

Elder Law Attorney

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

Message from the Chair



What are the most significant issues that you face in your practice? As elder law attorneys, our answers to that question will vary. Are the issues substantive—Medicaid, guardianship, Medicare, estate planning, tax law changes, *et al.*; or are they practice oriented—how do I computerize, market, manage, bill, get retained, hire, fire and find time for family, friends, life?

A bar association is a collection of attorneys with common interests, designed to serve and help manage the legal profession. In New York, the House of Delegates is the state bar's governing body, and in June I had an opportunity to attend its meeting in Cooperstown. The issues addressed by the "big bar" impact each of us, such as new Multidisciplinary Practice Rules; the requirement that attorneys send clients confidentiality notices; new rules on mandatory arbitration of fee disputes; and more. New Association President Steven C. Krane has set a broad mandate, and his approach will help the state bar serve its members well, and advance the cause of attorneys in all fields.

President Krane in turn attended our Section's Executive Committee Meeting on August 8, and expressed a keen interest in helping our Section fulfill its obligation of advancing the cause of elder law in New York State. Legislative actions and proposals, guardianship reform, judicial issues, MDPs in elder law, CLE and law school issues were among the topics discussed, and Mr. Krane displayed an ability to quickly understand our issues, and offer practical advice on how to solve them. At his recommendation, we are submitting the Section's report on MHL Article 81 to the House of Delegates, along with a proposed resolution, to be discussed at its November

meeting. In light of the impending release of the Birnbaum Commission Report on Fiduciary Appointments, having a forum such as the House of Delegates to address our guardianship concerns will be timely and valuable.

The Elder Law Section Summer Meeting was held August 8-12 in Florence, Italy, the first-ever joint session with the Trial Lawyers Section, and it was a remarkable success. Presentations by Section members Joan Robert, Steven Rondos, Robert Kruger and Bernard Krooks, were all well done and well received. The participation of Judges Levine, Cardona and Nicolai added an aura of judicial credibility, and each of the judges proved to be able presenters and excellent listeners to the members of both the elder law and trial bars. The tour that preceded the conference, which was planned by Mitch Rabbino and Ellen Makofsky, was a grand tour of northern Italy, and by all reports it was magnificent. The other events at the conference, ably coordinated by Catherine Dolginko and Kim McHargue of the State Bar Association, included a very popular cocktail reception at the Bargello Palace, which houses an impres-

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sive collection of Renaissance sculpture including several Michelangelo's, which was surpassed only by the gala reception and dinner at the Villa D'Maiano, built in 1400 in the hills overlooking Florence with a spectacular panoramic garden overlooking the city. Museums, art galleries, and trips to Siena, Pisa and Chianti rounded out an exceptional program.

The Section's Fall Meeting was held at the Albany Marriott on October 10-12, 2001. Following an Executive Committee Meeting on October 10, a substantive presentation chaired by Bob Freedman was conducted from 2:00-5:00 p.m. on the topic of "Counseling Clients on Paying for Long-Term Care." Section member Peter Strauss spoke on long-term care insurance and its impact on housing and care options, and a special presentation was made by Susan Peerless from the New York State Department of Health, who spoke to us on Governor Pataki's Senior Housing Program, including an assisted living bill which is to be developed this fall. On Thursday, October 11, an intensive forum was conducted on long-term care financing, which included a keynote address from former U.S. Senator David Durenburger, founder of Citizens for Long-Term Care in Washington, D.C. Senator Durenburger's work on long-term care reform has gained national attention, and his efforts to build a coalition to reform the long-term care system in America parallels the efforts of our Section to

stimulate discussion in New York State. Senator Durenburger was joined by Judy Feder, Dean of Policy Studies at Georgetown University, and a top health policy expert, and a stellar panel of representatives from provider groups, insurance companies, the state legislature and executive branches, consumer groups and our own Elder Law Section. In-depth analysis on issues of long-term care financing, Medicare, Medicaid, private insurance, and other proposals for government and private-sponsored programs was done, and on Friday, October 12, the Section held its annual Advanced Institute, with expert speakers on a broad range of elder law topics. This program has consistently been one of the highest rated seminars by those Section members who have attended.

Our January meeting, which is part of the Annual Meeting of the State Bar Association in New York City, is being chaired by Dan Fish. The program will focus on practical issues facing the elder law attorney, including the use of trusts, Medicaid transfers, deeds with retained life estates and other timely and important topics.

Now that the summer is over, we all need to roll up our sleeves and get back to work. Get involved; I encourage each of you to join a committee and attend the committee meetings. Enjoy your autumn.

Louis W. Pierro

Join the
ELDER LAW SECTION LISTSERVE
for a lively discussion of substantive and practical elder law issues

To join send a blank e-mail to:
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Editor's Message

Over the past several years, my firm has become a big supporter of the New York State Coalition for the Aging (NYSCA). I remember the first time that I heard about the organization was when a member of my staff, Barbara Wolford, L.P.N., who serves as our in-house Geriatric Care Manager, introduced it to me after joining its board. Since then I have come to appreciate the invaluable contributions it brings to the aging community and I have, in turn, made the personal commitment to serve as the honorary chair of its annual membership event.



Prior to my introduction to NYSCA a few years ago, I was completely unaware of what it was and what its role was in the aging community. Since then I have come to learn what it stands for: that older adults have the right to live as independently as possible, with dignity, in their homes and communities with the appropriate support services. To this end, NYSCA unites all of the government, not-for-profit and for-profit organizations that serve the elderly in this capacity. These organizations comprise the NYSCA membership.

What NYSCA really accomplishes is the coordination of the continuum of care. The truth is that there are many great organizations that serve the elderly in their homes and in their communities, but the delivery of services is at times fragmented, the funding sources diverse, and the ultimate quality of care is not consistent from patient to patient.

As elder law attorneys, we are part of the aging network. We are stakeholders in the overall continuum of care. As such we should be aware of and support an organization whose goals are consistent with

our own; that our clients be able to obtain the highest quality of care, dignity and security as they age.

It is with all this in mind that I dedicate this Fall 2001 edition of the *Elder Law Attorney* to NYSCA and the Continuum of Care. The first article in this issue was written by Greg Olsen, who currently serves as NYSCA's Executive Director, and whose help was invaluable in putting this entire THEME together. On behalf of the entire Elder Law Section of the New York State Bar Association, I thank you Greg. His article will introduce you to NYSCA, its services and its goals. Following Greg's article are five other articles which highlight certain members of NYSCA and their role in the continuum of care. While there are literally hundreds of NYSCA members and hundreds of parts which make up the whole continuum of care, these articles are meant to honor the concept of the continuum of care, rather than trying to cover the entire field.

I trust that you will find this issue interesting and that it will help you counsel your clients as together we try to navigate the waters of the continuum of care. It is nice to know that NYSCA is out there to help. Helping elder law attorneys is clearly within its mission because we are clearly part of the continuum of care ourselves. And as members of this continuum of care, it is appropriate for us to be members of NYSCA and have a voice in supporting our common goals. I urge you to join and become involved.

In addition to 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

In the Spring 2000 edition of the *Elder Law Attorney*, we included an excellent equation written by James D. Gabler, which is helpful in determining the Medicaid transfer penalty under certain parameters. Please note that if you are interested in such equations, our past Chair, Vincent Russo, wrote a very detailed article containing at least five such equations for the Fall/Winter 1992 edition of our journal.

The New York State Coalition for the Aging

By Greg Olsen

The New York State Coalition for the Aging (NYSCA) and our members believe that older adults have the right to live as independently as possible, with dignity, in their homes and communities with the appropriate support services. For over 30 years, NYSCA has provided strong advocacy, professional development, leadership skills and education for individuals and organizations serving older adults. We are dedicated to strengthening and expanding community-based services that serve older adults in their homes.



There are so many organizations with dedicated staff who do tremendous work in New York serving the variety of needs of older adults. The New York State Coalition for the Aging is the only statewide organization that represents the myriad of community-based service providers. Our members include senior centers, county offices for the aging, social adult day care providers, Alzheimer's associations, Catholic Charities, ARCs, home care agencies and senior providers from towns and municipalities. What all of our members have in common is their dedication to providing quality services to older adults and their belief that seniors can, and most oftentimes should, be cared for in their homes and communities with the appropriate support services.

Based in Albany, NYSCA works with state and federal lawmakers, state agencies and other senior organizations to enhance and strengthen the local senior service delivery system to meet the individual needs of older adults. We do this by collecting information from our members on the issues and trends they are experiencing at the local level and communicating these issues and their possible solutions to decision-makers. NYSCA has nine geographic representatives who are conduits to local programs and providers and help organize local trainings, participate in meetings, gather information about what is happening in local communities and relay important state and federal information to local program and service providers. The geographic representatives are the key to NYSCA's success and they are the gateway

to getting to know what is occurring with senior programs and services in communities throughout the state.

In New York, the service delivery system for the aging is complex. There are a variety of service providers, there are a variety of funding streams, there are a variety of services offered and depending on where you are in the state, there are different systems in place with their own processes and their own politics. Many communities have multiple providers supplying similar services. Some communities do a good job coordinating services and others have providers doing similar work that do not communicate at all. There are differences in the way services are delivered in all 62 counties in New York.

"The New York State Coalition for the Aging is the only statewide organization that represents the myriad of community-based service providers."

People who work in the field of aging talk about "the continuum of care." This concept describes all the various support services available at the community level for older adults, from information and referral services to nursing home services and everything in between. It is the continuum of care that we talk about when we discuss strengthening and expanding senior services. The ultimate goal is to have a seamless system where multiple providers can freely communicate with one another about their clients so that the holistic needs of the client can be met. One organization may be providing home-delivered meals, another may be providing transportation, another may be providing case management, but all should be communicating with one another, coordinating their services and meeting the individualized needs of their clients. While we are all striving to make this a reality, much work needs to be done in the field to work more closely together and to trust one another. If our goal as individual organizations is to provide quality programs in the community for seniors and if our goal as a network is to do

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the same, then we should be working to create a seamless, coordinated and non-duplicative system of service delivery.

The continuum of care includes many services provided by a variety of government and non-government providers. Services include case management, home-delivered meals, adult day services, information, assistance and referral, expanded in-home services for the elderly (EISEP), homemaker personal care, transportation, housekeeping chores, health promotion, outreach, personal emergency response system, senior center recreation and education, congregate meals, escort services, home health aide, caregiver support, respite, legal assistance, energy assistance, prevention services, nutrition education, nutrition counseling, telephone reassurance, inter-generational programming, accident prevention, blood pressure screening, flu shots, medication monitoring, senior employment, entitlement assistance, home repair, weatherization, counseling and shopping assistance. Some of these services are provided for free or on a sliding scale, others are paid for by the individual.

The continuum of care also includes medical care such as hospitalization, outpatient care, nursing home care, medical adult day care, housing options, assisted and independent living centers and so forth. All of the services provided in the continuum of care are provided by medical professionals, managed care organizations, county offices for the aging and their subcontractors. The subcontractors include senior centers, nonprofit and for-profit corporations, visiting nurse services and many other organizations that may provide just one service or a variety of services. Many towns and municipalities fund the services listed above, but unfortunately, because they do not receive any, or very little, state or federal funding, many of the services that are provided go unreported. As a network, we have never had a true picture of the need and all the services that are available.

The money trail begins at the federal level with the Older Americans Act, which is the primary source of federal funding to the states for community-based services for older adults. Other federal funds that help older adults include the Social Services Block Grant, Housing and Urban Development (HUD—housing), USDA Nutrition Program for the Elderly, Low-Income Energy Assistance Program, Senior Volunteers and so forth. Funding for these programs are provided to states based on a complex formula. New York, with the third largest senior population behind California and Florida, receives a fairly good piece of

the pie because the formula is partly based on the number of persons over the age of 60 a state has.

The way programs are funded is very important because it dictates who controls the process that determines which organizations are a priority to receive funding and which are not. Of course, with any public dollars comes much paperwork and regulation, and some programs, particularly those run by towns, do not receive much, if any, public dollars from these sources. Once the state receives the federal funding, it then turns around and provides counties with their share of the money, again, based on a fairly complex funding formula. As a general rule, New York City receives about 40 to 45 percent of the money because it has a large senior population. The New York State budget provides additional dollars to counties, as do the counties themselves, because federal dollars are not close to sufficient to meet all the needs of the senior population and in order to receive federal and state funding, counties must provide a match.

At the local level, county offices for the aging must have a local planning process that includes senior providers (possible subcontractors) that is designed to ensure that the limited government dollars are utilized effectively and efficiently to deliver the appropriate level of services to seniors based on locally determined needs. Some county planning processes work well and others are mainly for show. Counties, under law, must subcontract out their services to local providers if they are available in that county to provide services. Other counties, mostly the rural counties, provide the services directly where no subcontractors are available. Some counties do both, provide services and subcontract services. There is no one way to describe how each county works in New York. This is important because depending on where you are in New York, finding the appropriate services for your clients, friends, neighbors and clients can sometimes be difficult.

This is exactly why coordinating services, working together and communicating with one another is so critical in the continuum of care and the delivery system. There are so many different players providing services, and usually the ones who communicate the best and have the best relationships with the money handlers (county offices for the aging) receive the subcontracts. Due to inadequate funding for most aging services, relationships at the local level are critical to an organization's success.

The New York State Coalition for the Aging, Inc. is working with the New York State Office for the

Aging, the New York State Association of Area Agencies on Aging (association representing county offices for the aging) and other aging organizations and senior advocacy groups to work more closely at the local level to ensure that the best possible coordinated services are being provided to older adults throughout the state. This is a major challenge, but one that must be pursued. New York currently has 3.2 million people age 60 and older. By the year 2010, we will have 5.5 million people age 60 and over and by 2015 we will have 6.4 million. This will be a doubling of the population over the next 14 years! The fastest growing segment of the population are those 75+ and 85+. These older seniors require the most extensive and expensive services due to increasing disabilities and chronic conditions. Demand for services often exceed family and informal caregivers' capabilities and/or the seniors ability to pay for care.

"Those elderly individuals who are in poor health and are frail, usually are so due to chronic conditions. Chronic conditions are the leading cause of illness, disability and death in the United States."

Economic Status

Since 1935, with the introduction of social programs such as Social Security, Medicare and the Older Americans Act in 1965, the number of elderly who were living below poverty has decreased substantially. These programs have helped tremendously in reducing poverty by guaranteeing health care and income while in retirement. However, there are still many elderly individuals in New York who are below the poverty level and many more that are considered "near-poor," barely above the poverty threshold set by the federal government. **In fact, 47.6 percent, or 1,457,471 households headed by an individual 60+, have incomes below \$10,000. Furthermore, 62 percent, or 1,896,287, had incomes below \$15,000.**

This data reveals that although there has been a steep decline in the percentage of the elderly that were living in poverty over the years, there are still many seniors who are poor or near poor. This data is critical in understanding the day-to-day decisions that seniors have to make in order to survive. In a high cost state such as New York, \$10,000 to \$15,000 per year is inadequate to meet daily needs, let alone

pay for ever-increasing health costs such as prescriptions, co-payments and deductibles. Increases in the cost of living, year after year erode the purchasing power of a senior on a fixed income, especially in areas such as health care. The modest cost-of-living adjustment from Social Security has not kept up with inflation.

Living Arrangements

Almost all of New York's elderly live at home in the community. Only 4.7 percent live in group quarters such as nursing homes. Two-thirds of all older persons (65.9 percent) live with their spouses or other relatives in family arrangements. Of these seniors living in the community, 952,495 live in houses and 1,029,205 live in apartments, where the average rent is \$395 per month. One in every four (26.2 percent), or 835,818, lives at home alone.

Of the total aged 60+ living alone, 75.9 percent are older women, 44.5 percent are persons aged 75+, and 35.8 percent are women 75 years of age or older. The number of older persons living alone has grown by more than 10 percent since the 1980 Census, and those aged 75+ grew by almost 30 percent since the 1980 Census.¹ Although alternative living arrangements such as retirement communities and assisted living are gaining momentum and popularity, these arrangements are financially out of reach for many seniors who also prefer to remain in homes that they have lived in for years.

Health Characteristics

Many individuals perceive aging as a time of disease, disability and dependence. Although these characteristics can and do occur among the elderly, most elderly individuals consider themselves in good health and active. Investments in health and wellness and other community-based programs can help keep seniors in their homes.

Those elderly individuals who are in poor health and are frail, usually are so due to chronic conditions, which are the leading cause of illness, disability and death in the United States. Three out four deaths are attributed to chronic conditions, which include arthritis, asthma, heart disease, hypertension, diabetes, blindness, hearing impairments, etc. In 1995, 99 million people had at least one chronic condition. One quarter of these people are elderly. These conditions cost taxpayers \$470 billion in direct health care costs every year.

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In New York State, 469,194 senior citizens have some type of chronic limitation. Mobility limitations affect 354,362 people and 294,792 have a self-care limitation. Even though the elderly account for only 25 percent of all chronic conditions, the type of conditions that affect the elderly are more severe and disabling than those that affect the non-elderly.

Older adults, who represented 12.8 percent of the population in New York in 1995, accounted for 38 percent of all hospital stays and 48 percent of all days of care in hospitals. Under Medicaid, 34 percent of the state's expenditures are on the elderly and 70 percent of these expenditures are to cover long-term care costs.

The growing population will place an even greater demand on services, and the changing face of the older population will demand different alternatives and choices of types of services and where they are received. This is a time for lawmakers, the public, senior services providers and senior advocacy organizations to look at the current system and develop and plan for ways to strengthen the local system of delivery. We currently have waiting lists for services throughout New York. This will increase in the coming years because the federal and state commitment to community-based programs for seniors has remained relatively stagnant. The cost of doing business and inflation is eroding the purchasing power of these programs and it is requiring providers to try to keep up with current caseloads with less money. This has placed a great strain on the aging network. A shift needs to take place that looks at front-end services as the delivery method of choice.

There is much more to this debate though than funding. As an aging society, we need to plan not only to meet today's needs, but tomorrow's. Many lawmakers are trying to find ways to lower health costs (Medicare and Medicaid) at the federal and state level. Cuts to these budgets are common at all levels of government. New York State is similar to other states in that the primary method of delivering services to seniors is based on the medical model—providing care in a hospital, nursing home, rehabilitation setting or requiring medical home care. While we believe that these medical services are critically important for people of all ages, we strongly believe and encourage the use of prevention and health and wellness services that are provided at only a fraction of the cost in one's own home and community.

In New York State in 2000, over \$8 billion was spent through the Medicaid program on nursing

home care, home care and other medical expenses related to aging. Furthermore, over \$17 billion was spent through the Medicare program in New York in 1997 (the most recent data), for such things as hospitalization and physicians visits. This does not include the out-of-pocket costs paid by those over the age of 65 for long-term care, prescription drugs and other medical costs (hearing aids, eyeglasses, dental and so forth) as well as the countless hours and dollars provided annually by caregivers. All said, well over \$25 billion is spent annually on health care for seniors in New York.

Community-based services that meet a senior's individualized needs based on an assessment and a care plan often delay and/or prevent hospitalization, nursing home placement and medical home care by identifying a problem and addressing it before it becomes chronic in nature and requires more expensive services in an acute care setting.

These services, while preventive in nature, receive very little attention from the public and from lawmakers and very little funding from the state or federal government. These services help seniors of all ages and levels of frailty remain in the least restrictive environment for as long as possible. Based on all the available print and anecdotal data, this is where seniors want to remain and this is where family members want their loved ones to be. In addition, a senior who remains in their community continues to be an important part of the economy by purchasing goods and services and paying taxes. The alternative, such as institutionalization, which can run as high as \$90,000 per year in New York, eventually comes from the state's Medicaid program and impacts local property taxes. County government's largest cost is usually Medicaid and it is always looking at ways to control these costs. Usually, a senior citizen must first become impoverished, or close to it, to become eligible for the Medicaid program. This all too often scenario is not in the best interest of any party involved.

According to a recent audit by the Comptroller, from April 1, 1999 through March 31, 2000 (New York's fiscal year), New York State spent \$56 million to these front-end, cost-effective, preventive health and wellness services. The federal government, through the Older Americans Act, allocated through its funding formula only \$64 million for these services in New York. Finally, counties in New York spent \$113 million for these services over the same time period. A total of \$233 million was spent at the local level to identify problems and needs and prevent more costly care in a medical setting. Again,

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over \$25 billion was spent in New York providing medical to older adults.

It is our strong belief that the future of aging policy is to provide appropriate cost-effective services in one's community. We know that this is where seniors and their families want to receive services and we know that they heal better and have better outcomes in a comfortable environment, such as their homes.

"We must articulate to the public, the press and to lawmakers, that aging policy has to be community focused."

NYSCA is reaching out and organizing senior centers and service providers around the issue of the funding and priority imbalance. There are over 800 senior centers in New York State alone, and many more senior service providers. Collectively, these organizations could begin to change the dialogue concerning the importance of their services and the need for an investment in front-end, health and wellness programs that keep seniors in their communities. It is long past time that the public and lawmakers begin to see senior services for what they really are—health and wellness programs. If we can begin to change the perception of these services and programs from social to health, resources as well as prestige will follow and this will benefit the senior, their families, caregivers and the state treasury. It will also begin the critical planning process for a large population that will draw on these services as they age in place and demand a better system, with more choices, than we currently have.

NYSCA will begin offering training to senior center and senior service staff and their advisory councils on the techniques of advocacy, including using the media, how to organize in one's community, how Albany politics works and so forth. This will enable

senior citizens and senior providers to more effectively communicate with lawmakers and other community leaders the importance of senior programs and the need to plan.

It is our goal to reach out to all communities, particularly in upstate New York, with a focus on rural and minority community organizations. Reaching out and organizing the senior provider network will help bring the needed and deserved attention to these critically important programs and services.

The individuals that we are serving and that we are advocating for are people we all know. They could be you, your mother or father, your aunt or uncle or relative, your child or brother or sister, your neighbor or your friend. We must articulate to the public, the press and to lawmakers, that aging policy has to be community focused. The current system will not be sustainable financially for individuals or the state, and it currently does not provide the outcomes that families and individuals desire.

There are many resources for an elder law attorney to consider should his or her clients need services. Depending on the county you live in and serve, the county office for the aging, senior centers and town and municipal programs are your best first step. These agencies can either provide the service themselves, or refer you to someone who can, after a needs assessment is performed to identify the holistic needs of the particular client.

Finally, the articles that follow will describe in more detail the continuum of care and the services that are provided by a variety of NYSCA members throughout the state.

Elder law attorneys should feel free to call our office at 518-465-0641 for more information or questions.

Endnote

1. New York State Office for the Aging, 1996, 1997, U.S. Census.

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

The St. Lawrence County Office for the Aging

The Leading Advocate to Those Age 60+ in St. Lawrence County

By Barbara R. McBurnie

To meet the diverse needs of the growing numbers of older persons in the United States, the federal Older Americans Act (OAA) of 1965, as amended, has allowed for the creation of entities within each state known as area agencies on aging (or offices for the aging). During the early 1970s, area agencies on aging were established as public or private nonprofit agencies designed by the states to address the needs and concerns of all older Americans at the regional and local levels. There are now over 625 area agencies on aging in the United States whose purpose is to be the local leaders for organizing, coordinating and providing home- and community-based services and opportunities for older Americans (age 60+) and their families.



The St. Lawrence County Office for the Aging was established as a county government department in July of 1973. Its budget is part of the county budget and the director reports to the St. Lawrence County Board of Legislators. In its mission, the Office for the Aging strives to preserve the dignity, independence and security of older adults and their families. Non-medical, cost-effective home- and community-based services are developed and coordinated so that older citizens, age 60+, of St. Lawrence County (which covers over 2,800 square miles) may remain in their own homes and communities for as long as possible. Targeted are those persons age 60+ with the greatest social and economic needs.

Located in the northern quadrant of New York State and bordering upon Ontario, Canada, St. Lawrence County is the largest county in the state. Five major towns, several villages and many hamlets are located throughout the county, portions are contained in the Adirondack Park as well as other state forest preserves outside of the park boundary, and many older residents are low income. The beauty of the local flexibility found in the OAA as well as in additional state-funded programs, is that St.

Lawrence County is allowed to develop and provide services best suited to the needs of low-income rural residents. Home-delivered meals, widely spread out Food and Friendship (nutrition) Centers, transportation, home repair, personal care, homemaking, employment (for those 55+), legal services, fitness programs, assistance in entitlement and other program (EPIC, Medicaid, STAR, IT 214, Food Stamps and others) application, family counseling, information and referral, and much more are determined to be the most needed and accommodatable services for older adults in St. Lawrence County. Fiscal management is tricky. The funds are provided as a pot of money, not as entitlement funding, therefore additional costs must be provided by local county tax dollars.

"The beauty of the local flexibility found in the OAA as well as in additional state-funded programs, is that St. Lawrence County is allowed to develop and provide services best suited to the needs of low-income rural residents."

During the course of a day in the office, calls will be taken about a needed wheelchair ramp to accommodate the mother who just moved in, an individual being released from the hospital who needs home-delivered meals and home care, how to obtain farmer's market coupons, a daughter in need of a friendly voice to assure her that she's not alone in her frustration of caring for her elderly mother who has dementia, an invitation to speak or attend a community-based group's meeting, a mutual client with the Department of Social Services to coordinate services, an inability to purchase needed prescription drugs or fuel, bats that are in the house because of cracks in the old chimney (a rabies epidemic exists in the area), a need for a ride to the clinic (40 miles away) next week, when the next 55 Alive program is, and many more.

Services are provided to those age 60+ at no charge. Voluntary donations are encouraged, but no one is denied service because of their inability to pay. In 2000, 3,000 older adults and their families were assisted by the St. Lawrence County Office for the Aging. Over 50,570 meals were served to isolated or homebound residents and over 19,800 hours of personal care/housekeeping chore services were provided. New funding in 2001 has our office jumping to think out of the box to design and deliver these programs to best serve the needs of our older residents today and in future years. Established programs have been improved on throughout the 28 years of the office's existence. Current programs are detailed below.

Food and Friendship Program (Elderly Nutrition Program)

Since 1974, the St. Lawrence County Office for the Aging has served residents with companionship and a hot, nutritious meal at congregate sites and with home-delivered meals (better known as meals on wheels). Currently there are nine Food and Friendship Centers (nutrition sites) within the county located in Brasher Falls, Potsdam, Norwood, Canton, DeKalb Junction, Edwards, Star Lake, Morristown and Ogdensburg. In addition to preparing the congregate meals, the centers located in Brasher Falls, Potsdam, DeKalb, Edwards and Morristown also prepare and package home-delivered meals which are delivered on nine routes, totaling over 500 miles daily that serve the areas of Brasher Falls, Canton, Colton, DeKalb, Edwards, Fine, Fowler, Gouverneur, Hammond, Hermon, Madrid, Morristown, Norwood, Norfolk, Potsdam, Russell, South Colton, Star Lake, Waddington and Winthrop. To serve Massena, a modest sum of OAA funds are subcontracted to Massena Meals on Wheels. The names, "Food and Friendship Program" and "Food and Friendship Centers" were recently adopted to give the nutrition program a more upbeat look on life and to help attract younger seniors to the programs of the St. Lawrence County Office for the Aging.

Nutrition funds come to the office from several sources. Titles III C-1 and III C-2 of the OAA provide dollars for congregate and home-delivered meal services (a 10 percent local match), as do a per meal reimbursement from the U.S. Department of Agriculture, New York State Senior Nutrition Assistance Program (SNAP) dollars, local county dollars, FEMA funds (for home-delivered meals) and client donations. This allows the St. Lawrence County Office for

the Aging to pay the costs of nutrition staff salaries and fringe benefits, including that of a registered dietitian/nutrition programs coordinator, as well as food costs, rent, vehicle maintenance and gas, supplies, gas/electric/garbage/water, equipment purchases (recent purchases include a walk-in cooler/freezer unit and a new station wagon each year). Funding is limited to what is received through the above-mentioned grants and donations; increases have only recently been obtained which allow for some cost-of-living increase, yet little local match (and overmatch) relief. Thus, the Food and Friendship Program relies on volunteers. In addition to volunteers of all ages, older workers, summer youth workers, student interns, community service workers and Workfare participants are utilized to maintain daily (Monday to Friday) service to older adults of the county. Nutrition education and nutrition counseling are also provided.

Transportation Program

Public transportation does not exist in St. Lawrence County due to its vast and rural nature. Taxis are restricted to three towns; no bus or other transit system is in existence. Many older women, now widows, never learned to drive in their lifetimes. For proper preventive health care, they need to get to medical appointments which can be over 50 miles from their homes. Volunteer drivers, reimbursed only for mileage, allow the St. Lawrence County Office for the Aging to provide service to many who have no ability to get to and from needed medical appointments. There is a cap on the number of trips provided per month per person because of limited funding.

Expanded In-Home Services for the Elderly Program (EISEP)

New York State provides state dollars to augment OAA dollars to allow for the provision of a minimal in-home care program. Personal care, housekeeping, personal emergency response system and case management services are provided to frail elderly on a cost-sharing basis. The services are not to duplicate other federally-funded programs such as Medicaid; if a client is Medicaid-eligible, they are assisted with the Medicaid application. The provision of in-home care is subcontracted to several home health agencies, but staffing shortages and significant mileage costs sometimes make it difficult to provide care for some isolated older adults. The county Board of Legislators has chosen to make personal care pro-

vision top priority; most requests for housekeeping services are not met. Case management is provided directly to the clients by St. Lawrence County Office for the Aging staff.

Senior Community Service Employment Program (SCSEP)

St. Lawrence County, being over 60 miles from the nearest interstate highway, missed out on the economic boom of the 1990s. Unemployment rates in 2001 have ranged from 7 percent to over 9 percent. Older workers compete with low-income workers for minimum wage jobs mostly available in the service/retail sector. Decent wage employment is found at the aluminum producers Alcoa and Reynolds, but most of those jobs are not suited to workers over age 55. With OAA funding, community service employment is provided to low-income workers age 55 and older who wish to work. Job training, resume preparation, interviewing skills, job referrals and more are provided to mature workers enrolled in the SCSEP. Recent requirements to participate and coordinate employment services with other Workforce Investment Act programs have allowed for the creation and office for the aging participation in the One-Stop Career Center.

Legal Services

One of the mandates of the OAA is to provide legal services, at no charge, to older adults. Subcontracts with two legal providers in St. Lawrence County allow for older residents to obtain assistance and representation in civil matters.

Home Repair and/or Weatherization

Many older adults in St. Lawrence County wish to remain in their longtime family homesteads until the end of their lives. In the early years of the St. Lawrence County Office for the Aging, dirt floors and lack of plumbing and/or electric service were common among homes in the county. Rehabilitation grants were leveraged through other public entities, which allowed for the needed improvements to bring homes up to 20th century standards. Now, many of these homes are in dire need of repair in order to maintain safe living quarters for older adults and sometimes their families. The St. Lawrence County Office for the Aging continues to leverage assistance for home repair and weatherization through the USDA Rural Development, the local HUD agency, and several county and town housing assistance

agencies. Small repair requests such as rebuilding stairs, providing railings, constructing wheelchair ramps, new doors, minor plumbing problems, handicap shower or bath modifications, well problems, septic tank cleaning and many more, are provided by a handyman on staff of the St. Lawrence County Office for the Aging, utilizing funds from New York State and the OAA. Often, homes, especially mobile homes, are in need of such extensive repairs, that it becomes questionable if assistance can be provided. For those, counseling on senior housing options is provided by office staff.

"One of the mandates of the OAA is to provide legal services, at no charge, to older adults."

Health Insurance Information, Counseling and Assistance Program

Coordinated by an office staff member, this program assists individuals through the health insurance/Medicare maze. Volunteers help people with problems understanding medical bills, Medicare, managed care and other health insurance. Information and counseling on Medigap policies, EPIC (Senior Drug Program), long-term care insurance and many others are available.

Ombudsman Program

Coordinated by office staff, certified volunteers work with residents, their families and the staff of long-term care facilities to improve the quality of life in each facility and to prevent elder abuse, neglect and exploitation. Ombudsmen act as advocates for residents and their families and must report serious deficiencies to the State Health Department. Often, Ombudsmen become friendly visitors and a kind face to many long-term care residents who have limited or no family contact.

Health Promotion Services

It is well known that healthier and more fit individuals live longer and healthier lives. Recent programs funded through the OAA by the St. Lawrence County Office for the Aging include a senior "Fit for Life" and an "Arthritis Aquatic Exercise" program. These programs are provided in conjunction with a local university, so that exercise and education focus-

NYSCA AND THE CONTINUUM OF CARE

ing on topics such as flexibility, nutrition, home workouts, strengthening routines, resistance training, and basic gait analysis are provided. Response to these programs is extremely positive, but limited location availability make it difficult for all interested older adults to participate.

Information and Assistance

Often this is the most important service the St. Lawrence County Office for the Aging and its volunteers provide. Every issue can easily be an older adult issue. Information and referral is regularly provided to all who inquire about a wealth of programs and information, such as energy assistance, housing rehab, long-term care, health insurance, support groups, senior housing options, living wills, power of attorney, home care, nutrition, nuisance animal removal, immunizations, child health programs, older driver assistance and many more.

Elder Abuse Education and Prevention

A one-time New York State grant was recently provided to the St. Lawrence County Office for the Aging to design a program of education and outreach regarding elder abuse. A brochure targeting the new Telemarketing Fraud Act and the No-call Registry was produced, a video highlighting the signs of elder abuse is in production, an Elder Abuse Task Force was created, and a computerized telephone reassurance program, "Are You Okay?" was purchased and installed in the St. Lawrence County Sheriff's Office.

Family Caregiver Support Program

With the reauthorization of the OAA as amended in the Fall of 2000, a new family caregiver program was established. The St. Lawrence County Office for the Aging intends to service family caregivers with information, counseling and assistance, support groups, caregiver training, adult day care (only one small program at one end of the county) and respite

care. Future planning needs will be determined through a comprehensive caregiver survey. New funding is wonderful, but it boils down to about \$5 per person and doesn't provide adequate funds to hire additional staff to coordinate the program.

"No two area agencies are identical in nature: local needs are addressed by local providers with the area agency serving as the lead coordinator for services to those age 60+."

The beauty of the foundation of the OAA allows each area agency on aging to provide an array of services either directly or subcontracted to other senior organizations or senior centers that are designed to best meet the needs of the local population. As a rural county, the St. Lawrence County Office for the Aging targets more dollars into transportation and meal delivery functions. An urban area may provide more social adult day care. No two area agencies are identical in nature: local needs are addressed by local providers with the area agency serving as the lead coordinator for services to those age 60+. Some areas have large waiting lists for all services, some have waiting lists for just one or two services. Waiting lists may be because of limited funding or, in the case of the St. Lawrence County Office for the Aging, inability to provide enough meal routes to cover every sector of the county.

Area agencies on aging continue to be the lead advocates for services and funding for older Americans. They also continue to serve as many needs as possible on a shoestring. Success is measured by the satisfied client and family who can remain in their own homes and communities for a longer period of time because of the variety of services provided by area agencies on aging throughout the United States.

Barbara R. McBurnie was appointed Director of the St. Lawrence County Office for the Aging in February 1996. She worked as an employment and training counselor before coming to the Office for the Aging a year earlier. She has a bachelor's degree in psychology from St. Lawrence University and a master's degree in teaching from SUNY Potsdam. She recently established a county Elder Abuse Task Force and serves as Vice President of the St. Lawrence County Housing Council. The St. Lawrence County Office for the Aging is a member organization of The New York State Coalition for the Aging, where she is active in the North Country region.

The Delivery of EISEP Services in New York City

By Glee Kleinberg

Article Abstract

This article, which is written by the Associate Executive Director of health services of Sunnyside Community Services (SCS), presents an overview of a community-based organization's experience in providing Expanded In-Home Services for the Elderly Program (EISEP) case management and home-care services to the frail and homebound elderly of western Queens. Key information is provided regarding program eligibility, scope of services, accessing services, cost of care, coordination of EISEP with other community services and the handling of emergencies, service complaints and diversity. Typical cases are highlighted along with questions and answers to common inquiries received from professionals and the lay public.



Agency Profile

SCS is a multi-service settlement house, serving the communities of western Queens. The organization provides services for immigrants, youth, elderly and their families through a range of health care, social, recreational and educational programs designed to improve the quality of life of community residents. Programs include a senior center, a geriatric mental health program, home health care, adult day services for the physically frail and dementia client, meals on wheels, inter-generational programs, English classes, citizenship assistance, after-school programs, teen center and summer day camp. On a daily basis, the agency services 1,500 homebound elderly and disabled people, 250 seniors and 500 youth.

Introduction

From its inception in 1974 as a community-based organization the mission of SCS has been the development and provision of a continuum of care for the well and frail elderly—assisted living without walls. In the mid-1980s SCS began contracting with the Department for the Aging (DFTA) to provide EISEP home-care services. SCS also offers other homebound and congregate care services to the frail elderly. Such programs include the Medicaid home attendant service, home health aide service from the Visiting Nurse Service of New York, adult day care for dementia clients and the

physically frail, private-pay home care, meals on wheels, senior center services, transportation and volunteer homebound services.

What Types of Services Are Provided Under the EISEP Program?

Under EISEP funding the following services are provided: information and referral, case management, housekeeping and homemaking/personal care. For housekeeping and homemaking services, low-income clients are asked to make voluntary donations while higher income clients are required to pay fees based on a sliding scale. Case management services are provided without charge. Normally, clients receive a mix of case management and home care, but some clients require only the assistance of a case manager to help them deal with the problems associated with their growing frailty or other difficulties related to their well-being or the care of a family member.

For example, an older frail parent of a disabled adult may require the assistance of a case manager to help plan for the future care of their adult son or daughter. Or a spouse of an Alzheimer's client may need assistance with planning for the care of the client in the event of the well spouse's illness.

Individual case management agencies will also aim to complement EISEP services with other agency programs. SCS has established a Friends of the Homebound program, a volunteer service that provides telephone reassurance and friendly visiting, social adult day care programs for physically frail and dementia clients, a caregiver support group, private pay home care and transportation. In accordance with DFTA rules, these services may also be enhanced by coordination with private-pay and Medicare services as long as the services do not overlap. Additionally, the agency will also coordinate with other community programs including meals on wheels, protective services for adults, mental health services and medical care.

What Population Is EISEP Designed to Serve?

EISEP, a statewide program for the disabled elderly, is administered by the New York State Office for the Aging through county or area offices for the aging. In New York City, it is DFTA which contracts with various community-based organizations throughout the

city to provide case management and home-care services to specific community districts. These contracts are awarded based on an RFP process required by the city. A complete list of these contract agencies may be obtained through DFTA's Information and Referral Department.

State funding is limited and is designed to fill an important gap in funding for disabled elderly, especially the low-income minority population over the age of 60 who are not eligible for other government funded programs, such as Medicaid. However, clients eligible for Medicaid can be serviced for a temporary period of time while applying for the Medicaid home-care program.

Originally conceived as a nonmedical support program EISEP fills an important gap in the care continuum between wellness and severe disability. Clients appropriate for the EISEP home-care program are unable to function independently in the community without formal help. Many require assistance with household activities, personal care and mental health counseling. Clients must be able to function safely with part-time assistance, normally less than 20 hours per week. At minimum, clients must have functional limitations of at least one activity of daily living (bathing, personal hygiene, dressing, mobility, transfer, toileting or eating). Or they must be limited in a minimum of two instrumental activities of daily living (cleaning, laundry, shopping, use of transportation, meal preparation, reheating meals, handling personal business/finance, use of telephone). The case manager documents this need by conducting an assessment visit in the client's home, utilizing the DFTA Assessment Instrument, a comprehensive tool, designed to assess the client's functional capabilities as well as limitations, unmet needs, informal support systems, housing issues and eligibility for benefits.

Additionally, a standardized financial tool is utilized to determine the hourly fee or donation for housekeeping or homemaking services. Clients receiving only case management services will be asked for financial data in order to assess for other benefits, but it is not required.

What Is EISEP Case Management?

According to the Department for the Aging, case management is defined as:

a process of planning, arranging, coordinating services and resources to maximize the functional independence, and economic and social well-being of clients. The process involves

screening to identify appropriateness for service, assessment of client needs (and the client's family when appropriate), care plan development, authorization or referral for services, and ongoing support, counseling and advocacy, and long term planning across a continuum of care.¹

Case management is an indispensable service for the frail elderly population in the community. Without it this population would have difficulty accessing community and government services. The experience of a seasoned professional is often needed to know what is available as well as how to expediently negotiate the service systems. For example, a client applying for Medicaid home attendant services may not be aware of the intricacies of the application process, leave out an important document and thus delay the processing of the application. Often this delay can be unfortunate for the needy client whose physical condition could deteriorate before the service application is approved and the care provided.

Keeping one's knowledge base up-to-date regarding available resources is critical to the case management process. On an on-going basis, case managers attend educational programs. DFTA, the Council of Senior Centers and Services and other organizations such as the Brookdale Center on Aging, are sponsors of excellent training programs. On an annual basis, DFTA requires that case managers attend at least 16 hours of in-service annually, though most case managers exceed this standard, in addition to attending community meetings and keeping up with the professional literature.

With many providers involved in the service delivery system, the role of the case manager (CM) involves the skills of collaboration, customer service and advocacy. The CM must develop and nurture a diverse and often fragmented network of community providers, including doctors, visiting nurses, discharge planners and lawyers, home care agency staff and caseworkers from the Medicaid program. The CM's ultimate goal is to facilitate the timely provision of appropriate services for the community client. And that may depend on the CM's ability and perseverance to effectively collaborate with all providers, an extremely time-consuming aspect of the job.

The following are three typical situations that require a careful intake, assessment, care planning, arranging of services, monitoring, reassessment and advocacy. Each case also demonstrates the value of the provider and community networks, and the vital role of the CM, without which these clients may be prema-

turely institutionalized, or if they remain in the community experience a decreased quality of life.

Mrs. J., 88 years old, has lived in Sunnyside, Queens, for 40 years. She resides in a second floor walk-up in a rent-stabilized apartment. Her income is \$849 from Social Security and a small pension from a job in a millinery factory. She had sporadically attended senior programs at a local church and from time to time at the SCS senior center. Over the past few months she has become increasingly frail, lacking the stamina to shop, cook, do her laundry and go out of the house alone. She is alert, has slight problems of forgetfulness though she is capable of managing her financial affairs. She is fiercely independent and is reluctant to accept help from an agency. Her two sons are estranged, have multiple family problems and reside 50 miles away in Suffolk County, Long Island. Other than her neighbor, she has no friends who drop by. Her neighbor encourages her to attend church or the senior center, but she is despondent regarding her appearance and just says she isn't up to it. A neighbor who has been helping with shopping and banking contacted the social worker at the SCS Senior Center, wondering if Mrs. J. might be eligible for meals on wheels. The social worker refers the case to the case management division.

Mr. B. is 92 years old, frail and living with his 85-year-old wife. In addition to his frailty, Mr. B. was diagnosed six weeks ago with insulin dependent diabetes. He was briefly hospitalized after collapsing from the results of high blood sugar. Upon discharge he was referred to the Visiting Nurses for diabetic education and monitoring. Over the period of six weeks under the direction of the visiting nurse, he has become well stabilized in his daily regimen. His wife has learned to manage his daily insulin injections and oversee his diet regimen. Mr. B., however, has become frailer and requires assistance with his personal care. His wife has limited stamina due to arthritis and is unable to assist her husband with the personal care, i.e., a bath that he requires. Prior to discharge from the Visiting Nurses he is referred to the SCS' Case Management Program that is administered under its affiliate, Sunnyside Home Care Project, Inc. Mr. B. will be evaluated for acceptance into the program for homemaking services.

Mrs. K. is afflicted with Alzheimer's disease. She is 70 years old, lives with her husband and has become increasingly dependent in all her activities of daily living. The combined monthly income for this family is \$1,750. Their assets are approximately \$12,000. Mr. K. has made every effort to assist his wife with all her needs. But he is becoming increasingly weary and wonders whether a nursing home is an option. He has

been in touch with the New York City chapter of the Alzheimer's Association, which advised him about the possibility of SCS Adult Day Care Services, which would provide door-to-door escorted transportation and a full day of structured and stimulating activities. He has also been advised about the possibility of home-care services, though he is doubtful about this option since his wife rejects strangers coming into the home.

How Does Someone Access Services?

The case management agency is open Monday through Friday and a CM is always available to answer inquiries promptly and conduct an immediate telephone screening/intake. One important purpose of the screening/intake is to quickly assess whether the referral is appropriate. For example, recently hospitalized clients are frequent callers requesting EISEP services. For these clients, it is important to assess the possibility of referral to the Visiting Nurses, which is covered by Medicare, Medicaid or other insurances. Other clients like Mrs. J. might have a condition that warrants nursing care. A discussion with Mrs. J.'s physician, after she gives permission, would be valuable in determining the possibility of a home health care referral to the Visiting Nurses. Sometimes neglected or evicted clients are more suitably managed by Adult Protective Services. The CM will work closely with the client or referring source to ensure that the client is able to access the appropriate service. For example, the CM can help Mr. K. in considering adult day services, perhaps meeting him at the center to introduce him to the program.

In working with clients such as Mrs. J., the CM aims to establish a working alliance that is geared to helping sustain her independence. This initial call provides an opportunity for the agency to establish a positive relationship with a client who may very well be hesitant to request help from the community. Sensitivity to this issue is important in order to establish adequate rapport for future planning. The onset of frailty is a crisis through which the CM must carefully guide clients in order to sustain their dignity and sense of self-worth. At the same time, the CM will encourage Mrs. J. to recognize the value of accepting some household help, perhaps transportation to the senior center, or attending an adult day program for the physically frail.

Information is provided to the client or referring source regarding the scope of available services. Many clients referred to alternate resources will eventually return to be serviced by the community agency and

should be aware of when to once again contact the agency in sufficient time to ensure continuity of care from one agency to the next. Visiting Nurses also communicate with the EISEP program as discharge plans are formulated. Again, the collaboration between the networks of providers is critical to smooth service delivery.

The case management supervisor reviews all intakes to determine the appropriate disposition. Sometimes an assessment home visit should occur immediately. Often this is necessary, as in the example of Mrs. J. Immediate home visits are also conducted if a confused client calls the agency. Most cases are assessed within ten days. If the case management agency is quite busy, the client may have to be placed on a waiting list for an assessment. The client is so informed and is advised of alternative resources. DFTA has special guidelines regarding the maintenance of waiting lists. Before home-care services are provided, an assessment visit must be conducted in the home.

Under certain circumstances, emergency services are provided before a home assessment. For example, in the Mrs. J. case, emergency meals on wheels might be suitable. Additionally, the agency could dispatch a volunteer to assist her in getting to the physician and the CM might also assist the client in reconnecting with her doctor. Fortunately the agency has developed a corps of volunteers who assist clients with escorting, shopping and other related errands. Emergency house-keeping and personal care can also be obtained.

If a Client Is Eligible for Housekeeping and Homemaking, How Long Does it Take Before Home-care Services Are Provided?

Within six days of the home assessment, the case manager must prepare a care plan approved by the supervisor. The approval must occur no later than ten days after the assessment visit. A referral is then made to the home-care provider who must provide services expeditiously to the client. Each case management program refers clients to a DFTA designated home-care agency(ies). SCS works with two agencies. Each home-care agency has a specific amount of housekeeping and homemaking units to be delivered annually for each community district. The case management agency is responsible for monitoring utilization of these units for the designated community districts.

Upon receipt of the referral, the home-care agency's nurse will visit the client to review the client's plan of care and to orient the home-care worker to his or her duties. A plan of care for the home-care worker is collaboratively developed with the client, who retains a copy for on-going reference.

Clients are oriented to their rights by the CM and the home-care agency nurse or supervisor. The rights emphasize the client's right to complain, as well as his or her right to privacy. Clients are encouraged to voice his or her concerns when the need arises. Assigning a consistent supervisor is one way of encouraging appropriate communication. The home-care worker's supervisor visits the client every three months. The CM will conduct a reassessment visit every six months.

The case management agency and the home-care agencies closely collaborate. Any changes in the client's needs and disruptions in service are reported. The case management agency also contacts the client the first working day after the scheduled start date and 15 days thereafter to ensure adequacy of service. At least every two months the CM contacts the home-care client.

How Are Donations and Fees Collected?

Clients either make a voluntary donation for the service or are required to pay a sliding-scale fee to the home-care agency. These payments are made monthly. Clients paying fees are called cost-sharing clients and must make payments in order for the service to continue. Each agency has a collection procedure in place. Normally the client has up to 90 days from the point of the late payment notice to make payments. Various payment options may be implemented for hardship situations. Most fees are low and normally do not create an excessive hardship. Donations as noted are strictly voluntary and will not receive past-due notices for nonpayment.

What Are the Qualifications of Home-Care Workers and How Are They Supervised?

Home-care workers must have training certificates from a training program certified by the State Department of Health. Workers have a minimum of 40 hours of training in various aspects of personal care and housekeeping duties. Awareness of what to do in an emergency is also emphasized. Workers also receive an orientation to working with a diverse population, which asks them to respect different cultures, sexual orientation and client preferences. The workers must submit time records to the agency, which can be collected electronically via the telephone system or on paper. Every three months, the agency supervisor visits the worker in the client's home to evaluate the worker's performance. Workers are counseled or may be removed from the case if performance does not adequately meet an agency's standards of care.

If a Client Is Denied Services, Is There an Appeal Process?

If the case management agency determines that the client is not eligible for services or services are to be terminated, there is an appeal process that is managed through the Program Officer at the Department for the Aging. Clients are notified in writing about the hearing request procedure.

How Do the EISEP Agencies Manage to Serve the Diverse Population of New York City?

Community-based organizations are usually attuned to the many different cultures of their surrounding communities. The ethnicity of agency staff and volunteers tends to reflect the ethnic composition of the local community. Staff attend training programs that sensitize them to cultural differences that impact upon service utilization. Gender relationships, family roles, various biases and religious conventions and food preferences are discussed. Staff also learn effective ways to understand and restrain prejudiced behavior. Agencies also utilize and collaborate with advocacy and service agencies that specialize in serving distinct communities of people, e.g., religious groups, gay and lesbian organizations and ethnic populations. There are no right answers in providing services to a diverse community. It is important to be sensitive to differences, ensure that staff or volunteers speak the language of the clients and be aware of one's own biases, and to reach out to community leaders that may represent the various groups in the community.

Are There Issues That Need to Be Addressed in the Future?

Certainly the funding for EISEP, which has been basically static, must grow. Increased funds are needed to retain and recruit qualified professional staff and to pay home-care workers a living wage. The largest growing part of the population is the 85+ elder population, which is frailer and more isolated, with fewer family caregivers available. The EISEP funds are needed to pay for this growing population. The Council of Senior Centers and Services, a citywide advocacy organization, has been playing a role in advocating for more funding and equitable salaries. The future funding needs of this population must be addressed in order to deliver the level of care that is required to help people remain in the community.

New York State has played a leadership role in developing human service programs. EISEP is a model of service that has helped many older people remain in their communities with a sense of dignity. As the population of older people grows, continued efforts are needed to expand the EISEP scope and the service delivery model so that frail older persons can retire in their own communities.

SCS is a member of the Council of Senior Centers and Services of New York City, an organization representing 265 agencies providing community-based services to over 300,000 older New Yorkers in New York City.

Endnote

1. Definition is found in the 1995 DFTA Program Management Manual and is based on the NASW Standards for Social Work Case Management, June 1992.

Glee Kleinberg, R.N., M.A., was appointed Associate Executive Director of Sunnyside Community Services in July 2001. Previously she was Director of the Sunnyside Home Care Project (SHCP), an SCS subsidiary, since 1976. She built SHCP from a small volunteer program providing friendly visiting and telephone reassurance to a multi-funded, multi-service home health care operation serving the needs of the chronically disabled in western Queens. SHCP and its new initiative, the Sunnyside Home Attendant Program, now serve 1,500 individuals with more than 52,000 hours of home-care every week.

Ms. Kleinberg has a long history of developing new programs, often in creative collaboration with other organizations. Some of the initiatives that have been undertaken under her leadership include the Share the Care volunteer respite program, operated in collaboration with the New York City chapter of the Alzheimer's Association, to provide family caregivers of Alzheimer's patients with some time to themselves, and more recently, in collaboration with the director of the SCS Senior Center, establishment of an adult day services program at SCS for seniors with Alzheimer's and other memory disorders. Similarly, she was instrumental in developing SCS's Integrated Senior Services Program, which blends home-care and congregate-care services, reducing dependence on formal home-care services while enhancing quality of care. To address a growing shortage of home health care workers, she has worked with LaGuardia Community College to create and implement a job training and vocational ESL program that has trained more than 350 workers in recent years. A new collaboration with the worker's union, 1199, will use SCS's new adult day services facility to provide skills to 700 home-care workers in addressing the special needs of Alzheimer's patients.

Multi-Service Senior Centers—The Amherst Center

By Mary Ellen Walsh

The senior center movement began more than 50 years ago as a means of meeting the needs of older people for socialization, recreation and other services. Today, senior centers range from small, one-room organizations in church basements to large, multi-purpose agencies providing both on-site programming and services reaching out into the community. The Amherst Center for Senior Services is a model of the latter.



In 2000, the town of Amherst near Buffalo, NY, opened a new 53,000-square-foot Center for Senior Services which incorporated all of the center's programs, activities and services, formerly housed at six different locations, under one roof. The single-site design was determined to be the most effective and cost-effective way to address the needs of future seniors who are likely to be more active, mobile and accustomed to the convenience of "one-stop shopping." The center serves the more than 23,000 senior residents of Amherst. On a daily basis, more than 800 people use services on-site and another 300 people receive services in their homes. Amherst is a municipality-sponsored center. Members must be residents of the town.

Seniors, ranging in age from 55 to almost 100, come to the center for a variety of reasons. Younger seniors often join to take advantage of activities such as classes or clubs, or sports such as golfing or bowling. Other seniors come to the center after having lost a spouse, seeking social contact and perhaps a support group to deal with the loss of a loved one. Activities such as billiards and cards are very popular. Occasionally, people in their 90s decide they are finally "old enough" to join the center. Senior centers also provide many volunteer opportunities for those wishing to serve the community.

Classes and Activities

The center offers approximately 70 classes. These include watercolor and oil painting, art history,

dance, music appreciation, cooking, sewing, discussion groups, organ classes, china painting, ceramics, bridge, genealogy and many others. New classes are added as members request them.

Special interest groups and clubs include the Men's Club, Travel Club, Camera Club, Bridge and Pinochle Clubs, Dinner Club, Knitting Club, Quilting Club, Sports Club and theater trips, woodworking, stained glass, singing and a computer group.

"The single-site design was determined to be the most effective and cost-effective way to address the needs of future seniors who are likely to be more active, mobile and accustomed to the convenience of 'one-stop shopping.'"

The center offers many special activities such as holiday and other celebrations, and an annual craft fair. Housing, health and insurance fairs are held annually and offer opportunities for community businesses which provide these and related services to come into the center to discuss their services with members.

Health and Wellness

Maintaining each member at his or her optimal functional level is part of the mission of the agency. Exercise programs range from very active to passive, taking into account the physical stamina of various participants. Slimnastics, aerobics, line dancing as well as chair yoga, floor exercises and tai chi are very popular. Sports offered include cross country skiing, walking, swimming, bowling, tennis, golf and others.

In the Health Resource Room, weekly blood pressure checks are provided by a volunteer nurse, periodic screening is offered for hearing and vision problems, bone density and others. Monthly educational programs are held on a wide range of health-related topics. More than 1,000 seniors received flu

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shots at the center last year. Audio and videotapes and reading materials are available on a variety of health-related subjects.

Nutritional Services

The center operates a large kitchen with a capacity of producing up to 1,000 meals. Meals for the congregate lunch program, the meals on wheels program and the adult day services program are prepared at the center.

The congregate lunch program, offered by almost all senior centers, is a federally funded program to provide a nutritionally balanced hot meal to seniors who might be at nutritional risk due to social isolation, the difficulty of cooking for one, or due to financial limitations. Many seniors who live alone initially participate because of the lunch program and then become involved with other activities as they make friends.

The center operates the town's meals on wheels program in partnership with Amherst Meals on Wheels, Inc., a nonprofit agency. The program operates independently and does not receive federal, state or county funds. This program serves homebound residents aged 18 and up, providing a hot meal and a cold supper, which are delivered to a client's home five days a week. A physician's referral is required to receive the services and a social work assessment and periodic reassessment are provided. More than 275 volunteers assist in the operation of this program. The program has close relationships with the town's engineering department, which will assist with meal deliveries when bad weather makes it impossible for volunteers to get out, and the town's police department, which assists when there is concern that a client may have fallen or become ill and unable to respond when volunteers attempt to deliver a meal. The program provides a valuable check on frail, homebound seniors, as well as nutritional support. The program collaborates with the Audubon Library to provide Food for Thought. The library provides books, tapes and videos which are delivered to homebound clients by meals on wheels volunteers.

Volunteer Opportunities

The center serves as a clearinghouse for volunteer opportunities. Many people volunteer at the center, itself, helping to man the front desk, operate the gift shop, assist with serving lunch and so forth. Others assist with providing services—delivering meals on wheels, making phone calls to homebound seniors or

visiting them and helping with senior day programs. Still others go out into the community, volunteering at hospitals, schools, nursing homes, hospice, soup kitchens and many health and social agencies. More than 1,000 senior citizens volunteer through the center. With more mothers working, senior citizens have become a highly important resource in meeting a community's need for volunteers.

Adult Day Services

For individuals who are too impaired mentally or physically to participate in activities at the center itself, a social adult day services program is available. This program is cosponsored by the local hospital system. Activities such as exercise, games, cooking, singing, field trips, crafts, cards, parties and holiday celebrations are provided. The program is open five days a week, from 7 a.m. to 4 p.m. Transportation is available. Caregivers may leave a loved one in this safe environment while taking advantage of the center's activities in the same building. The program is funded through client fees, state subsidies and support from the town of Amherst and Kaleida Health, a regional health-care system.

Senior Outreach Services and Social Work

Social workers are available to members at the center who may wish to discuss a personal problem, or obtain information about eligibility for services available to them. Several support groups are offered as well.

For those who are too frail to come to the center, a county-sponsored case management program, offered through the center, is available. Caseworkers visit clients and their families in the home, conduct a comprehensive assessment, and provide information and referral to community services. This may include information on home care, legal questions, eligibility for Medicaid, health insurance, nursing home care, transportation, day services and many other issues.

Transportation

The center's Amherst Senior Transportation Services (ASTS) provides senior residents of the town with van transportation to the center and for medical care. Residents of participating senior residences also are eligible for transportation for shopping at supermarkets and malls. The program also provides transportation to clients of the adult day services program. ASTS is a not-for-profit agency which is funded by

town support, clients fees, member agency fees and donations.

Funding

Senior centers are generally either not-for-profit or sponsored by local municipal or county governments. Some federal funding is available through the Older Americans Act. Funding may affect membership eligibility, and to some extent, how services may be offered. For example, as a government agency, Amherst does not permit individual agencies to present information or promote services, as this might be construed as an endorsement. However, the community health fairs, housing fairs, etc., which are held provide an opportunity for any agency providing services to offer information to the public.

One-Stop Shopping Concept

There are many advantages to offering both traditional senior center programming and community services at a single site:

- The availability of these programs and services at one site provides convenience for the seniors. As noted earlier, caregivers can take advantage of programs and activities at the center while knowing that their loved one is also enjoying activities at the adult day services program. Information about services and what is available is easily obtained and accessible when all programs are on-site.
- The center is perceived as a busy, active place, attracting both younger and older seniors.
- There is a better flow within the continuum of services. Staff of the various programs and

services meet regularly and are familiar with members and clients. For example, someone who is beginning to experience difficulty functioning independently at the center may be guided to the adult day services program or other programs. Frequently, clients are receiving multiple services from a variety of programs. Staff collaboration assures that linkages are made and needed services are received.

- Members who experience short or long-term illness are likely to fall between the cracks. Social workers follow up with members at home and refer to various services, including the telephone assurance program or Friendly Visitors.
- The large "critical mass" of seniors located at one site makes partnerships more attractive to health care providers, businesses, public schools, area colleges and other community agencies.
- Single sites are more cost-effective. The preparation of meals at one location for the congregate lunch program, meals on wheels and adult day services program reduces the per unit cost to each of these programs. Staff costs are reduced. Duplication of furniture and equipment is eliminated.

The success of this concept at the Amherst Center for Senior Services has been demonstrated by a 40 percent increase in participation since the center opened less than a year ago. New membership has increased by 13 percent. The center enjoys considerable community support due to the active volunteer program and special programs and events, which are open to the general public and generally draw large crowds.

Mary Ellen Walsh has been Executive Director of the Amherst Senior Services for ten years. Formerly, she was Director of Long-Term Care Planning and Health Systems Agency of Western New York and Director of Social Work and Community Services at Sisters of Charity Hospital in Buffalo, NY. She has a master's degree in social work and is on the board of directors of several community agencies. She is a founding member and former President of the Network in Aging of Western New York. Amherst Senior Services is a member organization of the New York State Coalition for the Aging, where she serves as geographic representative.

Retirement Lifestyle Alternatives

By Kathleen Johannsen and Diane Stork

The early retirement years can be exciting. It's a time to rediscover the things you enjoy in life. It's a time to make new friends, develop new interests and explore new avenues of learning—a time to relax, renew and revitalize.

Over the past decade, the number of older New Yorkers has increased dramatically. For example, the number of Long Islanders 85 years and older surged 38 percent—more than six times the growth rate of the overall Long Island population—according to census figures.

Those 85 and older now number 4.2 million nationwide.

- One out of every ten persons is now over 60; by 2050 one out of every five will be over 60; and by 2150, this number will shrink to one out of every three.
- The oldest (80 years or older) currently make up 11 percent of the population; they are the fastest growing segment of the older population and by 2050 will reach 19 percent.
- The majority of older persons, 55 percent, are women. Among the oldest, 65 percent are women. These proportions will remain relatively unchanged over the next 50 years.
- According to information summarized from the U.S. Bureau of Census, the population of people 85 and older is expected to increase by 33.2 percent between the years 2000 and 2010.
- According to Census figures, about 6.5 million older people need assistance with daily living activities. As the number of older Americans continues to increase, that number is expected to double by 2020.
- The increased net worth of older people. The number of persons 80 or older with incomes sufficient to afford (independent or assisted living options) has increased; over 57 percent had



Kathleen Johannsen

incomes topping \$15,000 in 1999, and over 38 percent had incomes of at least \$25,000.

Due to the increase of the elder population in New York State, more choices than ever are available in senior living. Although there are a number of options, two options in particular have become extremely popular so that individuals can select the lifestyle that fits their personal needs. Independent retirement communities and assisted living communities both offer a range of services, amenities and health and wellness programs, all geared toward helping residents stay healthy and independent for as long as possible.



Diane Stork

Independent living is a residential living setting for elderly or senior adults that may or may not provide hospitality or supportive services. Under this living arrangement, the senior adult leads an independent lifestyle that requires minimal or no extra assistance. Generally referred to as elderly housing in the government-subsidized environment, independent living also includes rental assisted or market rate apartments or cottages, where residents usually have complete choice in whether to participate in a facility's services or programs.

Congregate housing is similar to independent living except that it usually provides convenience or supportive services like meals, housekeeping and transportation in addition to rental housing.

Assisted living has really become a catchall term for many types of congregate senior housing. The New York State Office for the Aging defines these as one of the following:

- **Supportive Senior Housing:** Nonlicensed, provides some supportive services such as meals, housekeeping, laundry, transportation and socialization activities, usually through a services coordinator who helps residents access other services from community-based agencies.

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- **New York State Licensed Adult Home:** Housing for five or more adults that provides private or shared rooms, meals, housekeeping, laundry/line service, transportation, social activities, some personal care and 24-hour supervision and is licensed and regulated by the New York State Health Department.

- **New York State Licensed Enriched Housing:** A program that provides senior residents in apartment housing with a package of services that includes meals, housekeeping, shopping, transportation, social activities and some personal care assistance.

Some enriched housing programs provide services for all residents and are licensed and regulated by the State Health Department. Other enriched housing programs provide services for a limited number of residents. These buildings are not licensed, but the enriched housing program operating in them is licensed and regulated by the State Health Department.

- **Enriched Housing or Adult Home with Limited Licensed Home Care Agency (LLHCA):** Provides residents with additional personal care and health-related services. The LLHCA is licensed and regulated by the State Health Department.

- **New York State Licensed Assisted Living Program:** This is a program that provides nursing home-eligible residents of adult homes or enriched housing with home health care in addition to the services routinely provided by the operator. This program is licensed and regulated by the State Health Department.

Independent living provides coordination of resident services, such as one to three meals per day, transportation, activities, some housekeeping assistance and help coordinating community services.

Assisted living provides, in addition to the above, some assistance with activities of daily living, such as medication management and 24-hour oversight.

Independent residents move about independently and are able to seek and follow directions. In assisted living, residents are mobile but may require an escort or assistance due to poor vision, weakness or confusion.

In an independent community, residents are able to prepare some of their own meals, although generally, two meals per day are available. In assisted living, all meals and snacks are provided and residents may require assistance opening packages or cutting food.

Independent living residents provide all of their personal care needs, including bathing, dressing, toileting and personal laundry, while assisted living residents may require assistance with bathing, dressing, toileting, incontinence management or hygiene, including reminders.

Independent living residents are oriented to person, place and time, but may have occasional forgetfulness. They are totally responsible for self-administration of medications. In assisted living, a resident may be generally oriented as to time and place, but may require occasional direction, and experience some confusion or require periodic intervention from staff to cope with situational stress. They may be able to self-administer medications or staff may remind or monitor them.

Independent living residents do daily housekeeping, with weekly services provided by the community.

Laundry and housekeeping services are provided for assisted living residents.

Costs for Both Independent and Assisted Living

Costs vary with the residence, room size, and types of services needed by the residents. Across the nation, daily basic fees range from approximately \$15 to \$200—generally less than the cost of home health services and nursing home care. A basic assisted living fee may cover all services, or there may be additional charges for special services. Most assisted living residences charge month-to-month rates, but a few residences require long-term arrangements.

Who Pays the Bill for a Retirement Community?

Residents or their families generally pay the cost of care from their own financial resources. Depending on the nature of an individual's health insurance program or long-term care insurance policy, costs may be reimbursed. In addition, some residences have their own financial assistance programs. Government payments for assisted living residences have been limited. Some state and local governments offer subsidies for rent or services for low-income elders. Others may provide subsidies in the form of an additional payment for those who receive Supplemental Security Income or Medicaid. Some states also utilize Medicaid waiver programs to help pay for assisted living services.

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How to Find a Retirement Community

Consumers interested in locating a retirement community should:

- Visit the searchable ALFA on-line directory of assisted living providers at Care Guide, or New Lifestyles Magazines at (800) 869-9549.
- Call the national Eldercare locator service at (800) 677-1116. Calls are accepted between 9 a.m. and 5 p.m. Monday through Friday.

- Contact the New York State Office for the Aging at (800) 342-9871. Government agencies are generally listed in the blue pages of the telephone directory.
- Check the library for the National Directory of Retirement Facilities.

For a state listing of retirement residences:

- Contact Gloria Luis, Consumer Referral Manager at consumerinfo@alfa.org.

Kathleen Johanssen is the Regional Director of Operations for Forest City Daly Enterprises and Sterling Glen Communities. Before that, she was Executive Director of The Bristol at East Meadow.

Prior to joining The Bristol, she was Executive Director of Atria Lynbrook, formerly known as Senior Quarters. She joined the company in 1995 as an accounts receivable coordinator at the Regency in Glen Cove and was named assistant to the administrator a year later. In 1997 she served as the assistant administrator of Senior Quarters in Huntington Station.

She was a speaker at the Long Island Alzheimer's Foundation 12th annual "Coping and Caring" conference in March 2000, speaking on "Understanding the Caregiving Puzzle: Assisted Living".

She grew up in Bayside, Queens, the oldest of four children, and attended St. Francis Preparatory High School in Fresh Meadows. She is a 1979 graduate of St. Johns University, with a B.S. in business management. She resides in West Hempstead with her husband Bill and two sons Brendan, 12 and Sean, 7. She is a member of the Senior Umbrella Network of Nassau, New York State Coalition for the Aging and the Long Island Coalition for the Aging. She served as past treasurer for the Lynbrook-East Rockaway Rotary Club and is an active member of the West Hempstead PTA and St. Thomas the Apostle Youth Group.

Diane Stork is the Executive Director of the Mayfair of Great Neck, an independent living facility for older adults. It is a Sterling Glen Community, with Forest City Daly Enterprises, Inc. Before joining the Mayfair of Great Neck, she was the Executive Director of Atria at Lynbrook.

She is Past President of the Long Island Coalition for the Aging. She is also Vice President of the New York State Coalition for the Aging. She is an active member of the Lynbrook-East Rockaway Rotary Club.

She attended St. Agnes Academic High School in College Point, New York and graduated with an Academic degree. She received her B.S. in Psychology from SUNY Old Westbury and her MS degree in gerontology from Hofstra University.

She grew up in Fresh Meadows and now lives in Lynbrook and Poquott with her husband Al. She is the mother of three, Christine, Michelle and Michael.

Caregivers: The Quiet Heroes

By Marty Haase

Today, there are 54 million caregivers in the United States. Medical technology has produced many wonderful cures and people are living longer. This longevity has created a role for caregivers that can extend 5, 10 or 15 years. Often a caregiver is caring for a loved one with a chronic illness. Over time the role becomes more demanding. Caregivers tend to have unrealistic expectations of themselves. They feel "guilty" or like "failures" when they cannot do all the caregiving themselves. This leads the caregiver to "burn out" and experience other stress-related illnesses and conditions. Today, there is help out there for caregivers.



Fourteen years ago, very few people knew what it meant to be a caregiver. I started the Caregivers Respite Program of Catholic Charities in 1987 to help the caregiver. Traditionally, the emphasis has always been on the patient, the diagnosis and treatment; the focus has always been on the patient's needs. There was very little attention given to the caregiver and the caregiver's needs. Now, 14 years later, there is a \$125 million federal funding stream available to all 50 states for the development and maintenance of programs specifically for caregivers and for grandparents who are raising their grandchildren. In New York State, the federal money from the National Caregivers Act will be funneled through the New York State Office for the Aging in the amount of \$7.5 million. The New York State Office for the Aging will in turn pass the money on to the local offices for aging. Localities will be required to submit their plans to the New York State Office for the Aging for approval and to receive their share of the money. The counties are required to come up with a 25 percent match for a total of \$2.5 million, making this a \$10-million program.

Another growing issue that needs attention in our society is the increasing number of grandparents and other relatives raising children. Children are being neglected and abused by their parents for a variety of reasons, including drug and alcohol abuse. In some cases both parents are dying from AIDS. Ten percent

of the federal money from the National Caregivers Act is set aside for each state to develop support groups and resource centers for "relatives as parents." The issue of relatives as parents is very complex. Relatives as parents are dealing with their own aging process, living on fixed incomes, feeling guilty about their own children, dealing with the loss of their own children, dealing with their loss of their retirement dreams, dealing with their grandchildren's issues of loss and the damage done to the children from abuse and neglect. The relatives have to deal with the legal system, the medical system, the educational system and the Department of Social Services. In addition, many of the children have Fetal Alcohol Syndrome and many of the relatives are raising children with developmental and learning disabilities. These children need to be in special programs to meet their special needs.

The Caregivers Respite Program of Catholic Charities offers the following services:

1. **Respite Services**—Respite means a break for caregivers to recharge and rejuvenate themselves, and have time away from the stress of caregiving. The service includes home health aides, adult day care, a short stay in an adult home and/or nursing home. The cost of the program is co-paid by the caregiver, with the program paying the remaining cost through a variety of other sources.
2. **Volunteer Caring Companion Program**—This program involves volunteers who come into the home as a caring companion/friendly visitor. This allows caregivers a "little" break from their caregiving responsibilities while the volunteer supervises and interacts with the individual. This allows time for caregivers to go shopping, run errands, go to medical appointments and so forth with the knowledge that their loved one is being cared for in a comfortable environment.
3. **Caregivers Support Groups**—People who have been in similar situations can offer intuitive advice and support for coping because they have already been there. It is a proven fact that support groups help with the longevity of the caregivers' role by providing

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strategies for coping and dealing with stress, and having a group that makes them feel they are not alone.

4. **Grandparent Support Groups**—These support groups are geared toward relatives who are raising their grandchildren. This is an especially needed support group because more relatives are taking on the responsibility of raising young children.
5. **Information and Referral Service**—Many caregivers have no idea where to start and need guidance and help as to what services are available to them. They often call in a time of crisis and need an expert who can spend time with them and explain the various resources and options clearly. This program provides one-on-one assistance to find the right services and how to access them.
6. **Caregivers Home Maintenance Program**—The elderly are vulnerable to a multitude of scams. This program gives caregivers the assurance of reliability and safety of contractors providing housecleaning, minor home repairs, etc. Home maintenance contractors are screened and have a history with the program to ensure that they are reliable and can be trusted. This is important to caregivers who receive the service from a trusted source.
7. **Newsletter**—We provide a newsletter that helps us communicate with caregivers about the resources, services and information they can use should they ever need it. It is distributed quarterly and provides a wealth of information for caregivers to utilize.
8. **TV Show “Take Care”**—We developed a weekly public access program geared especially to caregivers and care receivers. Guests on the program are experts in the field and provide in-depth information about programs and issues of interest to the aforementioned individuals. This has been a highlight of the program as we are able to reach thousands of viewers, either before they become caregivers, during caregiving or post-caregiving.

There are many programs for caregivers statewide with some of our components or pieces of our program. To access specific programs for caregivers in New York State, start with the Eldercare locator number at the New York State Office for the Aging, which is toll free, (800) 342-9871. Also, there is a nationwide Eldercare number, (800) 677-1116, east-

ern standard time, Monday to Friday, 9 a.m. to 8 p.m. In addition, the New York State Office for the Aging has a Web site listing the grandparents support groups in the state. It can be accessed at www.aging.state.NY.US/caring/grandparents.

To search for help for caregivers, or to refer clients and their families to these resources, call the local office for the aging, explain the situation, ask for information regarding services available for caregivers and request that a brochure about their services and a listing of local senior centers, etc., be mailed to you. They can be found in the blue pages of any phone book. In addition, a New York State Office for the Aging Resource Guide can be requested by calling (800) 342-9871, or logging on to <http://aging.state.NY.US>.

For information nationally on the issue of Relatives As Parents, contact the American Association of Retired Persons (AARP), Grandparent Information Center, 601 E Street NW, Washington, DC 20049, telephone (202) 434-2296, e-mail: www.aarp.org. The Grandparent Information Center provides information and resources to grandparents who are primary caregivers raising their grandchildren. The center is working with national and local community-based service agencies in child care, aging, legal and family services to address this rapidly emerging phenomenon. The Grandparent Information Center also issues a newsletter for grandparents four times a year, which may be ordered by calling the telephone number above.

Today, there are many national and statewide organizations and other sources geared to caregivers, including: the National Family Caregivers Association; *Today's Caregivers* magazine; the Well Spouse Foundation; the Interfaith Caregiving Alliance; Children of Aging Parents Association; AARP and Caregiver Resource Center; the Brookdale Center on Aging; The National Council on the Aging; the National Association of Area Agencies on Aging; and local libraries.

Caregivers' issues are getting more exposure. I am finally seeing a “family approach” by the medical profession. They are becoming aware of the need to educate caregivers about their own self-care, along with meeting the needs of the patient. Doctors, nurses and social workers are trying to educate the whole family about the dynamics of being a caregiver. This education must include both patients and caregivers for their health and well-being.

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In closing, I would like to increase the community's awareness of why the caregiving role is so difficult. It is because both parties are dealing with loss issues. As Dr. Elizabeth Kubler-Ross indicates in her book, *On Death and Dying*, that there are five stages one must go through in dealing with loss. These stages are denial, anger, depression, bargaining and acceptance. There is no sequence to these stages and a person may stay stuck in one stage. If both parties are dealing with different stages, one can see why there is

so much conflict. For example, a patient can be in *denial* about his or her ability to care for his or her personal needs while the caregiver is feeling *depressed* that his or her parent's health is failing. Each of these stages represents a coping mechanism. Caregivers need to be aware of what stage of loss they are experiencing and be honest about their feelings. This can be very complicated, so my parting words are "support groups and/or a support person to talk to is key."

Marty Haase is an honored member of *Who's Who Worldwide* (1993/1994) and *Who's Who Registry of Global Business Leaders*. She received a Bachelor of Science in Nursing in 1967 from Russell Sage College. She accepted the position of Director of Nurses of the Schenectady City Health Department in 1972.

Between 1981 and 1985 she began the St. Peter's Hospice Home Care Program, as well as the St. Peter's Home Health Aide Program. Marty held positions of Supervisor of St. Peter's High Tech Nursing and Supervisor of St. Peter's Home Care Discharge Planners.

Recognizing the needs of caregivers, she established the Caregivers Program in 1987 to provide education and training programs for caregivers. Awarded the first Capital Region Respite Program Grant from the New York State Office for the Aging in 1989, the program continues with funding through the New York State Office for the Aging, and the New York State Legislature, United Way and Catholic Charities.

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NEW YORK CASE NEWS

Recent New York Cases

By Judith B. Raskin

We actively solicit receipt of New York cases that you would like to see included in the New York Case News article. Please send your New York cases to Judith B. Raskin, Esq., Raskin & Makofsky, 600 Old Country Road, Suite 444, Garden City, NY 11530.

Plaintiff class appealed from a decision that N.Y. Social Services Law § 122 (SSL), which denied them state Medicaid benefits based upon their legal alien status, was not unconstitutional. Reversed. *In re Aliessa v. Novello*, 96 N.Y.2d 418 (2001).



Plaintiffs were 12 legal aliens suffering from serious illnesses. They were either admitted as permanent residents holding green cards or they were permanently residing under color of law (PRUCOLs) in the United States. The plaintiffs claimed that SSL § 122 improperly denied them state Medicaid benefits. They claimed they were discriminated against based upon their legal alien status in violation of the Equal Protection Clauses of the U.S. and New York State Constitutions and article XVII, § 1 (article XVII) of the New York State Constitution. The latter states, “[t]he aid, care and support of the needy are public concerns and shall be provided by the state and by such of its subdivisions and in such manner and by such means, as the legislature from time to time may determine.”

New York enacted SSL § 122 pursuant to the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA). PRWORA cut welfare benefits to promote self-sufficiency and discourage immigration for the sole purpose of receiving welfare benefits. Title IV of PRWORA restricts the eligibility of aliens for many public assistance benefits including Medicaid. Aliens are categorized and eligibility for benefits is based upon these categories. All aliens remain entitled under the federal law to emergency medical treatment. The legislation authorized the states to follow suit. New York did so by enacting SSL § 122. SSL § 122 denies plaintiffs Medicaid benefits that the state had previously determined to provide as an enhancement to the federal Medicaid program.

The New York County Supreme Court, using the strict scrutiny standard, granted summary judgment in favor of the part of plaintiff’s motion that declared SSL § 122 in violation of the Equal Protection Clauses of the federal and state constitutions. In addition, the

court found section 122 in violation of article XVII of the New York Constitution. A few days after the supreme court decision, the Appellate Division held, in a similar case regarding food assistance, that the standard to be applied is the less rigorous rational basis standard. The supreme court granted reargument and, using the rational basis standard, vacated its decision that SSL § 122 was in violation of the Equal Protection Clauses. The court retained the part of its decision that section 122 violated article XVII.

On appeal, the Appellate Division held that SSL § 122 did not violate the Equal Protection Clauses of the U.S. Constitution and the New York State Constitution or article XVII.

The Court of Appeals reversed, holding that SSL § 122 violated both Equal Protection Clauses and Article XVII. The Court reached its decision on the Equal Protection claim by applying strict scrutiny where plaintiffs are a “discrete and insular minority” and cannot vote. The state cannot rely upon the authorization in PRWORA to avoid a test of strict scrutiny or to discriminate against aliens. PRWORA authorizes states to extend or deny benefits only as state law and policy provide and does not set a uniform standard for states to follow. Article XVII requires the state to provide for the needy and although the state has the discretion of defining need, SSL § 122’s denial of benefits is based upon legal alien status and not need.

The parties appealed from an order that the commissioner of the New York State Office of Mental Retardation and Developmental Disabilities (OMRDD) be trustee of respondent Medicaid recipient’s inheritance and that OMRDD pay respondent’s legal fees. Reversed. *In re Patrick “BB”* — A.D.2d __ (3rd Dep’t 2001).

The respondent was 65 years old, developmentally disabled and residing in a family care home. The petitioner, OMRDD, was providing case management services. When respondent inherited \$19,041.55, OMRDD sought the appointment of an Article 81 guardian and requested reimbursement for Medicaid benefits incorrectly paid. The Office of Mental Hygiene, on behalf of respondent, cross-moved for the creation of a supplemental needs trust (SNT) to hold the inherited funds.

The Supreme Court appointed a guardian, ordered reimbursement of the benefits incorrectly paid, and ordered the creation of an SNT with the remainder of the funds. Respondent appealed but the appeal was dismissed when petitioner dropped its request for reimbursement and agreed to fund the SNT with the full inheritance. Petitioner then argued its commissioner should hold the funds as trustee. The respondent requested the funds be placed in a charitable pooled trust. Both parties sought to have legal fees paid by the other party.

The court appointed the commissioner of OMRDD as trustee of the funds to be managed as an SNT and each party was ordered to pay certain legal fees of the other. Both parties appealed.

The Appellate Division reversed and remitted the matter to the lower court with direction to seek appointment of a neutral guardian of the funds. The court held that OMRDD should not have been

appointed as special guardian. The N.Y. Mental Hygiene Law (MHL) sections relied upon by the petitioner, namely MHL § 29.23 (applicable where patient's property is held by third parties) and MHL § 13.29 (applicable where patient's property is gifted to the state) are not relevant. Additionally, the MHL prohibits the appointment of a guardian whose only interest is that of a creditor unless no other appointment is available. In addition, the petitioner, as a public agency, is not authorized under the MHL to act as guardian. The court noted that the charity proposed by the respondent, NYSARC, is a potential creditor as it must reimburse agencies for care of the respondent.

The Appellate Division also held that the petitioner was not responsible for respondent's legal fees. The petitioner's case was not without merit as the court did find it was entitled to payment for Medicaid incorrectly paid before withdrawing its claim.

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.

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The *Elder Law Attorney* is looking for an attorney who is willing to fulfill the role of writer of a new section called *National Case News*. If you are interested in filling this position, please contact:

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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.

In re Appeal of Anonymous Holding

A limited lifetime power of appointment drafted in an irrevocable *inter vivos* trust will cause all assets placed in the trust to be treated as available for Medicaid eligibility purposes.



Ellice Fatoullah

Facts

On March 1, 2000, appellant applied for Medicaid for herself, retroactive to January 1, 2000. The appellant is 74 years old, disabled, and has resided in a nursing home since March 5, 1995. Appellant privately paid for the cost of her medical care from March 5, 1995, through December 31, 1999.

On February 17, 1995, appellant's community spouse created an irrevocable *inter vivos* trust. The grantor retained neither the right to the income nor the principal. The trust provided that the grantor's children would be "sprayees" of the trust, and the trustees of the trust were given the power to pay out the entire principal of the trust to either or both of the grantor's two children. The two children were the named residuary beneficiaries under the trust and were also the trustees. The trust directed that no trust income or principal could be distributed or be available to the community spouse. The trust term was the life of the community spouse. And the grantor community spouse retained the limited power to change the beneficiaries to any legal entity other than himself or his spouse, and his creditors, his estate, his estate's creditors, as well as his spouse's creditors, estate and estate's creditors.

In February 1995, two back-to-back transfers were made transferring appellant's home from the name of appellant and spouse to spouse alone, and then from community spouse to the trust. In both instances, the grantor on the deed retained a life estate.

In April and May of 1995, various stock funds were transferred from the appellant and the community spouse as joint tenants to the aforementioned

trust. And two Prudential Life Insurance policies insuring the community spouse were transferred from the name of the community spouse into the trust.

By notice dated July 7, 2000, the agency informed the appellant of its determination to deny the appellant's medical assistance application on the grounds that the appellant's household had resources in excess of the allowable medical assistance standard, namely the assets held in the trust.

The community spouse retained bank account assets of \$31,219.05, which when added to the value of assets held in the trust totaled \$269,261.14.

On July 24, 2000, appellant requested this fair hearing.

Applicable Law

New York State regulations, N.Y. Comp. Codes R. & Regs. tit. 18, §§ 360-4.1 and 360-4.8(b) (N.Y.C.R.R.), provide that all resources actually or potentially available to a Medicaid applicant or recipient must be deemed available to the applicant or recipient; and that a Medicaid applicant whose available non-exempt resources exceed the resource allowance will be ineligible for Medicaid benefits until he or she incurs medical expenses equal to or greater than the amount transferred.

Available resources are defined in 18 N.Y.C.R.R. § 360-4.4 as

- (a) property of all kinds, including real and personal property. It includes both tangible and intangible property.
- (b) An applicant's/recipient's available resources include:
 - (1) all resources in the control of the applicant/recipient. It also



René H. Reixach

- includes any resources in the control of anyone acting on the applicant's/recipient's behalf such as a guardian, conservator, representative, or committee;
- (2) certain resources transferred for less than fair market value as explained in subdivision (c) of [section 360-4.4];
 - (3) all or part of the equity value of certain income producing property, as explained in [19 N.Y.C.R.R. § 360-4.4(d)];
 - (4) certain resources of legally responsible relatives, as explained in [18 N.Y.C.R.R. § 360-4.3(f)]; and
 - (5) certain resources of an MA-qualifying trust, as explained in [18 N.Y.C.R.R. § 360-4.5].

In regard to trust fund assets, N.Y. Social Services Law § 366.2(b)(2)(ii) (SSL) states, in part:

(b)(2) In evaluating the income and resources available to an applicant for or recipient of medical assistance, for purposes of determining the eligibility for and the amount of such assistance, the department must consider assets in or paid from trusts created by such applicant or recipient, as determined pursuant to the regulations . . . , in accordance with the provisions of this subparagraph:

(ii) In the case of an irrevocable trust created by an applicant or recipient, as determined pursuant to regulations . . . ; any portion of the trust corpus, from which no payment can under any circumstance be made to such applicant or recipient must be considered, as of the date of establishment of the trust, or, if later, the date on which payment to the applicant or recipient is foreclosed, to be assets disposed of by such applicant or recipient for purposes of paragraph (d) of subdivision five of this section; any portion of the trust corpus, and of the income generated by the trust corpus from which payment could be made to or for the benefit of such applicant or recipient must be considered to be an available

resource, payment from the trust to or the benefit of such applicant or recipient must be considered to be available income; and any other payments from the trust must be considered to be assets disposed of by such applicant or recipient for purposes of paragraph (d) of subdivision five of this section.

Regulation § 360-4.5 explains that the above applies without regard to whether the Medicaid qualifying trust is revocable or irrevocable, or whether the trustee actually exercises discretion with respect to the distribution of payment to the grantor.

Discussion

The fair hearing found that the agency's determination to deny the appellant's March 1, 2000 application on the grounds of excess resources was correct. The decision reasoned that the right to change the beneficiaries of the trust by the exercise of a testamentary power of appointment coupled with the statutory power to terminate the trust with the agreement of all the beneficiaries, pursuant to Estates, Powers and Trusts Law 7-1.9 (EPTL), gave the grantor sufficient power over the trust corpus to have it deemed available for Medicaid eligibility purposes. Specifically, the decision reasoned that the facts presented in this case presented a circumstance, under SSL § 366 (2)(b)(2), under which payment of trust principal to or for the benefit of the grantor/applicant could be made, and therefore the trust corpus was deemed available.

The fair hearing decision also found support from *In re Reynolds*.¹ In *Reynolds*, the N.Y. Court of Appeals found that the retention of a limited power of appointment constituted the "power to dispose" of a trust corpus; and relying heavily on the public policy argument of protecting a spouse's right of election, the Court held that the trust corpus would be deemed a testamentary substitute in violation of the surviving spouse's right of election. The fair hearing decision reasoned that while the instant matter does not involve the right of election, a similarly strong public policy matter is presented in this case, namely, the need to conserve the public fisc and provide Medicaid benefits only to those who are truly needy. Therefore, the fair hearing decision found the limited power of appointment in the instant matter should similarly be construed against the grantor/applicant draftsman.

The fair hearing decision also cited *Case v. Fagnoli*² for the proposition that when a grantor retains a power to change beneficiaries, "as a practical matter, a power to change the remainder interests

in a self-settled trust is very nearly a power to dispose of the principal"; and *Amendolia v. New York City HRA*³ as holding that the mere retention by a Medicaid applicant of a testamentary power of appointment over the corpus of a trust made the corpus an available resource for Medicaid eligibility purposes.

The decision reasoned that *Amendolia* in conjunction with *Reynolds* and *Fargnoli* provided strong guidance that the retention of a limited *inter vivos* power of appointment to change the beneficiaries of the trust constitutes the power to dispose of the trust for the benefit of the Appellant through her community spouse. The decision also noted that previous fair hearing decisions to the contrary, notably *In re E.S.* and *Antoinetta G.* decided prior to the Court of Appeals decision *Reynolds*, would not be controlling on the department.

The argument by appellant that the limited power of appointment was drafted solely for tax purposes was given short shrift. The decision stated that even if that was the purpose for drafting the limited power of appointment, under the aforementioned Medicaid laws and New York cases the trust corpus would still be deemed available. Likewise unpersuasive was the argument that all requisite transfer of assets penalty periods had lapsed because the application was filed more than 60 months after the assets were transferred into the trust. The decision stated that such expiration was "immaterial" here as "the sole issue" concerns an interpretation of the trust document itself, and whether under any circumstance, any portion of the corpus of the trust can be paid to the appellant or her legally responsible spouse. There was no issue concerning the transfer of assets penalty period.

The Fair Hearing Decision

The decision found that the agency's July 7, 2000 determination to deny appellant's Medicaid application on the ground that appellant possessed excess resources in the form of the corpus of an irrevocable trust, established by the appellant's spouse more than five years before the application for Medicaid benefits was filed, was correct insofar as the trust contained a lifetime limited power of appointment under which the grantor's assets would be deemed available.

Editor's Comments

This is yet another case highlighting the need to make sure that if a trust fund is used in Medicaid planning *no* limited power of appointment is drafted. Remember also, that if you are in New York City, the city will agree to amend the trust deleting the limited power of appointment language.

Note also the difference in public policy slant taken by the fair hearing decision and in *In re Kashmira Shah*,⁴ where in response to the state's argument about the need to conserve the public fisc and that Medicaid benefits should be used only for those who are truly needy, the Court of Appeals stated that:

No agency of the government has any right to complain about the fact that middle-class people confronted with desperate circumstances choose voluntarily to inflict poverty upon themselves when it is the government itself which has established the rule that poverty is a prerequisite to the receipt of government assistance in the defraying of the costs of ruinously expensive, but absolutely essential medical treatment.

Further, in *Case v. Fargnoli*,⁵ it was the support language contained in the *inter vivos* trust which actually rendered the trust asset available.

Finally, it is important to remember that no spousal refusal was submitted in this case. Had there been one, there could have been no issue as to the availability of trust fund assets created by the community spouse of a Medicaid nursing home patient.⁶

Appellant was represented by Harvey Lasner, Esq., of Chautauqua, New York.

In re Appeal of R.D.

Holding

Social Security income is inalienable. Thus, the Medicaid agency cannot direct that Social Security income come first in computing an enhanced community spouse resource allowance (CSRA); and after the enhanced CSRA is determined, the patient spouse can direct that his Social Security income be made available to the community spouse.

A community spouse resource allowance will be adjusted upward at a fair hearing so that interest on the resources are sufficient to generate the minimum monthly maintenance needs allowance (MMMNA) amount. An amount higher than the MMMNA can be approved at a fair hearing in cases of "exceptional circumstances." Exceptional circumstances are shown when the community spouse spends \$1,807 per month for necessary home attendant services.

Facts

On June 25, 1999, an application for nursing home Medicaid was submitted to the agency on behalf of the appellant. On July 11, 2000, the agency accepted the application for Medicaid, retroactive to

April 1, 1999, subject to the application of a net available monthly income (NAMI).

For 1999, the agency determined that appellant's NAMI was \$794.

For 2000, the agency determined that the appellant's NAMI was \$815.

On August 2, 2000, this fair hearing was requested to review the agency computation of the NAMI, for an increase of the community spouse's resource allowance and the community spouse's monthly income allowance, and to re-budget the Medicaid's effective date to March 1, 1999.

On August 26, 2000, appellant passed away.

In determining the amount of the appellant's NAMI, the agency allocated a portion of the appellant's pension income to increase the amount of income available to his community spouse because the income of the community spouse was less than the MMMNA. However, the agency did not allocate any of the appellant's income from Social Security benefits for such purpose.

The agency determined that the appellant and his spouse had total combined countable resources of \$151,999.31 as of March 1, 1999.

The monthly income (interest/dividends) generated by the total combined resources was \$566 for 1999, and \$344.25 for 2000. The appellant's attorney-in-fact submitted a statement to the agency stating that for purposes of Medicaid budgeting the appellant's Social Security income was not available to his spouse, unless needed for her support after all available resources had been utilized.

In determining the amount of the appellant's NAMI, the agency allocated a portion of the appellant's pension income to increase the MMMNA of the community spouse because the income of the community spouse was less than the MMMNA. However, the agency did not allocate any of the appellant's income from Social Security benefits for such purpose.

The agency determined the appellant's 1999 income as follows:

The Year 1999

Appellant:	
Pension	\$966.00
Health insurance premium deduction	<u>-22.70</u>
Available to the community spouse	\$943.30
Social Security	\$844.00
Personal needs allowance	<u>-50.00</u>
NAMI	\$794.00

Community spouse:

MMMNA in 1999 was	\$2,049
net Social Security income	\$395.00
interest and dividends	
on total combined resources	<u>+566.00</u>
total income =	\$961.00
Minus health insurance	
premium deduction	-10.00
Appellant's contribution	<u>+943.30</u>
Total income of the community spouse =	\$1,894.30

\$2,049 - 1,894.30 = \$154.70 shortfall from NAMI.

The Year 2000

Appellant:	
Pension	\$966.00
Health insurance premium deduction	<u>-23.90</u>
Available to the community spouse	\$942.10
Social Security	\$865.00
Personal needs allowance	<u>-50.00</u>
NAMI	\$815.00

Community spouse:

MMMNA in 2000 was	\$2103
net Social Security income	\$406.00
interest and dividends	
on total combined resources	<u>+344.25</u>
total income =	\$750.25
Minus health insurance	
premium deduction	-10.00
Appellant's contribution	<u>+942.10</u>
Total income of the Community Spouse =	\$1,682.35

\$2,103 - 1,682.35 = \$420.65 shortfall from NAMI

In addition, the community spouse had become wheelchair-bound and required home health services. From January 2000 until August 2000, when she died, she spent \$14,967.78 on home care services, or \$1,807.97 per month. She also paid \$5,500 for a wheelchair ramp.

Applicable Law

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

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

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

(3) Community Spouse monthly income allowance means the amount

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

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

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

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

(b) Treatment of income.

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

in accordance with subdivision (c) of this section.

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

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

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

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

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

(3) The eligibility of an institutionalized spouse for MA for the first month or partial month of institutionalization will be determined by comparing his/her net available income, computed in accordance with section 360-4.6(a)(1) and (2) of this Part, and any income actually contributed by the community spouse, to the appropriate MA or PA income standard for one person. Thereafter, the institutionalized spouses eligibility for MA and liability for the cost of care will be determined in accordance with this section and with sections 3601.4(c) and 360-4.9 of this Part until the month following the month in which he/she ceases to be an institutionalized spouse.

(4) In determining the amount of the institutionalized spousal income to be applied toward the cost of medical care, services and supplies in

accordance with section 360-4.9(b) of this Part, the following items will be deducted from the otherwise available monthly income of the institutionalized spouse in the following order:

- (i) a personal needs allowance;
- (ii) a community spouse monthly income allowance, but only to the extent that the income is made available to or for the benefit of the community spouse;
- (iii) a family allowance for each family member; and
- (iv) any expenses incurred for medical care, services, supplies or remedial care for the institutionalized spouse not subject to payment under this Title or by a third party.

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

(c) Treatment of resources. The following rules apply in determining the resources available to the institutionalized spouse and the community spouse when determining eligibility for MA for the institutionalized spouse.

(1) At any time after the commencement of a continuous period of institutionalization, either spouse may request an assessment of the total value of the resources, or may request to be notified of the amounts of the community spouse monthly income allowance, the community spouse resource allowance, and the family allowance, and/or the method of computing such amounts

* * *

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

* * *

(7) If either spouse establishes that the income generated by the community spouse resource allowance established by the social services district, is inadequate to raise the community spouse's income to the minimum monthly maintenance needs allowance, the department must establish a resource allowance adequate to provide such minimum monthly maintenance needs allowance from those resources considered to be available to the institutionalized spouse.

In *Robbins v. Debuono*⁷ the Second Circuit held that Social Security income could not "come first" when New York State computed an enhanced CSRA at a fair hearing. The federal court based its decision on *Johnson v. Harder*⁸ interpreting the Social Security Act,⁹ which prohibits the alienation of Social Security benefits. Thus, the *Robbins* court held that Social Security income could not be alienated, or assigned, in any way not directed by the Social Security recipi-

ent, and that includes attributing Social Security income in computing an enhanced CSRA at a fair hearing.

A GIS, No. MA/027, issued on November 10, 2000, implemented the *Robbins* decision. Specifically, the GIS stated, “The Department can no longer attribute an institutionalized spouse’s Social Security income to the community spouse unless the institutionalized spouse intends to make this income available to the community spouse.” The GIS however, goes on to say that: “Social Security income is, however, considered to be available for the cost of care and should be entered with any other NAMI amount.”

Discussion

In his fair hearing memorandum, appellant argued that: (1) the resource allowance of the community spouse should be increased from \$81,960 to \$151,999.31, the total combined countable resources of the couple as of March 1, 1999; (2) the appellant’s Social Security benefits should be budgeted to meet the MMMNA of the community spouse after the resource allowance is increased; and (3) the MMMNA should be increased by \$2,558.27 for the period from January through August 2000, due to exceptional expenses for medical care.

Appellant also argued that under *Robbins* in adjusting the CSRA of the community spouse, the patient’s Social Security income should not be considered as available to her.

The agency’s initial determination was made before the GIS was issued, and therefore was correct when made. However, under the department’s spousal impoverishment rules, if the amount of monthly income otherwise available to a community spouse is less than the MMMNA, the institutionalized spouse may transfer income to the community spouse to bring the community spouse’s income up to the MMMNA. If the institutionalized spouse’s income is insufficient to bring the community spouse’s income up to the MMMNA, an increased community resource allowance must be established to generate income to bring the community spouse’s income up to the MMMNA pursuant to a fair hearing or a court order.

The fair hearing decision determined that the CSRA should be increased to the full amount of the total combined resources of the couple, or \$151,999.31 to generate needed income for the community spouse. The decision then explains that since the agency determined the appellant had countable resources during the months of March and April, and since the CSRA was being adjusted to the full amount of resources owned by the couple, therefore, there

would be no excess resources in this case, and the Medicaid pick-up date was adjusted back to March 1, 1999.

The decision also found that since appellant’s son, as the appellant’s representative, opted to make appellant’s Social Security income available to increase the MMMNA, Social Security income needed to reach the MMMNA could not be applied towards the patient’s NAMI, and would be transferred to the community spouse. Thus, \$154.70 per month of appellant’s Social Security income for 1999 would be allocated to the community spouse; and appellant’s NAMI would be correspondingly reduced. In 1999, the NAMI would be \$639.30 per month (\$794 minus \$154.70).

For 2000, \$420.65 of Social Security income should have been allocated to the community spouse, without figuring in the increased MMMNA due to exceptional expenses. However, since the amount of the MMMNA for 2000 was increased by over \$1,800 per month due to medical expenses for home health care, and this exceeds the amount of the appellant’s remaining unallocated Social Security benefits, the appellant’s NAMI for 2000 would be reduced to \$0.

Finally, the decision found that the MMMNA for 2000 would be increased from \$2,103 to \$3,974 by adding the community spouse’s average monthly cost of exceptional medical expenses for home health care during the period from January 2000 through August 2000. The decision reasoned that it could not reasonably be expected that such medical expenses for long-term care could reasonably be met from the community spouse’s MMMNA. However, wheelchair cost sought to be used to further increase the MMMNA were disallowed as in essence, the decision reasoned that these costs should be amortized over a much longer period of time than the period of January through August.

Fair Hearing Decision

The agency determination of the effective date of the Medicaid coverage and the amount of the NAMI the appellant must apply toward the cost of his institutional care was correct when made. However, the agency is now directed to:

1. adjust the effective date of eligibility for Medicaid coverage from April 1, 1999 to March 1, 1999;
2. adjust the appellant’s NAMI for 1999 to \$639.30; and
3. adjust appellant’s NAMI for 2000 to \$0.

Editor's Comments

We note that the agency's decision to accept the case was made 11 months after the application was filed. This is way beyond the agency's own rules, and federal law, which require that an application be processed with reasonable promptness, that is to say within 45 days for most eligibility issues.

What makes the decision so important is that after *Robbins* the agency appeared to take the position that the applicant cannot have it both ways: an applicant cannot direct Social Security income away from the community spouse for the purpose of computing an enhanced CSRA, but after enhancement of the CSRA, have that very same Social Security income transferred to the community spouse for her income needs. And in fact, the above-quoted GIS appears to take this position. Had the agency continued with this position, *Robbins* would have been a Pyrrhic victory. However, this fair hearing decision clearly holds that Social Security income need not come first in computing a community spouse's adjusted CSRA, thereby allowing for a higher CSRA. And yet after the CSRA is adjusted, the patient is still entitled to direct that his

Social Security income be applied towards the community spouse's income needs.

Appellant was represented by Legal Services for the Elderly of Erie County, New York.

* * *

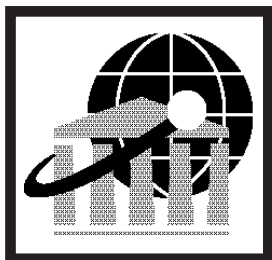
Copies of the Fair Hearing decisions analyzed above may be obtained by visiting the Western New York Law Center at www.wnylc.com/fairhearingbank.

Endnotes

1. 87 N.Y.2d. 633 (1996).
2. 182 Misc. 2d. 996, (Sup. Ct., Tompkins Co. 1999).
3. 20 A.D.2d. 344 (2d Dep't 2000).
4. 95 N.Y.2d 148, 163 (2000).
5. 182 Misc. 2d. 996 (Sup. Ct., Tompkins Co. 1999).
6. 42 U.S.C. § 1396r-5(c)(3); SSL § 366.3a.
7. 218 F.3d 197 (2d Cir. 2000).
8. 383 F. Supp. 174, *aff'd*, 512 F.2d 1188 (2d Cir. 1975).
9. 42 U.S.C. § 407.

Ellice Fatoullah is the principal of Fatoullah Associates, with offices in New York City and New Canaan, CT. She is Chair of the Long Term Care Reform Committee of the New York State Bar Association's Elder Law Section, a fellow of the National Academy of Elder Law Attorneys, and a board member of FRIA, a New York City advocacy group monitoring quality of care issues in nursing homes. She was the founding Chair of the Elder Law Committee of the New York County Bar Association, founding Chair of the Public Policy Committee to the Alzheimer's Association—New York City Chapter, and a member of its board for seven years. In 1996, she served on the New York State Task Force on Long Term Care Financing. She writes and lectures regularly on issues of concern to the elderly and the disabled.

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



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LEGISLATIVE NEWS

By Howard S. Krooks and Steven H. Stern

Patient's Bill of Rights

The Patient's Bill of Rights, just passed by the House of Representatives, is essentially the bill passed by the Senate in June. It has virtually all of the necessary patient protections *except* that there were amendments added that undercut the provisions to hold health plans accountable and that essentially eliminate a meaningful right to sue (and may make this aspect of patient protections worse than it is now).



Howard S. Krooks

In June, the Senate passed a very strong bipartisan patient's rights bill. However, President Bush argued vehemently in opposition (mainly the right-to-sue provisions) and clearly and repeatedly threatened to veto the bill.

As the action shifted to the House of Representatives, the strongest proponents were Reps. Charlie Norwood (R-GA), Greg Ganske (R-IA), and John Dingell (D-MI), who had championed the excellent bill passed in 1999 with the support of 68 Republicans. They decided to adopt the Senate-passed bill (with minor changes). However, the Republican leadership pushed an alternative bill put forward by Rep. Ernie Fletcher (R-KY), which was weaker in all aspects (not just the right-to-sue). A vote was scheduled, but the Republican leadership had to delay because the Norwood-Ganske-Dingell forces had the votes to win.

The administration saw controlling the Republican majority in the House as a major test of its strength, and it was concerned about Bush's prominent veto threat. On the one hand, it didn't want to veto a popular patients' rights bill; on the other hand, it needed to show that its veto threat meant something so it could be used effectively in the future.

The President and Vice President stepped up their opposition. They lobbied vigorously, putting pressure on all the wavering Republicans but saving their strongest fire for Charlie Norwood. There were numerous White House sessions, lots of meetings, and the President and Vice President both went to the Capitol to lobby (which we're told has never been done before). As a result of all this pressure, and despite his promise to other key patients' rights

champions in the House and Senate that he would accept no deal unless they agreed, Norwood caved. He worked out a deal with Bush that significantly changed the right-to-sue and the external review provisions.

The House of Representatives recently voted. The base bill was the Norwood-Ganske-Dingell bill (the Senate-passed bill), which contained all of the needed patient protections. However, the legislation also included several additional amendments.



Steven H. Stern

The most important was the Norwood-Bush deal. This amendment passed 218-213, with six Republicans voting against and three Democrats voting in favor. This amendment significantly changed the right-to-sue provision. It allows suits in state court after an external appeal. However, it creates a strong presumption for the court that the result of the appeal is correct. This creates quite a hurdle for a consumer to overcome in court (in legal parlance, it's called a rebuttable presumption). In addition, there were caps placed on court awards for noneconomic and punitive damages of \$1.5 million, unless the state has a lower cap. There is also some concern that this result may be worse than nothing, in that the courts have been moving towards recognizing some right-to-sue under current law.

The Norwood-Bush deal also changes the external appeals process by creating a federal external appeals provision, thereby wiping out good provisions won by advocates in the states. The rules for the appeals seem to be fine, but the plans would choose (and pay for) the entity that would hear the appeal, thus raising conflict-of-interest concerns.

The final bill, with the amendments, passed 226-203. All the Republicans voted for it, and five Democrats crossed party lines to join them.

The following commentary is provided by Families USA:

THE PROGNOSIS: President Bush and the Republican House are getting a lot of credit for compromising and passing this bill. The press coverage has been gigantic, and the public will think that we've passed a good patients' rights bill.

Democrats in the House and Senate lambasted the House-passed bill in the strongest terms. They feel sold out by Charlie Norwood (who is now the new darling of the Republican party, they even chanted his name on the House floor when they passed the bill!).

The legislation now has to go to a House-Senate conference committee. We've been there before: In 1999 the House passed a strong bill, the Senate passed a very weak bill, and nothing ever came out of that conference committee. With feelings so hot right now, it's hard to see how a compromise can be reached. The House Republicans probably see no reason to compromise (they will argue that they have already compromised and, in any case, they have the President with them). The Senate Democrats feel the right-to-sue is critical and can't see themselves supporting a bill without it.

It won't be easy, but we still hope that some way can be found to enact a strong patients' bill of rights this Congress.

The authors would like to thank *Families USA* for assistance with this article. It can be reached at familiesusa.org.

Olmstead Executive Order

On June 18, 2001, President George W. Bush signed an Executive Order promoting community-based alternatives rather than institutions for individuals with disabilities. This Executive Order directs key federal agencies to work closely with states to ensure full compliance with the Olmstead ruling and the American with Disabilities Act (ADA). Recall that in the decision, the U.S. Supreme Court held that under public services portion of ADA, states are required to provide community-based treatment for persons with mental disabilities when the state's treatment professionals determine that such placement is appropriate, affected persons do not oppose such treatment, and placement can be reasonably accommodated, taking into account the resources available to state and the needs of others with mental disabilities. Americans with Disabilities Act of 1990. In addition, the court explained that undue institutionalization of persons with mental disabilities qualifies as "discrimination" by reason of disability under public services portion of ADA. President Bush's executive order:

EXECUTIVE ORDER

COMMUNITY-BASED ALTERNATIVES FOR INDIVIDUALS WITH DISABILITIES

By the authority vested in me as President by the Constitution and the laws of the United States of America, and in order to place qualified individuals with disabilities in community settings whenever appropriate, it is hereby ordered as follows:

Section 1. Policy. This order is issued consistent with the following findings and principles:

(a) The United States is committed to community-based alternatives for individuals with disabilities and recognizes that such services advance the best interests of Americans.

(b) The United States seeks to ensure that America's community-based programs effectively foster independence and participation in the community for Americans with disabilities.

(c) Unjustified isolation or segregation of qualified individuals with disabilities through institutionalization is a form of disability-based discrimination prohibited by Title II of the Americans with Disabilities Act of 1990 (ADA), 42 U.S.C. 12101 et. seq. States must avoid disability-based discrimination unless doing so would fundamentally alter the nature of the service, program, or activity provided by the State.

(d) In *Olmstead v. L.C.*, 527 U.S. 581 (1999) (the "Olmstead decision"), the Supreme Court construed Title II of the ADA to require States to place qualified individuals with mental disabilities in community settings, rather than in institutions, whenever treatment professionals determine that such placement is appropriate, the affected persons do not oppose such placement, and the State can reasonably accommodate the placement, taking into account the resources available to the State and the needs of others with disabilities.

(e) The Federal Government must assist States and localities to implement swiftly the Olmstead decision, so as to help ensure that all Americans have the opportunity to live close to their families and friends, to live more independently, to engage in productive employment, and to participate in community life.

Sec. 2. Swift Implementation of the Olmstead Decision: Agency Responsibilities. (a) The Attorney General, the Secretaries of Health and Human Services, Education, Labor, and Housing and Urban Development, and the Commissioner of the Social Security Administration shall work cooperatively to ensure that the Olmstead decision is implemented in a timely manner. Specifically, the designated agencies should work with States to help them assess their compliance with the Olmstead decision and the ADA in providing services to qualified individuals with disabilities in community-based settings, as long as such services are appropriate to the needs of those individuals. These agencies should provide technical guidance and work cooperatively with States to achieve the goals of Title II of the ADA, particularly where States have chosen to develop comprehensive, effectively working plans to provide services to qualified individuals with disabilities in the most integrated settings. These agencies should also ensure that existing Federal resources are used in the most effective manner to support the goals of the ADA. The Secretary of Health and Human Services shall take the lead in coordinating these efforts.

(b) The Attorney General, the Secretaries of Health and Human Services, Education, Labor, and Housing and Urban Development, and the Commissioner of the Social Security Administration shall evaluate the policies, programs, statutes, and regulations to their respective agencies to determine whether any should be revised or modified to improve the availability of community-based services for qualified individuals with disabilities. The review

shall focus on identifying affected populations, improving the flow of information about supports in the community, and removing barriers that impede opportunities for community placement. The review should ensure the involvement of consumers, advocacy organizations, providers, and relevant agency representatives. Each agency head should report to the President, through the Secretary of Health and Human Services, with the results of their evaluation within 120 days.

(c) The Attorney General and the Secretary of Health and Human Services shall fully enforce Title II of the ADA, including investigating and resolving complaints filed on behalf of individuals who allege that they have been the victims of unjustified institutionalization. Whenever possible, the Department of Justice and the Department of Health and Human Services should work cooperatively with States to resolve these complaints, and should use alternative dispute resolution to bring these complaints to a quick and constructive resolution.

(d) The agency actions directed by this order shall be done consistent with this Administration's budget.

Sec. 3. Judicial Review. Nothing in this order shall affect any otherwise available judicial review of agency action. This order is intended only to improve the internal management of the Federal Government and does not create any right or benefit, substantive or procedural, enforceable at law or equity by a party against the United States, its agencies or instrumentalities, its officers or employees, or any other person.

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REGULATORY NEWS

Same Issues, Different Agency: Transfer Penalties and Trust Rules Under the Section 8 Housing Program

By Louis W. Pierro and Edward V. Wilcenski

Introduction

In the past two issues of the *Elder Law Attorney*, we discussed in some detail recent changes to the resource provisions of the Supplemental Security Income (SSI) rules on trusts and transfers of resources. The Foster Care Independence Act of 1999,¹ effective December 14, 1999, reinstated the transfer of asset penalty provisions that had been absent from the SSI program since 1988. The SSI statute contains much of the same transfer of asset language found in the Medicaid statute, and includes a number of exceptions, including an exception for transfers of assets (or “resources” as used in the SSI statute) to a valid First Party Supplemental Needs Trust (SNT).² In our most recent article, we discussed some inconsistencies in the treatment of these transfer of asset rules between the two programs.³

As most elder law practitioners are aware, participation in the SSI program will guarantee full Medicaid coverage in New York State. Thus, while the new SSI transfer of asset rules (and the inconsistencies with the more familiar Medicaid transfer of asset provisions) create an additional layer of complexity, in many cases establishing eligibility for the SSI program will ensure that a disabled individual’s necessities are provided for, including room and board, medical care, service coordination, prescription medication, etc. For a client with a severe developmental disability who requires institutionalization or who resides in a Medicaid-funded community setting, he or she will receive the majority of his or her services through the Medicaid program by reason of his or her participation in the SSI program.

Unfortunately, unless one is willing to limit his or her practice to representing this single segment of the disabled population, planning in the context of benefit eligibility is not quite that simple. Many disabled individuals continue to reside in the community and receive their support through a patchwork of federal, state and local government benefit programs, some targeted specifically to the disabled, others targeted towards those with low incomes without regard to age or disability. Clients whose disabilities are less severe or whose onset can occur later in life (e.g.,



Louis W. Pierro

mental illness or brain injury) will often find themselves relying on a much broader spectrum of benefits, and like the Medicaid and SSI programs, many of these benefit programs will also have resource and income limitations and transfer of asset rules of their own. However, aside from the correlation between the SSI and Medicaid programs here in New York State (and any other states that provide Medicaid benefits to “categorically eligible” individuals), establishing eligibility for one program does not necessarily ensure participation in another. As such, it becomes much more difficult to predict and negotiate the consequences of transferring and otherwise restructuring the financial affairs of a disabled individual who may, through inheritance, gift, personal injury settlement or otherwise, receive a sum of funds that would jeopardize eligibility for one of these programs. Below we consider this planning issue in relation to one program that is frequently part of the patchwork of benefits that support the disabled in the community: Section 8 of the Housing Act of 1937.



Edward V. Wilcenski

Section 8 Housing Benefits

Because of the importance of reliable and stable housing for all individuals, there are more programs designed to assist the elderly and disabled than could ever be included in a single textbook, much less a single article. Subsidized loans for purchase, construction and modification of residences; rental supports; anti-discrimination initiatives; residential rehabilitation and support; tax breaks—a myriad of laws and regulations governing all of these items and more can be found at the federal level, in every state of the country, and in many municipalities. In this article we have chosen to highlight the Section 8 program, both because of its importance in allowing many of our clients to lead relatively independent lives in the community, and because of the program’s treatment of certain financial transactions that serve as the core of an elder/disability law attorney’s planning arsenal.

The Section 8 program is part of a much larger and quite complicated system of federally supported

housing that stems from the Housing Act of 1937, the first federally subsidized housing program in the country.⁴ While it was originally designed for the working poor, today it serves as a crucial support program for the non-working elderly and disabled alike.⁵

Section 8 of the act provides rental assistance to low income families and individuals who meet the program's income criteria.⁶ A reference to "Section 8" generally refers to public housing assistance, which is targeted to a particular public housing project, or to the voucher and certificate programs, which are targeted to an individual or family, and will travel with the recipient to any qualified residence within a certain geographic area. Each program contains different conditions for participation and varying methods of calculating the level of the Section 8 benefit.⁷ The Section 8 program is administered at the federal level by the Department of Housing and Urban Development (HUD), and general information on the various HUD programs can be found on the agency's Web page,⁸ as well as from the Public Housing Authority that administers the program in a given locality.

As many elder law and disability practitioners have discovered, the Section 8 program has its own, independent rules regarding the treatment of trusts and transfers of assets by a participant or, in some cases, other members of the household. Definitions of income, applicable exclusions, and the treatment of transfers of property can be found generally in the Code of Federal Regulations tit. 24, §§ 5.601-5.611 (C.F.R.).⁹ These regulations have been interpreted internally by HUD and are contained in Handbook No. 4350.3 entitled "Occupancy Requirements of Subsidized Multifamily Housing Programs," available on the agency Web site (the "Handbook").

While the Section 8 program determines financial eligibility based on income, there is actually an "indirect" asset limitation. Specifically, the program counts all income generated on "net family assets" exceeding \$5,000, or if no income is being generated on those assets, then the rules require that income be "imputed" to those assets at a rate fixed by the agency, currently 2 percent per year.¹⁰ If a Section 8 participant transfers assets that otherwise would have generated income, those assets will continue to be counted as part of the net family assets generating income to the recipient for a period of two years.¹¹ This includes transfers of assets to what the regulations refer to as "non-revocable," (i.e., "irrevocable") trusts. Just as with outright transfers, funds held in the trust will be counted in determining eligibility, (ie. income will be imputed to trust assets) for a period of two years. Following the two-year period, only income actually distributed will be counted.¹²

There is a variation on this theme for "non-revocable" trusts that are funded with personal injury settlements, in which case only income distributed from the trust will be counted in determining the Section 8 subsidy. And just to make things interesting, there is a further exception to this exception. As explained in the Handbook, if a trust holding personal injury proceeds is "under the control of a family member," then the preference granted to trusts holding personal injury proceeds will not apply, and all income, distributed or undistributed, will be counted.¹³

This last item brings up an interesting question. How would the program treat the relatively common situation where a First Party SNT is funded with proceeds from a personal injury settlement, and a family member is serving as *co-trustee*? Predictably, neither the regulations nor the internal guidelines found in the Handbook contain (to our knowledge) any specific reference to SNTs, so we would expect that the trust would be considered "under the control of a family member," and all income would be counted in determining the Section 8 subsidy for two years subsequent to its funding.

Absent any preference for SNTs, a practitioner counseling a disabled Section 8 participant who receives assets that will jeopardize participation in the program will need to consult the regulations and internal guidelines to best estimate the impact of the settlement and funding of a SNT on continuing participation in the Section 8 program. The client would then need to decide whether the advantages of funding the trust compensate for the adverse effect on Section 8 benefits, if any.

Obviously, the need to heed the Section 8 program rules will depend in large part upon the value of the assets being used to fund the SNT. For larger trusts, it may be most beneficial to use the trust funds to supplement a different housing arrangement, and terminate participation in the Section 8 program altogether. This may not be an option for beneficiaries of trusts of lesser amounts. In our most recent encounter, we recommended that our client fund a First Party SNT (in this case with inherited assets) and accept the reduced Section 8 rental supplement. We then provided advice on how to maximize distributions from the trust so as to leave more discretionary income at the end of the month to pay the increased net rent amount.

One interesting side note on the text of the regulations is warranted. Section 5.609(c)(17) makes an apparent reference to an exclusion from income under the Section 8 program for "amounts specifically excluded by any other federal statute. . . ." We submitted a written request to the HUD asking for clarification, and asking whether the department had

issued any internal guidelines on the nature and scope of this particular exclusion. Our obvious hope was that an income exclusion applicable to another program (like the SSI program) would also apply in determining Section 8 rental income. If so, then there would have been at least a hint of consistency between these two benefit programs, and practitioners might be able to look to the SSI program rules for guidance.

The response from the HUD, in an undated letter from Willie Spearman, Director of the Office of Business Products (no, that is not a typo) received in June of 1999, was as follows: "the Department has not issued any further guidance identifying benefits that qualify for the income exclusion at 24 C.F.R. § 5.609(c) which excludes amounts specifically excluded by any other federal statute. However, [the other sections of the regulations] sufficiently respond to the issues raised in your letter."

Conclusion

Attorneys and other professionals who practice in the government benefits arena understand that there is rarely any communication between separate agencies, and often there is inconsistent treatment of identical issues within the same agency. Moreover, internal agency guidelines often take liberties with the language of the statute and regulations in a manner that can strain reasonable interpretation. These issues only serve to highlight what we believe to be the most

important rule when representing a client with a disability: know the nature of the disability, and obtain complete information on *all* benefit programs that support the individual in the community before you begin making recommendations. Providing advice without having first obtained this information can lead to especially serious consequences for this often vulnerable segment of our population.

Endnotes

1. Pub. L. 106-169.
2. 42 U.S.C. § 1396(p)(d)(4)(A); 42 U.S.C. § 1382b(e)(5).
3. See Louis W. Pierro & Edward V. Wilcenski, *Social Security Administration Issues New Guidelines on Treatment of Trusts for SSI Recipients*, Elder Law Attorney, Vol. 11, No. 3 at 37 (Summer 2001).
4. 42 U.S.C. §§ 1437 *et. seq.*; 24 C.F.R. pt. 941.
5. The Section 202 program is designed specifically for the elderly (12 U.S.C. § 1701q), and the Section 811 program is designed specifically for the disabled (42 U.S.C. § 8013).
6. 24 C.F.R. pts. 982, 983.
7. For an excellent general discussion of the Section 8 and other housing programs, see Lawrence A. Frolik, *Residence Options for Older or Disabled Clients* (1999).
8. <www.hud.gov> (last visited August 2001).
9. See 24 C.F.R. § 5.609.
10. 24 C.F.R. § 5.609(b)(3); Handbook §§ 3-15(a), (b).
11. 24 C.F.R. § 5.603(b) (definition of "net family assets"); Handbook § 3-16.
12. 24 C.F.R. § 5.603(b); Handbook § 3-14(b)(4)(a).
13. Handbook § 3-16(d)(1).

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TAX NEWS

Estate Tax Repeal?

By Ami S. Longstreet and Anne B. Ruffer

The Economic Growth and Tax Relief Reconciliation Act of 2001 (the "Act")¹ and its significant changes to the federal estate tax regime has garnered much media attention. Practitioners who work in the field of elder law should be aware of these changes, as clients are likely to ask how they are impacted by the new laws.



Ami S. Longstreet

To say that Congress has repealed the federal estate tax is a simplification of what will most likely be a very complicated process. For the years 2001 through 2009, federal estate tax will be due on property transfers as a result of death if the value of decedent's property exceeds the applicable federal exclusion amount. In 2010 there will be no federal estate tax. To complicate matters, especially from a planning point view, the Act contains a "sunset provision." In 2011, the estate tax returns to the 2001 rules, in most cases, unless Congress provides otherwise.

Clients and potential clients interested in these changes will likely inquire as to what planning should be done and how the tax changes affect an individual's already established estate plan. This article outlines the major law changes contained in the recent legislation affecting estate taxes. Practitioners should be aware that this is a complicated area of the law and that each client's specific set of circumstances should be reviewed and evaluated independently.

The most immediate result of the new estate tax rules is the increase in the value of property that can pass federally tax free upon death ("applicable exclusion amount"). In 2002, the applicable exclusion amount, which was to be \$700,000 under the old rules, will jump to \$1 million. The applicable exclusion amount continues to increase as follows: \$1 million in 2003; \$1.5 million in 2004-05; \$2 million in 2006-08; and \$3.5 million in 2009. Additionally, the new highest estate tax rates beginning in 2002-09 will decrease beginning with 50 percent in 2002 to 45 percent in 2009. For 2010, no federal estate tax will be due upon the transfer of property at death. This Act contains a sunset provision, providing for the new

laws to expire on December 31, 2010, and the laws in effect at the time the legislation was enacted to become automatically reenacted, for the majority of the legislation.

The recent legislation significantly changes the applicable exclusion amount and the gift tax exclusion amount. Prior to this legislation, these two exclusion amounts were parallel. The gift tax exclusion will rise to \$1 million on January 1, 2002. This exclusion will stay at \$1 million up through 2010 and thereafter (pending any other Congressional changes). In other words, Congress has intended to prevent income shifting by keeping the gift tax regime in place.

Therefore individuals can gift tax free \$1 million during their lifetime after 2001. Practitioners should note that the application of this law is not as straightforward as it may seem. Each client's gifting history should be examined, as the client's gift tax bracket will determine how much unified credit will actually be available on January 1, 2002. Any gifts in excess of \$1 million will be subject to gift tax. Again it should be noted that gift tax is not repealed during 2010 as is the estate tax. In addition, in 2011, when the current estate rules come back into law, both the estate and the gift tax applicable exclusion amounts will again be equal at \$1 million.

The rules concerning the tax basis of assets transferred at death also change significantly in the new legislation. At present and through the year 2009, in general, most assets transferred at death receive a "step-up" to fair market value. After the estate tax repeal in 2010, the basis rules will be similar to those of the basis rules for gifting. Currently when an asset is gifted, it does not receive a step-up in basis. Rather the donee uses a "carryover" basis; in other words, the donor's cost basis. Not surprisingly, the legislation is not straightforward regarding the basis rules. A step-up in basis will be permitted for \$1.3 million of assets transferred to a non-spouse, and \$3 million to a spouse. Those assets to be subject to the step-up in basis must be separately identified. Again, it should be noted that this legislation contains a sunset provi-



Anne B. Ruffer

sion for 2011. Therefore the current step-up in basis rules will return on January 1, 2011.

The carryover basis idea included in the recent legislation is not the first time that Congress has enacted such laws. In both the 1920s and the late 1970s Congress enacted similar carryover basis rules, and twice these rules were repealed due to their complexity. Congress and the Internal Revenue Service will hopefully provide guidance to heirs and executors to assist them in determining the decedent's basis in assets, which can be very diverse, from publicly and privately traded stocks, real estate, art work and self-constructed assets, to antiques. This will likely not prove to be an easy task.

The new legislation contains extensive reporting requirements for executors once the new basis rules are in effect. Practitioners may wish to make those clients who they know to be executors or future executors aware of these requirements and the penalties for noncompliance. These rules require executors, for example, to report to the IRS the name and taxpayer identification number of the recipient of an asset inherited in an estate, a description of the property, the adjusted basis of the property in the hands of the donor or decedent, the holding period for such property, information to determine whether gain would be ordinary or capital gain, and any other additional information the IRS may require in regulations that will likely follow the new law. The penalty for noncompliance when there are noncash transfers at death over \$1.3 million is \$10,000.

Some additional changes to present law made by the Act to note involve conservation easements and estate tax installment payments. The legislation expands the availability of qualified conservation easements. These changes are in effect for decedents dying after December 31, 2000. In addition, the Act expands the availability of installment payments of estate tax for certain closely held businesses for decedents dying after December 31, 2001. The types of businesses for which the installment plan will be available have been expanded to include qualifying lending and financing businesses. Furthermore, the

installment payment option has been expanded to include partnerships or corporations with 45 partners or shareholders (prior law was 15 or fewer). If a practitioner is assisting in the administration of an estate which includes a closely held business, this opportunity should be reviewed to see if it would be advantageous for the particular estate involved. Also, for decedents dying after December 31, 2009, the exclusion of up to \$250,000 of gain on a sale of principal residence is extended to estates, certain trusts and heirs.

As can be seen, the Act contains numerous and extensive changes to the present estate law. Attorneys practicing in the estate planning area should be fully aware of the estate tax provisions in the recent legislation and review existing estate plans with clients to insure that these plans are appropriate under the new law. For example, many wills prepared by practitioners in the past included the basic credit shelter trust, to utilize the applicable exclusion amount, which is currently \$675,000. Under the new estate tax regime, if the individuals' combined assets are less than the higher applicable exclusion amounts, the credit shelter trust may no longer be required or appropriate. For such clients, their estate planning documents should be reviewed and modified in light of the new laws, for example, to contain some type of language permitting the surviving spouse or the trustee to determine the necessity of the trust depending upon the tax rules in existence in the year of death.

The fact that many headlines read that Congress has repealed the federal estate tax is misleading. There is much required of practitioners regarding estate planning, to be assured that their clients' estate plans are appropriate under the new legislation.

Further analysis of the Act may be found at many of the large accounting firms' Web sites.

Endnote

1. Pub. L. No. 107-16.

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ADVANCE DIRECTIVE NEWS

To Do or Not to Do: The Dilemma of the Do Not Resuscitate Order

By Ellen G. Makofsky

Modern medicine can be amazing. Medical teams using new and improved technology are capable of many more life-saving feats than they were just a few years ago. This improved medical technology often fits neatly with our value system that places great importance on preserving life. Sometimes however, the technology is not up to the task and can result in a prolonged, painful or violent death.



Effective techniques for cardiopulmonary resuscitation (CPR) were developed in the early 1960s.¹ CPR refers to the medical procedures used to restore a patient's heartbeat and breathing in case of heart and respiratory failure. CPR may involve simple techniques such as mouth-to-mouth resuscitation and external chest compression, or may be more complex and involve the administration of electric shock, insertion of a tube to open the patient's airway, injection of medications into the heart and, in extreme cases, open chest heart massage. CPR is a striking example of medical technology that can run amok. When it works, CPR can be life-saving. When it doesn't, CPR may result in a more furious death or a period of prolonged and severe debilitation before death.²

"Even where a patient has appointed a health care proxy and advised the health care agent not to allow extraordinary measures to preserve or extend life, CPR will be undertaken in an emergency situation when the health care agent is not available because of the legal presumption for resuscitation."

Under New York State law, where there is no direction from the patient or surrogate health care decision-maker, there is a presumption for resuscitation.³ This presumption can result in very aggressive actions taken in an attempt to bring a very sick

patient back to life. Even where a patient has appointed a health care proxy and advised the health care agent not to allow extraordinary measures to preserve or extend life, CPR will be undertaken in an emergency situation when the health care agent is not available because of the legal presumption for resuscitation.

"A mere 5 percent of hospitalized patients who receive CPR recover and resume their regular lives."

The presumption to resuscitate can be overcome with a do not resuscitate order (DNR) placed in a patient's chart by a physician.⁴ Before issuing an order not to resuscitate, the physician must obtain the consent of the patient. Where the patient no longer has the capacity to consent, a health care agent has the power to provide such consent where it is consistent with the patient's wishes or, if the patient's wishes are unknown, the decision may be made according to the best interests standard. Where there is no health care agent, the statute contains a hierarchy of persons to consent to the DNR.⁵

CPR offers the opportunity to defeat death, but the cost of victory is often high. Immediately prior to CPR, because of a heart stoppage or respiratory problems, a patient may suffer from a lack of oxygen, resulting in non-reversible brain injury. Much physical trauma to the body can occur as a result of a resuscitation attempt. Statistics are kept in regard to the success of CPR. Often "success" in the CPR arena means that the patient survives to leave the hospital or remains in the nursing home, or at home, with no quality of life remaining. When evaluating actual success rates for post-CPR survival without a diminished quality of life, the statistics are shocking. A mere 5 percent of hospitalized patients who receive CPR recover and resume their regular lives. For nursing home residents the success for unobserved arrests is between 0 and 3 percent.⁶

As elder law attorneys, our clients are often frail and in precarious health. When the client is hospitalized or admitted to a nursing home, or if the person is receiving care at home from a home health care agency, the issue of DNRs often surfaces. The health

care institution or home care agency asks the client to make a decision to authorize a DNR because they want direction in an emergency situation. Clients and their families are often offended or horrified that they were asked to consent to a DNR. Frequently, the client or family will turn to the elder law attorney for advice and counsel. As attorneys, we can best help

"Our job as elder law attorneys is often not easy, but we must remain focused on providing our clients with the information necessary to make a decision that is right for the client and for the family."

guide our clients by making the distinction for them between the power of a health care agent to direct care, and the need for a standing order in regard to resuscitation in the midst of an emergency situation. Once this distinction is made clear, there needs to be sensitivity in helping the client and family determine (in the particular situation) whether aggressive resus-

citation is imperative for the patient, or whether resuscitation is contraindicated.⁷

Our job as elder law attorneys is often not easy, but we must remain focused on providing our clients with the information necessary to make a decision that is right for the client and for the family.

Endnotes

1. K. Kreamer, *Do-Not Resuscitate Policies for Home Care: The Time Has Come*, Caring, Aug. 1988 at 27.
2. Miller & Swidler, *Legislative Initiatives on Life-Sustaining Treatment: The Do-Not-Resuscitate Law and The Health Care Proxy Proposal*, N.Y. St. B.J., vol. 61, no. 2, at 31 (Feb. 1989).
3. N.Y. Public Health Law § 2962 (PHL).
4. PHL art. 29-B.
5. PHL § 2965 authorizes the following order of persons to consent to a DNR: a committee of the person or a guardian appointed pursuant to art. 17-A of the SCPA; the 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.
6. M. Christopher, *End-of-Life Care Reform: Is It about "Us" or "Them"?*, 14 NAELA Quarterly, 2 Spring 2001 at 13, citing J. Stoddard, *A Practical Approach to DNR Discussions*, 14 Bioethics Forum XXX (1998).
7. K. Kreamer, *Do Not Resuscitate Policies for Home Care: The Time Has Come*, Caring, Aug. 1988 at 26.

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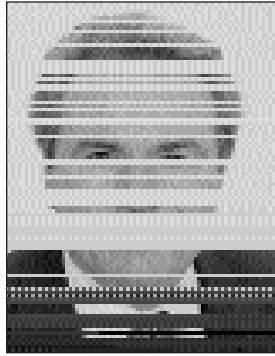
CAPACITY NEWS

A Few More Interesting Cases

By Michael L. Pfeifer

Here are a few interesting capacity cases:

In re the Estate of Colby,¹ the issue was whether a personal representative could waive the attorney/client privilege on behalf of an incapacitated person (IP). To aid in the pursuit of a claim of fraud brought on behalf of the IP by his guardian, the guardian sought to have his attorneys produce documents concerning his estate planning and related matters.



The court first looked at the case law and concluded that there was no case on point in New York. "The other jurisdictions which have considered the issue, however, are unanimous in holding that a decedent's successor-in-interest may waive the privilege (citations omitted)." The court then considered the legislative history of the attorney/client privilege and concluded that there was nothing in such history that would preclude a personal representative from asserting the privilege.

The court concluded by saying:

Since the client could have waived the privilege to protect himself or to promote his interest, it is reasonable to conclude that, after his death, his personal representative stands in his shoes for the same purposes. Moreover, a contrary conclusion would in effect allow the shield intended for the client to be misappropriated for the benefit of the very persons against whom the client may have had claims.

*In re Appointment of a Guardian For Olear*² presents the issue of whether a 21-year-old incompetent can change his domicile. The IP's parents were awarded joint custody of him pursuant to a judgment of divorce entered in March 1988. The IP's mother moved him to Arizona to be with her. In an apparent attempt to have the IP returned to New York, his father petitioned for the appointment of a guardian of the person under Surrogates Court Procedure Act 17-A (SCPA). The mother moved to dismiss the petition alleging, *inter alia*, that the court had no jurisdic-

tion over the IP because he was a domiciliary of Arizona. In reply, the court stated:

Michael is a domiciliary of Nassau County. New York was his domicile of origin. The domicile of an infant follows that of his parents (*Lang v. Lang*, 9 A.D.2d 401, *aff'd*, 7 N.Y.2d 1029). Following a divorce, domicile follows the parent who has custody (49 N.Y.2d, *Domicile and Residence* 37). In this case joint custody was awarded. The domicile of origin continues until a new one is acquired (*Matter of Pingpank*, 134 A.D.2d 263). After he reached majority Michael lacked the capacity to change his domicile from Nassau County to another jurisdiction. An incompetent person generally lacks the capacity to form the union of choice and intent required to change domicile (*Matter of Beasley*, 234 A.D.2d 32; *Matter of Levine*, NYU, Sept. 21, 2000, p 27, col 5; *Matter of Phaff*, NYU, May 7, 1999, at 35, col 1).

In re Application of Bronx Psychiatric Ctr.,³ the IP was suffering from a worsening psychosis and was noncompliant with treatment. Petitioner hospital concluded that it was in the IP's best interest to commence treatment. The IP objected. The petitioner hospital decided that the IP should be evaluated to determine whether she should be treated over her objection. Petitioner hospital conducted an evaluation without giving prior notice to the IP's counsel. On the basis of this failure to notify the IP's counsel, the Supreme Court, Bronx County, dismissed the petition and the appellate court affirmed. The procedure for having an involuntary patient treated over her objection must be strictly adhered to by the petitioner. The procedure is as follows: First, the patient's treating physician must make a determination that the proposed treatment is in the patient's best interests and that the patient lacks the capacity to make a reasoned decision concerning the treatment. Once this evaluation is made, he or she informs the clinical director of his determination and requests further review. He or she is also required to notify MHLS and any other representative of the patient of his request and determination. The clinical director then

conducts the review or, as in the instant case, may appoint a designee to be a reviewing physician. The reviewing physician personally examines the patient and reviews his or her records. Finally, the clinical director conducts a final review and determines whether to seek a court order.

If a court order is sought, the petitioner must show by clear and convincing evidence that the involuntary patient does not have capacity to make a reasoned decision to decline treatment. The court held that timely notification of the IP's counsel prior to evaluating her was essential:

Notification to a patient's attorney can only be meaningful when the counsel would be in a position to act on behalf of the patient. No reason was provided to explain why the notification was tardy in this case. And no reason was tendered to suggest why all such notifications could

not be timely delivered. Particularly where counsel is provided for an allegedly incompetent patient, timely notification would be important as a matter of common sense. As the IAS court correctly held, timely notification is also important as a matter of regulatory law and the failure to provide such notice prior to Dr. Ali's review of Dr. Mathai's conclusion was properly considered a failure by petitioner to exhaust administrative remedies.

Endnotes

1. 187 Misc. 2d 695, 723 N.Y.S.2d 631 (Sur. Ct., N.Y. Co. 2001).
2. 187 Misc. 2d 706, 724 N.Y.S.2d 283 (Sur. Ct., Nassau Co. 2001).
3. ___ A.D.2d ___, 728 N.Y.S.2d 10 (1st Dep't 2001).

Michael L. Pfeifer, Esq., practices in Garden City in the areas of estate planning, probate, elder law and real estate. He frequently writes and lectures on these topics. He is currently serving as Chairperson of the Solo/Small Firm Practice Committee of the Nassau County Bar Association.

REQUEST FOR ARTICLES

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

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

GUARDIANSHIP NEWS 1

Access to an Infant's Recovery

By Robert Kruger

Introduction

To what extent may an infant's tort recovery be used to benefit the infant? The infant's family?

There are three statutes addressing these issues: (1) Article 12 of the N.Y. Civil Practice Law & Rules (CPLR); (2) Article 17 (and 17A) of the N.Y. Surrogate's Court Procedure Act (SCPA) and (3) Article 81 of the N.Y. Mental Hygiene Law (MHL).



There is a related issue percolating to the surface: the applicability of Article 81 to individuals under the age of 18 years. The vast majority of courts do apply Article 81 to infants whose disability is permanent but a few do not, and the issue remains unsettled. However, in early July 2001, Judge Lebedeff rendered a thoughtful and thoroughly researched opinion in *In re Cruz*,¹ in favor of applying Article 81 to infants.

CPLR Article 12, entitled "Infants, Incompetents and Conservatees," and pertains to recoveries by infants for their personal injuries. Section 1206(c) of this article permits "withdrawals only upon order of the Court."

SCPA Article 17, entitled "Guardians and Custodians," comes into play in the context of wrongful death compromises where a child has lost both a parent and parental support. The infant's share of the wrongful death compromise is intended to replace that lost financial support; SCPA 1713(1) therefore provides that the surrogate's court "may by order direct the application by the guardian of the infant's property to (a) the support and education of the infant."

MHL § 81.21(a) is entitled "Powers of Guardian: Property Management," and provides that the guardian may provide for the maintenance and support of the incapacitated person, and those persons depending on the incapacitated person, "[w]hether or not the incapacitated person is legally obligated to provide that support."² This article deals with the compensation received by the infant for her injuries, pain and suffering and permanent disability.

The following fact patterns are designed to explore the application of these articles to fairly typi-

cal fact patterns. At the outset, however, Judge Lebedeff in *In re Cruz* concludes there is little material difference between these three articles *provided* the parent/guardian operating under Article 12 or Article 17 is bonded. The author is not sanguine about the ability of poor parents to obtain bonds when the recovery is substantial, or about the flexibility of Article 17 to appoint a professional or institutional co-guardian for bonding purposes, much less a sympathetic co-guardian responsive to the parents' issues. While many infant compromise orders direct the parent to proceed to guardianship or supplemental needs trusts (SNTs), many do not and those compromise orders which contain no such direction are not likely to accommodate bonding problems at such an early stage of the proceedings.

Fact Pattern No. 1—Laura G.

Laura is now 9 years old. She is the victim of medical malpractice at birth and suffers from cerebral palsy. She suffered neurological damage, but it is not certain that she will be permanently disabled cognitively when she reaches 21. She is borderline disabled, and a judge might, with some justification, deny her mother's request for guardianship under Article 81.

Her case has now been settled for the net sum of \$1,000,000.

Laura receives physical therapy, occupational therapy and speech therapy from the special education school she attends. She can walk with difficulty; she has problems with balance. In other respects, her medical needs are typical of a normal 9-year-old. Because of her therapy needs, the decision is made to request an SNT. A guardian is appointed, the SNT is authorized and the mother and a professional co-guardian are appointed as co-guardians of her property and as co-trustees of Laura's SNT.

Laura receives SSI. Laura's father is not in the picture and provides no support for her. The mother is on public assistance because of life's circumstances and is not unresourceful, but she has few options for productive employment with a disabled child at home. She is the sole caregiver for Laura.

The family lives in subsidized housing in a poor neighborhood, and there are safety issues and drug issues in that neighborhood.

The mother's agenda is fairly typical. She wants (and needs?):

1. continuing therapy for Laura;
2. a newer, safer, larger home;
3. a vehicle; and
4. a monthly stipend for the services she provides Laura.

Fact Pattern No. 2—Victor W.

Victor is 13 and developmentally disabled. Similar to Laura in many ways, he is in special education; but he is further behind in school. He is far more impaired and, without doubt, will not be able to manage his own affairs at age 21. His father is not in the picture and his mother, who is on public assistance, is getting her master's in special education.

His recovery provided him with **\$250,000** in cash and a **\$5,500** plus monthly annuity starting in April 2007 (when he reaches 18).

He suffers seizures, which creates huge prospective employment problems for the mother since she must be on call if a medical emergency arises. While she is clearly employable once she completes her teacher training, she may not be able to get a job that gives her the freedom to attend to Victor's medical emergencies. Victor is too much of a burden to place on his only sibling, a 16-year-old sister.

Without funds herself, she wants to purchase a house with Victor's present assets and open a day care center which is likely to generate enough income for her to support her family and carry the mortgage on the house.

She lives in Westchester County, which is unsympathetic to Article 81 proceedings for infants. Her recourse is Article 17, with or without an SNT.

Fact Pattern No. 3—Melanie S.

Melanie S., unlike Laura, is profoundly disabled, and she always will be. She is totally dependent on her mother and nurses for care. She cannot walk; she is wheelchair-bound and must be carried and lifted between bed and wheelchair. The family lives in an apartment house, and Melanie (and her wheelchair) must be carried down two flights of stairs to go outside. She is 9 years old and now weighs about 60 pounds. The mother is a slight woman who is fast approaching the limits of her endurance and strength in carrying Melanie.

Unlike in Laura's case, Melanie's father is part of the household. He is a livery cab driver and his income is \$30,000 as reported, with another (estimated) \$10,000 unreported. The family exceeds poverty level but it is struggling to make ends meet. Melanie has an older teenage brother who attends school.

The settlement of her medical malpractice action yielded her \$700,000 net, plus a monthly structure of \$3,500 (with a COLA) for 20 years guaranteed and life. Because of her obvious, permanent disability and ongoing need for the therapies she receives in special education, she has a SNT, but no guardian, with the parents and an independent professional as co-trustees of her SNT.

The family's agenda is the same as Laura's: continuing therapy, a house, a vehicle and a stipend.

Article 12

In *Leon v. Walker*,³ a most respected and scholarly jurist from the last generation, Hon. Matthew M. Levy, rejected a request for withdrawal, stating:

But it is not the function or obligation of an eight-year-old child to support her mother, father, sisters and brothers, when (as in the case at bar) the child's sole assets consist of a recovery in a lawsuit for serious personal injuries occasioned by the fault of another. I cannot permit my personal sympathy for the plight of this family to becloud my judicial responsibility to protect and preserve the child's fund. The parental duty of support of the family, and even the communal responsibility in the sense of public welfare, should not be permitted to be shifted to this infant because, fortuitously, she was gravely physically injured and was successful in now having on hand what the family might consider a financial windfall. Cf. *Matter of Guardianship of Salm*, 282 N.Y. 765, 27 N.E.2d 46.

At that point, withdrawals for anything other than exceptional circumstances were frowned upon.

Section 202.67(f) of the Uniform Court Rules liberalized the rule somewhat to provide for withdrawal for necessities if the family is financially unable to provide for the requested item. Section 202.67(g) states that:

No authorization will be granted to withdraw such funds, except for unusual circumstances, where the parents are financially able to support the infant and to provide for the infant's necessities, treatment and education.

The 1983 amendments to DRL §§ 236 and 240 (1-b)(f) and Family Court Act § 413(i)(f)(i), which state that the court could consider the child's

resources in fixing the parental child support obligation, have certainly shifted the focus somewhat from the parents' obligations to the child's resources.

Despite the shift in focus, suppose that Laura's recovery was in an account which her mother held jointly with a financial institution under Article 12? Except for continuing her therapies, her funds could not likely be used under these circumstances to purchase her home, to buy a vehicle, or to give her mother a stipend. These items are not necessities for Laura. Laura's potential competence as an adult would militate strongly against using her resources for these items. Unlike Melanie, who cannot walk and is wheelchair-bound, it is difficult to conjure up facts that would make the case for acquisition of a vehicle by Laura's mother. Conversely, for Melanie (and Victor?) it is the permanent disability that leads to the SNT and courts allowing the use of the infants' resources on lifetime acquisitions.

The purchase of a home for Laura should not receive a warmer judicial reception than the request to buy a vehicle. Is the home a necessity? If moving is so important (for safety reasons), why not rent? Article 12 might provide a rent subsidy if Laura's mother is poor. Moreover, there are important secondary considerations that do not fit neatly into a request for a withdrawal under Article 12. Who will pay the real estate tax bill? Or the insurance? Or the fuel and utilities? Or repairs? Melanie's family members are blue-collar working-class. They can contribute and avoid inundating the court with numerous applications. Laura's family and Victor's family cannot now pick up the cost of these necessary ancillary expenses. The costs involved in the purchase and maintenance of a house for Laura or Victor, assuming the absence of adequate parental financial support, do not fit neatly into the finite, quantifiable and certain world of withdrawals under Article 12. It was the broader context of Article 81 (and the SNT), where the disability (not competence) of the child is the focus, and the needs of the child are perceived in the context of her family, that enabled Laura's mother to achieve her agenda.

Victor's mother's application is doubly suspect. Beyond the above stated problems with Laura's application under Article 12, there is a serious speculative element to her projected proposal. There will likely be little left (until April 2007, when the annuity payments resume) if permission to purchase the house is granted. Beyond that, the ability to make a living running a day care program is speculative. The mother is certain that her plan will succeed. Will a judge be as confident of her success? Lastly, Victor's funds will be used to enable his mother to make a living in a particular way so she can be available if Victor suffers a seizure. As much as she needs help and, perhaps, deserve help, this plan is not unlikely to

receive judicial endorsement under Article 81, Article 12 or Article 17. At bottom, the funds are insufficient to purchase a house and protect Victor. The former must yield.

An application to purchase a home for Melanie under Article 12 might succeed (as it did under the SNT), because her disabilities (and her funds) are much greater. Special accommodations for disabilities, such as wider doorways and larger bathrooms, are impossible to find in rental apartments and are not reasonably available in cooperative apartments. Provided enough money remains after a purchase, an application to purchase a home made under Article 12 might succeed.

The case authority and judicial culture obtaining in Article 12 withdrawals appears to cover requests for one-time withdrawals of finite sums and, as Rule 202.67(f)(2) makes clear, these withdrawals require a sworn statement of the reasonable cost of the proposed expenditures. Although bonding could provide greater flexibility to pay recurring bills, none of these parents, including Melanie's, are bondable. It is not likely that a court, presented with an infant's compromise order, would focus on bonding. The court wants a disposition, not a social work problem.

Article 17

The context in which an application is brought under Article 17 to allow withdrawals for the support of infants, ordinarily, is wrongful death compromises of personal injury actions for a parent's death. The recovery of the infant distributee is directed to a guardian appointed for the infant under SCPA Article 17. There is no reason, however, why a disabled infant beneficiary of an infant's compromise order cannot apply to an Article 17 guardian as well.

In *Petition of Curry*,⁴ the Dutchess County surrogate contrasted the scope of discretion allowed under CPLR Article 12 and SCPA Article 17.

Article 17 differs from a recovery of damages for personal injuries sustained by an infant which have a disabling effect, placing him at a permanent disadvantage in the survival process. On the one hand, the recovery for personal injuries is established as a fund to lessen the consequences of the injuries which the infant sustained. On the other, the recovery for wrongful death is established as a fund to replace a lost source of support while the infant remains unable to provide for himself.

This analysis, of course, allows use of the infant's recovery for the infant's support. It does nothing to satisfy the collateral agenda of Laura's, Melanie's or Victor's families. One obvious reason is that, if there is a recovery for the infant when a parent is lost, there is also a recovery for the spouse of decedent, if one survives.⁵ Of perhaps equal importance is the fact that the infant, when he or she reaches majority, can decide for himself or herself whether to give money to the family. There is no reason for the court to reach out and allow a home to be purchased with the infant's funds, absent special circumstances.

One rare case where approval to purchase a home was obtained under Article 17 is *Estate of M.H.H.*,⁶ in which a Fifth Avenue cooperative apartment note was under threat of foreclosure. Use of the infant's funds to "rescue" the apartment was financially sound and important to the infant's emotional well-being. The surrogate noted that the circumstances were unique. The convergence of the obvious financial advantage to the infant, with his emotional attachment to the apartment following the violent (unexplained) death of his father, resulted in judicial permission to use \$200,000 of the infant's \$510,000 recovery to pay off the loan.

Somewhat more typical is *In re Bilick*,⁷ where consistent with the 1983 child support amendments, permission to use the infant's income, but not the principal, was granted for the infant's support. The court cited *In re Polinsky*,⁸ where the surrogate of Kings County permitted a limited withdrawal from the income of the infant's funds by the guardian. Withdrawal of funds for support from the corpus of an infant's funds is not favored without a showing of need. *Query*: Would the same reluctance be manifest in cases of permanent disability, as with Melanie?

There is one daunting problem in accessing Article 17 in permanent disability cases. Beyond obtaining jurisdiction over absent parents, and beyond the bonding problem and the appointment of a stranger in many instances as co-guardian, there is the problem of a judicial culture attuned to will contests and disputes over money. Surrogates do not volunteer for work requiring intense involvement in interpersonal relationships.

These reasons may underlie the relatively few reported decisions where use of infants' funds were sought under Article 17; none appears to involve permanently disabled children. It may be that the decisional law under Article 17 will evolve, as has that of Article 81, but Article 17 is not yet the flexible instrument that Article 81 is.

Article 81 of the Mental Hygiene Law

Article 81 was adopted in April 1993; reported decisions on support issues are few. The leading case on the home/vehicle/support issues is *In re Marmol*.⁹

In *Marmol*, we have many classic components of a guardianship case: a poor mother, an absent father, a permanently and severely damaged child, a substantial recovery for the child (\$2,000,000), a desire to escape poverty, other minor children on the scene, and requests for a home and a vehicle. In *Marmol*, the "unusual" element was a seriously injured mother and a \$330,000 recovery for her. We also had a second "husband," who was the father of the other two minor children in this family unit, and a desire to return the family to the Dominican Republic. Also, because she had funds, no request for a salary for the mother was apparently made.

The author of *Marmol*, Judge Robert Lippman easily allowed "treatment for disabilities which are occasioned by the accident. In this category fall all the costs associated with the various therapies, special education, neurological and orthopedic treatment, the replacement of the leg brace, as well as the concomitant expenses of a rehabilitation case manager."¹⁰

He also allowed the infant's funds to be used to employ the services of an accountant, an attorney and a home aide, only the last of which would conventionally fall into the category of "unusual circumstances."

Next, he allowed the infant's funds to be used to purchase a vehicle.

Given the importance of therapy to Adonis' development and well-being, and the frequency with which he must attend therapeutic sessions of various kinds, and in view of the fact that these would not be necessitated but for his injuries, the court is of the view that the expenditure should be deemed extraordinary.¹¹

While he imposed the cost of "maintenance, mileage and insurance" on the infant's family, it is difficult indeed to imagine any court dealing with an Article 12 or Article 17 application allowing the use of the infant's funds for such a purpose, without limiting that contribution to income (Article 17) or requiring the mother to contribute (Article 12). Yet, most guardianship attorneys would find that permission to purchase a vehicle and a home, provided sufficient funds remain, will ordinarily be granted for disabled children such as Laura, Melanie and Victor. While, the statute broadens the scope of support to benefit those for whom no obligation to support

exists, and while the focus of Article 81 encompasses social needs rather than a narrow transactional analysis, the primary reason is that Article 81 deals with the permanently, primarily neurologically, disabled, who will never be in a position to decide independently to make that purchase, and who are far more dependent and needy than the subjects of the other proceedings.

It followed that, after a thorough review of decisions reported and unreported, Judge Lippman approved the purchase of a house:

The court is of the view, however, that in the long term it may be more prudent to have Adonis fully finance the purchase of the house, with title vested entirely in his name, thus securing his investment against liens and attachments as well as protecting it against mortgages or use as collateral against loans made by any family member now or in the future.¹²

Again, were the infant's funds sufficient for her foreseeable future needs? The problem faced by Victor, unlike Melanie, is the sufficiency of funds.

Similarly, when a vehicle or a handicapped-accessible van is sought, courts are disinclined to relegate parents to the burdensome chore, as with Melanie, of shoehorning the wheelchair-dependent child into a small vehicle when sufficient funds are available to do better for the child, even if there is obvious collateral benefit for the parents, as long as the funds are adequate.

A similar result obtained in *In re Addo*.¹³ As with Judge Lippman, Judge Lottie Wilkins approved the purchase of a home from the infant's funds.

Extracting the guidelines from these cases it may be concluded that the use of infants' funds for the purchase of a family home will be judicially authorized provided 1) by clear proof the parents show they cannot afford the purchase price or a portion thereof; 2) the house has features beneficial to the child and accommodates his physical limitations; 3) the purchase price is fair; 4) title is vested in the child at least to the proportionate degree of his investment in the house; 5) necessary measures are taken, where needed, to safeguard the investment against the profligacy of the parent; 6) parents offer a quid pro quo; 7) the funds remaining after the outlay are sufficient to meet the

future needs of the infant and where the child is expected to remain incompetent, for the anticipated duration of his life. See *Matter of Marmol*, *supra*.

Finally, a salary for the mother of \$25,000 per year was approved, albeit less than the \$45,000 the parents sought (the settlement was close to \$5,000,000).

Since the income in *Addo* was clearly adequate and (\$45,000 represented 4 to 5 percent return on \$1,000,000), the lesson of *Addo* may well be not to ask for everything at once.

Conclusion

Certain aspects of these decisions leap out. First, the more comfortable and middle class the child's family, the more likely that the burden of support will remain, where it belongs, on the parents. If the family is a poor one, that burden may shift and, if the disability is great, it will likely shift further under the liberal standards of Article 81. The presence of a permanent disability will likely result in a far greater judicial willingness to permit use of a child's funds now, rather than in the future.

In addition, use of a child's income in Article 17 cases, often without a showing of parental need, can be obtained, but permission to invade principal will be granted with difficulty. Further, permission to withdraw an infant's funds under Article 12 for ongoing obligations is difficult to accomplish. In all circumstances, it is critical that the child be left with sufficient resources to meet other unanticipated needs. Until Article 17 ameliorates significant cultural roadblocks, Article 81 will remain of far greater use in the permanent disability cases.

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: (212) 732-5556, fax: (212) 608-3785 and e-mail: RobertKruger@aol.com.

Endnotes

1. Unreported as of submission date.
2. MHL § 81.21(a)(2).
3. 1 Misc. 2d 219, 147 N.Y.S.2d 331, 332-33 (Sup. Ct., N.Y. Co. 1955).
4. 128 Misc. 2d 760, 491 N.Y.S.2d 217, 219 (Sur. Ct., Dutchess Co. 1985).
5. *In re Kaiser*, 100 N.Y.S.2d 218 (Sur. Ct., N.Y. Co. 1950).
6. 118 Misc. 2d 224, 459 N.Y.S.2d 1000 (Sur. Ct., N.Y. Co. 1983).
7. 176 Misc. 2d 293, 671 N.Y.S.2d 639 (Sur. Ct., Sullivan Co. 1998).
8. 33 Misc. 2d 1002, 225 N.Y.S.2d 855 (Sur. Ct., Kings Co. 1962).
9. 168 Misc. 2d 845, 640 N.Y.S.2d 969 (Sup. Ct., N.Y. Co. 1996).

10. *Id.* at 850.

11. *Id.* at 851.

12. *Id.* at 854.

13. *In re Addo*, N.Y.L.J., Sept. 30, 1996, p. 26 col. 4 (Sup. Ct., Bronx Co.).

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, Trusts 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 1963 and the University of Pennsylvania (Wharton School of Finance (B.S. 1960)).

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GUARDIANSHIP NEWS 2

Elsie "B": Good, Bad or Indifferent?

By G. Warren Whitaker

I wrote an article in the *New York Law Journal*,¹ which was reprinted in the *Trusts and Estates Law Section Newsletter*² recommending the use of revocable trusts in New York. In that article I criticized the decision on *In re Elsie "B,"*³ in which a guardian for a person who had previously created a revocable trust was permitted to exercise the settlor's retained power to modify the trust. My esteemed colleague, Robert Kruger, took issue with my critique of the opinion in the Spring 2001 issue of the *Elder Law Attorney*.⁴ I would like to continue the dialogue and reaffirm my concerns about *Elsie "B."*

First, briefly, the facts:

Elsie "B" was an elderly New York resident who created a revocable trust and named herself, her attorney and her brother, William, as co-trustees. The trustees were not given the power to appoint successors, and there was no requirement that there always be three trustees. Elsie contributed most of her assets to the trust. She later became incompetent, and William was appointed as her guardian in order to manage the few assets that she had not transferred to her trust. The order appointing him gave him only the standard "authority over financial affairs" and made no mention of the trust. After his appointment, however, he claimed that as guardian he possessed the grantor's right to amend the trust agreement, which he purported to do by a document entitled, "Notice of Alteration, Amendment and Modification of Trust," in order to appoint his two sons (Elsie's nephews) as successor co-trustees. William then died and the nephews claimed that they now became trustees. The Supreme Court upheld (and the Third Department affirmed) the guardian's power to amend the trust pursuant to Mental Hygiene Law § 81.21 (MHL).

Contrary to Bob's article, the Third Department did not merely approve the appointment of successor trustees, but stated that "[b]ecause Elsie retained the right to modify the trust in this manner, [the] Supreme Court could authorize her guardian to exercise that right on her behalf." That statement could be applied to any modification a guardian might wish to make.

Elsie "B" could have named her nephews as successor trustees; she did not. She could have given brother William the power to appoint his successor as trustee; she did not. She could have provided that there must always be three, or at least two, trustees

acting; she did not. We must assume that she knowingly made those decisions regarding the persons who would manage her property during her incapacity and, absent extraordinary circumstances, her wishes should have been honored. They were not.

While the two nephews are also beneficiaries of a portion of the trust at Elsie's death, the overwhelming bulk of the trust assets will pass to other individuals and to charities at her death. This possible conflict may help explain Elsie's decision to exclude her nephews from management of her finances.

No one would dispute that there exist circumstances under which a guardian should be able to amend a revocable trust, with court approval and upon notice to all parties, in order to safeguard the best interests of the settlor. The chilling aspect of *Elsie "B"* is that no showing of exigency was ever made or requested by the court. William used his appointment as guardian to exercise powers that the settlor had specifically chosen not to give him in the trust agreement, and that were not required for the proper administration of the trust.

Bob Kruger refers to two cases in which the guardian for the settlor amended a revocable trust. In the first case, the settlor was arguably incompetent at the time the trust was created, and the attorney-trustee arguably committed malfeasance in its administration of the trust. No such allegations were made in *Elsie "B."* In the second case, the trustee was not adequately performing its duties. Again, there were no such allegations in *Elsie "B."*

When the settlor of a revocable trust has taken the care to specifically provide how that trust would be administered during the settlor's incapacity, a guardian later appointed for the settlor should be permitted to amend the trust only after meeting a substantial burden of proof that the welfare of the settlor is likely to be jeopardized if no amendment were made.⁵ No such burden of proof was required by the court in *Elsie "B";* if it had been, there is no indication that it would have been met.

It is precisely this broad, sweeping assumption of the grantor's powers by the guardian, without any showing of malfeasance by the trustee, inadequacy of the trust documents or any motive other than the guardian's personal preference, that I find troubling in *Elsie "B."*

Endnotes

1. G. Warren Whitaker, *Using Revocable Trusts in New York: Why Not?*, N.Y.L.J., Sept. 22, 2000, p. 1, col. 1.
2. See G. Warren Whitaker, *Revocable Trusts in New York: Why Not?*, Trusts and Estates Law Section Newsletter, Vol. 34, No. 1, at 11 (Spring 2001).
3. *In re Elsie "B,"* (Sup. Ct., Albany Co. Mar. 1, 1999), *aff'd*, 265 A.D.2d 146, 707 N.Y.S.2d 695 (3d Dep't 2000).
4. Robert Kruger, *Guardianship News: Guardianship and Trusts*, Elder Law Attorney, Vol. 11, No. 2, at 59 (Spring 2001).
5. See MHL §§ 81.21(b), (c), (d), (e).

G. Warren Whitaker is a partner in the New York law firm of Hughes and Whitaker, which specializes exclusively in domestic and international trusts and estates. He is the Treasurer of the Trusts and Estates Law Section of the New York State Bar Association and former Chair of its Estate Administration and International Estate Planning Committees. He is a member of ACTEC, and of the Estate and Gift Tax Committee of the Association of the Bar of the City of New York.



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PUBLIC POLICY NEWS

NAELA's White Paper on Assisted Living; Elder Law Section's Comments on the Status of New York Law Regarding Assisted Living Facilities; Pending Legislation

By Ronald A. Fatoullah and Stacey Meshnick

Need for State and/or Federal Legislation

The board of directors of the National Academy of Elder Law Attorneys (NAELA) recently approved a White Paper on Assisted Living (the "White Paper"). The White Paper was prepared by NAELA's Public Policy Committee's Subcommittee on Long Term Care, Co-chaired by Thomas D. Begley, Jr., Esq., of New Jersey and Morris Klein, Esq., of Maryland, Ronald A. Fatoullah, Esq., and Alfred Chiplin, Co-chair the NAELA's Public Policy Committee. Ronald Fatoullah presented the White Paper to NAELA's board of directors at the board's annual retreat held in Beaver Creek, Colorado in July.



Assisted living facilities are proliferating throughout the United States, and more of our clients are choosing to reside in assisted living facilities, either prior to or in lieu of nursing homes. NAELA has recognized the need for regulation to protect the rights of seniors residing in these facilities.

There has yet to be a true definition of assisted living. Further, it is difficult to define the quality of care in these facilities. According to researchers, there are currently three regulatory models—one model, based on old board-and-care regulations, generally does not allow residents eligible for nursing homes to be admitted; a second model licenses or certifies facilities providing assisted living services that are defined by law or regulation; and the third model focuses on the provider of services, whether it is the residence or an outside service provider.

There is no uniformity among states regarding categories of licensure. Some states license new assisted living facilities under old categories, such as personal care homes or adult foster care homes, which makes it difficult to determine exactly what level of care the facility provides. Fees are based on a variety of different factors, which can make it extremely difficult for a prospective resident to determine what services they are paying for.

Of major concern is that seniors often expect a facility to accommodate their changing needs, and this may not be realistic. It is important for consumers to understand the limitations of the different facilities in which they are interested. Seniors must recognize that an assisted living facility will likely not provide them with a continuum of care throughout their lifetimes.

"NAELA's Public Policy Committee proposes uniform guidelines regarding monitoring and inspection of facilities, which includes frequency of inspection, content of inspections, and guidelines for staff."

Many states inspect and monitor facilities to ensure that they comply with licensing requirements. NAELA's Public Policy Committee proposes uniform guidelines regarding monitoring and inspection of facilities, which includes frequency of inspection, content of inspections, and guidelines for staff. Regardless of the type of inspection performed, similar problems exist in the facilities. According to an examination of issues conducted by the assisted living industry and confirmed by findings of the General Accounting Office, medication issues were cited as one of the most commonly reported problems.

Many in the assisted living industry are looking to accreditation to replace or supplement current state monitoring and inspections. Industry leaders want more flexibility and believe that accreditation will increase flexibility. Accreditation is conducted by not-for-profit organizations. The Joint Commission on Accreditation of Healthcare Organizations (JCAHO) and the Commission on Accreditation of Rehabilitative Facilities (CARF) have developed initiatives for accreditation. Some state laws permit the use of accreditation while other states are considering it. The White Paper cites several problems with accreditation. First, there are questions concerning a conflict of interest, as both JCAHO and CARF are funded by the regulated institutions that they are supposed to inspect. Also, the lack of public access to the results of such inspections prevent consumers

from being informed about the quality of care when choosing a facility. Finally, there are no clear enforcement mechanisms against facilities that may be found to have deficiencies.

It is important for prospective residents to know that assisted living facilities are not obligated to retain residents whose resources have been depleted. They should further be aware that Medicare does not provide for assisted living expenses, and Medicaid coverage is provided under only very limited circumstances. Some long-term care insurance policies may include assisted living coverage, but it is important for consumers to be aware of when that policy may deem the individual eligible for assisted living benefits.

Another issue of concern is consumer protection. Marketing of assisted living facilities may be very misleading to consumers. Advertising materials are often inconsistent with services provided, and litigation against assisted living providers has brought these issues to the surface. Unfortunately, there are no statutory or regulatory schemes addressing marketing issues. Further, in states that require a contract, few mandate provisions that the contract must include. Thus, rather than uniformity, there is wide range of the type of information that is provided in contracts, making it very difficult for consumers to compare the services and costs of facilities.

Finally, residents' rights, or lack thereof, also vary from state to state. Many state laws do not govern residents' rights pertaining to assisted living. Laws regarding transfer and discharge are also inconsistent among states.

In light of the aforementioned concerns, NAELA:

1. supports minimum standards and licensure, regulation and oversight of assisted living facilities and programs sufficient to meet individual resident's rights needs and preferences;
2. opposes granting "deemed as status" to facilities and programs accredited by private organizations in lieu of state licensure, certification or enforcement standards;
3. supports state monitoring and enforcement functions and public access to the results;
4. supports the initiative to increase the availability of affordable assisted living options and access to those options by persons of low and moderate means;
5. supports increased availability of public and private funding for residents whose funds are exhausted while living in assisted living facilities

so that those residents do not have to be discharged because of their inability to pay;

6. supports the promulgation of regulations requiring a residents bill of rights and that a copy of the rights be delivered to each resident; and
7. encourages increased funding of the Older Americans Act Long Term Care Ombudsman Act to expand access to an ombudsman by residents of assisted living facilities, and expand volunteer ombudsman programs in any state, including training of such volunteer ombudsman.

New York State Legislation

New York State, like most other parts of the country, has experienced an explosive growth in the development of assisted living facilities over the last decade. Nevertheless, our state's assisted living facilities operate without clear federal or state standards.

What adds to the confusion in New York is the distinction between licensed and unlicensed facilities. Licensed facilities are the enriched housing programs and adult homes. These forms of congregate living are often sponsored by not-for profit entities. These licensed facilities are inspected and regulated. However, the vast majority of facilities for frail elderly that the general public associates with assisted living are not licensed assisted living facilities. These so-called "look a-likes," sometimes called "assistive living," are not licensed and not regulated.

In 1999, Governor Pataki's office proposed an Assisted Living Reform Act, presumably to address some of the above concerns, but as of the time of this writing, the bill has not been reintroduced.

The following are issues that the New York State Bar Association's Elder Law Section have identified that affect the consumer's ability to evaluate an assisted living facility before taking residency; the resident's rights and obligations under the contract presented by the facility; and the individual's quality of life after becoming a resident:

1. uniformity of the laws governing assisted living;
2. uniformity of contract between residents and facilities, including the following provisions: full disclosure by the operator of the facility regarding ownership and operations requirement; criteria for admission; clear explanation of payment obligations; clear explanation of obligations other than payment; minimum services provided; circumstances of termination;

discharge procedure; residents' rights; procedure for enforcement of rights; disclosure regarding handling of emergency care; disclosure of applicable statutes; informed consent; third-party guarantee;

3. quality assurance;
4. development of payment options for people with limited ability to privately pay, including the following: development of a Medicaid waiver; coordination of a Medicaid waiver with the public-private partnership for long-term care insurance; review and revision of current statutes governing long-term care insurance to include coverage for assisted living.

"The cost of a nursing home is usually significantly higher than that of an assisted living facility."

New York State Senator Maziarz has introduced *Senate Bill S.5382*, which addresses many of the concerns set forth in the report of the New York State Bar Association's Elder Law Section. This bill offers a uniform definition of assisted living. However, the bill requires only registration and so it does not address the distinction between licensed/non-licensed facilities. The following are some of the provisions of the bill that address the Elder Law Section's areas of concern:

1. Each resident is entitled to an Individualized Service Plan a written plan developed by the facility and the resident or his or her family.
2. Each residency agreement should offer full disclosure of the operator/owner and should be in plain English.

3. Involuntary discharge and transfer criterion are to be set out, with safeguards, such as notice, where appropriate.
4. Resident's rights are to be set out and made clear.

The Elder Law Section applauds the efforts of this bill, while noting that more needs to be accomplished. In particular, our legislators should examine all of the public policy issues of government assistance in paying for assisted living. While government assistance may be available for the home care component (the provisions of home care aides or personal care aides), government assistance is not available to provide for the monthly rental fee in an assisted living facility.

Unfortunately, under current circumstances, when private dollars run out, residents must leave the facility. If they have no further resources, they may find themselves in a nursing facility, paid by Medicaid dollars. The cost of a nursing home is usually significantly higher than that of an assisted living facility. It would be prudent from a humanistic/moral point of view and would likely be cost-effective to provide Medicaid dollars to pay for a resident's stay in an assisted living facility when his or her private funds are depleted.

Conclusion

The New York State Bar Association's Elder Law Section and NAELA have the same goal—to protect consumers by enacting meaningful federal and/or state regulation to govern assisted living facilities. There is a growing need for such legislation, as more and more of our clients reside in these facilities, and face challenges when the care in these facilities is not adequate, or when they can no longer afford to stay in a facility.

Ronald A. Fatoullah, Esq., is the senior attorney of Ronald Fatoullah & Associates, an elder law and estate planning law firm with offices in Great Neck, Forest Hills and Brooklyn. Mr. Fatoullah lectures regularly on the financial and legal concerns of the elderly and disabled, and estate planning techniques available to all individuals. He is a Fellow of the National Academy of Elder Law Attorneys (NAELA), currently serves on its board of directors, and co-chairs its Public Policy Committee. Mr. Fatoullah was awarded certification as an Elder Law Attorney (CELA) by the National Elder Law Foundation. He currently serves on the Executive Committee of the Elder Law Section of the New York State Bar Association. Mr. Fatoullah chaired the Legal Advisory Committee of the Alzheimer's Association, L.I. Chapter. He is also a member of the Elder Law Sections of the New York State, Nassau County and Queens Bar Associations; the Trusts and Estate Sections of the Nassau County and Queens County Bar Associations, and is a former Secretary to the Elder Law Committee of the New York County Lawyer's Association.

Neil T. Rimsky, Esq., and Elizabeth Radow, Esq., assisted in the preparation of the New York State segment of this article.

SNOWBIRD NEWS

Florida's Limited Medicaid Provisions for Assisted Living Facilities and Community-Based Care

By Julie Osterhout

Florida has adopted various Medicaid waiver programs as a supplement to the nursing home Institutional Care Program. These waiver programs are limited in what they provide and are woefully underfunded. One of the waiver programs is titled "Assisted Living for the Elderly" (ALE). It was implemented in February 1995.



The program provides for case management and assisted living. In order to be eligible for the ALE waiver, the applicant must be 65 years or older, or between the ages of 60 and 64 and determined disabled according to Social Security standards. The applicant must meet the level of care criteria for a nursing home facility and meet the income and asset requirements of standard nursing home Medicaid provisions (gross income less than \$1,590 per month and countable liquid assets less than \$2,000). The level of care criteria can be met under one of the following:

1. Require assistance with four or more activities of daily living (ADLs);
2. Require assistance with three ADLs plus supervision for administration of medication;
3. Require total help with one or more ADLs;
4. Have a diagnosis of Alzheimer's or other dementia with required assistance for two or more ADLs;
5. Have a diagnosed degenerative or chronic medical condition requiring nursing services that cannot be provided in the standard ALF but is available by an ALF with an extended congregate care license;
6. Reside currently in a nursing facility awaiting discharge, but unable to return to a private residence because of need for supervision, personal care, periodic nursing services, or a combination of the three.

The ALE waiver program provides for a daily rate of reimbursement for the assisted living services and case management services at a monthly rate. Incontinence supplies are reimbursed separately per month. The reimbursement for assisted living includes attendant call systems, attendant care, behavior management, companion services, homemaker services,

incontinence supplies, intermittent nursing, medication administration, occupational therapy, personal care, physical therapy, specialized medical equipment and supplies, speech therapy, and therapeutic social and recreational services.

The waiver program has a limited budget which, although recently increased by the governor and legislature, has been unable to meet the needs in Florida. In order to get on the waiting list for the program, one must meet the financial criteria and then he or she is rated based on need for placement on the waiting list. Placement in line can change, making it at times virtually impossible to get program funding. In essence, the waiver program has been prioritizing people who are in need of nursing services, and placing those people who need nursing home care in the assisted living facilities to obtain a lower reimbursement rate. This uses up funding available for others who are not in as great a need, but clearly do need assisted living. In recent legislation, the state has enacted the Nursing Home Tort Reform Act (the "Act"). The Act, among other things, has placed a moratorium on building additional nursing home facilities with an effort to more fully utilize the assisted living facilities in the state. It is hoped that additional funding will be diverted to the waiver program to fund this legislative push to utilize assisted living facilities as opposed to nursing facilities. There have been sizable funding increases, but there are still waiting lists, even after the budget increase in July of this year.

The following is the method of calculation of the benefits and income that can be retained by the applicant under the Medicaid waiver program for assisted living.

Example 1

A. Patient responsibility computation

- | | | |
|----|-------------|--|
| 1. | \$1,316.42 | Gross income of applicant |
| 2. | - \$758.00 | Needs allowance (standard) |
| 3. | = \$ 558.42 | Patient responsibility—used by ALF to determine how much they can bill to Medicaid |

B. Maximum amount ALF can receive from Medicaid

- | | | |
|----|---------|---|
| 1. | \$28.00 | Amount Medicaid will pay per day (standard) |
|----|---------|---|

2. $\times 30$ Days in a month*
 3. = \$ 840.00 Maximum amount that Medicaid will pay ALF per month
- C. Maximum amount ALF can bill Medicaid monthly for Medicaid applicant's bill
1. \$ 840.00 Maximum amount Medicaid will pay ALF per month (from B.3)
 2. - 558.42 Patient responsibility amount (from A.3)
 3. = \$ 281.58 Amount that Medicaid will pay per month to ALF
- D. Total amount ALF will receive from Medicaid and Medicaid applicant
1. \$1,413.71 Total amount ALF will receive from Medicaid and Medicaid applicant towards monthly ALF bill (this is the monthly amount billed by the ALF)
 2. - 281.58 Amount that Medicaid will pay ALF per month (from C.3)
 3. = \$1,132.13 Partial income of Medicaid applicant
- E. Funds not required to be paid to ALF
1. \$1,316.42 Gross income of Medicaid applicant
 2. + 281.58 Amount that Medicaid will pay ALF per month (from C.3)
 3. - 1,413.71 Total amount ALF will receive from Medicaid and Medicaid applicant towards monthly ALF bill (from D.3)
 4. = \$184.29 Balance of income that Medicaid applicant can keep (amount family did not have to pay to ALF)

Example 2

- A. Patient responsibility computation
1. \$ 972.00 Gross income of applicant
 - 1a. - \$ 74.23 Supplemental health insurance premium
 2. - \$ 758.00 Personal Needs Allowance standard (Standard)
 3. = \$ 139.77 Patient responsibility—used by ALF to determine how much ALF can bill to Medicaid
- B. Maximum amount ALF can receive from Medicaid
1. \$ 28.00 Amount Medicaid will pay per day (standard)
 2. $\times 30$ Days in a month*
 3. = \$ 840.00 Maximum amount that Medicaid will pay ALF per month
- C. Maximum amount ALF can bill Medicaid Monthly for Medicaid Applicant's bill
1. \$ 840.00 Maximum amount Medicaid will pay ALF per month (from B.3)
 2. - 139.77 Patient responsibility amount (from A.3)
 3. = \$ 700.23 Amount that Medicaid will pay per month to ALF
- D. Amount applicant and family must pay to ALF
1. \$1,580.00 Monthly Amount of ALF bill
 2. - 700.23 Total amount ALF will receive from Medicaid (C.3)
 3. = \$ 879.77 Balance that family and applicant must pay to ALF

*Please note that the above calculations are based upon a 30-day-per-month basis.

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.

PUBLIC ELDER LAW ATTORNEY NEWS

New York's Highest Court Orders Medicaid Coverage for Immigrants

By Valerie J. Bogart

In a stunning victory for New York State's immigrant and legal services communities, the New York Court of Appeals in Albany ruled on June 5, 2001 that New York State cannot deny Medicaid coverage to immigrants who lawfully reside in the state. The Court's unanimous landmark decision in *Aliessa v. Novello*¹ held that New



York's refusal to provide Medicaid coverage to otherwise needy and eligible lawful New York immigrants violates their right to care for the needy under article XVII of the New York State Constitution, and their right to equal protection under both the New York State and U.S. Constitutions. The Court found that the state's denial of Medicaid to lawful immigrants "impos[es] on plaintiffs an overly burdensome eligibility condition having nothing to do with need, depriving them of an entire category of otherwise available basic necessity benefits."

The Court makes it clear that New York's Constitution prohibits the state from treating needy New Yorkers differently than other New Yorkers merely because they don't carry U.S. citizenship cards. As Judge Sheila Abdus-Salaam wrote in her original decision after the trial, "virtually all of us are immigrants, or descendants of immigrants. Because of today's decision, thousands of our fellow New Yorkers will live."

The *Aliessa* case was filed in 1998, challenging New York's 1997 Welfare Reform Laws, which cut off Medicaid coverage for several categories of immigrants lawfully residing in New York State. The law particularly affected elderly persons, including several of the 11 named plaintiffs who had been Medicaid recipients for years, and who abruptly lost their critically needed health care coverage when the law took effect on August 20, 1997. The 1997 law, codified at N.Y. Social Services Law § 122 (SSL), cut off two broad groups of legal immigrants who had previously been eligible for Medicaid—those who are known as "PRUCOLs," and those who are here legally but who entered the U.S. after August 22, 1996.

The law cut Medicaid off for thousands permanently residing under color of law (PRUCOL). These are immigrants who are not "lawful permanent resi-

dents," so do not have a green card, but "who are residing in the United States with the knowledge and permission of the INS and whose departure from the United States the INS does not contemplate enforcing."² Many have petitions pending with the INS to change their status, or are people who, because of infirmity or advanced age, the INS simply would not attempt to deport on humanitarian grounds. Under the 1997 laws, PRUCOL immigrants were no longer eligible for Medicaid, except for a handful of former Medicaid recipients who were "grandfathered" in—those who, on August 4, 1997, the day the law was effective, were already receiving Medicaid *and* were either residing in a nursing home or were diagnosed with AIDS on that date. Elderly persons receiving

"The Court makes it clear that New York's Constitution prohibits the state from treating needy New Yorkers differently than other New Yorkers merely because they don't carry U.S. citizenship cards."

Medicaid home care or hospital care on August 4, 1997, but no nursing home care, did not qualify for this exception and were cut off. Those who first needed Medicaid *after* August 4, 1997 were not eligible except for bare-bones emergency Medicaid. As a result, for the last four years, hospitals could not discharge PRUCOL immigrants who needed long-term care—nursing homes would not accept them for lack of payment, and no Medicaid home care was available. The only recourse for these immigrants was placement in one of only a handful a beds in public nursing homes, or to obtain a green card or petition for citizenship—a process that would not only take years but, for citizenship, requires passage of a difficult citizenship test that was beyond the mental, physical or language capacity of many elderly persons.

A second group of immigrants who were disqualified under the 1997 were lawful permanent residents who did have green cards, but who came to the U.S. after August 22, 1996, or who came to the U.S. before that date but had not continuously resided in the U.S. A five-year waiting period was imposed on these immigrants before they could receive Medicaid,

unless they had proof that they—with their spouse—had earned 40 qualifying work quarters. Only certain refugees, asylees, and a few other small groups were exempt from these onerous requirements and could qualify.

“Now, effective June 1, 2001, PRUCOL immigrants and anyone with a green card will be fully eligible for Medicaid, regardless of whether they came to the U.S. after August 22, 1996.”

For example, named plaintiff Pajan Kaur, a lawful immigrant from Malaysia, has lived near Syracuse with her daughter’s family—all of whom are U.S. citizens—since 1991. In the spring of 1997, she began to receive Medicaid coverage after her health began to deteriorate significantly. Without Medicaid, Ms. Kaur could not obtain critically needed medications, which cost \$300 per month, let alone any other health care. In September 1998, Ms. Kaur received a notice that she was going to lose her Medicaid solely because of her immigrant status. As a named plaintiff, Ms. Kaur’s Medicaid coverage had remained intact pending the decision, relief not available to thousands of other legal immigrants, including Parvin Tabeshian, a 66-year-old immigrant from Iran who has lived with her U.S. citizen daughter’s family in Rochester since 1997. She applied for Medicaid when she developed serious heart problems in 1999, but her application was denied solely because of her immigrant status. Because Ms. Tabeshian was not part of the original *Aliessa* lawsuit, she has been without Medicaid coverage all this time. Ms. Tabeshian’s family have done their best to pay for her health care these past two years, but it has been extremely difficult.

Now, effective June 1, 2001, PRUCOL immigrants and anyone with a green card will be fully eligible for Medicaid, regardless of whether they came to the U.S. after August 22, 1996. Only those immigrants who have only temporary visas, or who have no legal status and are not known to the INS—the so-called

“undocumented aliens,” are ineligible for Medicaid. As was true before welfare reform, they may receive solely emergency Medicaid.³

On July 16, 2001, the New York State Department of Health issued a directive to all counties on implementing *Aliessa*.⁴

Plaintiffs’ lawyers will also be asking New York to reimburse the medical expenses paid by all lawful immigrants who were wrongfully denied Medicaid coverage since August 1997, solely because of their immigrant status.

Counsel for immigrants who believe they were denied Medicaid coverage because of their immigrant status should contact plaintiffs’ counsel: Ellen M. Yacknin of the Greater Upstate Law Project in Rochester (716) 454-6500 ext. 8; Elisabeth Benjamin of The Legal Aid Society in New York City at (212) 577-3575 and Constance Carden of the New York Legal Assistance Group at (212) 750-0800.

Endnotes

1. 2001 N.Y. LEXIS 1407 (June 5, 2001), <http://www.courts.state.ny.us/ctapps/decisions/73opn.pdf>.
2. New York State Dep’t of Health General Information System (GIS) GIS 01 MA/026 (July 16, 2001, Attachment B) (to be posted at <http://www.wnyc.net/pb/docs/GIS01MA026.pdf>). This GIS directive contains an extensive listing of PRUCOL categories.
3. Unfortunately, a longstanding injunction was recently lifted by the Second Circuit Court of Appeals that had entitled pregnant women to receive Medicaid even if they were undocumented aliens. In *Lewis et al. v. Thompson*, 252 F.3d 567 (2d Cir. 2001), 2001 U.S. App. LEXIS 13264, this injunction was lifted. Counsel for plaintiffs, which include The Legal Aid Society representing pregnant women and the city of New York which intervened in support of Medicaid coverage for prenatal care, are petitioning for *certiorari* as well as seeking an amendment to state law that would guarantee Medicaid eligibility.
4. New York State Dep’t of Health GIS 01 MA/026 <http://www.wnyc.net/pb/docs/GIS01MA026.pdf>. Attachment B of the state’s directive includes a detailed description of the PRUCOL categories. See also GIS 01 MA/015 (June 11, 2001) (<http://www.wnyc.net/pb/docs/GIS01MA015.pdf>).

This article is adapted from a news release by the Greater Upstate Law Project.

Valerie Bogart has been a senior attorney with Legal Services for the Elderly in New York City since 1990, specializing in litigation, training and policy in Medicaid and access to long-term care services. Since 1997, with a grant from the New York Foundation, she founded and has directed on a part-time basis The Home Care Project at the Center for Disability Advocacy Rights (CeDAR), a non-profit organization established in part to do class actions prohibited by federal restrictions on legal services offices. She is a graduate of NYU School of Law.

GRANDPARENT RIGHTS NEWS

Family Court Judge Expands Children's Rights

By Gerard Wallace

In an attempt to find a child-centered solution to the determination of custody and visitation disputes when children have "parent-like" relationships with non-parents, an Albany County Family Court judge has decided a case of apparent first impression. In *Webster v. Ryan*,¹ (*Webster*) Judge W. Dennis Duggan held that "a child has an independent, constitutionally guaranteed right to maintain contact with a person with whom the child has developed a parent-like relationship," stating



The narrow holding in this case is that a statutory scheme that permits court intervention to order contact between a child and a parent or his sibling or grandparent is an unconstitutional denial of a child's right to equal protection of the laws when the law does not provide a procedure for the child to assert the same right with respect to a person with whom the child has a significant or substantial parent-like relationship.

Judge Duggan reasoned that the U.S. Supreme Court's substantive due process jurisprudence together with the dissenting opinions regarding children's rights to relationships with non-parent caregivers by Justice Stevens in *Troxel v. Granville*,² and Judge Kaye in *Alison D. v. Virginia M.*,³ establish the foundation for a new fundamental liberty interest for children.

Judge Duggan's pronouncement will find support among children's rights groups and opposition from parent rights organizations. His holding makes clear, however, that he is not eliminating long standing presumptions that favor parental decision making, but instead, is seeking to establish balance between parental autonomy and the legitimate interests of children.

Webster is the final chapter in a typically unfortunate Family Court dispute. The child, born with a positive toxicology for cocaine, was placed in a foster home. The mother's rights were terminated. The father successfully defended his rights and eventually

won custody of his child. He then sought to end visitation between the child and the child's foster mother. The foster mother petitioned for visitation, but Judge Duggan, following *Smith v. Organization of Foster Families for Equality and Reform*,⁴ rejected the foster mother's claims to standing, even while opening the door for arguments regarding the establishment of a child's liberty interest in maintaining such a relationship, *Webster v. Ryan*⁵ (*Ryan III*).

Judicial Determination of Un-enumerated Fundamental Rights

The reasons for establishing a new fundamental liberty interest are both practical and legal. Judge Duggan criticizes the current framework for resolving custody and visitation disputes as too adversarial and insufficiently centered on the interests of children. His reasoning for the establishment of this children's right is grounded in the asymmetrical protections that New York affords to the interests of siblings, children, parents and grandparents. While the state has provided a statutory basis for parents, siblings and grandparents to seek visitation with children, it has not provided a similar basis for children to seek visitation, and thus Judge Duggan believes that the state has failed to provide equal protection under the Fourteenth Amendment and Article I, § 9 of the New York State Constitution.

"Judge Duggan criticizes the current framework for resolving custody and visitation disputes as too adversarial and insufficiently centered on the interests of children."

In a 44 page decision, the *Webster* court first examines the historical roots of fundamental freedoms and outlines the U.S. Supreme Court's late entry into the realm of substantive due process. Finding that the U.S. Constitution is "not the source of fundamental rights" because the Declaration of Independence, the Constitution itself, and the Bill of Rights all posit the existence of additional un-enumerated inalienable rights, Judge Duggan sees these rights as not only protected from unwarranted government intrusion but also from government

exclusion. "This case does not involve a state intrusion into a constitutional right but rather an exclusion of a constitutional right. It is a maxim of law that for every right there must be a remedy."

Regarding the role of the judiciary in protecting these rights, Judge Duggan recounts the development of the U. S. Supreme Court's authority to announce fundamental rights and the inability of the Supreme Court to enunciate a clear road map for establishing such rights. However, the lack of a "generally accepted method of rights determination" does not defeat the fact that "the course of judicial decision making has moved steadily (though not unvaryingly) forward with a consistent expansion of the individual rights of the governed."

"[Judge Duggan's] concern reflects the view that the legal system's overarching allegiance to the rights of parents fails to protect the rights of children."

The Use of Substantive Due Process

Turning to substantive due process, Judge Duggan notes that it is rooted in "the worst Supreme Court decision ever rendered."⁶ For its first 80 years, substantive due process was chiefly utilized to protect economic interests, but then reappeared as a protector of personal liberties in a line of cases that includes *Griswold v. Connecticut*⁷ and *Planned Parenthood v. Casey*.⁸ "Neither the Bill of Rights nor the specific practices of the States at the time of the adoption of the Fourteenth Amendment marks the outer limits of the substantive sphere of liberty which the Fourteenth Amendment protects."

In defense of his use of substantive due process to justify his holding, Judge Duggan lists 18 Supreme Court decisions that show a trend which "expands the rights of families and individual family members." This trend, according to the court, easily encompasses a "holding that the State cannot deny (or in this case, refuse to enforce) the First Amendment rights of a child to associate with another person with whom the child has developed a parent-like relationship."

Parents' and Children's Rights

In the third part of his decision, Judge Duggan notes that the right of the child to associate with non-parents invariably conflicts with the parents' right to

raise their children unencumbered by unwarranted state interference. However, in further support for his decision, Judge Duggan shows that, under different circumstances, the state routinely and often without compelling reasons has interfered in parental autonomy. As examples, he offers compulsory education laws, a list of highest state court cases awarding custody to relatives over parents, a sampling of statutes that place prohibitions on parental control, laws that empower courts to take charge of juvenile delinquents, and a line of U.S. Supreme Court cases that permit state interference. All these cases exemplify the power of the state as *parens patriae* to intrude on parental control.

The *parens patriae* power of the state conflicts with the constitutional protection of parental autonomy, but the Supreme Court has not chosen to extend this deference to liberty interests of children. In *Michael H. v. Gerald D.*,⁹ Justice Scalia, writing for the majority, takes just three pages to dismiss the child's claim that she was denied equal protection of the laws. While both her mother and father could challenge California's legitimacy presumption, she could not. Judge Scalia notes that the child's claim must fail because "there was no basis in law, history or tradition for a child to make a claim of multiple fatherhoods." In contrast, Justice Stevens concurrence noted that there may be a "constitutionally protected relationship" between a child and a natural father.

Finding little precedential support for a child's liberty interest, Judge Duggan turns to the dissenting opinions in *Troxel v. Granville*¹⁰ and *Alison D. v. Virginia M.*¹¹ In *Troxel*, the dissents of Justice Stevens and Justice Kennedy both posit that the relationships between children and non-parent caregivers could warrant state intrusion into parental autonomy. Justice Stevens goes further and opines that children have a fundamental liberty interest in maintaining such intimate relationships. In *Alison*, a *per curiam* decision of the N.Y. Court of Appeals, "the Court declined to read 'de facto' parent into the definition of parent in Domestic Relations Law § 70," but did not reach the liberty interest of children. In dissent, Judge Kaye argued for the inclusion of "de facto" parent within the definition of parents.

Within the confines of this sparse analytical framework, Judge Duggan finds enough support to declare a child's fundamental liberty interest. However, he does not extend this liberty interest to adults who have "parent-like" relationship with children. In *Ryan III*, he specifically denies that the foster parent possesses a parallel liberty interest in maintaining such a relationship. Instead, Judge Duggan indicates that his holding is limited to the narrow position that

children have a fundamental right to maintain "parent-like" relationships.

A Response to Parental Failure

With this position Judge Duggan joins many other judges and legislators who are grappling with the failures of parents to successfully parent. His concern reflects the view that the legal system's overarching allegiance to the rights of parents fails to protect the rights of children. Regardless of whether Judge Duggan establishes a new liberty interest, he has clearly raised the level of debate regarding the legal rights of children and non-parent caregivers. Most of these caregivers only reluctantly intrude into family affairs because they perceive a need to assist children whose parents cannot provide proper care. When they seek legal assistance, their cause frequently aligns with the cause of children. Hopefully, the *Web-*

ster decision will heighten the interest of judges and legislators in reorienting proceedings towards the maintenance of loving relationships between children and their non-parent caregivers.

Endnotes

1. 729 N.Y.S.2d 315 (Fam. Ct., Albany Co. 2001).
2. 530 U.S. 57 (2000).
3. 77 N.Y.2d 651 (1991).
4. 431 U.S. 816 (1977).
5. 187 Misc. 2d 137 (2001).
6. *Dred Scott v. Sandford*, 60 U.S. 393 (1857).
7. 381 U.S. 479 (1965).
8. 505 U.S. 833 (1992).
9. 491 U.S. 10 (1989).
10. 530 U.S. 57 (2000).
11. 77 N.Y.2d 651 (1991).

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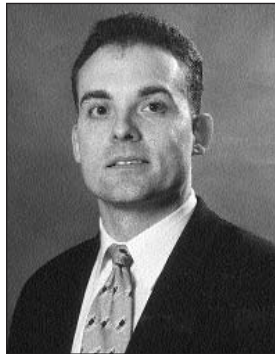


BONUS NEWS 1

The Caretaker Child Exception (Part II: Tax, Lien and Estate Recovery Issues)

By Robert J. Kurre

Part I of this article (which appeared in the Summer 2001 issue of the *NYSBA Elder Law Attorney*) examined the elements of the caretaker child exception and offered an analysis as to how far this exception to the transfer penalty rules extends. Part I focused on the circumstances under which title to a Medicaid applicant's homestead can be transferred, without the imposition of a penalty period, to a caretaker child and concluded that such an exempt transfer can take place provided a biological or adopted child of the applicant has maintained his or her domicile in the applicant's primary residence for the entire two-year period immediately preceding the institutionalization of the applicant. This part of the article will examine the tax, lien and estate recovery considerations associated with each of the methods commonly used for transferring ownership of a homestead to a caretaker child (i.e., by outright transfer or by transfer subject to a retained life estate) as well as the tax, lien and estate recovery issues associated with the failure of an applicant to transfer the homestead's title to a caretaker child during the applicant's lifetime. All references to a "caretaker child" in this part of the article will presume that the child of the applicant has qualified as a "caretaker child" under applicable law.¹



Outright Transfer of a Homestead to a Caretaker Child

A Medicaid applicant may make an outright transfer of his or her homestead to a caretaker child without incurring a penalty period. The applicant would transfer his or her entire ownership interest in the homestead to the caretaker child without reserving, in the deed, the right to occupy the premises.

There are two potential problems associated with transferring title to the homestead to the caretaker child in this manner. First, if the applicant receives the benefit of any real property tax exemptions (i.e., veteran's, senior citizen's or STAR), such benefits will be lost as the applicant no longer would have an ownership interest in the property. Second, by transferring the homestead to a caretaker child in this manner, the caretaker child will acquire the applicant's cost basis

in the property (i.e., carryover basis)² which could result in a significant capital gains tax liability of the caretaker child upon the sale of the property by the caretaker child. For example, assume the applicant purchased the property 30 years ago for \$30,000 and the property now has a fair market value of \$300,000. The caretaker child would acquire a cost basis of \$30,000 in the property (assume for the purpose of this example that no improvements were made to the property which would increase the basis) and would have a very significant capital gains tax liability if the caretaker child received proceeds from the sale of the homestead equal to \$300,000. This problem may be overcome if the caretaker child maintains his or her primary residence in the homestead for at least the next two years before selling the property. I.R.C. § 121 provides an exclusion from gross income for the sale of a principal residence if the property was owned and used by the taxpayer as the taxpayer's principal residence for two of the five years preceding the date of the sale. The amount of the gain excluded is \$250,000 for a taxpayer filing individually and \$500,000 for taxpayers filing jointly.

There is an important timing issue to be considered whenever a transfer of a homestead to a caretaker child is being contemplated. Medicaid law does *not* extend exempt status to a homestead which remains titled in the name of the Medicaid applicant where a caretaker child continues to live in the homestead following the applicant's institutionalization. If an individual becomes institutionalized, the homestead will only be exempt if it is occupied by the applicant; the applicant's spouse; or the applicant's minor, blind or disabled child³; or if the applicant executes a statement of intent to return home.⁴ Thus, if the applicant becomes institutionalized without having a spouse who will continue to live in the homestead and the applicant has not executed a statement of intent to return home, the home will remain exempt only if the caretaker child also qualifies as a minor, blind or disabled child. Furthermore, Medicaid law allows a lien to be placed by the Department of Social Services (DSS) on a homestead titled in the name of a Medicaid applicant even if a caretaker child continues to live in the homestead following the applicant's institutionalization. A lien cannot be placed on a homestead only if the homestead is occupied by the applicant's spouse; the applicant's minor, blind or disabled child; or a sibling of the applicant who has resided in the homestead for at

least one year immediately before the applicant's institutionalization and who has an equity interest in the homestead.⁵ Thus, by not *actually* transferring title to the homestead to a caretaker child prior to requesting Medicaid eligibility, the homestead may (1) become an available resource for eligibility purposes, and (2) be subject to a lien (assuming there is no spouse or sibling who meets the statutory requirements) if the caretaker child does not also qualify as a minor, blind or disabled child. The lien, however, must be removed if the applicant returns to live in the homestead.⁶ Although DSS has the right to place a lien on a homestead titled in the name of a Medicaid applicant and occupied by a caretaker child, it is prohibited from enforcing the lien as long as the caretaker child lives in the homestead.⁷

Accordingly, transfer of the title to the homestead from an applicant to a caretaker child should ordinarily be completed prior to attempting to establish the eligibility of the applicant since the homestead may count as an available resource if not transferred. Once the homestead is transferred from the applicant to the caretaker child, it will not be an available resource for Medicaid eligibility purposes. In addition, the pre-eligibility transfer of the homestead to the caretaker child will foreclose the possibility of DSS imposing a lien on the property, as the applicant will no longer be the owner. The caretaker child, as the new owner, is not legally responsible for the cost of the institutionalized parent's medical expenses. Under this scenario, no estate recovery is possible against the homestead for the same reasons.

In those situations where the homestead is highly appreciated and the caretaker child has no intention of living in the homestead for at least the next two years, an outright transfer of the homestead may not be desirable due to the capital gains tax exposure to the caretaker child. Instead, the applicant's transfer of the homestead's title to the caretaker child with the applicant retaining a life estate may be more prudent.

Transfer of a Homestead to a Caretaker Child Subject to a Retained Life Estate

A Medicaid applicant may convey a homestead to a caretaker child and retain a life estate for himself or herself without incurring a penalty period. By retaining a life estate in the homestead, the Medicaid applicant retains the right to remain in the homestead for life.

The retention of a life estate by the applicant may be more desirable than making an outright transfer of the homestead to a caretaker child for several reasons. First, significant tax advantages may exist by transferring a homestead to a caretaker child subject to the

retention of an unrestricted life estate (i.e., the life tenant maintains the right to receive rental income). An applicant's property tax exemptions (STAR, senior citizen's or veteran's) will be preserved when a life estate is retained by the applicant provided the deed is properly drafted.⁸ A restricted life estate (i.e., the life tenant gives up the right to receive rental income) may, however, adversely affect the tenant's continuing eligibility for property tax exemptions. Additionally, significant capital gains tax advantages may be present as the holder of the remainder interest will receive a 100 percent step-up in the basis of the homestead upon the death of the life tenant.⁹ The step-up in basis is an income tax concept, whereby the basis of the property acquired from a decedent is its fair market value at the time of the decedent's death. Any capital gains taxes due following the subsequent sale of the homestead will be minimized.

A lien cannot be placed on the life estate interest of a Medicaid applicant.¹⁰ Thus, if the homestead is transferred to a caretaker child and the applicant retains a life estate in the homestead, DSS cannot, under any circumstances, place a lien on the life estate interest of the Medicaid applicant. The institutionalization of the life tenant would not subject the homestead to the risk of the imposition of a lien. Moreover, a lien could not be imposed against the caretaker child's remainder interest in the homestead since a child is not legally responsible for the cost of a parent's medical expenses.

No estate recovery is possible against the applicant's life estate interest in the homestead as it is extinguished upon the death of the life tenant and the homestead passes as a nonprobate asset (i.e., by operation of law) to the remaindermen. Under New York law, estate recovery is presently only possible against a Medicaid recipient's probate estate.¹¹ Similarly, no estate recovery is possible against the caretaker child's remainder interest in the homestead since a child is not legally responsible for the cost of a parent's medical expenses.

Transfer of title to the homestead from an applicant to a caretaker child subject to the retention of a life estate in favor of the applicant ordinarily should be completed prior to attempting to establish the eligibility of the applicant, since the homestead may count as an available resource if not transferred. A life estate interest of an applicant, however, is not considered a countable resource.¹² The pre-eligibility transfer of the homestead, subject to the applicant's life estate, to the caretaker child will also foreclose the possibility of DSS imposing a lien on the homestead as the applicant's life estate interest, as discussed above, cannot be liened and the caretaker child's remainder interest in the homestead cannot be liened

since a child is not deemed to be legally responsible for the cost of an institutionalized parent's medical expenses.

The practitioner should be cautious, however, in transferring the homestead of a Medicaid applicant subject to a retained life estate since there are potential disadvantages. If the homestead is sold for any reason during the lifetime of the Medicaid applicant, a portion of the proceeds equal to the value of the life estate will belong to the life tenant. If the life tenant is receiving Medicaid benefits, the funds received by the life tenant will adversely affect the life tenant's continuing Medicaid eligibility. Additionally, the life tenant would need the consent of the remaindermen to sell the property (and vice versa). Lastly, the transfer of the homestead subject to a retained life estate may adversely affect the ability of the life tenant to maximize the \$250,000 (\$500,000 for married couples) exclusion on the gain from the sale of the homestead. For these reasons, where there is a distinct possibility that the homestead may be sold during the life tenant's lifetime, it may be advisable to make an outright transfer of title to the caretaker child.

Failure to Transfer Title During Applicant's Lifetime

What if a Medicaid applicant retains the entire ownership interest in the homestead and does not transfer title to the caretaker child by either of the above-discussed methods during his or her lifetime (i.e., by outright transfer or by deed subject to a retained life estate) but instead the homestead only passes to the caretaker child through the applicant's will or through intestacy?

As already discussed, a homestead will no longer be exempt if it is not occupied by the applicant; the applicant's spouse, minor, blind or disabled child; or if the applicant does not execute a statement of intent to return. Even if the applicant executes a statement of intent to return home making the home an exempt asset, DSS can place a lien on a homestead occupied by a caretaker child to recover the Medicaid benefits paid to the individual for nursing home care or its equivalent. Accordingly, as discussed above, transferring the homestead out of the institutionalized person's name to a caretaker child should be completed prior to attempting to establish the applicant's eligibility. But what if title to the homestead is kept in the applicant's name because the applicant (1) resides in a nursing home becoming eligible for Medicaid institutional benefits by executing a statement of intent to return home (making the homestead an exempt resource), or (2) continues to reside at home (making the homestead an exempt resource) and receives Medicaid home care benefits?

If title to the homestead remains in the name of the applicant and only passes to the caretaker child through the applicant's will, or through intestacy, the applicant will continue to benefit from any STAR, veteran's or senior citizen's tax exemptions because the applicant is still the owner of the property. Additionally, the caretaker child would receive a 100 percent step-up in basis in the homestead upon the death of the applicant if the homestead passes by will or through intestacy to the caretaker child.¹³

However, DSS may place a lien against the homestead (even where the applicant executes a writing declaring his or her intent to return home) if it determines the individual to be permanently absent from the homestead even if a caretaker child lives in the homestead. The lien must, however, be removed if the individual returns home.¹⁴ Thus, by maintaining title to the homestead in the applicant's name, the risk of the imposition of a lien on the homestead exists which would enable DSS to recover for Medicaid benefits paid to the individual for nursing home care or its equivalent. Although DSS has the right to place a lien on the homestead under these circumstances, it is prohibited from enforcing the lien as long as a caretaker child lives in the homestead.¹⁵ If the applicant is living in the homestead and receiving Medicaid home care benefits, no lien can be imposed on the homestead.

An additional exposure in connection with the homestead whose title is not transferred out of the applicant's name is the risk of recovery against that individual's estate. DSS may assert a claim against the estate of a deceased Medicaid recipient who is not survived by a spouse or a minor, disabled or blind child.¹⁶ Accordingly, unless the applicant's spouse is alive or the caretaker child also qualifies as a minor, blind or disabled child, Medicaid may assert a claim against a homestead that passes by will (or through intestacy) to the extent of Medicaid benefits paid when the decedent was age 55 or older.¹⁷ This right of recovery is further limited, however, as DSS can only recover from the estate of an applicant for benefits paid within ten years of the individual's death.¹⁸

Conclusion

By understanding the tax, lien and estate recovery ramifications of the different methods commonly used to transfer a Medicaid applicant's ownership interest in a homestead to a caretaker child, the practitioner can best serve the client. In order to qualify for Medicaid nursing home benefits and avoid the imposition of a lien on the homestead, a Medicaid applicant ordinarily should transfer title to the homestead to a caretaker child prior to seeking to establish

eligibility. The practitioner should analyze and weigh the following factors to determine the more appropriate method of transferring title to the homestead to the caretaker child (i.e., by outright transfer or by deed subject to a retained life estate): the likelihood that the homestead will be sold during the applicant's lifetime; the possible loss of property tax exemptions; and, if there is a low cost basis in the property, the likelihood that the caretaker child will continue to use the homestead as his or her primary residence for at least the next two years. An outright transfer of the homestead to the caretaker child is generally advisable where there is a distinct possibility that the homestead may be sold during the applicant's lifetime and, if there is a low cost basis in the property, the caretaker child is likely to continue residing in the homestead for at least the next two years. Transferring the homestead subject to a retained life estate is generally advisable where the homestead is unlikely to be sold during the applicant's lifetime, and, if there is a low cost basis in the property, the caretaker child is unlikely to live in the homestead for at least the next two years. The loss of property tax exemptions is usually not a dispositive factor in determining which method of transferring title is preferred since its economic value is usually minimal when compared to the economic consequences associated with the other factors. Nonetheless, a case-by-case analysis of each factor should be completed.

The practitioner should also understand and educate the client about the consequences of not making a lifetime transfer of the homestead's title to a caretaker child. The consequences include difficulty in establishing Medicaid eligibility, the risk of a lien being placed on the homestead, and the risk that Medicaid may assert a claim for recovery of benefits paid against the homestead as part of estate of the Medicaid recipient.

Endnotes

1. N.Y. Social Services Law § 366(5)(d)(3)(i)(D) (SSL); N.Y. Comp. Codes R. & Regs. tit. 18, § 360-4.4 (c)(2)(iii)(b)(4) (N.Y.C.R.R.).
2. Internal Revenue Code § 1015 (I.R.C.).
1. SSL § 366 (2)(a)(1); 18 N.Y.C.R.R. § 360-4.7(a)(1).
4. *Anna W. v. Bane*, 863 F. Supp. 125 (W.D.N.Y. 1993).
5. SSL § 369(2)(a)(ii); 18 N.Y.C.R.R. § 360B7.11(a)(3)(ii).
6. SSL § 369(2)(a)(ii); 18 N.Y.C.R.R. § 360B7.11(a)(3)(i).
7. SSL § 369(2)(b)(iii)(B); 18 N.Y.C.R.R. § 360-7.11(b)(3)(ii).
8. Real Property Tax Law § 467(10); 3 Op. NYS Att'y Gen. 45 (1973).
9. I.R.C. § 1014(b). Note, however, that under the Economic Growth and Tax Relief Reconciliation Act of 2001, modified carryover basis rules apply with respect to property acquired from an individual who dies between January 1, 2010 and December 31, 2010. The new rules do provide certain exceptions which allow the executor of a decedent's estate to "step up" the basis of assets owned by the decedent and acquired by the beneficiaries at death, up to an aggregate of \$1.3 million. In addition, the basis of property transferred by a decedent to a surviving spouse can be increased by an additional \$3 million. *See* I.R.C. § 1022.
10. 96 ADM-8 at 21.
11. SSL § 369(6).
12. 96 ADM-8 at 21.
13. *See supra*, note 9.
14. SSL § 369(2)(a)(ii); 18 N.Y.C.R.R. § 360-7.11(a)(3)(i).
15. SSL § 369(2)(b)(iii)(B); 18 N.Y.C.R.R. § 360-7.11(b)(3)(ii).
16. SSL § 369(2)(b)(ii); 18 N.Y.C.R.R. § 360-7.11(b)(2).
17. SSL § 369(2)(b)(i)(B); 18 N.Y.C.R.R. § 360-7.11(b)(1)(i). Note, however, that the New York State regulation has not yet been updated to reflect the reduction in age from 65 to 55 as the age after which benefits are subject to recovery.
18. SSL § 104(1).

Robert J. Kurre, J.D., is an associate with the law firm of Littman Krooks & Roth P.C. with offices in New York City and White Plains.

He is a member of the National Academy of Elder Law Attorneys where he serves on the Bylaws Committee. He is also a member of the New York State Bar Association's Elder Law Section and Trusts and Estates Law Section as well as the Elder Law, Social Services and Health Advocacy Committee and Surrogate's Court, Estates & Trusts Committee of the Nassau County Bar Association. He formerly was an Adjunct Professor of Law at Long Island University-C.W. Post Campus and he has taught classes in elder law at New York University's School of Continuing Education.

He is a graduate of St. John's University, *magna cum laude*, and Hofstra University School of Law where he served as a Notes and Comments Editor of the *Hofstra Property Law Journal*. He devotes his practice to elder law, estate planning, guardianships, and planning for elderly and disabled clients.

BONUS NEWS 2

The 529 Plan: A Well-Kept Secret

By Antonia J. Martinez

In 1997, the Internal Revenue Code (I.R.C.) provided a mechanism for saving for higher education, while providing significant tax advantages. Section 529 of the I.R.C. allows any state to establish its own college tuition savings plan, and presently 48 states, including New York, have done so.¹



Requirements and tax advantages vary from state to state. Some states allow an income tax deduction for contributions made to the plan. Others vary the annual amount that can be excluded from state income tax, along with state variations on age requirements and limits on investment amounts per beneficiary. Log onto www.collegesavings.org to find out the particulars of each state.

Account Owner Retains Control

Only the account owner can direct withdrawals. If the funds in a 529 plan are not going to be used for their intended purpose, the account owner may designate a different beneficiary, albeit limited to the immediate family of the original beneficiary. The account owner also has options if the beneficiary doesn't use the money for other reasons. For example, if the beneficiary dies, becomes disabled, or receives a scholarship, no penalty is assessed and the account owner may: (1) take the money back; (2) designate a new beneficiary within the immediate family of the previous beneficiary; or (3) leave the money in the account for another future beneficiary. From an estate planning perspective, it is unprecedented that one can gift assets, and then take them back if the beneficiary does not use the gift for its intended purpose.

Practice Tip: the account owner should designate a contingent account owner to control the use of these funds in the event the account owner dies or becomes incompetent. If no contingent account owner is listed, the account owner's estate executor may designate a new account owner.

Distinct from a Custodial Account

A 529 plan differs significantly from custodial accounts, which usually bear the designation Uni-

form Gift to Minors Act (UGMA) or Uniform Transfers to Minors Act (UTMA). Assets in such custodial accounts are available to their beneficiaries when they reach their age of majority, usually age 18 or 21. Thus, if the beneficiary, now sporting green hair or other non-organic color, decides college is a waste of time and decides instead to spend the money on a BMW or to save the world, the account owner is powerless to do anything. In contrast, the 529 plan can require the beneficiary to go to college or forfeit his or her benefits. It allows the account owner to guard against the use of his or her savings for frivolous expenditures (with no offense intended to those who own BMWs or want to save the world).

"Section 529 of the I.R.C. allows any state to establish its own college tuition savings plan, and presently 48 states, including New York, have done so."

New federal legislation makes 529 plans even more appealing. Congress recently amended § 529 to make interest earned on these types of accounts after December 31, 2001, tax-free, as long as the money is used for qualified educational expenses. For the remainder of 2001, the tax imposed on the earned income is at the beneficiary's rate, usually lower than the account owner's taxable rate. Even if the designated beneficiary chooses not to go to school immediately, the money will be available for that purpose years later. Compare these benefits with a custodial account, where the income on a custodial account is taxed annually.²

A May 2001 article in the *Wall Street Journal*³ gave 529 plans a lukewarm rating. But the conclusions from that article have been superseded by the new federal legislation. And T. Rowe Price, whose analysis was cited in the *Wall Street Journal* article, has since concluded, "529 performance likely will outpace alternative college-savings vehicles,"⁴ in light of legislative changes in the tax laws.

A 529 plan account owner may have some investment limitations, depending both upon what a state offers and what some account owners want. A 529

plan may not be a suitable vehicle for someone who, for example, believes that commodities or rare coins are the best long-term investment. But for the majority of Americans who invest in stocks, bonds, and money market funds already, the 529 plan provides the financial benefits of those investment vehicles, while at the same time insuring that money invested for education will be used for its intended purpose. Given its advantages, the 529 plan offers unique features that are otherwise unavailable.

Excellent Tax and Estate Planning Advantages

As an added bonus, in many states, the account owner (typically the parent or grandparent) will also save on state income taxes and may deduct contributions made to such plans from their state taxable income. Be sure to check the applicable provisions for the state in which you reside to determine what, if any, tax incentives exist in your state.

Gift taxes are another advantage. Aside from saving on income taxes, an account owner can give up to \$50,000 at one time without paying a gift tax, and a married couple filing jointly, up to \$100,000, which is then credited or “carried forward” for the next five years. The designated beneficiary of a 529 plan can start earning interest on an account owner’s gift immediately without the imposition of a gift tax on the account owner. If the account owner dies before the five-year period, the *pro rata* portion of the \$50,000 will be brought back into the account owner’s estate.

“Anyone can set up a college savings account, no matter what his or her relationship is to the beneficiary: parents, grandparents, uncles, aunts. An account owner doesn’t even have to be related to the beneficiary.”

Similarly, contributions to 529 plans are excluded from the account owner’s estate. If your client has a taxable estate presently over \$675,000,⁵ the 529 plan provides a way to reduce his or her assets for estate tax purposes, while providing for the education of a loved one.

New York Version

The New York College Savings Program (NYCSP) is New York’s version of the 529 plan.⁶ Only now are people becoming familiar with the tax advantages it offers. NYCSP allows an account owner to:

- Receive an annual New York State tax deduction;
- Own the account and control the use of his or her savings;
- Set up a college savings account no matter what his or her relationship is to the beneficiary;
- Save for college on a tax-deferred basis and after January 1, 2002, on a tax-free basis.

The NYCSP even allows the account owner to set up an account for himself or herself. If such a person is or will be pursuing a degree in the future, he or she can name themselves as beneficiaries and deduct the amount contributed toward the plan for that taxable year from their New York State income tax bill (up to \$5,000 per person; \$10,000 if married and filing jointly).

Anyone can set up a college savings account, no matter what his or her relationship is to the beneficiary: parents, grandparents, uncles, aunts. An account owner doesn’t even have to be related to the beneficiary.

Educational Options and Tax Benefits

The account owner’s designated beneficiary has educational choices outside of New York State, even though the account owner receives New York State tax benefits. The beneficiary, for example, is not limited to attending New York State schools. Funds can be applied toward education in schools outside of New York State, including public or private, as well as graduate school, law school, medical school, part time studies, vocational school, and some international studies. Nor does the beneficiary of the account have to reside in New York. Even though the account owner is subject to New York State income taxes, he or she may choose to benefit a child residing in another state, and still take advantage of New York State tax benefits.

As an added bonus, the New York State account owner (typically the parent or grandparent) will also save on state income taxes. The account owner may deduct contributions up to \$5,000, per person per calendar year on New York State income tax. A married couple filing jointly may deduct even more, up to \$10,000.

If you live outside of New York State, check your particular state to determine what, if any, tax incentives exist in your state.

Investment Options

The NYCSP plan offers four investment options depending on the account owner's appetite for market risk. The funds, administered and managed by TIAA-CREF are: (1) Guaranteed Option, which provides a minimum rate of return of 3% and offers potential for greater return based on investment performance; (2) Managed Allocation Option, a blend of stock, bond and money market funds—the mix of funds changes with the age of the beneficiary; (3) Aggressive Managed Allocation Option, similar to the Managed Allocation Option, but with a greater exposure to equities; and (4) High Equity Option, which consists of 75% to 100% stock holdings.

Issues to Keep in Mind About the NYCSP

- There is a 10% penalty on money used for a purpose other than the beneficiary's higher education (a non-qualified withdrawal). Monies withdrawn in this manner are subject to a 10% tax on earnings, not contributions. For example, an account owner who contributed \$50,000 and saw his or her account grow to \$105,000, would pay 10% of \$55,000, the amount earned, not contributed.
- The total amount contributed cannot exceed \$100,000.
- Once the account owner chooses an investment plan for a 529 plan account, it cannot be changed. But the account owner can subsequently invest additional funds into different investment options for the same beneficiary. Example: an individual chooses the High Equity investment option for his or her child's account. Later when the child is older, the individual wants to diversify and invest funds into a more conservative fund. He or she may do so by investing additional funds into a different investment option.
- An account must be opened three years before a qualified withdrawal can be made. That

means if the account owner expects the beneficiary to attend college at age 18, the account should be opened before the beneficiary is 15 years old. Any time after is not a good time to start, unless the account owner is planning to finance an advanced degree or wait to use the money toward the end of his or her child's educational career.

- Monies deposited in a NYCSP account are protected from creditors in bankruptcy proceedings, and creditors also are limited in their ability to satisfy judgments using NYCSP accounts, even outside of bankruptcy proceedings.

Individuals can open an account for as little as \$15 and make periodic payroll contributions of \$15 through an automatic investment plan such as a payroll deduction. More information is available at 877-NY-SAVES. Program representatives are knowledgeable and very helpful. Or log onto www.nysaves.org.

Endnotes

1. Georgia and South Dakota presently have no such plan in operation, although Georgia will commence a college savings program in 2002.
2. The first \$750 of income is not taxed, the next \$750 of income is taxed at the child's rate, typically lower than the parents' rate. After the child reaches age 14, the income is taxed at the parents' rate.
3. Jonathan Clements, *Getting Going Column, Saving for College: Not as Easy as 5-2-9*, Wall St. J., May 22, 2001.
4. Aaron Lucchetti, *Is Your Tuition Account Most Likely to Succeed?*, Wall St. J., June 15, 2001.
5. This amount will increase to \$1 million in 2002.
6. State of New York, Program Brochure, *New York's College Savings Program* (Nov. 15, 2000); discussions with program representatives on various dates.

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BONUS NEWS 3

Initiating a Guardianship

By Clifford A. Meirowitz

The appointment of a guardian significantly deprives a person of power, control and independence. Therefore, the New York State Legislature, when enacting Article 81 of the Mental Hygiene Law (MHL), provided numerous substantive and procedural safeguards designed to ensure that the proceedings would be conducted with the utmost consideration for the rights of the alleged incapacitated person (AIP). These safeguards were meant to ensure that each order appointing guardian, if necessary, would be as narrowly drawn as possible to meet the specific needs of a person unable to provide for personal needs and/or property management. Article 81 and the ever-developing case law interpreting its provisions provide a maze of substantive and procedural issues for the petitioner's attorney to navigate. This article will focus on issues that must be addressed during the initiation of the guardianship including to the filing of the order to show cause (OTSC) and petition.

"... it is critical that an AIP's functional level and limitations are adequately assessed prior to commencement of a guardianship."

Functional Level and Limitations

To appoint a guardian, the court must find by clear and convincing evidence that the AIP has functional limitations to an extent that the person is likely to suffer harm because of an inability to provide for personal needs and/or property management and cannot adequately understand and appreciate the nature and consequences of such disabilities.¹ Therefore, it is critical that an AIP's functional level and limitations are adequately assessed prior to commencement of a guardianship.

Availability of Less Restrictive Alternatives

Article 81 requires that the court impose the least restrictive form of intervention. Alternatives less restrictive than a guardianship must be considered even if the person suffers from substantial functional

limitations. Prior to commencement of a guardianship, petitioner must investigate whether the AIP previously executed a trust, durable power of attorney, health care proxy and/or living will. If so, several questions must be asked. For example, were the agents acting reliably as fiduciaries for the AIP and meeting the AIP's needs? Were the documents executed at a time when the AIP's capacity was questionable or in a context where there may have been undue influence?

The Relationship of the AIP to the Petitioner

Most anyone genuinely interested in the AIP's welfare may be the petitioner in a guardianship. MHL § 81.06 states that the petitioner must be either: the AIP; a presumptive distributee of the AIP; an executor or administrator of an estate to which the AIP may be a beneficiary; a trustee of a trust to which the AIP may be a grantor or beneficiary; the person with whom the AIP resides; a person otherwise concerned with the welfare of the AIP (including a corporation or a public agency); or the chief executive officer of a facility, hospital or school where the AIP is a patient or resident.

Jurisdiction

Guardianships in New York City are commenced in the Supreme Court, County Court outside of New York City and in Surrogate's Court under certain circumstances. The jurisdiction applies to residents of the state and nonresidents of the state present within the state, or a nonresident as per MHL § 81.18.

Venue

Venue plays an important role in the procedural safeguards of Article 81. The venue provision is designed to ensure that the AIP can participate in the guardianship process. Therefore, MHL § 81.05 provides that venue lies in the county or judicial district where the person resides or is physically present. If the person is presently in a facility such as a hospital, alcohol treatment center or adult care facility, etc., then venue lies where the facility is located. If the AIP is an out-of-state resident, venue is in

the county where some or all of the AIP's property is located.

OTSC

Guardianships are initiated by OTSC and an annexed verified petition. Article 81 places strict formal requirements on the content of the OTSC. The OTSC alerts the AIP in simple, clear and concise language of the serious nature and possible consequences of the proceeding. The OTSC includes the rights of the AIP, the guardianship powers requested and a warning, in large, bold-faced type of the seriousness of the matter. The judge appoints a court evaluator and/or counsel for the AIP in the OTSC. Furthermore, the judge sets the hearing date, time and place in the OTSC, which should be no more than 28 days from filing.

The Petition: MHL § 81.08 provides that the petition must be verified under oath and a comprehensive list of information to be included in the petition. The petition must state, for example, "a description of the alleged incapacitated person's functional level, including the alleged incapacitated person's ability to manage the activities of daily living, behavior, and understanding and appreciation of the nature and consequences of any inability to manage the activities of daily living." Furthermore, "specific factual allegations as to the personal actions or other actual occurrences involving the person alleged to be incapacitated which are claimed to demonstrate that the person is likely to suffer harm because he or she cannot adequately understand and appreciate the nature and consequences of his or her inability to provide for personal needs" and/or property management. The petition must include "the particular powers being

sought and their relationship to the functional level and needs of the AIP," and "any other information which in the petitioner's opinion will assist the court evaluator in completing the investigation and report in accordance with Section 81.09 of the Mental Hygiene Law."²

"Article 81 contains many procedural and substantive safeguards to ensure that the least restrictive form of intervention is imposed by judges."

Careful assessment of the function level and limitations of the AIP and investigation into any prior plan to provide for the AIP's needs in the event of disability is crucial before the commencement of a guardianship. Article 81 contains many procedural and substantive safeguards to ensure that the least restrictive form of intervention is imposed by judges. It seeks to respect the "personal wishes, preferences and desires" of the AIP and afford "the person the greatest amount of independence and self determination and participation in all the decisions affecting such person's life."³ An order appointing a guardian, if necessary, should be finely tailored to meet the individual needs of a person unable to manage his or her person and/or property.

Endnotes

1. MHL § 81.02(b).
2. See MHL § 81.08(1-15).
3. MHL § 81.01.

Clifford A. Meirowitz's practice focuses on elder law. He has received appointments as court evaluator, guardian, attorney for AIP and counsel/referee in guardianship proceedings. He is a graduate of Connecticut College, where he studied abroad at the London School of Economics, and the Benjamin N. Cardozo School of Law, where he was an Alexanders Fellow. At Cardozo, he participated at Bet Tzedek Legal Services representing indigent, elderly and disabled individuals in cases involving entitlement programs such as Medicaid, Medicare and Social Security. He has served on the editorial board of the *Brooklyn Barrister*, a publication of the Brooklyn Bar Association. He successfully represented clients in *In re Heller* (Ratner) and *In re Warshawsky*, both of which resulted in published opinions in the *New York Law Journal*. Mr. Meirowitz has recently had an article entitled "Supplemental Needs Trusts: An Introduction to Practitioners" published in the Spring 2001 volume of "Bill of Particulars," of the New York State Trial Lawyers Institute. He is a member of the National Academy of Elder Law Attorneys, the Association of the Bar of the City of New York's Committee on Legal Problems of the Aging, the New York State Bar Association Elder Law Section and a faculty member for CityBar Certified Training for Guardians and Court Evaluators. He has spoken on behalf of the Elder Law Section of the New York State Bar Association on Decision Making Day and before the elder law class at Benjamin N. Cardozo School of Law, the 92nd Street Y, the Alzheimer's Association, the Jewish Community Center on the Upper West Side and various other organizations.

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Co-sponsored by the Association's Trusts and Estates Law Section, *Probate and Administration of New York Estates* is an invaluable text of first reference for both the novice and the experienced attorney. Written by veteran trusts and estates practitioners, this comprehensive text covers all aspects of estate administration, from preliminary preparations to filing the accounting.

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The 2001 cumulative supplement brings the extremely well-received first edition up-to-date. The chapter on the federal estate tax has been completely revised and includes a section on the new New York estate tax procedures. The other chapters have been extensively updated to reflect case law and statutory changes that have occurred. Future supplements will cover what are sure to be many more changes to the estate tax.

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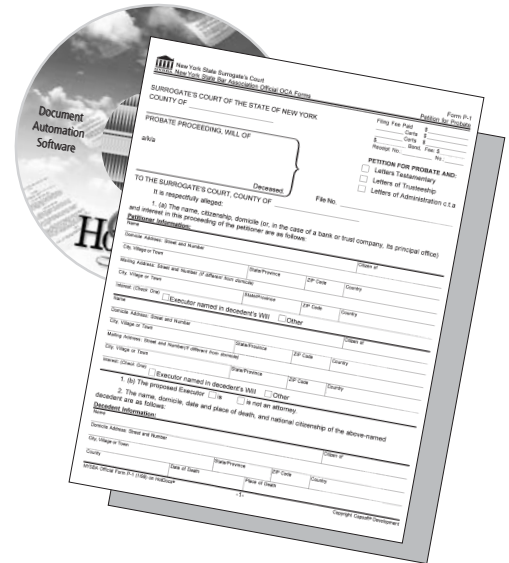
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