of the statute creating the right." It then ruled that "no lien will attach unless the infant possessed money or property in excess of his needs at the time the assistance was granted."[11] The court found that a pain and suffering award for personal injuries "can never be considered 'money or property in excess of his reasonable requirements,'" and it determined that a lien would not attach to such portion of the award. A contrary conclusion was reached, however, with respect to the payment of medical expenses as it was held that such "expenditure involved no loss to the infant, must be considered 'excess' funds within the meaning of the statute, and is subject to lien and recovery by the Department."[12]

The lower courts in *Gold* and *Santiago* determined that the source of the agency's rights lie in the assignment, subrogation and recoupment sections of the Medicaid law, rather than in the lien sections of SSL § 104, relying on the statement by the Court in *Cricchio v. Pennisi*.[13] The flaw in plaintiffs' theory that the lien cannot be satisfied until the recipient's death is that it fails to appreciate this critical distinction between the assets of a responsible third party and assets belonging to the Medicaid recipient.[14]

Appellant in *Gold* and *Santiago* argued that the Court of Appeals' statement in footnote 4 that, for infant plaintiffs, SSL § 104 is the statute creating the right, not the assignment, subrogation and recoupment sections of the law. If this is correct, *Baker v. Sterling* would have controlled.

Obviously, the Court of Appeals, in *Gold*, rejected the distinction it made in footnote 4, just as it rejected the point it made in *Costello v. Geiser* on the subrogation issue. The *Costello* Court cited out-of-state decisions in which counsel fees were prorated against the Medicaid agency to support its analysis that the rights of the agency in subrogation were no greater than the rights of the party to whom the agency was subrogated. The point of this argument was to limit the damage from an adverse ruling by imposing on the agency at least its *pro rata* share of counsel fees.

The *Costello* court tantalized us with its discussion of *Hedgebeth v. Medford*,[15] where the New Jersey Supreme Court, in holding that the State must pay its *pro rata* share of legal expenses when it seeks to recover its Medicaid lien, stated: "In this State, right of subrogation carries with it the equitable requirement of paying a *pro rata* share of counsel fees. Although earlier cases in other jurisdictions sometimes had refused to follow this rule (citations omitted) it is now clearly accepted." (Citations omitted).

Also cited was *White v. Sutherland*,[16] on allocation of a proportionate share of fees to the Medicaid agency. These cases, and the argument it provoked in *Calvanese*, have been rejected without mention in *Calvanese* and *Gold*.

In *Calvanese* it was argued that, as a matter of fundamental fairness, it is unjust for a tort victim to suffer permanent injury but receive no compensation for it. We have tort laws for one primary reason: to compensate victims. There is little reason for tort victims to bring an action if they stand to gain nothing by doing so. Beyond this, defendants in personal injury actions would have little incentive to settle them quickly where the Medicaid lien is and will continue to be substantial, because delay would drain the value of the case for the plaintiff unless he/she settles at a huge discount.

If an action is not brought, DSS will lose altogether its right of recovery from the responsible third party unless it invokes the assignment clause and institutes action itself. This is hardly likely unless a huge case, such as the tobacco cases, can be brought. Because of the sheer number of tort actions, DSS will be unable to act in the tort victim's place. The failure to commence actions for personal injuries will negatively impact DSS's recoveries from responsible third parties. The reality of loss of recoveries is poor policy,

even if the obvious rejoinder, that this is DSS's concern, not plaintiff's, has some force.

If, as the Court stated, subrogation is an equitable doctrine, where the agency stands in the "juridical shoes" of the tort victim, DSS is not moving into "the juridical shoes" of the tort victim, by assignment or subrogation. Rather, DSS is getting a free ride on the back of the tort victim, and plaintiff's attorney. If DSS does not, or cannot, take over the litigation burden, there is no equity for DSS to let plaintiff do the work and profit not. That is why, at the very least, DSS's lien recovery should be reduced by the counsel fees attributable to the lien recovery.

What was, in essence decided in *Cricchio*, *Calvanese* and *Gold* was that the assignment, subrogation and recoupment provisions in federal and state Medicaid law, adopted as they were in 1981, trump the field. Therefore, the equitable principals of subrogation, as well as contrary rulings such as *Baker v. Sterling*, which was grounded in SSL §104(2) were overridden by the 1981 amendments.

The *Gold* Decision

The Court of Appeals made short work on appellants' arguments, stating on pages 5-6 of its decision:

> Since this Court decided *Baker v. Sterling*, the relevant regulatory scheme has undergone considerable development.[1] Federal law now requires States to "take all reasonable measures to ascertain the legal liability of third parties * * * to pay for care and services available under the plan" and seek reimbursement from them (*see*, 42 USC § 139a[a][25][A][B]). To further this objective, Congress and the Legislature have added special Medicaid provisions pertaining to assignment, subrogation and recoupment (*see*, Pub L 103-66, 107 Stat 312, at 632, § 13622; L 1981, ch 319, §§ 1-2). . . .
>
> * * *
>
> As a result of this statutory scheme, the Medicaid agency "obtains all of the rights that the recipient has as against the third party to recover for medical expenses, including the ability to immediately pursue those claims against the third party" (*see*, *Cricchio v. Pennisi*, 90 N.Y.2d 296, 30 7; *see also*, *Calvanese v. Calvanese*, 93 N.Y.2d 111, 117). Thus, as lawmakers have repeatedly stressed—and as evidenced by these congressional and legislative enactments—Medicaid remains the "payor of last resort" (S Rep No. 146, 99th Cong, 2d Sess 1, 312, *reprinted* in 1986 U S Code Cong & Admin News 42, 279).
>
> * * *
>
> The *Cricchio/Calvanese* analysis is applicable here. As in those cases, the Medicaid agencies are not relying on Social Services Law § 104(4) for their recoupment rights. Rather, they rely on Medicaid's own assignment, subrogation and recoupment provisions (*see*, Social Services § 366[4][h][1], § 367-a[2][b]; 18 NYCRR 360-7.4[a][4], [6]). The agencies have broad authority under those provisions to satisfy the lien from the entire amount of the personal injury judgment or settlement. Contrary to appellants' contention, our holding does not read the limitation in section 104(2) out of existence. This case involves unique recoupment provisions specific to Medicaid, while section 104(1) continues to be a recoupment mechanism when other forms of public assistance are involved. Thus, when public welfare officials rely solely on section 104(1), the limitation in section 104(2) continues to apply.

There is, however, one issue of great importance remaining. As described in the decision

> Finally, the Golds argue that the trial court improperly ordered that $2,173,626 be set aside from the settlement proceeds as a reserve for Abraham's future medical and custodial needs. Instead, they contend, the court should have had these funds placed in a supplemental needs trust so as to preserve Abraham's continued Medicaid eligibility. Under CPLR 1206, the trial court has discretion to invest or disburse the proceeds of an infant's recovery in order to serve the infant's best interests. Here, however, the trial court appears not to have exercised that discretion but instead to have made its allocations mathematically—

> without citing any statutory or other authority—based on the proportional share of the various damage items in the jury's verdict. Moreover, the parties have not cited any reason why the trial court was under an obligation to do so if it believed that an alternative arrangement would best serve the infant's interests. Thus, we remit the matter to Supreme Court for exercise of its discretion pursuant to CPLR 1206 as to the amount to be placed in a supplemental needs trust.

Can it be seriously argued that the best interests of the infant will be served if the Supplemental Needs Trust has less money, not more. Is it beyond the reach of medical science to say, with a reasonable degree of medical certainty, that medical science, over this child's lifetime, cannot assist or benefit the child to recover function sufficiently to live outside an institution, or can medical science say, with a reasonable degree of medical certainty, that the child will remain at his/her current level of dependence, unchanged and forever?

We know that medical science, at this time, offers such child very little in the way of improvement. I do not believe that this child or the parents, should be denied the ray or glimmer of hope that improvement may come. Of course, the courts have not treated these cases kindly in the past few years. Yet the best interests of the child standard necessarily involves projecting the future. One hopes that, given the mandatory payback provisions of the SNT, and the annual accounting and review of such accounting by the agency, there are sufficient safeguards for the agency to protect its legitimate interests and not foreclose the child's future, in the same way that the child's birth defects have foreclosed the child's present.

I invite letters and comments from the bar and the judiciary. I can be reached at 225 Broadway, Suite 4200, New York, NY 10007, phone number: (212) 732-5556, Fax: (212) 608-3785 and E-mail address: RobertKruger@aol.com.

Endnotes

1. 39 N.Y.2d 397 (1976).
2. 39 N.Y.2d at 405-6.
3. 90 N.Y.2d 296 (1997).
4. 93 N.Y.2d 111 (1999).
5. 85 N.Y.2d 103.
6. *In re Costello v. Geiser*, 85 N.Y.2d 106 (1995).
7. *Cricchio v. Pennisi*, 90 N.Y.2d at 308-8.
8. *Id.*
9. 90 N.Y.2d at 307.
10. *Cricchio v.Pennisi, supra*, 90 N.Y.2d at 398.
11. 39 N.Y.2d at 405.
12. 39 N.Y.2d at 405-406.
13. 90 N.Y.2d at 307.
14. "Nor are we persuaded that this Court's decision in *Baker v. Sterling*, 39 N.Y.2d 397, 384 N.Y.S.2d 128, 348 N.Y.E.2d 584, requires a different result. In *Baker*, this Court explained that Social Services Law § 104-b is a "purely procedural" statute that "'relates to the remedy rather than to the right' and the scope of the remedy is governed by the terms of the statute creating the right" (*id.*, at 405, 384 N.Y.S.2d 128, 348 N.E.2d 584). The Court went on to conclude that in an action by welfare officials to recover from an infant public assistance recipient, Social Services Law § 104 was the statute creating the right, and thus DSS' right to recover was "subject to the limitations imposed by section 104" (*id.*, at 405, 384 N.Y.S.2d 128, 348 N.E.2d 584).

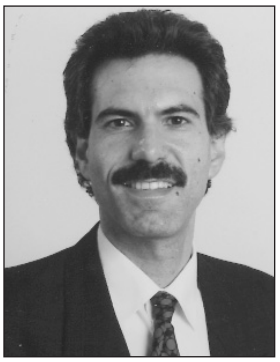
    By contrast, under the specific facts and circumstances of this case, the right to recover from responsible third parties at issue is not derived from section 104, but rather from the assignment, subrogation, and recoupment provisions created by 42 U.S.C. §§ 1396a and 1396k, and Social Services Law § 366(4)(h)(1) and § 367-a(2)(b). Accordingly, any limitations found in section 104, including the section 104(3) prohibition on actions by DSS against a supplemental needs trust for reimbursement are not relevant here."
15. 74 N.J. 360, 368-369, 378 A.2d 226, 229-230 (1977).
16. 92 N.M. 187, 585 P.2d 331 (1978).

Robert Kruger is the Chairman of the Committee on Guardians and Fiduciaries, Elder Law Section of the New York Bar Association. He is also Chairman of the Subcommittee of Financial Abuse of the Elderly, Trust and Estates Section, New York State Bar Association. Mr. Kruger is author of the Chapter on Guardianship Judgments in the book on guardianships published last fall by the New York State Bar Association 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 Article 81 (Guardianship) training course from 1993 through 1997 at the Kings County Bar Association and has experience as guardian, court evaluator and court-appointed attorney in guardianship proceedings. Robert Kruger is a member of the New York State Bar (1964) and New Jersey Bar (1966). He graduated from the University of Pennsylvania Law School in l963 and the University of Pennsylvania (Wharton School of Finance (B.S. 1960)).

Public Policy News

Health Care Decision Making . . .
The Time Is Ripe for a Default Surrogate Decision-Maker Statute in N.Y.
An Interview With Charles Sabatino, Esq.

By Ronald A. Fatoullah



This article is broken down into two portions. First, is an interview with Charles Sabatino, Esq., who is the Assistant Director of the American Bar Association's Commission on Legal Problems of the Elderly, the current President of the National Academy of Elder Law Attorneys (NAELA), and is a part-time professor at Georgetown University Law Center. Mr. Sabatino is well versed on health care decision-making issues in all states and provides a national perspective on the issue. The second part is a short discussion of the "Family Health Care Decisions Act," Bill #A.5523, sponsored by Assemblyman Richard N. Gottfried, D-Manhattan. This proposed legislation appears to address many of the shortcomings in the current state of New York law regarding health care decision making.

RF: Congratulations on becoming the new President of NAELA. I find it impressive that you know the changing status of health care decision making, end-of-life and palliative care in all 50 states. How and why did you get involved with these issues?

CS: Well, I've been here at the ABA for 16 years and there have always been issues surrounding health-care decisions. Health care decision making really got off the ground as an issue in the mid 1970s with the Karen Quinlan case. The ABA Commission was thinking of modifying the first Uniform Act on this issue called the "Rights of the Terminally Ill Act" promulgated in 1985. By 1985, we were very dissatisfied with the Uniform Act as a model and were pushing for something more comprehensive that would cover at least the following three items: (1) instructions about one's health-care in the living will; (2) appointment of an agent; and (3) default surrogate decision makers if an individual hasn't named an agent. Of course, the last item is still a big issue in New York.

RF: Yes, unfortunately that is still a big issue in New York. In New York, if there is no health care agent, and a DNR is inappropriate because cardiopulmonary resuscitation is not the issue, the New York Court of Appeals has ruled that no one, including family members, may deny or withdraw life-sustaining treatment for an incapacitated person. Fortunately, we have a very good health care proxy law in New York. The form is simple to complete and does not require a notary. However, I find that more than half of the clients that walk through my door do not have health care proxies. The NYSBA has an annual "Health Care Proxy Day" to educate the public and promote the use of proxies. In addition, my firm has sporadically held health care proxy seminars at senior centers where we assist seniors in executing their proxies. But let's get back to the Uniform Law Commissioners and what has happened since 1985.

CS: Well, in 1991, they convened a new drafting committee to look at the 1985 Uniform Act of the Terminally Ill. The result was the establishment of the current Uniform Healthcare Decisions Act promulgated in 1993 and has been a model since then. I think it's a very good model. It is interesting though that most Uniform Acts draw upon the best features of various laws that are out there. However, this Uniform Act was really shaped by a view of what the law should be and didn't reflect any other law out there. It is far simpler, far looser and far more flexible than any of the interactive laws out there. In fact, that is why many states don't like it because it's too loose and too open for abuse. For example, it doesn't require witnesses of your directives. It suggests that witnesses be used, but doesn't require them. There's a big concern about overreaching and abuse of these instruments, even though there is little or no evidence of abuse in the 25 years of using them.

RF: I want to focus on the default surrogate decision maker issue shortly, but what else intrigues you about New York law in this area?

CS: The other intriguing thing about New York is that the clear and convincing evidence standard is high.

RF: Yes, if a health care proxy is not appointed in New York, and a DNR is not applicable because the decision does not involve resuscitation from cardiac

or respiratory arrest, you must prove the principal's health care wishes by "clear and convincing evidence."

CS: There is also the practical realization that when you put things in writing sometimes they can backfire on you. I have the sense that there is this fiction consciously propagated that the agent you name knows all your wishes, and is really there just to report what your wishes would be rather than just to make decisions for you. We all know it really doesn't work that way. Hopefully we give them some guidance but the tough job is really on the shoulders of the agent.

RF: Very true. All too often, clients have health care proxies in place, but have never uttered one word to the agent about their health care wishes. Fortunately, we very rarely hear of cases regarding abuse by a proxy.

CS: Yes, health care surrogates can be dysfunctional and conflicted, but you will rarely find somebody with any kind of malicious intent during the whole process.

RF: As you mentioned, New York has a clear and convincing evidentiary standard. In *Matter of Westchester County Medical Center ("O'Connor")*, 72 N.Y.2d 517 (1988), the Court of Appeals required clear and convincing evidence of a patient's wishes before life-sustaining treatment could be rejected. What standards are used in other states?

CS: Well, for most states, there is no clear and convincing standard. The standard is a "substituted judgment" standard to the extent that you can ascertain the person's wishes. In the event that you cannot, there is the best interest notion. I really don't think that these are two different standards. I think the better way to describe it is that you try and define what is in the individual's best interest, and you have guidance from the patient to the extent that he/she has set forth his/her wishes.

RF: Do you think New York will move away from the clear and convincing evidentiary standard?

CS: To demand clear and convincing evidence is really kind of a legal artifact which does not really jive with the decision making. It is there to make us feel better in the law, but I don't think it really has a beneficial impact as to what goes on in the real world. But, it is very hard for a state like New York to change when this standard has become its public policy. To change the evidentiary standard sounds like you're willing to accept incorrect decision making. So politically, I doubt that you can pull back from that high standard.

RF: But most elder law attorneys and health care practitioners that I speak to in New York believe that the clear and convincing standard is too difficult to overcome and is unfair. Do you think that there might be some legislation that would be appropriate without saying that we are willing to accept incorrect health care decisions by a surrogate? This issue will need to be addressed if New York adapts a default surrogate decision-maker statute in the future.

CS: Yes, if legislation does succeed in New York for authorizing default surrogates in the future, you will need to address advance directives and evidentiary standards. The principal can say that his/her agent knows his/her wishes, but you really can't say that with a default surrogate. They are the family members or close friends for whom the responsibility lands on their shoulders and they're in a very tough spot. If you impose a clear and convincing evidentiary standard on default surrogates, it's going to be very hard for anyone to make decisions. My worry would then be that default surrogates would not be able to make decisions which itself could be inflicting torture on someone for whom treatment is inappropriate.

RF: How are default decision-making statutes structured in other states?

CS: The way other states deal with default surrogates is quite varied. Most default surrogate statutes use the general next-of-kin approach and now many more also recognize close friends. There's another model to listing a simple priority order of surrogates, and that's one that was first done in Colorado, and now Hawaii has adapted it. In Colorado, the law states that the interested parties are the following and the law then lists the next of kin such as the spouse, children, close friends, etc., and they basically say that the appropriate decision maker is for that *group* to decide. The physician's job is to inquire of those reasonably available who will be the decision maker.

RF: And you had mentioned "friends" . . . how are "friends" defined or determined in various states? In New York's DNR statute, Public Health Law, Article 29B, a "close friend" is defined as "any person, 18 years of age or older, who presents an affidavit to an attending physician stating that he/she is a close friend of the patient and that he/she has maintained such regular contact with the patient as to be familiar with the patient's activities, health, and religious or moral beliefs and stating the facts and circumstances that demonstrate such familiarity."

CS: There are different definitions of "close friends" in various statutes. However, the focus is really on (1) whether the friend has known the per-

son for a long time; (2) whether the friend knows the individual's values and wishes or; (3) whether they have trust in their relationship. This definition is becoming fairly common even in the states with a strict priority. The close friends are usually at the bottom of the list but are most often the most appropriate decision maker. If there is a conflict among people with the same priority, for example among children, then in most states, the majority rules. In Colorado, a consensus is required. If you cannot get a consensus, then someone has to go to court.

RF: If the decision has to be made quickly, and you have to have this whole group come to a consensus, isn't it very cumbersome?

CS: The physician's job is to ask the group. When you have a response from one of the group members and no one objects to it, the physician is actually protected in going along with that person's direction, who is then considered the designated decision maker.

RF: So the decision maker could be just that one person?

CS: Yes.

RF: In other states, there is a priority list of default decision makers. In New York's DNR statute, there is a list of priority default decision makers, i.e., a guardian, a spouse, a son or daughter 18 years of age or older, a parent, a brother or sister 18 years of age or older, and a close friend. But, the surrogate in a DNR case can only make decisions regarding cardiopulmonary resuscitation. How does this typically work in those states that have adopted this standard for all health care decisions?

CS: There is a pecking order of decision makers that start with the spouse, then the adult children and then the parents if they are alive. States vary as to how far down the kinship may go. Some states go to any relative, so the decision maker could be a relative you've never met in your life who somehow has a blood connection. That, of course, makes no sense. So in those states you would need a better model. But, no one is really complaining about the way it's working in those states, and I think that's evidence of how families and health care providers somehow get through these decisions in a way that everybody can live with, regardless of what the law says.

RF: Senator Arlen Specter's (R-PA) "Health Care Assurance Act" recently introduced as bill number S.24 contains a provision that would create a national federal advance directive. What is your opinion about a national advance directive that will be uniform in all states?

CS: I think this is a double-edged sword. I think if written and implemented with a great deal of flexibility, a national advance directive could enable people to have their written wishes respected. What I am afraid of is that when Health and Human Services creates a specific form, the form will get all the attention rather than the process. People may pick up statutory forms from their state, check off a couple of boxes and sign them and think that they have gotten everything taken care of. If you name an agent and never really talk with them in depth about your values and your wishes, when the time comes to make use of the advance directive, it's not going to do them much good.

RF: So, would you support a nationwide Health Care Proxy?

CS: If you asked me that question five years ago, I would say yes. Today, I think I would back off from that position. What I would much rather see is clarification at the federal level, so that any state that gets federal money will respect the directives of patients regardless of how they are communicated, provided that there is no concern about authenticity. I think that the Constitution and common law support the principle that any expression of your wishes should be respected.

RF: Charlie, thank you for your unique insight regarding these important issues. I hope that this article will be a catalyst for legislative changes in New York in the area of default surrogate decision-makers as well as the clear and convincing evidentiary standard.

* * *

Assemblyman Richard N. Gottfried, D-Manhattan, has recently sponsored the Family Health Care Decisions Act, Bill number A. 5523, that would establish a process to select a surrogate who will be empowered to make health care decisions for patients who lack capacity to make those decisions for themselves, and who have not executed a Health Care Proxy, do not have a court-appointed guardian over their person, and have not provided clear and convincing evidence of their treatment wishes. The bill would enable family members and others to authorize the withdrawal of life-sustaining treatment in carefully defined circumstances.

The bill provides for one person to be chosen from the following list, chosen from the class highest in priority when persons in prior classes are not reasonably available, willing and competent to act:

a. a guardian authorized to decide about health care pursuant to Article 81 of the MHL;

b. an individual, over 18, designated by another otherwise qualified to act as the surrogate, provided that no person on the surrogate list objects to the designation;

c. the spouse, if not legally separated;

d. a child over 18;

e. a parent;

f. a sibling over 18;

g. a close friend or close relative (as defined in the proposed law) over 18.

The proposed bill provides that the default decision maker is to make decisions based on the following:

a. the patient's wishes, including the religious and moral beliefs; or

b. if the patient's wishes are not reasonably known and cannot with reasonable diligence be ascertained, in accordance with the patient's best interests. In either case, health care decisions shall reflect the values of the patient, including the patient's religious beliefs, to the extent reasonably possible.

I believe that the time is ripe for a default surrogate decision-maker statute in New York. However, the Gottfried-sponsored proposal probably has little chance of passage without the support of the New York State Catholic Conference. In the past, the Catholic Conference had insisted that any surrogate decision-making bill address withholding medical intervention only, and not basic nourishment. The Catholic Conference had other concerns, for example, regarding the determination of who would act as agent for the homeless and the impact withholding treatment would have on the fetus of a pregnant woman. If the current version of the bill succeeds in alleviating the concerns of the Catholic Conference, the bill will have a much greater chance of successfully passing through the state legislature. Bill number A.5523 can be easily found on the web at: http://assembly.state.ny.us/leg/?bn=A05523&sh-t. I urge you to read this proposed legislation carefully and provide comments to Assemblyman Gottfried at his district office located at 242 West 27th Street, New York, N.Y. 10001 ,or his Albany office located at LOB 822, Albany, N.Y. 12248. Assemblyman Gottfried can also be reached via e-mail at gottfrr@assembly.state.ny.us.

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SNOWBIRD NEWS

Representing the Younger Disabled Client: The Hodgepodge

By Julie Osterhout

This article will review three of the main topics that impact representing the younger disabled client in Florida. They include the Uniform Transfers to Minors Act, guardianships, and advance directives.

Florida has adopted provisions similar to the Uniform Transfers to Minors Act, which of course is known as the Florida Uniform Transfers to Minors Act, contained in Chapter 710 of the Florida Statutes. Florida provides that a custodian may be appointed under the Act by registering the asset in the name of an adult or trust company ownership, with words followed in substance "as custodian for *name of minor* under the Florida Uniform Transfers to Minors Act." Assets that have title, including real property, are easily placed in custodianship by using the words of custodianship as just set out. For property that does not contain title or some other written evidence of ownership, custodianship can be accomplished by creating a written assignment in the following form:

> Transfer under the Florida Uniform Transfers to Minors Act
>
> I, (name of transferor or name and representative capacity if a fiduciary) hereby transfer to (name of custodian), as custodian for (name of minor) under the Florida Uniform Transfers to Minors Act, the following: (insert a description of the custodial property sufficient to identify it).
>
> Dated:_____
>
> (signature)
>
> (name of custodian) acknowledges receipt of the property described above as custodian for the minor named above under the Florida Uniform Transfers to Minors Act.
>
> Dated:_____
>
> (signature of custodian)

Florida provides that only a single custodian can serve at a time. However, you can designate successor custodians can be designated. The custodian is entitled to deliver to the minor or for the minor's benefit as much of the custodial property as the custodian considers advisable without court order or without regard to the duty or ability of the custodian personally or others to provide income or support to the minor. An interested person or minor, if the minor has reached the age of 14, may petition the court to force the custodian to pay money or expend for the minor's benefit as much of the custodial property as the court considers advisable. The custodianship terminates upon the minor attaining the age of 21, if the custodianship was established by will or trust or by some other irrevocable gift or irrevocable exercise of a power of appointment such as provided on an account designation. If, however, the custodianship was established by a fiduciary such as a personal representative or trustee when there is no will, or the will or trust does not contain a specific authorization to utilize the Uniform Transfers to Minors Act, then the custodianship terminates upon the minor attaining the age of 18. If a personal representative or trustee attempts to make a transfer that is not specifically authorized by the will or trust, it must be based upon a *best interest decision* for the minor and not otherwise prohibited by any will or trust agreement and is *authorized* by the court if the amount transferred is greater than $10,000.

"Although the Uniform Transfers to Minors Act was established to create a less expensive alternative to guardianship, it has been my experience that judges frequently will not allow a transfer under the Act, but require a court-supervised guardianship when the transfer has not otherwise been authorized by a will or trust agreement."

Although the Uniform Transfers to Minors Act was established to create a less expensive alternative to guardianship, it has been my experience that

judges frequently will not allow a transfer under the Act, but require a court-supervised guardianship when the transfer has not otherwise been authorized by a will or trust agreement. Therefore, if your client wants to use a less supervised method of representation for a minor that will delay distribution to age 21, then the will or trust document should at least authorize a distribution under this Act and maybe even require it. If this is not in the will or trust, then the court will likely require a guardianship.

"Under Florida law, both those persons acting under an advance health care directive (including decisions regarding life-prolonging procedures) and court-appointed guardians are only able to exercise substitute judgment."

The custodian may be reimbursed from the custodial property for reasonable expenses. The custodian also has a right to elect compensation during the calendar year for reasonable compensation. If the election is not taken during that year, compensation is not awardable as a cumulative matter from year to year.

The second area of law impacting on young clients is guardianships. The natural parents of a child are considered the "natural guardians" of that minor. However, the natural guardians have limits on their authority. In particular, the Florida statutes authorize the natural guardians to settle any claim or cause of action, and to otherwise manage and receive money, as long as the amount does not exceed $5,000. Therefore, any time a minor receives an inheritance or proceeds from a life insurance policy or has any settlement or claim or cause of action in excess of $5,000, the natural guardians will need to establish a formal guardianship under the court system to obtain authority to effectuate the settlement and otherwise hold the funds. In addition, if there is a claim for personal injury, property damage or wrongful death in which the *gross settlement* for the claim of the minor equals or exceeds $10,000, the court will likely appoint a *guardian ad litem* to represent the minor's interest. If the gross settlement exceeds $25,000, the court is required to appoint a guardian *ad litem* in review of the settlement.

Although Florida has a significant elder population that frequently finds itself in the guardianship court, with all of the due process protections and mental examination provisions, an alternative form of guardianship has been provided for people who suffer from developmental disabilities.

In an effort to avoid the stigma of the label "incapacitated," the Florida legislature created Chapter 393 for people born with developmental disabilities. This includes people who suffer from retardation, cerebral palsy, autism, spina bifida, or Prader-Willi syndrome, such that it constitutes a substantial handicap that can reasonably be expected to continue indefinitely. Under these statutory provisions, Florida allows a more abbreviated and economical procedure. The court is presented with evidence relevant to the person's disabilities, documenting the condition and needs of the individual. There is no requirement for appointment of a three-person examining committee, as is required under the general guardianship procedures. This avoids at least $1,000 in expense to outside experts or doctors for the purpose of establishing the need of the guardianship.

The third item of Florida law that impacts on the younger disabled client involves Florida's statutes dealing with advance directives. In particular, those clients who have been born with a developmental disability or otherwise through accident or illness became incapacitated prior to reaching majority, face the situation that they now obtain legal capacity without ever having true mental capacity. Florida statutes Chapter 765 is the source of all medical advance directives in Florida. This chapter was recently amended to provide that it has no application to individuals who never had capacity. Also contained in the Florida statutes dealing with advance directives are the provisions for living wills and decisions regarding life-prolonging procedures. This creates a hole in authority for those younger clients who became mentally disabled prior to reaching the age of majority. In short, that client has no opportunity or statutory authority to have appointed an individual who will exercise that client's decisions regarding health care. Under Florida law, both those persons acting under an advance health care directive (including decisions regarding life-prolonging procedures) and court-appointed guardians are only able to exercise substitute judgment. This term means that medical decisions are based on what the decision maker believes the patient would have decided. This is contrasted with a decision based on "the best interest" of the patient or client. Traditionally, Florida family law, in trying to resolve the disputes of child rearing between natural parents/guardians, is based upon a "best interest" decision for that minor. Once the minor reaches the age of majority, the law provides that the decision shall be based upon what that adult would have decided if they could make the decision. This begs the question as to whether a minor who

had no legal capacity could express wishes that could then be utilized by a surrogate decision maker as what that person would decide if mentally and legally capable.

". . . clients having Florida real estate that is not their principal residence can now transfer it into trust for the purpose of probate avoidance."

Ultimately, these holes in authority are decided by courts in some strained reasoning or outright ignoring of decision standards. These holes should be addressed by the Florida legislature by specifically authorizing a best interest decision when you have a disabled client past the age of majority who never had capacity prior to reaching the age of majority. This would enable a less expensive resolution of the problem and less turmoil to the family by using family members or other surrogate decision makers without resorting to the court system.

Update on Property Issues in Florida

In a previous article done for this newsletter, we had indicated the situation regarding insuring non-homestead title when transferred out of a trust after the settlor's death. In the past, the major underwriting title insurers took the position that since Florida law did not provide for a method to deal with creditors' claims except through a formal probate proceeding, any disposition of non-homestead real estate without a probate in Florida to cut off creditors' claims could not be insured against those creditors' claims until after the expiration of the two year non-claim statute that would bar creditors in Florida. The Attorneys' Title Fund (one of the largest and most conservative title insurers in Florida), as of December, 2000, will insure title to non-homestead from a trust without a probate if the transfer is a for-value market sale. This type of sale would replace the real estate with an equivalent value in cash. Therefore, clients having Florida real estate that is not their principal residence can now transfer it into trust for the purpose of probate avoidance. If the trust beneficiaries are interested in selling the real estate after the settlor's death, the trustee may do so immediately without having to open a Florida probate and then distributing the proceeds from the sale that was received by the trust back out to the beneficiaries. If the beneficiaries are interested in holding onto the property and taking an in-kind distribution, they will still need to wait for the expiration of the two year creditors' non-claim statute or open a Florida probate estate to bar the creditors if they want to sell the land subsequent to the in-kind distribution. An alternative to the use of a trust still includes the use of an enhanced life estate deed which was described in our previous article.

Julie Osterhout has been practicing law in the Fort Myers, Florida area since 1980. She received her Juris Doctorate in 1980 from Mercer Law School and opened her private practice in 1990. She has concentrated on the laws and issues affecting the elderly since 1982. Her practice includes estate planning, probate, guardianship, asset protection planning and Medicaid qualification. In 1995, Julie was certified as an Elder Law Attorney by the National Elder Law Foundation. Julie is the immediate past chair of the Elder Law Section of The Florida Bar. Julie is a current member of the Board of Directors of the National Academy of Elder Law Attorneys, and was named a Fellow of the National Academy of Elder Law Attorneys in 1997.

GRANDPARENT RIGHTS NEWS 1

Grandparent Visitation Statute Faces Constitutional Question

By Gerard Wallace

Since June 2000, when the U.S. Supreme Court handed down its decision in *Troxel v. Granville*[1] regarding the constitutionality of a Washington State visitation statute, at least four New York lower courts have ruled on the constitutionality of New York's grandparent visitation statute, Domestic Relations Law § 72. These decisions are split; two for the statute's constitutional validity and two against. As a result, both parents and grandparents face exceptional uncertainty in disputes about visitation. Until appellate decisions bring clarity to the controversy, the law regarding visitation petitions by grandparents remains unclear.

The controversy arises because the U.S. Supreme Court's decision is not easily understood. In *Troxel*, the Supreme Court reviewed the decision of Washington State's highest court that had found its own visitation statute unconstitutional. That statute permitted "any person" at "any time" to petition for visitation with children, despite the united opposition of the parents. The statute also mandated that visitation should be decided solely upon consideration of what is in the child's best interest.

The grandparents in *Troxel* sought increased visitation with the daughters of their deceased son and were resisted by the mother. While these facts are typical of many grandparent visitation statutes, Washington State's statute was not typical of the narrower grandparent visitation statutes enacted in most states. Still, many thought that the U.S. Supreme Court intended to resolve the constitutionality of state grandparent visitation statutes.

Washington State's highest court found the Washington State statute invalid because it violated the Due Process Clause of the Fourteenth Amendment of the United States Constitution.[2] The Washington State Supreme Court interpreted past U.S. Supreme Court decisions to mandate that a state cannot interfere with parental autonomy unless the state shows that its interference prevented a harm or a potential harm to a child. Using this reasoning, the Washington State Supreme Court declared the Washington State statute unconstitutional because the court found no harm to be prevented.

However, contrary to expectations, the U.S. Supreme Court did not address the harm standard. The nine justices on the nation's highest court were unable to find much common ground upon which to build an opinion. Justice O'Connor writing for herself and three other justices (JJ. Rehnquist, Ginsberg, and Breyer) acknowledged that "normally" a state cannot interfere with fit parents, but she then asserted that, in this instance, the "problem here is not that the Washington Superior Court intervened, but that when it did so, it gave no special weight at all" to the parent's determination of the children's best interest. The issue was not the state's right to interfere, but how it had interfered. The plurality opinion found that the trial judge applied Washington State's visitation statute in an unconstitutional manner. The judge failed to give "special weight" to the parent's decision to deny visitation. The grandparents, not the parent, should have born the burden of proving that the decision by the parent to deny visitation was not in the best interest of the children. Because there was no deference to the parent's decision, the plurality agreed that the statute, *as applied,* was unconstitutional.

The two concurring judges did not join in this reasoning but offered separate opinions for finding the statute unconstitutional. Justice Thomas came close to endorsing the harm standard, declaring that parents' fundamental liberty interest deserved the highest protection. Justice Souter found the statute unconstitutional because it empowered an overly broad category of persons with the opportunity to seek visitation.

The disunity in the Supreme Court's reasoning and the plurality's failure to clearly indicate the circumstances under which states could interfere in parental autonomy directly contributed to the conflicting decisions by New York judges.

New York's statute limits visitation petitions to grandparents, but does not provide clear standards which must be met before courts can consider whether visitation is in the best interest of a child. Neither does it indicate that special weight should be given to parental decisions to deny visitation during a court's best interest analysis. The statute only declares that "where either or both of the parents of a minor child, residing within this state, is or are deceased, or where circumstances show that conditions exist which equity would see fit to intervene," then judges should inquire whether it is in the best

interest of children for grandparents to have visitation.

In *In re Emanuel S. v. Joseph E.*,[3] New York's highest court interpreted this provision to mean that, when both parents were alive, only grandparents who had a relationship with their grandchildren or who sought to have a relationship but were prevented by the parents could go forward with their petitions. Thus, New York courts must hold a preliminary hearing on these issues before inquiring into the best interest of a child. The New York Court of Appeals has not endorsed any rule of deference to parents during the best interest phase of visitation proceedings.

So far, two judges have ruled that New York's statute is unconstitutional based on the statutory failure to mandate sufficient deference to parental autonomy, and two judges have ruled the statute to be constitutional based on a review of case law which showed that trial judges, in applying the statute, do defer to parents.

In *Hertz,* a grandfather's petition was brought against parents united in opposition. The Kings County trial judge found that the statute's failure to recognize that the parent's decision is entitled a presumption of validity or added weight resulted in unconstitutional state interference with a fit parent's right to raise their children.[4] A second trial judge went further. In a case involving a paternal grandmother and the widowed mother, the judge declared that there must be a finding of parental unfitness before the state can "exercise its judgment and discretion on the issue of a child's best interest relative to grandparent's visitation. . . ."[5]

Two other decisions reach the opposite conclusion. In *Smolen v. Smolen*,[6] an Onondaga County dispute between two grandparents and their daughter, the Family Court judge noted that "a review of later case law, however, reveals that Domestic Relations Law § 72 has generally been interpreted to require substantial deference to the authority of parents in both aspects of the analysis." In fact, decisions have limited awards of visitation to situations where "there is possible harm to the child, or where the parental decision making is based on factors which are immaterial to the child's best interest." In *Fitzpatrick v. Youngs*,[7] a Jefferson County contest between the paternal grandfather (the father is deceased) and the natural mother, the presiding judge asserted that "*Troxel* cautions that parental decision making must be given some deference, and as applied this has occurred in New York." Looking at the statute's application, these two judges denied the parent's motion to dismiss based on the unconstitutionality of the statute.

Since the four decisions are all by trial courts, they do not bind other trial judges. Although judicial reasoning may be of assistance in another court's deliberations, at present, New York trial judges are still interpreting *Troxel* without guidance from higher courts. Of the four lower court cases, *Smolen* and *Fitzpatrick* are not being appealed. *Hertz* is being appealed. The petitioner in *Levy* has yet to decide whether to appeal.

Endnotes

1. 530 U.S. 57, 120 S. Ct. 2054, 147 L.Ed.2d 49.
2. *In re Smith,* 137 Wash. 2d 1, 969 P.2d 21 (1998).
3. 78 N.Y.2d 178, 573 N.Y.S.2d 36, 577 N.E.2d 27.
4. *Hertz v. Hertz,* 717 N.Y.S.2d 497 (Sup. 2000).
5. *Levy v. Levy,* Kings Co. Supreme Court, 38897/99.
6. 713 N.Y.S.2d 903 (Fam. Ct. 2000).
7. 717 N.Y.S.2d 503 (Fam. Ct. 2000).

Grandparent Rights News 2

Standby Guardianship Law Broadened

By Gerard Wallace

New York State has changed Surrogate's Court Procedure Act § 1726, its standby guardianship statute, to allow additional categories of persons caring for minors to designate future guardians for their charges. Previously, New York law permitted only parents or guardians who had a progressively chronic illness or irreversibly fatal illness to apply to a court for the nomination of a "standby guardian." A similar provision permitted such parents and guardians to name a standby guardian in a one-page writing similar to a will. Standby guardians nominated by a court can act upon incapacity or death of the principal. Standby guardians named via a writing can act upon the debilitation, incapacity, or death of the principal. Both are required to apply to court for a permanent appointment (nominees within 90 days, designees within 60 days) of the occurrence of the event that activated the guardianship, or their temporary power to act as guardian ceases. When such an application is made, the judge must find that the permanent appointment of the standby guardian is in the best interest of the child.

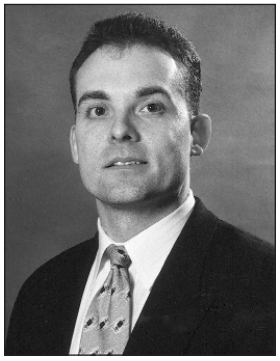
Effective 60 days after its signing on September 20th, 2000, New York added legal custodians and the "primary caretakers" of minors to those persons who can name a standby guardian, either by application to a court or by a witnessed writing. Primary caretakers must show that the actual parent, guardian, or legal custodian of the minor cannot be located with "due diligence." Although the addition of these categories was intended to assist "families and children living with HIV/AIDS . . . ," the standby guardian law is not limited to persons with illnesses caused by HIV/AIDS. Thus, this amendment to the standby guardianship statute insures that all parents, guardians, legal custodians, and many primary caretakers of minor children can choose the person who will continue to care for the child when they are no longer able to do so and the appointment of a guardian becomes necessary.

Gerard Wallace is the Director of the Grandparent Caregiver Law Center at the Brookdale Center on Aging of Hunter College in New York City. He is a member of the New York City Kincare Task Force, the New York State Bar Elder and Family Law Sections and the Advisory Council to Catholic Charities Grandparent Caregiver Program in Albany and Generations United in Washington, D.C. He graduated from Albany Law School in 1997 where, as a Sandman fellow, he published a monograph on the legal issues of grandparent caregivers. In private practice, he continued to concentrate on this issue.

Bonus News 1

The Caretaker Child Exception (Part I: How Far Does it Extend?)

By Robert J. Kurre



Your newest client has just entered your office and presented you with the following facts: your client is the 42-year-old adopted son of an 85-year-old widow who has just entered a nursing home for long-term care. The widow owns a building in her name alone which was purchased in December 1999 for cash. The building is worth approximately $500,000 and consists of a store and two apartments. One apartment is occupied by your client and his wife. The other apartment was occupied only by the widow up until the time of her institutionalization. The widow's only other asset is a bank account with a current balance of $3,000. Her monthly income consists of her social security check of $1,500 and rent of $750 from your client and $1,200 from the store. Your client had lived under the same roof as his mother for his entire life (until she entered the nursing home) with the exception of a six-month period starting in June 2000, in which he lived overseas while working on a research project related to his employment. The client advises that this was a short-term job assignment which he undertook with the intention of returning home to live in his apartment in his mother's building once the assignment was over. He did, in fact, return to live in the apartment in January, 2001. Your client has provided some minor assistance to his mother with her activities of daily living over the last five years. During this time period, her health has slowly but steadily deteriorated. Your client and his mother have not always enjoyed a stable relationship. In fact, in 1997 his mother called the police and filed a formal complaint against your client claiming that he had shoved her during an argument. Your client's paramount concern is whether his mother's primary asset—the building—will have to be sold to cover the cost of her care at the nursing home thus leaving him and his wife without a place to live.

Your initial reaction is that the widow may be able to transfer the home to your client as an exempt transfer thus not incurring any period of ineligibility for Medicaid nursing home benefits. However, given the facts, you are uncertain of the applicability of the exception that may apply to this situation—the exception commonly known as the "caretaker child exception."

This article will examine the elements of the caretaker child exception in the context of the above facts. It will offer an analysis as to how far this exception to the transfer penalty rules, in connection with Medicaid nursing home benefits, extends. Part II of this article will appear in the next issue of the NYSBA *Elder Law Attorney* and examine the issues of liens, estate recovery, tax considerations, and the different methods for transferring ownership of a homestead to a caretaker child.

The caretaker child exception provides that a Medicaid applicant may transfer, without penalty, his or her "homestead" to the applicant's "child" who "resid[ed]" in the homestead for at least two years "immediately" before the date on which the applicant was institutionalized and who "provided care" to the applicant which permitted the applicant to reside at home rather than in an institution or facility.[1]

The language of Social Services Law § 366(5)(d)(3)(i)(D) and the New York State Department of Health Regulation (18 N.Y.C.R.R. § 360-4.4(c)(2)(iii)(b)(4)) pertaining to the caretaker child exception raises the following issues:

- What is considered a homestead?
- Who may qualify as a child?
- What level of care is necessary to satisfy the requirement of providing care?
- What if the applicant and the child have lived together the last two years but they changed their residence within this time period?
- What if the applicant and child have not physically lived together during the entire two-year time period?

The Homestead

The property you are trying to preserve in our fact pattern is a hybrid property—it is both residential and commercial in nature. Specifically, it contains two apartments and a store. Can such a property qualify as a "homestead" under the caretaker child exception? In addition, does the fact that your client

and his mother live in separate apartments in the building prevent him from qualifying as a caretaker child?

A homestead is defined in the New York State Department of Health regulations as the primary residence occupied by a medical assistance applicant/recipient and/or members of his/her family. Family members may include the applicant's/recipient's spouse, minor children, certified blind or certified disabled children, and other dependent relatives. The homestead includes the home, land and integral parts such as garages and outbuildings. The homestead may be a condominium, cooperative apartment or mobile home. Vacation homes, summer homes or cabins are not considered to be homesteads.[2]

The regulations do not differentiate between single family and multi-family dwellings in defining what constitutes a "homestead." Nor do the regulations specifically address hybrid properties—such as the one in the present fact pattern—which consist of both residential and commercial units. However, the Medicaid Reference Guide does set forth that a homestead may be income producing.[3] Furthermore, 18 N.Y.C.R.R. § 360-1.4(f) provides that the "homestead" includes the "home, land and integral parts such as garages and outbuildings," suggesting that anything connected to the primary residence is part of the "homestead." Accordingly, a "homestead" should include multi-family dwellings provided the applicant uses one of the units as his/her primary residence. Similarly, hybrid properties should be considered homesteads provided any businesses on the property are part of the same building as the applicant's primary residence.

In our fact pattern, the building should thus qualify as a homestead, as this term is used in connection with the caretaker child exception, since your client's apartment and the store are each part of the same building that includes the applicant's apartment. Similarly, the fact that your client and his mother live in separate apartments is irrelevant as the apartments are within the same building.[4]

Who Is a Child?

Your client has advised that he is the adopted son of the applicant. Does an adopted child qualify as a "child" under the caretaker child exception?

Nothing contained in the Social Services Law or New York State Department of Health Regulations or Administrative Directives provides an answer to this question, however, in one fair hearing decision, a "child" was strictly interpreted to mean only a biological or adopted child of the applicant.[5] The Administrative Law Judge (ALJ) determined that a grandchild, niece, nephew, or foster child would *not* be considered a child as used in the caretaker child exception. Thus, such categories of relatives would not qualify as transferees of a homestead under the caretaker child exception. The ALJ upheld the Agency's determination that the applicant was ineligible for Medicaid nursing home benefits where the homestead was transferred to a *foster* child who had lived with the applicant in the homestead for *almost 60 years.* The ALJ stated: "[w]hile extremely sympathetic to the relationship between the [applicant] and her foster child, the Regulations do not allow the transfer of the household [to a foster child]."[6] The ALJ's narrow view of who may qualify as a child casts doubt on whether the definition of a "child" can be expanded beyond its common meaning of a biological or adopted child. In our fact pattern, your client should qualify as a "child" under the caretaker child exception provided he can document that he was legally adopted.

What Constitutes Providing Care?

Given the facts presented by your client, has he provided enough assistance to his mother to satisfy the element of providing care under the caretaker child exception? The facts presented indicate that your client has provided some assistance to his mother with her activities of daily living over the last five years. The facts, however, also indicate that he and his mother have had an uneven relationship with at least one physical altercation having occurred between the two of them within the last four years.

The element of providing care ordinarily can be satisfied without difficulty. The pertinent regulation provides that the care provided by the caretaker child must have "permitted [the applicant] to reside at home rather than in an institution or facility"[7] and references 18 N.Y.C.R.R. § 311.4(a)(1) for the definition of providing care. Section 311.4(a)(1) of 18 N.Y.C.R.R. states that the phrase "provid[ing] care" means making arrangements or actively participating in making arrangements for care directly or indirectly, in whole or in part. Similarly, 92 ADM-53 indicates that "provid[ing] care" means care which permitted the applicant to stay at home rather than in an institution and that this can be proven by submitting evidence that the child made arrangements or actively participated in arranging for care, either directly or indirectly, full time or part time. In practice, however, once it is demonstrated that the child is the biological or adopted child of the applicant, the only additional proof that normally is required by the local departments of social services is evidence that the caretaker child lived in the homestead with the applicant for at

least two years immediately prior to the date the applicant became institutionalized. Generally, Medicaid presumes that the child "provided care" unless there is evidence to the contrary.[8] Examples of proof that should be sufficient to demonstrate that a caretaker child resided in the homestead for at least two years may include a driver's license, bills, and tax returns bearing the caretaker child's name along with the homestead address.

Accordingly, the element of "provid[ing] care" would ordinarily be easily satisfied by your client given the presumption that care is provided. However, in this case, the formal complaint filed against your client by his mother could provide a stumbling block to satisfying the element of providing care should such facts come to light.

Change of Residence Within the Two-Year Period

In our fact pattern, your client and his mother had lived under the same roof their entire lives. However, the particular homestead where they lived, up until the time of her institutionalization, was only purchased in December 1999. Thus, two years have not elapsed since the date of purchase of the current homestead and the date the widow entered a nursing home. Is the caretaker child exception available in those situations where an applicant and her child have changed their residence within the two-year period immediately preceding institutionalization? The wording of the caretaker child regulation seems to foreclose the possibility that there is "tacking" or credit given for time periods in which the applicant and the caretaker child lived together in other homes prior to the time they lived together in *the* homestead which the applicant wishes to transfer to the caretaker child. The regulation makes specific reference to title to the homestead being transferred to a caretaker child who lived with the institutionalized spouse in "such homestead" for at least two years immediately prior to the date the applicant was institutionalized.[9] Thus, a literal interpretation of the regulation does not seem to allow for the possibility that the applicant and child may have moved within the two-year period immediately preceding institutionalization. Such a move is not uncommon as seniors sometimes purchase smaller, easier-to-maintain residences as their health begins to fail.

Federal law, however, seems to allow the use of the caretaker child exception even in those cases where the applicant and child have not lived together in the homestead being transferred for the requisite two-year time period as long as they have lived together during the entire two-year period preceding institutionalization. Section 1396p(c)(2)(A)(iv) of 42 U.S.C. provides, in relevant part, that the home may be transferred, without penalty, to a child of a Medicaid applicant "who was residing in *such individual's home* for a period of at least two years immediately before the date the individual becomes an institutionalized individual, and who . . . provided care to such individual which permitted such individual to reside at home rather than in . . . an institution or facility." (Emphasis added). Thus, the federal statute seems to allow the applicant to take advantage of the caretaker child exception where he/she has lived together with the child in any abode for the requisite two-year period.

Accordingly, the state regulation seems to provide a narrower standard than the federal statute since it requires the applicant and the child to have lived together in the homestead (which the applicant now seeks to transfer to the caretaker child) for the entire two-year time period immediately preceding institutionalization. The federal statute merely requires that the applicant and child must have lived together in the same home (not necessarily the homestead being transferred) for the entire two-year period immediately preceding institutionalization in order for an exempt transfer to take place. Thus, this aspect of the state regulation which seems in conflict with federal law may be ripe for challenge under the doctrine of federal supremacy. Accordingly, the caretaker child exception should still be available in those situations where the child and applicant have lived together in different residences as long as they have lived together for the entire two-year period immediately preceding institutionalization.

Time Spent Apart During Two-Year Period

Your client and his mother have not physically lived together during the entire two-year period immediately preceding her institutionalization. He lived overseas while on a work assignment from June 2000 through December 2000. Did this time that your client and his mother spend living in different places prevent him from qualifying as a caretaker child?

The state regulation[10] and the federal statute[11] each provide that the caretaker child must have "resid[ed]" with the applicant for at least the two-year period "immediately" preceding the date the individual becomes an institutionalized individual in order for the transfer to be approved as exempt. The presence of the word "immediately" preceding the phrase "before the date the individual became an institutionalized individual" seems to mandate that the applicant and child must have lived together continuously for the entire two-year period preceding

the applicant's institutionalization. However, a definition of "residing" is not spelled out under the state regulation or federal statute. Thus, it is unclear whether a transfer of the homestead to a child would constitute an exempt transfer where the child has not physically lived with the institutionalized person in the homestead for the entire two-year period immediately prior to institutionalization, however, the child maintained his/her legal domicile at the same residence as the applicant throughout that time period.

Your client should, in the opinion of the author, still meet the requirement of having lived in the homestead with the applicant during the requisite two-year period as he indicated to you that his intent was to maintain his domicile at his mother's residence during his absence from such residence due to his work assignment. If, however, your client had taken steps to change his domicile to the overseas location where he was working and such steps resulted in a lack of documentation evidencing his domicile at the same address as his mother, it would become very difficult to satisfy this element of the caretaker child exception.

Conclusion

The caretaker child exception is a valuable tool in the practitioner's arsenal of planning strategies to preserve the family home. It can be readily utilized in those situations where a biological or adopted child has maintained his/her domicile in the applicant's residence for the entire two-year period immediately preceding the applicant's institutionalization. By understanding its purview, the practitioner can best serve the client. Part II of this article (to appear in the next issue of the NYSBA *Elder Law Attorney*), will consider the issues of liens, estate recovery, tax considerations, and the different methods for transferring ownership of a homestead to a caretaker child.

Endnotes

1. Social Services Law § 366(5)(d)(3)(i)(D); 18 N.Y.C.R.R. § 360-4.4(c)(2)(iii)(b)(4).
2. 18 N.Y.C.R.R. § 360-1.4(f).
3. Medicaid Reference Guide (August 1999) at page 273.
4. If the mother did not transfer the building to your client and she executed a Statement of Intent to Return Home making the homestead an exempt asset (i.e., not counting towards her countable resource limit of $3,750 in 2001) for purposes of qualifying for Medicaid, it should be noted that the rent from the building would not be considered exempt. Accordingly, if title to the property remains in the name of the applicant, the net rent from the property (i.e., after deducting insurance, maintenance, and taxes) will be budgeted as part of the applicant's Net Available Monthly Income with all income over $50 per month being paid to the nursing home. As set forth in Part II of this article, if the homestead is not transferred to your client, there is an additional risk of the imposition of a lien on the building.
5. *In re Appeal of A.W.,* Fair Hearing #3171515N (November 4, 1999).
6. *Id.*
7. 18 N.Y.C.R.R. § 360-4.4(c)(2)(iii)(b)(4).
8. Medicaid Reference Guide (August 1999) at page 355.
9. 18 N.Y.C.R.R. § 360-4.4(c)(2)(iii)(b)(4).
10. *Id.*
11. 42 U.S.C. § 1396p(c)(2)(A)(iv).

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BONUS NEWS 2

The Use of Article 81 of the Mental Hygiene Law as an Effective Medicaid and Estate Planning Tool: A Primer

By Anthony J. Enea

In 1993, at the time of the enactment of Article 81 of the Mental Hygiene Law (MHL), I doubt that more than a handful of attorneys envisioned the extent to which it would one day be relied upon as a Medicaid and estate planning tool for the incapacitated.

In large part, as a result of the ingenuity and foresight of the legislature, the bar and the judiciary, Article 81, which provides, *inter alia*, for the appointment of a guardian of the person and property of an incapacitated person, has evolved into a highly effective Medicaid and estate planning tool. Whether the courts authorize a guardian to renounce an inheritance or to transfer assets for purposes of facilitating Medicaid planning, Article 81 plays a critical role in planning for the incapacitated and his/her dependents. In an ideal world all of our clients would have executed a Health Care Proxy, a sufficiently broad Durable General Power of Attorney, and any other advanced directive, thus perhaps obviating the need for a guardian. However, in far too many cases, no such planning has occurred.

Section 81.21's Statutory Recognition of the Common Law Doctrine of Substituted Judgment

In order to give the reader a flavor of the statutory framework of Article 81, the following is a summary of its provisions which are of relevance to the authority given a guardian to engage in Medicaid and estate planning. Section 81.21(a) of the Mental Hygiene Law provides that the court may authorize the guardian to exercise the powers necessary and sufficient to manage the property and financial affairs for the support and maintenance of the incapacitated person and those dependent upon the incapacitated person. The exercise of the powers must be consistent with the functional limitations of the incapacitated person, and his/her appreciation of the consequences and potential harm resulting from his/her inability to manage property and financial affairs. In exercising the powers, the guardian must give consideration to the wishes and preferences of the incapacitated person and the least restrictive form of intervention.

Fashioning the powers of the guardian in a manner that will insure the "least restrictive intervention" to the rights of the incapacitated person is given a high priority by the courts. During the course of the hearing it is not unusual for the presiding justice to make inquiry as to whether the powers sought will insure that the intervention sought is the least restrictive. For example, if the incapacitated person has the capacity to manage his/her finances to a certain extent, the court may require that the incapacitated have access to a limited sum of money to be expended at his/her discretion.

"During the course of the hearing it is not unusual for the presiding justice to make inquiry as to whether the powers sought will insure that the intervention sought is the least restrictive."

MHL § 81.21(a) further provides that the transfers may be in any form that the incapacitated person could have employed if he/she had the requisite capacity, with the exception of the execution of a new will or a codicil for the incapacitated person.

MHL § 81.21(a) further provides that the powers which may be granted include, but are not limited to the power to:

1. make gifts;
2. provide support for persons dependent upon the incapacitated person for support, whether or not the incapacitated person is legally obligated to provide that support;
3. convey or release contingent and expectant interests in property, including marital property rights and any right of survivorship inci-

dental to joint tenancy or tenancy by the entirety;

4. exercise or release powers held by the incapacitated person as trustee, personal representative, guardian for minor, guardian, or donee of a power of appointment;
5. enter into contracts;
6. create revocable or irrevocable trusts of property for the estate which may extend beyond the incapacity or life of the incapacitated person;
7. exercise options of the incapacitated person to purchase securities or other property;
8. exercise rights to elect options and change beneficiaries under insurance and annuity policies and to surrender the policies for their cash value;
9. exercise any right to an elective share in the estate of the incapacitated person's deceased spouse;
10. renounce or disclaim any interest by testate or intestate succession or by inter vivos transfer consistent with paragraph (c) of § 2-1.11 of the Estates, Powers and Trusts Law of New York;
11. authorize access to or release of confidential records; and
12. apply for government and private benefits.

As is appropriately noted in the Law Revision Commission Comments to MHL § 81.21 the above stated list of powers is intended to be "illustrative rather than exclusive." But more importantly, the Commission correctly recognized that § 81.21 gives statutory recognition to the common law doctrine of "substituted judgment" which is recognized by the courts in New York and other jurisdictions. For an example of the utilization of this doctrine, please see *In re Florence*.[1] Simply stated, the guardian, utilizing the power to engage in property management for the incapacitated person, including the power to transfer assets of the incapacitated person to another person, may be authorized to undertake the acts that the incapacitated person could have if he/she had the capacity to do so.

As will be discussed later, the courts in New York have been extremely receptive to the doctrine of "substituted judgment" by granting guardians the authority to transfer the assets of the incapacitated person in a varied set of circumstances. However, before the guardian is permitted to transfer the assets of his/her Ward, there are several factors delineated in § 81.21(b) which must be contained in the Petition requesting the transfer of assets and which need to be considered by the Court before ruling upon the requested transfer.

Factors Considered by the Court

Illustrative of the information that needs to be disclosed in the petition pursuant to the provision of MHL § 81.21(b) is:

1. whether the disposition is consistent with any known testamentary plan or pattern of gifts. It is most important that the petitioner requesting the transfer of assets articulate all of documentary proof whether it be contained in a last will, revocable or irrevocable trust or any other writing in which the incapacitated has previously expressed an intention to transfer his/her assets in a manner that is consistent with the transfers requested in the petition;
2. whether the incapacitated person expressed or manifested any intention that is inconsistent with the proposed disposition;
3. whether the incapacitated person has engaged in making any significant gifts or pattern of gifts prior to his/her incapacity; and
4. whether the incapacitated person has sufficient capacity to make the proposed disposition and if so his/her consent should be attached to the petition.

Pursuant to the provisions of MHL § 81.21(d) in determining whether the court should approve the proposed transfer, the court will consider, among other things:

1. whether the incapacitated person has sufficient capacity to make the proposed disposition and if so, whether there has been consent;
2. whether the incapacitated person's disability will be of long or short duration;
3. whether the needs of the incapacitated person and his/her dependents or others depending upon him for support can be met from the assets remaining after the proposed transfer is made;
4. whether the proposed donees of the transfer are the natural objects of the incapacitated person's bounty;
5. whether the proposed transfers will produce tax savings which will benefit the ward or his/her dependents;

6. whether the transfer is consistent with any known testamentary plan or pattern of gifts; and

7. any other factors that the court deems relevant.

Service of the Petition Upon Interested Persons

MHL § 81.21(a) specifically delineates upon whom the petition seeking the proposed transfer is to be served:

1. The persons entitled to notice in accordance with paragraph one of subdivision (d) of § 81.07 of this Article. For example, spouse if any, parents, if any, adult children, if any, etc.; and

2. If known to the petitioner or guardian the presumptive distributees of the incapacitated person as that term is defined in § 103 of the Surrogate's Court Procedures Act, unless the court dispenses with such notice; and

3. If known to the petitioner or guardian, any person designated in the most recent will or similar instrument of the incapacitated person as beneficiary whose sights or interests would be adversely affected by the relief requested in the petition.

It is most important that the attorney carefully scrutinize the incapacitated person's last will and any other documents of a testamentary nature executed to determine whom will be affected by the proposed transfer. It is not unusual to have one set of individuals who are interested parties for purposes of the Petition seeking the appointment of a guardian, and a different group of individuals being interested parties for purposes of the petition seeking the transfer of assets. Additionally, it is as equally important that a determination be made whether any interested person is a person under a disability, which would require an appointment of a *guardian ad litem* to protect his/her interests with respect to the proposed transfer. I recently had the experience as a court evaluator in a guardianship proceeding wherein a beneficiary named in the last will of an incapacitated person was believed to have an addiction to alcohol. Under said circumstances, the petition should clearly state that this individual, as an interested person, may be a person under a disability in need of a *guardian ad litem*. It is a material fact that could later pose a problem if it remained undisclosed.

Required Findings to Be Made by Court to Grant the Petition

MHL § 81.21(e) specifies that prior to granting the petition requesting a transfer of the incapacitated person's assets, the court must find by *"clear and convincing evidence"* and shall make a record of the following findings (emphasis added):

1. The incapacitated person lacks the requisite mental capacity to perform the act or acts for which approval has been sought and is not likely to regain such capacity within a reasonable period of time or, if the incapacitated person has the requisite capacity, that he/she consents to the proposed disposition;

2. A competent, reasonable individual in the position of the incapacitated person would be likely to perform the act or acts under the same circumstances; and

3. The incapacitated person has not manifested an intention inconsistent with the performance of the act or acts for which approval has been sought at some earlier time when he/she had the requisite capacity or, if such intention was manifested, what is the likelihood he/she would have changed such intention under the circumstances existing at the time of the filing of the petition. Clearly, these are factual issues that will require an investigation by counsel for the petitioner.

Clearly, the legislature's incorporation of the judicial doctrine of "substituted judgment" in MHL § 81.21(e)(2) was imperative in allowing both the elder law practitioner and the judiciary to be as creative and pragmatic as possible with respect to the transfer of assets for Medicaid and estate planning purposes.

Before discussing some of the case law illustrative of the Medicaid and estate planning that has been permitted pursuant to MHL § 81.21, I direct your attention to MHL §§ 81.16(b) and 81.22 which authorize the court to direct or ratify any transaction to establish protective arrangements including a trust (revocable or irrevocable) which may even extend beyond the life of the incapacitated person. These sections are often neglected provisions of Article 81, which the attorney can look to when confronted with Medicaid or estate planning issues for an incapacitated person.

Relevant Case Law Regarding Transfer of Assets Requests by Guardians Under Article 81

Commencing in 1994, the genesis of the judiciary's willingness to expansively interpret Article 81 began to take form. The following cases are illustrative of the scope and breadth of the judiciary's recognition of the doctrine of "substituted judgment."

In re Klapper, N.Y.L.J., Aug. 9, 1994, p. 26, col. 1 (Sup. Ct., Kings Co.)

The son/guardian of a nursing home resident (his mother) sought permission to transfer the majority of mother's assets (approximately $340,000) to his family. The court held that use of such Medicaid planning is legally permissible and the transfer for purpose of Medicaid planning would not violate public policy. In reaching its decision, the court found that the mother had an "extensive history" of consistently providing financial support to her son and his family. The court noted that the son's family's annual expenses were approximately $62,400, however, the son's family's annual income was approximately $43,000, a shortfall of $19,000, per year or $1,500 per month.

The court found that there is no question that the use of such Medicaid planning by competent persons is legally permissible and that proper planning benefits their estates. The Court opined that transfers for the purpose of Medicaid planning do not violate public policy. Rather, it appears to be the intention of Article 81 to permit such a transfer. The court opined that the fundamental policy underlying Article 81 is to assist the incapacitated person to compensate for his/her limitations and to provide the least restrictive alternative. In order to effectuate this policy, an incapacitated person should be permitted to have the same options available relevant to transfers of property that are similarly available to competent individuals.

In re Cooper (Daniels), 162 Misc. 2d 840, 618 N.Y.S.2d 499, 1994 (Suffolk Co.)

The sister/guardian of an incapacitated person sought authority to (a) renounce her ward's share in his deceased wife's estate; (b) transfer the assets of a bank account to the ward's two children, ages 20 and 23; and (c) transfer the ward's real property to her 20-year-old child. The court held that a "competent, reasonable individual . . . would prefer that his property pass to his child rather than serve as payment for Medicaid and nursing home care bills where a choice is available." The court further found that denying an incompetent person, through her guardian, the same rights to conduct Medicaid planning that are available to any competent person in the state of New York would achieve a result "in direct contravention of the expressed intention of Article 81."

The court allowed the requested renunciation and transfer of assets, while requiring retention of sufficient funds in the guardianship to pay for the nursing home care during the Medicaid penalty period. The court further allowed the transfer of real property to the 20-year-old child relying on Social Services Law § 366(5)(d)(3)(I)(B) which permits the transfer of a home to a child under age of 21 without negatively affecting Medicaid eligibility.

In re Parnes, N.Y.L.J., Nov. 2, 1994, p. 32, col. 2 (Sup. Ct., Kings Co.)

The petitioner requested permission to transfer $150,000 in liquid assets of an incapacitated nursing home resident to her husband who had liquid assets totaling $345,000 as well as the transfer of the incapacitated person's share of a jointly owned house ($110,000). The court held that the transfer would aid the husband in meeting his own household and medical expenses and in providing to his incapacitated spouse services and items not covered by Medicaid. The court granted the application even in absence of any evidence that the ward had ever contributed to her husband's support and in absence of any evidence of a pattern of gift giving. The court also noted that a husband's exercise of spousal refusal would not violate public policy.

In re DaRonco, 167 Misc. 2d 140, 638 N.Y.S.2d 275 (1995)

The conservator/wife of an incapacitated spouse sought to convert the conservatorship to a guardianship and to authorize the transfer of the entire incapacitated spouse's estate to herself, and to subsequently exercise a "spousal refusal" when applying for Medicaid. The court granted the petition converting the conservatorship to a guardianship, and authorized the requested transfers. The court determined that the cost of nursing home care for the ward exceeded the ward's monthly income and would eventually result in depletion of his entire estate in less than seven years. The court further held that the "spend down" of the incapacitated person's estate would eventually leave his wife/guardian and minor son destitute. The court also noted that, because the proposed transfers would be to a spouse, gift taxes would be avoided and no Medicaid penalty period would be incurred due to the spouse/guardian's invocation of her spousal refusal rights pursuant to Social Services Law § 366(3)(a).

***In re Baird*, 167 Misc. 2d 526, 634 N.Y.S.2d 971 (1995)**

The proposed guardian sought to renounce part of the incapacitated person's interest in the estate of a deceased friend for Medicaid planning purposes. The court held that N.Y.S. Dept. of Social Services was not a necessary party in the Article 81 proceeding. The court cited MHL § 81.07(d)(1)(viii) for authority that the local Dept. of Social Services and not the State Dept. of Social Services is a party entitled to notice of the proceeding.

The court held that the guardian under Article 81 has the power to renounce part of the incapacitated person's interest in the estate of a deceased friend in order to provide funds to pay for nursing home costs during the Medicaid "penalty period," while allowing the remaining funds to pass to her children and not be used for her nursing home expenses. The court opined that a competent reasonable person would make the renunciation and that a person involved in an Article 81 proceeding should have the same options available as a competent individual who has assets. Again, a clear invocation of the doctrine of "substituted judgment."

***In re Shah*, 95 N.Y.2d 148, 711 N.Y.S.2d 824 (6/8/2000)**

The Court of Appeals affirmed the decision of the Appellate Division, 2nd Department, which authorized the guardian/spouse to transfer to herself the entire assets of her incapacitated spouse for the purpose of allowing her to then exercise a spousal refusal and make her spouse eligible for Medicaid, and to further be able to refuse to use those assets for support of her spouse.

***In re Christine Banks*, N.Y.L.J., June 27, 2000 (Sup. Ct., N.Y. Co.)**

The court allowed the guardian of an incapacitated nursing home resident that had a large accumulated debt to be able to transfer one-half of $164,000 of her belatedly discovered assets to a pooled trust pursuant to Social Services Law § 366.2(b)(2)(iii)(B).

Social Services Law § 366.2 permits the establishment of a pooled trust for an incapacitated person that is funded by one-half of the person's assets. The other half is spent down and then the person is eligible for Medicaid.

Conclusion

As the baby boomer generation, of which I am a member, comes of age and begins to face all of the medical and physical problems associated with aging, I am certain that reliance upon Article 81 and its body of case law will increase with greater frequency. The continued creativity of the elder law bar partnered with the willingness of the judiciary to broadly interpret Article 81 and the doctrine of "substituted judgment" will help insure that the rights of the incapacitated are not in any way compromised.

I am confident that the commitment of the bar to protect the rights of an incapacitated person will continue to insure the viability of Article 81 as an effective Medicaid and estate planning tool.

Endnote

1. 140 Misc. 2d 393, 530 N.Y.S.2d 986.

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Letter to the Editor

Dear Editor:

I have read with interest the article by Jennifer R. Sessler in the Fall 2000 *Elder Law Attorney* concerning using an unequal joint tenancy to protect the family home.

I do not think that this idea will work.

The *Novak* case cited in the article specifically states that, "During the lifetimes of the joint tenants, their interests are *partitionable* . . ."

If the nursing home resident has a right to bring a partition action as a joint tenant, the joint tenancy interest is an available resource. The nursing home resident must either bring a partition action as a condition of eligibility or the partition action must be assigned to the Department of Social Services as part of the Medicaid application. Alternatively, the Department of Social Services could treat the joint tenancy and property the same as joint tenancy in a bank account, and deem that it is all the property of the Medicaid applicant.

Even if a partition action is necessary, I am sure that any Medicaid office in the State would bring a partition action to force the sale of a house because of the relatively large sums of money tied up in the house and the risk of losing all the potential recovery from the house if nothing is done until after the nursing home resident/joint tenant dies.

The reason why retention of a life estate in the house works is because a full life estate is not subject to partition under New York Law. The theory is that an exclusive life tenant is entitled to the use and occupancy of the whole of the premises, and there is nothing to partition.

It is true that a partition abates upon the death of one of two joint tenants. However, there is case law holding that when the only issue is the computation of the various interests, the action does not abate. (See, e.g., *O'Brien v. O'Brien*, 89 Misc2d 433 (Oneida County 1976). I believe that it would be relatively easy for a Department of Social Service to get an interim order requiring a partition. This is all that would be necessary to stop the clock from running and destroy the survivorship interest. Alternatively, a Department of Social Services could require a consent to partition as a condition of a Medicaid eligibility.

For all these reasons, I do not believe that a joint tenancy in real estate—be it equal or unequal—does anything to protect assets of an unmarried Medicaid applicant.

Very truly yours,

LEE A. HOFFMAN, JR.
HOFFMAN, WACHTELL, KOSTER & MAIER

Dear Mr. Davidow:

I am pleased that my recent article and Mr. Hoffman's Letter to the Editor gives us an opportunity to further discuss issues which are so important to our clients.

Mr. Hoffman is correct that a life estate is generally a better solution than a joint tenancy for preservation of a Medicaid applicant's home. However, this is only true where the applicant has planned properly with sufficient time to allow the period of ineligibility incurred as the result of the creation of the life estate to pass prior to making an application for Medicaid. My article addressed the situation where little or no planning was done by the applicant prior to the imminent need for nursing home care.

The reason a life estate is generally favored is that Medicaid has ruled that a life estate will not be considered a countable resource for Medicaid purposes without any reference to the applicant's intent or ability to return home. In addition, upon the death of the life tenant, the entire value of the home is includible in his estate for estate tax purposes which results in a stepped up basis. As I stated in the article, if the applicant/homeowner is in imminent need of nursing home care, the transfer of the property subject to a life estate may incur an extremely long period of ineligibility which would make such a transfer undesirable.

Two other options are available where imminent nursing home care is required: 1) Immediately sell the home, calculate the value of the asset after capital gains tax are paid (if any) and transfer away enough cash so that the remaining cash can be used to pay for nursing home care during the period of ineligibility created by the transfer. (This used to be referred to as the rule of halves) or 2) Create a joint tenancy.

This issue raised in Mr. Hoffman's letter as to a partition action are not applicable here. Despite a joint tenant's right to bring a partition action against the property, Medicaid will not consider the home an available resource as long as the applicant makes a subjective statement of intent to return home. Once Medicaid is notified of the applicant's intent, Medicaid cannot consider the vacant home as a countable resource and cannot force the sale of the property by partition or otherwise. Medicaid can, however, place a lien on the property. Once the home is considered exempt, a lien may be placed against a vacant home if the homeowner/recipient is permanently institutionalized. Medicaid's recovery rights in this situation are limited to the placement of a lien.

Once the application is approved, Medicaid can recover funds which were correctly paid during the life of the Medicaid recipient only upon the sale of property subject to a Medicaid lien or from the recipient's estate after death under specific circumstances (there are additional recovery methods which are not relevant to our discussion.) The transfer of the property upon the death of the joint tenant is not considered a sale. Further, for purposes of recovery against an estate by Medicaid, an estate is generally considered to include only those resources which the Medicaid recipient owned individually at the date of death, or benefits directly payable to the individual's estate. Real property jointly owned with a right of survivorship is not included in an individual's estate since they pass by operation of law upon the death of the joint tenant. It is interesting to note that OBRA '93 permitted states to redefine the term "estate" to include not only property subject to probate but also any assets in which the individual had any legal title or interest at the time of death, including, for example, an asset held by joint tenancy. However, New York did not elect to expand the definition of estate to include such property.

For the remainder of the discussion of the benefits and detriments of a joint tenancy and in particular unequal joint tenancy, I refer you to my article.

In addition, Mr. Hoffman's concern that the Department of Social Services could treat the joint tenancy and property the same as a joint tenancy in a bank account is easily allayed. Medicaid has specifically spoken to the issue of merely placing a person's name on a bank account by stating that such an action doesn't necessarily constitute a transfer of the asset. It's only when the joint owner/non-applicant actually withdraws or removes some of the assets will there be considered a transfer of those assets. By comparison, changing the title to real property via deed actually limits the Medicaid applicant's right to sell or dispose of the asset. The Medicaid transfer rules state that any action taken by a Medicaid applicant or any other person that reduces or eliminates the applicant's ownership or control over assets held in joint name will be considered a transfer of assets incurring a period of ineligibility for institutional services. Medicaid has recognized that real estate held under a deed is not treated like joint bank accounts under OBRA '93.

Thank you for the opportunity to clarify the issues raised by Mr. Hoffman's letter.

Very truly yours,

Jennifer R. Sessler

tions to problems which each discipline faces in its practice. We are fortunate to have preeminent members of the judiciary and bar who will present on topics such as personal injury settlements into supplemental needs trusts, guardianship issues, matrimonial issues facing seniors and ways to collaborate on cases to achieve the best result for our clients. As noted above, our Fall meeting will be in Albany on October 10 and 11, 2001, with our annual Advanced Institute to follow on Friday, October 12. For those who have not attended the Advanced Institute in the past, similar to the listserve it presents a tremendous opportunity to network and learn from experienced practitioners, in a small group setting, which allows for personal questions and cases to be discussed. Our January meeting will be chaired by Dan Fish, as part of the Annual Meeting of the New York State Bar Association in New York City. And, in addition to our regular Section meetings, there will be CLE programs and other events, all of which provide ample opportunity for your active participation.

A special thanks must go to the editor of this *Elder Law Attorney*, Lawrence Davidow, whose Herculean efforts have produced a newsletter that is the envy of not only other Sections of the New York State Bar Association, but other states as well. For those who do not read it faithfully, the articles and regular columns provide timely and topical information that is unparalleled.

Finally, I want to thank my friend and colleague Bernard Krooks for leaving me a healthy, energized and financially sound Elder Law Section. I look forward to working with my fellow officers, Chair Elect Cora Alsante, Vice-Chair Ira Miller, Secretary Joan Robert and Treasurer Mitch Rabbino, and with the dedicated Committee Chairs and Section members who have made participation in the Elder Law Section one of the most enjoyable and memorable experiences in my career.

My father used to say to me "Son, I'd like to compliment you on your work—when will it start?," and to my pop I reply, "Right now." I invite each of you to help me make this Section the best it can be.

Louis W. Pierro

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