SUFFOLK ACADEMY OF LAW
The Educational Arm of the Suffolk County Bar Association
560 Wheeler Road, Hauppauge, NY 11788
(631) 234-5588

ELDER LAW UPDATE 2017

FACULTY

George L. Roach, Esq.

SPONSORED BY:

ASTORIA BANK

March 3, 2017
SCBA Center - Hauppauge, NY

GEORGE L. ROACH

Past President
Suffolk County Bar Association (2001-02)

George L. Roach received his B.A. in government **cum laude** from Manhattan College and his law degree from St. John's University School of Law. He was with the Legal Aid Society of Suffolk County for 30 years, dealing exclusively with the problems of the elderly and the elderly poor. He was the attorney in charge of the Legal Aid Society of Suffolk County's Senior Citizen's Division. Mr. Roach is now with the Smithtown law firm Grabie & Grabie, LLP.

Mr. Roach is a former Dean of the Suffolk Academy of Law and has also served as Associate Dean of the Academy. He was the first chairperson of the SCBA's Elder Law Committee, a committee that he helped to launch, and has also served as chair of the Federal Court Committee. Mr. Roach received the Association's highest award, its President's Award, for his contributions in legal and public education. He is also a member of the American Bar Association, the NYS Bar Association and the National Academy of Elder Law Attorneys. He is licensed to practice law in both New York and Hawaii.

In September 2012, Mr. Roach was the first Public Interest Service Award recipient from his alma mater, St. John's University School of Law, where he is currently an Adjunct Professor of Law teaching Elder Law and Estate Planning.

In May 1998, Mr. Roach was chosen as the Suffolk County Office of the Aging's "Community Leader of the Year." This honor was bestowed upon him by then Suffolk County Executive Robert J. Gaffney.

Mr. Roach spends his free time training for and participating in Triathlon.

NEWSDAY 2-16-17

DEMENTIA KILLS MORE GLOBALLY THAN HIV/AIDS

Dementia has unseated AIDS as one of the world's top killers, new figures from the World Health Organization show, as drugmakers struggle to curb or cure it.

Alzheimer's disease and other forms of dementia killed 1.54 million people in 2015, more than twice the number of deaths in 2000, according to documents posted last month on the WHO website. It replaced HIV/AIDS as No. 7 on the global health watchdog's list of the 10 biggest causes of death. New therapies helped push fatalities from HIV/AIDS down from 1.5 million to 1.1 million over the same 15-year period.

Drugmakers have struggled to understand Alzheimer's, with Merck & Co. abandoning a high-profile study this week, less than three months after a similar defeat for Eli Lilly & Co. More than 100 experimental treatments have failed to slow the condition, which dismantles memories and leaves patients unable to take care of themselves.

Dementia afflicts some 47 million people around the world and the number of cases will probably rise to 75 million by 2030, said Shekhar Saxena, director of the WHO's department of mental health and substance abuse. "We are making slow progress," Saxena said, calling for more public money to be directed toward developing treatments. But "I am less optimistic than I would like to be."

Dementia's climb up the WHO ranking is partly due to the aging of society, and partly to doctors diagnosing it more frequently because they have become more familiar with the disease, he said.

In high-income economies, Alzheimer's and other dementia rank as the No. 3 cause of death, trailing only heart disease and stroke. By contrast, HIV/AIDS remains on the top 10 list in the poorest countries, alongside problems such as malaria and diarrhea.

The most recent drug to help treat symptoms of Alzheimer's is more than a decade old, and there is no cure. Merck is investing in another study and Biogen Inc. and Roche Holding are also pursuing potential treatments. — *Bloomberg News*

GOOD TO KNOW

Struggles in fighting Alzheimer's

BY MELISSA BAILEY
Kaiser Health News

Despite a 99 percent failure rate and a recent setback, Alzheimer's researchers are plowing ahead with hundreds of experiments and a boost in federal money to try to crack a deadly disease that has flummoxed them for decades.

A law passed by Congress in December and signed by President Barack Obama sets aside $3 billion over 10 years to fund research of brain diseases and precision medicine, a shot in the arm for Alzheimer's research. The law, called the 21st Century Cures Act, also includes prize money to encourage Alzheimer's experiments.

But billions of dollars have so far made little progress in decoding the memory-robbing disease, which affects more than 5 million Americans. Alzheimer's is the nation's sixth-leading cause of death. Decades of research have not produced a single drug that alters its course.

December began with a major setback: Eli Lilly & Company shared disappointing results of a late-stage clinical trial of its experimental drug solanezumab, which failed to significantly slow Alzheimer's progression. But scientists aren't giving up on the main hypothesis behind Eli Lilly's trial: that Alzheimer's can be defeated by using drugs to attack amyloid plaques that build up in the brain. Some scientists believe these cause the disease. Many observers hold out hope for another anti-amyloid drug, Biogen's aducanumab, which in an early trial improved cognitive decline in a small number of patients.

Other potentially groundbreaking research aims to intervene even before symptoms emerge. Using PET scans, scientists can identify amyloid plaques building up years before Alzheimer's develops. One study, for instance, is testing solanezumab in adults who are accumulating amyloid plaques but showing no signs of Alzheimer's, such as memory loss or cognitive decline. Other scientists are targeting what they believe is the true culprit, tau, the disease's other primary marker, a protein that creates what are called "tangles" in the brain.

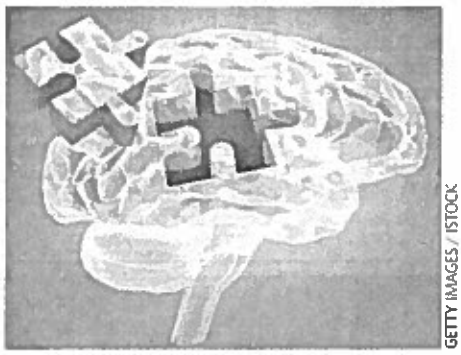
The experiments continue against a bleak backdrop: No new Alzheimer's therapies have won federal approval since 2003, and according to published reports, Alzheimer's clinical trials have had a 99 percent failure rate. Only five drugs have been approved by the Food and Drug Administration to treat Alzheimer's, and those merely alleviate symptoms, such as memory loss and confusion; they don't prevent, slow or reverse the disease. "The history of clinical trials results has been a history of disappointment," said Keith Fargo, director of scientific programs and outreach at the Alzheimer's Association.

Still, 77 Alzheimer's drugs are being investigated or developed, according to the trade group PhRMA. And other experiments seek to repurpose drugs approved for other conditions, such as diabetes or cancer, to see whether they can help Alzheimer's patients — and cut several years from the drug development process. Non-pharmaceutical solutions are also being explored.

Observational studies have shown that people who exercise more and have healthier diets seem to get the disease later in life. Researchers are conducting trials to measure the effects of exercise and diet. One trial underway at Wake Forest University in North Carolina, dubbed EXERT, is testing the effects of high-intensity aerobic exercise on adults with mild cognitive impairment by enrolling them in exercise programs at a YMCA.

Even before passage of the 21st Century Cures Act, public funding for Alzheimer's research was rising. The National Institutes of Health allocated almost $1 billion to the disease in fiscal 2016 — a $350 million increase over the previous year, according to Laurie Ryan, chief of NIH's Dementias of Aging Branch. There are 468 open clinical trials related to Alzheimer's — and more than 100 more in progress — listed in the government's ClinicalTrials.gov database.

Meanwhile, Alzheimer's advocates still grapple with a basic question: Is the rate of Alzheimer's actually going down? A study in the Journal of the American Medical Association in November found that even as scientists have made no progress in changing the course of Alzheimer's, overall dementia rates — which include Alzheimer's and other dementias — appear to be dramatically declining. The paper cast doubt over a major talking point of the Alzheimer's lobby: that as baby boomers age, the number of Americans living with Alzheimer's will explode from the current 5 million to 14 million in 2050. The study also suggested that lifestyle changes may make a difference.



GETTY IMAGES / ISTOCK

According to published reports, Alzheimer's clinical trials have had a 99 percent failure rate.

While some heralded that as good news, others played down the finding. Even if dementia rates drop, Alzheimer's remains a major killer, and the number of afflicted people will probably still rise because the United States' population is aging so rapidly, Fargo predicted. He also questioned the study's methods, which relied largely on telephone interviews. "It's not time to let our foot up off the gas," Fargo said. Eli Lilly's closely watched trial, Expedition 3, was the latest potential breakthrough to fall flat.

In 2,100 people with mild dementia, solanezumab failed to show significant results compared with a placebo. Some critics said the failure casts doubt on the hypothesis that Alzheimer's is triggered by the buildup of amyloid plaques. But Eli Lilly spokeswoman Nicole Hebert said more work is needed to test the hypothesis because the trial explored just one method of removing amyloid on one subgroup of people. She said the company is pursuing seven other lines of attack. "Rumors of the death of the amyloid hypothesis have been around for many years, and they're probably premature," Hebert said

Fargo agreed. Fargo noted that brain imaging has shown that amyloid plaques start to build up 15 to 20 years before signs of dementia appear. So to really test the amyloid hypothesis, he said, scientists may have to intervene earlier than they did in Expedition 3. Despite the latest failure, Fargo said, "there's still more optimism in Alzheimer's research right now than there has been for 10 years." The answer to Alzheimer's, Ryan said, is not going to be one "magic bullet," but an array of solutions tailored to different patients.

Will scientists ever find a cure? Ron Petersen, director of the Alzheimer's Disease Research Center at Mayo Clinic, isn't betting on it. But there's still "a lot going on to be hopeful about," he said. "I think slowing the progression and/or delaying the onset are realistic goals."

Costly Mistakes — Why Clients Need an Elder Law Attorney

By Melissa Negrin-Wiener

Elder Law is rooted in an intricate and detailed set of statutes and regulations. Unlike most areas of practice, the field of Elder Law is constantly changing. In the Medicaid arena, the Department of Health regularly directs the local Departments of Social Services to re-interpret the Medicaid regulations. These directives are often followed by appeals, the outcome of which can change the planning and processing of all Medicaid cases.

A recent trend has shown clients seeking lower-cost advice and services by utilizing non-lawyer, "Medicaid specialists" to process Medicaid applications. However, like the old adage, you get what you pay for. Mistakes in the Medicaid context can easily cost tens or even hundreds of thousands of dollars. An attorney immersed in this type of work must undertake proper legal planning and accurate and thorough processing of a Medicaid application.

One example of costly mistakes can be found in the handling of real property. Marcia[1] lived with her mother in the home she grew up in for the last 30 years. Marcia's mother sought assistance in applying for Medicaid benefits and was referred to a non-attorney "Medicaid specialist." Title to the house that Marcia lived in was solely in her mother's name. A Medicaid application was submitted and approved. When Marcia's mother passed away, however, Marcia received a Notice of Claim wherein Medicaid asserted a lien against the real property for the $225,000 paid for her mother's care. The only asset of the estate was the house — the house that Marcia planned to live in for the rest of her life.

The Social Services statute and implementing regulations[ii] states that a person will be eligible for Medicaid if the applicant's house is transferred to that person's:

1. Spouse.
2. Child who is blind, disabled or under age 21.
3. Sibling who has an equity interest in the home and who resided in the home for at least one year before the person was institutionalized; or
4. Child who resided in the home for at least two years before the person was institutionalized and provided care to maintain the person at home ("caretaker child").

Clearly, Marcia was entitled to the "caretaker child" exemption. Accordingly, the home could have been transferred to Marcia during the Medicaid planning process and it would have been completely protected; Medicaid could not assess a lien on the house and Medicaid could not impose a penalty upon the transfer. The "Medicaid specialist" did not know the law and Marcia was incorrectly advised that as long as she lived in the home, it would be protected. Marcia now needs to sell the house or otherwise come up with $225,000 to pay back the state. As is often the case, these costly mistakes are not discovered until it is too late.

Melissa Negrin-Wiener

In another case, John and Diane[3] lived with John's mother in her home for the past seven years. The Medicaid application filed by a "Medicaid specialist" was approved with a penalty period of 40 months based on the transfer of title to the home to John and Diane. Although John fell into the category of "caretaker child," the deed was transferred to both John and Diane. The case law interpreting this regulation makes clear that the "caretaker child" exemption extends only to natural children. Further,

(Continued on page 27)

Ethical Considerations for the Elder Law Attorney Under the Rules of Professional Conduct

By Nancy Burner

Ethically speaking, it is a challenge to practice elder law, where the clientele often suffers from diminished capacity at some point in the representation. While the client may have full capacity at the first representation, over time the client's capacity is likely to change. Even so, it is not uncommon for an elderly client to come to the initial consultation with one or more family members. To further complicate the situation, the client frequently depends upon a family member to gather and deliver information to the attorney's office. As a result, there may be additional interaction between the attorney's office and the non-client family member.

It is axiomatic that an elder law attorney should be familiar with the ethical standards in the legal profession. Recognizing who the client is is critical where the line between client and non-client is often blurred. Preserving the attorney/client privilege and protecting confidentiality require careful thought when there are multiple individuals involved in a client's case. The first question is "Whom do you represent?" Once you establish who your client is, the New York Rules of Professional Conduct[1] (hereinafter "the Rules") will "provide a framework for the ethical practice of law."[2]

A. Informed Consent

Many of the Rules require a lawyer to obtain ***informed consent*** from the client.

> "Informed consent" denotes the agreement by a person to a proposed course of conduct after the lawyer has communicated information adequate for the person to make an informed decision, and after the lawyer has adequately explained to the person the material risks of the proposed course of conduct and reasonably available alternatives.[3]

While a lawyer may adequately explain the legal and practical solutions, the client may not fully understand the lawyer's explanation or may not have the desire to understand, preferring to shift the responsibility to a non-client family member. It is imperative that the attorney establish a relationship with the client in the first instance.

Nevertheless, over time the client may suffer from diminished capacity and there is likely to come a time when the lawyer is asked to reveal confidential information to the client's agent or to another family member. If the client is unable to give informed consent, the ethical consideration for the lawyer is to determine what constitutes confidential information and to whom that information may be given. The Rules will assist the lawyer in solving this ethical conundrum.

There are essentially two broad areas where informed consent plays an important role in the elder law attorney/client relationship. The first is in the area of Confidentiality of Information under Rule 1.6. The second is with respect to Conflict of Interest with current and former clients which is addressed under Rules 1.7, 1.8 and 1.9.

"It is axiomatic that an elder law attorney should be familiar with the ethical standards in the legal profession. Recognizing who the client is is critical where the line between client and non-client is often blurred."

B. Confidentiality of Information

Confidentiality is the hallmark of the attorney/client relationship. This duty to keep the client's confidence is sacrosanct. Rule 1.6 states that a lawyer shall not knowingly reveal ***confidential information***[4] or use such information to the disadvantage of the client or for the advantage of a third person. If the client cannot give informed consent, look at Rule 1.6(a)(2). The disclosure of confidential information without informed consent is permitted if it will advance the best interests of the client and is ***reasonable***[5] under the circumstances or customary in the professional community. The attorney may also reveal or use confidential information if the attorney reasonably believes it is necessary to prevent reasonably certain death or substantial bodily harm.[6]

Consider the following scenario:

You have Represented Mrs. A for several years and have prepared her estate planning documents. She has

two children, Bill and Mary. Originally, Mrs. A shared with you a deep distrust for her daughter Mary. She said that Mary owed her a large sum of money, but her son was not aware of the loan. She expects Mary to repay her. She asked you to draft documents to ensure that Mary would never be in a position to make health care decisions or control her money. Bill is named as Mrs. A's agent on both documents. In the letter of engagement, Mrs. A gave you the authority to speak with Bill in his capacity as her agent at any time. Several years later, Mrs. A. is suffering from dementia and her son Bill contacts you. He advises that Mary has moved in with Mrs. A and he suspects that Mary is stealing money and using Mrs. A's credit cards. Bill claims that Mrs. A's dementia is advanced and Mrs. A is unaware that Mary is financially exploiting Mrs. A.

The first issue to consider is whether you can speak to Bill. Clearly, the engagement letter allows you to do so. However, ascertain the client's ability to participate first; don't take Bill's statements as fact. The rules require you to seek your client's informed consent before you release confidential information. If you cannot get the client's informed consent then you must determine if the revelation of confidential information is in the client's best interests and is reasonable under the circumstances or customary in the professional community. In the alternative, if you reasonably believe it is necessary to prevent reasonably certain death or substantial bodily harm, then you may reveal that information. However, these are conclusions that the lawyer must reach on his or her own, not based upon assertions made by the agent alone. It would be prudent for the lawyer to meet with the client first in order to perform an independent assessment.

When you meet with the client, discuss the information given to you by the client's agent. Ascertain the client's ability to give ***informed consent*** to reveal confidential information. If the client cannot give informed consent, then you must consider if the disclosure of confidential information is in the client's best interests and reasonable under the circumstances[7] or necessary to "prevent reasonably certain death or substantial harm."[8]

Clearly, if the client does not have the capacity to give informed consent, but action is required by the client's agent under power of attorney, as long as the client expresses no objection to the agent's action and absent any information to the contrary, you may assist the agent to protect the client's interests. However, if the client disagrees, then there is a conflict of interest and you need to reconsider your ethical obligation to the client.

C. Conflict of Interest

Suppose some additional facts to the above scenario. Mrs. A shows clear deficits but at the same time, she has enough cognitive ability to express wishes contrary to what Bill has advised. Mrs. A professes her pleasure with Mary. Mrs. A likes that Mary lives with her. Mrs. A is shocked that Mary is accused or stealing. Fearful that Mary will leave her, Mrs. A does not want Bill to know anything that she has said about Mary and she does not want Bill to take any action. The question is whether you can represent Bill in this instance as agent for Mrs. A.

The more difficult problem is presented when you meet with the client and the client expresses intentions contrary to the agent. When the client's interests and the interests of the agent differ,[9] you cannot represent the agent. You must advise the agent that you are unable to take a position that is adverse to your client.[10]

D. Diminished Capacity

Contrary to the above, there are situations where the lawyer believes that the client is likely to suffer harm unless the lawyer takes some protective action. If there is a family member or agent that can remedy the situation, then the lawyer may speak to that person.[11] If the client is unable to protect himself or herself then it may fall upon the lawyer to take action.

Now assume the facts where neither the agent nor the other family members are acting in your client's best interests. If you choose to do nothing you may be abandoning a duty to the client. The Rules allow the lawyer to act in instances where the client suffers from diminished capacity. First, the lawyer must ***reasonably believe*** that the client has diminished capacity. Furthermore, the lawyer must ***reasonably believe*** that the client is at risk of substantial physical, financial or other harm unless action is taken.[12] Thus, the attorney cannot interfere if the attorney simply disagrees with the agent or family member. The consideration is whether or not the client may suffer substantial harm. This will be the extreme exception rather than the norm.

However, in situations where there is reason to believe that no one is protecting the client and they are likely to suffer harm, the lawyer may commence an action to have a guardian appointed.[13] In the context of a Guardianship matter, the Court will make findings of fact and order whatever relief is appropriate for the alleged incapacitated person. Nevertheless, even in that instance, the lawyer may reveal information about the client only to the "extent reasonably necessary to protect the client's interest."[14]

Thus, the Rules require the lawyer to consider what is **reasonable** or **customary** and to exercise the lawyer's best judgment in protecting confidentiality, even when the client has suffered diminished capacity. As the Preamble to the Rules state:

> The Rules of Professional Conduct are rules of reason. They should be inter-

preted with reference to the purposes of legal representation and of the law itself. Some of the Rules are imperatives, cast in the terms "shall" or "shall not." These Rules define proper conduct for purposes of professional discipline. Others, generally cast in the term "may," are permissive and define areas under the Rules in which the lawyer has discretion to exercise professional judgment.[15]

"The duty we owe to our clients is a heavy burden and as lawyers we must do our very best to protect the clients, their confidentiality and to avoid any and all conflicts of interests, even when they themselves no longer have the capacity to object."

The Rules are a guideline for the lawyer and they must be applied in light of the circumstances. The duty we owe to our clients is a heavy burden and as lawyers we must do our very best to protect the clients, their confidentiality and to avoid any and all conflicts of interests, even when they themselves no longer have the capacity to object.

Endnotes

1. New York Rules of Professional Conduct Part 1200 were promulgated as Joint Rules of the Appellate Divisions of the Supreme Court, effective April 1, 2009 (hereinafter "Rule" or Rules"). These Rules supersede the former Part 1200 Disciplinary Rules of the Code of Professional Responsibility (*available at* http://www.nysba.org/Content/NavigationMenu/ForAttorneys/ProfessionalStandardsforAttorneys/Professional_Standar.htm).
2. Preamble to the New York Part 1200—Rules of Professional Conduct.
3. Rule 1.0 (j).
4. Rule 1.6 (a)(3) definition: "Confidential Information" consists of information gained during or relating to the representation of a client, whatever its source, that is (a) protected by the attorney-client privilege, (b) likely to be embarrassing or detrimental to the client if disclosed, or (c) information that the client has requested be kept confidential. "Confidential information" does not ordinarily include (i) a lawyer's legal knowledge or legal research or (ii) information that is generally known in the local community or in the trade, field or profession to which the information relates.
5. New York Rules of Professional Conduct Rule 1.0 (q) terminology: "Reasonable" or "reasonably," when used in relation to conduct by a lawyer, denotes the conduct of a reasonably prudent and competent lawyer. When used in the context of conflict of interest determinations, "reasonable lawyer" denotes a lawyer acting from the perspective of a reasonably prudent and competent lawyer who is personally disinterested in commencing or continuing the representation.
6. Rule 1.6 (b)(1).
7. Rule 1.6 (a)(2).
8. Rule 1.6 (b)(1).
9. Rule 1.7 (a): Except as provided in paragraph (b), a lawyer shall not represent a client if a reasonable lawyer would conclude that either: (1) the representation will involve the lawyer in representing differing interests.
10. Rule 1.9 Duties to former Clients.
11. Rule 1.14 (b).
12. Rule 1.14 (b).
13. Rule 1.14 (b).
14. Rule 1.14 (c).
15. Preamble to the New York Rules of Professional Conduct [6].

Nancy Burner, Esq. is the Founding and Managing Partner of Burner, Smith & Associates. Practicing Elder Law and Estate Planning for 15 years, Nancy was recently re-appointed by the Court of Appeals for her fourth term as Trustee of the Lawyer's Fund for Client Protection.

State Bar aims to simplify New York's 'complex' power of attorney form

By Christina Couto and Lise Bang-Jensen

The New York power of attorney form is "too complex and prone to improper execution," according to a State Bar report that the House of Delegates (HOD) approved January 29.

"The current form is needlessly complex," said Ellen G. Makofsky of Garden City (Makofsky & Associates), chair of the Working Group on the Power of Attorney, who along with Working Group member David Goldfarb, presented the report to HOD attendees.

"I have clients whose modified power of attorney form is longer than the wills that I prepared for them," said Makofsky, who concentrates her practice on elder law.

There currently are no sanctions for third parties who unreasonably refuse to accept properly executed power of attorney (POA) forms.

"Unfortunately, the current form is problematic because banks and other financial institutions may refuse to honor a legitimate power of attorney form based upon technicalities in completing them," said President David P. Miranda of Albany (Heslin

Continued on page 6

Ellen Makofsky

NYSBA News March/April 2016.

State Bar report calls for 'too complex' Power of Attorney form to be simplified

Continued from page 1

Rothenberg Farley & Mesiti).

"The proposed changes will help clarify the intentions of individuals signing the power of attorney form," said Miranda.

The report, prepared by the Working Group on the Power of Attorney, proposes legislative changes to the existing New York power of attorney law, simplifying the forms and imposing monetary penalties on banks and other financial institutions that ignore them. Revisions in the 2008 and 2010 power-of-attorney statutes failed to meet the intended goal of strengthening protections for potentially incapacitated individuals, according to the report.

Work on the current report began after then-President Glenn Lau Kee of New York City (Kee and Lau-Kee) appointed a Working Group on Power of Attorney. It followed conflicting reports presented to the Executive Committee by the Elder Law and Special Needs Section and the Trusts and Estates Law Section at its April 2015 meeting.

The result was the report prepared by representatives of five Association sections—Elder Law and Special Needs, Trusts and Estates, Business Law, Real Property Law and Health Law—which includes three main proposals.

Findings, recommendations

First, the report addresses the issues that the POA form is too complex and prone to improper execution, urges the elimination of the "complicated" POA and statutory gifts rider (SGR) and that it revert back to "one, simpler form."

The current POA form is a multi-part document that consists of an initial POA form and a SGR. Both forms have different signing requirements and allowable modifications.

'Trap for the unwary'

Second, the requirement that the statutory POA contain the exact wording provided in the statute is "unduly burdensome and a trap for the unwary."

Current law requires that the POA form contain the exact wording provided by the statute. "The consequences to an attorney for an error in the exact wording can be dire," the report said. "As without compliance to the exact wording requirement, the power of attorney is not only no longer deemed a statutory form, but may also be deemed not valid."

In its place, the report recommends that the validity of a POA should be determined by a "substantial compliance" standard.

Sanctions for refusing POA

Third, the report indicates that "there are no sanctions for financial institutions or others who unreasonably refuse to accept a valid power of attorney."

The current remedy to compel them to accept a valid power of attorney is "to bring a burdensome and expensive special proceeding" in court. But even if a judge orders the financial institution to recognize a valid power of attorney, the judge cannot impose sanctions against the financial institution. The report calls the remedy "totally inadequate."

The state law was changed in 2008 and 2010 to require banks and other institutions to recognize legally valid power of attorney forms.

However, the report found, "many banks and financial institutions still mandate that their own forms be used because there are no sanctions for failing to honor a valid Statutory Power of Attorney."

The report urges that a court be allowed "to award damages, including reasonable attorney's fees and costs if the court finds that a third party acted unreasonably in refusing to honor the agent's authority under the Statutory Short Form Power of Attorney."

The report noted that similar remedies, such as damages and attorney fees, have been adopted in other states. "Banks and financial institutions profitably operate under these laws in those states. We see no reason why the same institutions cannot function under the same provisions in New York state."

The Power of Attorney Report and proposed amendments can be found at: www.nysba.org/POAreport. ◆

Bang-Jensen is NYSBA's director of media services and Couto is NYSBA's senior media writer.

POWER OF ATTORNEY
NEW YORK STATUTORY SHORT FORM

(a) CAUTION TO THE PRINCIPAL: Your Power of Attorney is an important document. As the "principal," you give the person whom you choose (your "agent") authority to spend your money and sell or dispose of your property during your lifetime without telling you. You do not lose your authority to act even though you have given your agent similar authority.

When your agent exercises this authority, he or she must act according to any instructions you have provided or, where there are no specific instructions, in your best interest. "Important Information for the Agent" at the end of this document describes your agent's responsibilities.

Your agent can act on your behalf only after signing the Power of Attorney before a notary public.

You can request information from your agent at any time. If you are revoking a prior Power of Attorney, you should provide written notice of the revocation to your prior agent(s) and to any third parties who may have acted upon it, including the financial institutions where your accounts are located.

You can revoke or terminate your Power of Attorney at any time for any reason as long as you are of sound mind. If you are no longer of sound mind, a court can remove an agent for acting improperly.

Your agent cannot make health care decisions for you. You may execute a "Health Care Proxy" to do this.

The law governing Powers of Attorney is contained in the New York General Obligations Law, Article 5, Title 15. This law is available at a law library, or online through the New York State Senate or Assembly websites, www.senate.state.ny.us or www.assembly.state.ny.us.

If there is anything about this document that you do not understand, you should ask a lawyer of your own choosing to explain it to you.

(b) DESIGNATION OF AGENT(S):

I, Phyllis [redacted]
(name of principal)

103 [redacted] Bethpage, NY 11714
(address of principal)

hereby appoint:

Jane D. [redacted]
(name of agent)

402 [redacted], St. James, NY 11780
(address of agent)

(*name of second agent*) (*address of second agent*)

as my agent(s).

If you designate more than one agent above, they must act together unless you initial the statement below.

( ) My agents may act SEPARATELY.

(c) DESIGNATION OF SUCCESSOR AGENT(S): (OPTIONAL)

If any agent designated above is unable or unwilling to serve, I appoint as my successor agent(s):

William P. [redacted] [redacted], Holbrook, NY 11741
(*name of successor agent*) (*address of successor agent*)

(*name of second successor agent*), (*address of second successor agent*)

Successor agents designated above must act together unless you initial the statement below.

( ) My successor agents may act SEPARATELY.

You may provide for specific succession rules in this section. Insert specific succession provisions here:

(d) This POWER OF ATTORNEY shall not be affected by my subsequent incapacity unless I have stated otherwise below, under "Modifications."

(e) This POWER OF ATTORNEY DOES NOT REVOKE any Powers of Attorney previously executed by me unless I have stated otherwise below, under "Modifications."

If you do NOT intend to revoke your prior Powers of Attorney, and if you have granted the same authority in this Power of Attorney as you granted to another agent in a prior Power of Attorney, each agent can act separately unless you indicate under "Modifications" that the agents with the same authority are to act together.

(f) **GRANT OF AUTHORITY:**

To grant your agent some or all of the authority below, either

(1) Initial the bracket at each authority you grant, or

(2) Write or type the letters for each authority you grant on the blank line at (P), and initial the bracket at (P). If you initial (P), you do not need to initial the other lines.

I grant authority to my agent(s) with respect to the following subjects as defined in sections 5-1502A through 5-1502N of the New York General Obligations Law:

(____) (A) real estate transactions;

(____) (B) chattel and goods transactions;

(____) (C) bond, share, and commodity transactions;

(____) (D) banking transactions;

(____) (E) business operating transactions;

(____) (F) insurance transactions;

(____) (G) estate transactions;

(____) (H) claims and litigation;

(____) (I) personal and family maintenance: If you grant your agent this authority, it will allow the agent to make gifts that you customarily have made to individuals, including the agent, and charitable organizations. The total amount of all such gifts in any one calendar year cannot exceed five hundred dollars;

(____) (J) benefits from governmental programs or civil or military service;

(____) (K) health care billing and payment matters; records, reports, and statements;

(____) (L) retirement benefit transactions;

(____) (M) tax matters;

(____) (N) all other matters;

(____) (O) full and unqualified authority to my agent(s) to delegate any or all of the foregoing powers to any person or persons whom my agent(s) select;

(PS) (P) EACH of the matters identified by the following letters:
A, B, C, D, E, F, G, H, I, J, K, L, M, N, and O.

You need not initial the other lines if you initial line (P).

(g) **MODIFICATIONS:** (OPTIONAL)

In this section, you may make additional provisions, including language to limit or supplement authority granted to your agent. However, you cannot use this Modifications section to grant your agent authority to make gifts or changes to interests in your property. If you wish to grant your agent such authority, you MUST complete the Statutory Gifts Rider.

(_____) (Q) Authority to engage in real estate transactions, including transactions with respect to all fixtures and articles of personalty therein;

(_____) (R) Authority to Enter into Personal Service Contract(s): I authorize my attorney(s)-in-fact to enter into a personal service contract(s) or caregiver agreement(s) on my behalf with third parties, including my attorney(s)-in-fact;

(_____) (S) Authority to Accept Gifts, Transfers, and Distributions: I authorize my attorney(s)-in-fact to accept gifts on my behalf and to accept transfers and distributions from any Trustee of any Trust on my behalf.

(_____) (T) Authority to Purchase a Life Estate on Real Property: I authorize my attorney(s)-in-fact to purchase a life estate on my behalf on real property, including the home of the attorney(s)-in-fact;

(_____) (U) Authority to Make Loans: I authorize my attorney(s)-in-fact to make a loan(s) on my behalf to third parties, including my attorney(s)-in-fact, and to accept a promissory note(s) as security for said loan(s) at a interest rate no less than the minimum Applicable Federal Rate;

(_____) (V) Authority To Purchase Exempt Resources: I authorize my attorney(s)-in-fact to purchase any type of property that is considered to be an exempt resource under New York's Social Services Law, or any equivalent law in another jurisdiction;

(_____) (W) Authority To Access and Disclose Medical Information: I authorize my agent(s) to request, receive, and review any information regarding my physical or mental health, including without limitation, medical and hospital records; to execute on my behalf any releases or other documents that may be required in order to obtain this information; and to consent to the disclosure of this information. My agent(s) shall have the power and authority to serve as my personal representative for all purposes of the Health Insurance Portability and Accountability Act and its regulations; I authorize my agent to request, receive and review any confidential information

regarding my personal affairs and/or my physical or mental health and to provide such information to any person and/or entity designated by my agent;

(_____) (X) Authority To Access Safe Deposit Box: I authorize my attorney(s)-in-fact to have access to any and all safe deposit boxes in my name and to open, inspect, inventory, place items in, or close said safe deposit box or boxes. In the event that the key to my safe deposit box cannot be located, I authorized my attorney-in-fact to drill it open;

(_____) (Y) Authority As To Retirement Benefits: I authorize my attorney(s)-in-fact to make all necessary decisions and elections, of whatsoever kind and nature, regarding my Social Security benefits and any annuity, pension or other retirement plan(s) or fund(s), or similar type of plans, that I may possess, including, but not limited to, lump-sum payouts, installment payouts, roll-overs or contributions;

(_____) (Z) Authority To Borrow: I authorize my attorney(s)-in-fact to borrow funds on my behalf for any reason;

(_____) (AA) Intent To Return Home: In the event that I am a patient in a nursing facility or health care facility of any type, kind or nature, it is and shall continue to be my wish and intent to return home, and as such, I authorize my attorney(s)-in-fact, orally or in a writing, to express my intent to return home to my personal residence;

(_____) (BB) Authority As To Insurance: I authorize my attorney(s)-in-fact to deal with any and all insurance policies I may own or may be qualified to purchase, including but not limited to the following types: life, medical, disability, long term health care for home care and/or nursing home care, homeowners and vehicle. Such power shall include but shall not be limited to the purchase and/or cancellation of any such policy or the liquidation of such policy;

(_____) (CC) Authority As Government Benefits: I authorize my attorney(s)-in-fact to qualify me and apply for any and all government entitlements that I may be eligible for, including, but not limited to, Medicare, Medicaid and SSI. This authority shall also include the power to litigate or settle any matter pertaining to any entitlements;

(_____) (DD) Authority To Employ: I authorize my attorney(s)-in-fact to retain and compensate attorneys, accountants, investment counsel and similar professionals, concerning my property and personal affairs;

(_____) (EE) Authority To Waive Attorney-Client Privilege: I authorize my attorney(s)-in-fact to waive attorney-client and other similar privileges to facilitate consultations between the attorney(s)-in-fact herein appointed and my attorney and other advisors;

(_____) (FF) Authority as To Domicile: I authorize my attorney(s)-in-fact to change my domicile to another state or within the state;

(_____) (GG) Authority to Enter into Trust Agreement(s): I authorize my attorney(s)-in-fact to enter into trust agreement(s), including but not limited to pooled income trusts;

(_____) (HH) Authority to Purchase an Annuity: I authorize my attorney(s)-in-fact to purchase and/or enter into an annuity contract with third parties, including my attorney(s)-in-fact;

(_____) (II) Authority to Purchase United States Savings Bonds: I authorize my attorney(s)-in-fact to purchase or surrender United States Savings Bonds, including, but not limited to, Series I and Series EE Bonds;

(_____) (JJ) Authority to make inquiry into my employment benefits, from current and/or prior employment, including but not limited to any and all personnel records and human resource records;

(_____) (KK) Authority to have access to and control of electronic, internet, and all personal online and internet information. To have full access to my emails, email accounts, library accounts, financial, stock and banking account passwords, websites, blogs and full power and authority to receive passwords and cancel any accounts that I have. My Agent shall have full power and authority to deal with any accounts, websites, or blogs that I have with Facebook, Pay Pal, Google, Yahoo, Twitter, LinkedIn, Amazon.com, Ebay, Kindle or other similar service/company in the same manner that I could (and to receive a refund of any monies due me).

(_____) (LL) Authority to deal with any telephone, internet and cable companies that I have service with, and to cancel or modify any service agreement that I have with such companies.

(_____) (MM) The acceptance of appointment as agent under this Power of Attorney hereby constitutes a consent to the release for medical information for purposes of the Health Insurance Portability and Accountability Act (HIPAA) to the named successor agent.

(P S) (NN) each of the above matters identified by the following letters: (Q), (R), (S), (T), (U), (V), (W), (X), (Y), (Z), (AA), (BB), (CC), (DD), (EE), (FF), (GG), (HH), (II), (JJ), (KK), (LL) and (MM).

(h) CERTAIN GIFT TRANSACTIONS: STATUTORY GIFTS RIDER (OPTIONAL)

In order to authorize your agent to make gifts in excess of an annual total of $500 for all gifts described in (I) of the grant of authority section of this document (under personal and family maintenance), you must initial the statement below and execute a Statutory Gifts Rider at the same time as this instrument. Initialing the statement below by itself does not authorize your agent to make gifts. The preparation of the Statutory Gifts Rider should be supervised by a lawyer.

(PS) (SGR) I grant my agent authority to make gifts in accordance with the terms and conditions of the Statutory Gifts Rider that supplements this Statutory Power of Attorney.

(i) DESIGNATION OF MONITOR(S): (OPTIONAL)

If you wish to appoint monitor(s), initial and fill in the section below:

( ) I wish to designate _____, whose address(es) is (are) _____, as monitor(s). Upon the request of the monitor(s), my agent(s) must provide the monitor(s) with a copy of the power of attorney and a record of all transactions done or made on my behalf. Third parties holding records of such transactions shall provide the records to the monitor(s) upon request.

(j) COMPENSATION OF AGENT(S): (OPTIONAL)

Your agent is entitled to be reimbursed from your assets for reasonable expenses incurred on your behalf. If you ALSO wish your agent(s) to be compensated from your assets for services rendered on your behalf, initial the statement below. If you wish to define "reasonable compensation", you may do so above, under "Modifications".

( ) My agent(s) shall be entitled to reasonable compensation for services rendered.

(k) ACCEPTANCE BY THIRD PARTIES:

I agree to indemnify the third party for any claims that may arise against the third party because of reliance on this Power of Attorney. I understand that any termination of this Power of Attorney, whether the result of my revocation of the Power of Attorney or otherwise, is not effective as to a third party until the third party has actual notice or knowledge of the termination.

(l) TERMINATION:

This Power of Attorney continues until I revoke it or it is terminated by my death or other event described in section 5-1511 of the General Obligations Law.

Section 5-1511 of the General Obligations Law describes the manner in which you may revoke your Power of Attorney, and the events which terminate the Power of Attorney.

(m) SIGNATURE AND ACKNOWLEDGMENT:

In Witness Whereof I have hereunto signed my name on the 25th day of January, 2017

PRINCIPAL signs here: ====> _____
Phyllis [redacted]

STATE OF NEW YORK)
) ss.:
COUNTY OF SUFFOLK)

On the 25th day of January, in the year 2017, before me, the undersigned, personally appeared Phyllis [redacted], personally known to me or proved to me on the basis of satisfactory evidence to be the person whose name is subscribed to the within instrument and acknowledged to me that she executed the same in her capacity, and that by her signature on the instrument, the individual, or the person upon behalf of which the individual acted, executed the instrument.

_____
Notary Public

GEORGE L. ROACH
Notary Public, State of New York
No. 02RO4657060
Qualified in Suffolk County
Commission Expires Nov. 30, 20[illegible]

(n) IMPORTANT INFORMATION FOR THE AGENT:

When you accept the authority granted under this Power of Attorney, a special legal relationship is created between you and the principal. This relationship imposes on you legal responsibilities that continue until you resign or the Power of Attorney is terminated or revoked. You must:

(1) act according to any instructions from the principal, or, where there are no instructions, in the principal's best interest;

(2) avoid conflicts that would impair your ability to act in the principal's best interest;

(3) keep the principal's property separate and distinct from any assets you own or control, unless otherwise permitted by law;

(4) keep a record or all receipts, payments, and transactions conducted for the principal; and

(5) disclose your identity as an agent whenever you act for the principal by writing or printing the principal's name and signing your own name as "agent" in either of the following manners: (Principal's Name) by (Your Signature) as Agent, or (your signature) as Agent for (Principal's Name).

You may not use the principal's assets to benefit yourself or anyone else or make gifts to yourself or anyone else unless the principal has specifically granted you that authority in this document, which is either a Statutory Gifts Rider attached to a Statutory Short Form Power of Attorney or a Non-Statutory Power of Attorney. If you have that authority, you must act according to any instructions of the principal or, where there are no such instructions, in the principal's best interest.

You may resign by giving written notice to the principal and to any co-agent, successor agent, monitor if one has been named in this document, or the principal's guardian if one has been appointed. If there is anything about this document or your responsibilities that you do not understand, you should seek legal advice.

Liability of agent: The meaning of the authority given to you is defined in New York's General Obligations Law, Article 5, Title 15. If it is found that you have violated the law or acted outside the authority granted to you in the Power of Attorney, you may be liable under the law for your violation.

(o) AGENT'S SIGNATURE AND ACKNOWLEDGMENT OF APPOINTMENT:

It is not required that the principal and the agent(s) sign at the same time, nor that multiple agents sign at the same time.

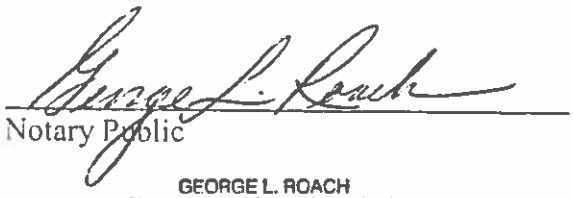
I, Jane D. [redacted], have read the foregoing Power of Attorney. I am the person(s) identified therein as agent(s) for the principal named therein.

I acknowledge my legal responsibilities.

Agent(s) sign(s) here: ==> 

STATE OF NEW YORK)
) ss.:
COUNTY OF SUFFOLK)

On the 25th day of JANUARY, in the year 2017, before me, the undersigned, personally appeared Jane D. [redacted] personally known to me or proved to me on the basis of satisfactory evidence to be the person whose name is subscribed to the within instrument and acknowledged to me that she executed the same in her capacity, and that by her signature on the instrument, the individual, or the person upon behalf of which the individual acted, executed the instrument.



Notary Public

GEORGE L. ROACH
Notary Public, State of New York
No. 02RO4657060
Qualified in Suffolk County
Commission Expires Nov. 30, 2017

(p) SUCCESSOR AGENT'S SIGNATURE AND ACKNOWLEDGMENT OF APPOINTMENT:

It is not required that the principal and the SUCCESSOR agent(s), if any, sign at the same time, nor that multiple SUCCESSOR agents sign at the same time. Furthermore, successor agents cannot use this power of attorney unless the agent(s) designated above is/are unable or unwilling to serve.

I, William P. [redacted], have read the foregoing Power of Attorney. I am the person(s) identified therein as SUCCESSOR agent(s) for the principal named therein.

Successor Agent(s) sign(s) here: ==> _____

STATE OF NEW YORK)
) ss.:
COUNTY OF SUFFOLK)

On the _____ day of _____, in the year 20____, before me, the undersigned, personally appeared William P. [redacted] personally known to me or proved to me on the basis of satisfactory evidence to be the individual whose name is subscribed to the within instrument and acknowledged to me that he executed the same in his capacity, and that by his signature on the instrument, the individual, or the person upon behalf of which the individual acted, executed the instrument.

_____
Notary Public

POWER OF ATTORNEY
NEW YORK STATUTORY GIFTS RIDER
AUTHORIZATION FOR CERTAIN GIFT TRANSACTIONS

CAUTION TO THE PRINCIPAL: This OPTIONAL rider allows you to authorize your agent to make gifts in excess of an annual total of $500 for all gifts described in (I) of the Grant of Authority section of the statutory short form Power of Attorney (under personal and family maintenance), or certain other gift transactions during your lifetime. You do not have to execute this rider if you only want your agent to make gifts described in (I) of the Grant of Authority section of the statutory short form Power of Attorney and you initialed "(I)" on that section of that form. Granting any of the following authority to your agent gives your agent the authority to take actions which could significantly reduce your property or change how your property is distributed at your death. "Certain gift transactions" are described in section 5-1514 of the General Obligations Law. This Gifts Rider does not require your agent to exercise granted authority, but when he or she exercises this authority, he or she must act according to any instructions you provide, or otherwise in your best interest.

This Gifts Rider and the Power of Attorney it supplements must be read together as a single instrument.

Before signing this document authorizing your agent to make gifts, you should seek legal advice to ensure that your intentions are clearly and properly expressed.

(a) GRANT OF LIMITED AUTHORITY TO MAKE GIFTS

Granting gifting authority to your agent gives your agent the authority to take actions which could significantly reduce your property.

If you wish to allow your agent to make gifts to himself or herself, you must separately grant that authority in subdivision (c) below.

To grant your agent the gifting authority provided below, initial the bracket to the left of the authority.

(P.S.) I grant authority to my agent to make gifts to my spouse, children and more remote descendants, and parents, not to exceed, for each donee, the annual federal gift tax exclusion amount pursuant to the Internal Revenue Code. For gifts to my children and more remote descendants, and parents, the maximum amount of the gift to each donee shall not exceed twice the gift tax exclusion amount, if my spouse agrees to split gift treatment pursuant to the Internal Revenue Code. This authority must be exercised pursuant to my instructions, or otherwise for purposes which the agent reasonably deems to be in my best interest.

(b) MODIFICATIONS:

Use this section if you wish to authorize gifts in amounts smaller than the gift tax exclusion amount, in amounts in excess of the gift tax exclusion amount, gifts to other beneficiaries, or other gift transactions. Granting such authority to your agent gives your agent

the authority to take actions which could significantly reduce your property and/or change how your property is distributed at your death. If you wish to authorize your agent to make gifts to himself or herself, you must separately grant that authority in subdivision (c) below.

(P.S.) I grant the following authority to my agent to make gifts pursuant to my instructions, or otherwise for purposes which the agent reasonably deems to be in my best interest: All authority as specified in numbered items 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13 and 14 below:

1. Authority To Make Gifts: I authorize my attorney(s)-in-fact to make gifts on my behalf of any amount (outright or in trust) including gifts of real and/or personal property that I may own to my spouse and/or lineal descendants and their spouses for the purpose of Medicaid eligibility now or in the future and/or estate planning and/or any other prudent purpose;

2. Authority to Create, Revoke, Modify and Fund Trusts: I authorize my attorney(s)-in-fact to create, revoke, fund with my assets and/or income and modify existing trusts on my behalf, including, but not limited to an Irrevocable Trust and/or Revocable Living Trust, and/or to act as Trustee, and/or to exercise a Limited Power of Appointment;

3. Authority To Engage in Estate and/or Medicaid Planning: I authorize my attorney(s)-in-fact to engage in estate and/or Medicaid planning on my behalf, including, but not limited to, making gifts, whether outright or in trust, of any or all of my cash, real or personal property or interests in property, including any right to receive income from any source; and to make gifts to individuals and/or organizations, whether charitable or otherwise, and/or to satisfy pledges I previously made; and to purchase and/or enter into an annuity contract with third parties, that is in compliance with the Deficit Reduction Act of 2005; and to use any other devices I would use if I had capacity, for the purpose of providing for my spouse and/or other members of my family or their spouses, and/or reduce tax liability and preserve assets for use by my spouse or other family members in the event I require long term health care.

4. Authority To Continue Making Gifts/Split Gifts: In addition to the gift giving authority granted to my attorney(s)-in-fact granted herein, I authorize my attorney(s)-in-fact to continue making gifts of my property to carry out my lifetime giving patterns, or to begin such a pattern if deemed prudent. Furthermore, I authorize my attorney(s)-in-fact to elect, in his or her discretion, a "split gift" with my spouse, if I am married, pursuant to section 2513 of the Internal Revenue Code, its successors, or its state law equivalent. I hereby give my consent to any such election and authorize my agent to sign, on my behalf, an affidavit or other proof necessary to effectuate such election;

5. Authority To Make Statutory Elections: I authorize my attorney(s)-in-fact to execute all statutory elections and disclaimers of whatsoever kind or nature, including, but not limited to, qualified disclaimers to effect tax savings, disclaimers to defeat the interests of any and all creditors, and disclaimers to pass properties to successors;

6. Authority To Purchase Life Insurance: I authorize my attorney(s)-in-fact to purchase and/or amend life insurance policy(ies) including, but not limited to changing beneficiary(ies) or ownership thereof;

7. Authority As To Debts: I authorize my attorney(s) in fact to forgive and collect debts;

8. Authority As To Insurance: I authorize my attorney(s)-in-fact to deal with any and all insurance policies I may own or may be qualified to purchase, including but not limited to

the following types: life, medical, disability, long term health care for home care and/or nursing home care, homeowners and vehicle. Such power shall include but shall not be limited to the purchase and/or cancellation of any such policy or the liquidation of such policy; and the change of ownership or beneficiary designations of any such policy;

9. Authority As To Safe Deposit Box(s): I authorize my attorney(s)-in-fact to remove the contents of any and all safety deposit boxes in my name, and distribute the contents thereof to my spouse and/or lineal descendants and their spouses, and/or to beneficiaries set forth in my Last Will and Testament;

10. Any gift of my property may be transferred in cash or in kind, and may pass outright to the recipient or may be transferred to a custodian under the Uniform Transfer to Minors Act which may be established by my agent(s);

11. Best Interest: In making gifts of my property, my "best interest" shall include gifts which would be likely to cause a reduction in estate or gift tax due or which would carry out a plan for the protection of my assets against the costs of potential future nursing home care and other future health care needs;

12. Authority to Purchase an Annuity: I authorize my attorney(s)-in-fact to purchase and/or enter into an annuity contract with third parties, including my attorney(s)-in-fact;

13. Authority For Banking Transactions: I authorize my attorney(s)-in-fact to establish, withdraw funds from, liquidate and/or transfer any and all stocks, bonds and/or accounts with any financial institution including but not limited to banks, brokerage firms and/or insurance companies; and to name and/or change any owner and/or co-owner and/or beneficiary and/or any Transfer on Death beneficiary designation to or for the benefit of my spouse, and any of my lineal decedents and/or their spouses;

14. Authority As To Retirement Benefits: I authorize my attorney(s)-in-fact to make all necessary decisions and elections, of whatsoever kind and nature, regarding my Social Security benefits and any annuity, pension or other retirement plan(s) or fund(s), or similar type of plans, that I may possess, including, but not limited to, lump-sum payouts, installment payouts, roll-overs, contributions, change of ownership, beneficiary designations or waiving non-employee spousal rights.

(c) GRANT OF SPECIFIC AUTHORITY FOR AN AGENT TO MAKE GIFTS TO HIMSELF OR HERSELF: (OPTIONAL)

If you wish to authorize your agent to make gifts to himself or herself, you must grant that authority in this section, indicating to which agent(s) the authorization is granted, and any limitations and guidelines.

(P. S.) I grant specific authority for the following agent(s) to make the following gifts to himself or herself: Jane D. [redacted] and William P. [redacted] shall have all authority as specified in numbered items 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13 and 14 below.

This authority must be exercised pursuant to my instructions, or otherwise for purposes which the agent reasonably deems to be in my best interest.

1. Authority To Make Gifts: I authorize my attorney(s)-in-fact to make gifts on my behalf of any amount (outright or in trust) including gifts of real and/or personal property that I may own to my attorney(s)-in-fact for the purpose of Medicaid eligibility now or in the future and/or estate planning and/or any other prudent purpose;

2. Authority to Create, Revoke, Modify and Fund Trusts: I authorize my attorney(s)-in-fact to create, revoke, fund with my assets and/or income and modify existing trusts on my behalf, including, but not limited to an Irrevocable Trust and/or Revocable Living Trust and/or to act as Trustee, and/or to exercise a Limited Power of Appointment in which my attorney-in-fact is a beneficiary and/or Trustee and/or Grantor;

3. Authority To Engage in Estate and/or Medicaid Planning: I authorize my attorney(s)-in-fact to engage in estate and/or Medicaid planning on my behalf, including, but not limited to, making gifts, whether outright or in trust, of any or all of my cash, real or personal property or interests in property, including any right to receive income from any source; and to make gifts to individuals and/or organizations, whether charitable or otherwise, and/or to satisfy pledges I previously made; and to purchase and/or enter into an annuity contract with third parties, including my attorney(s)-in-fact, that is in compliance with the Deficit Reduction Act of 2005; and to use any other devices I would use if I had capacity, for the purpose of providing for my attorney-in-fact, and/or reduce tax liability and preserve assets for use by my spouse or other family members in the event I require long term health care;

4. Authority To Continue Making Gifts/Split Gifts: In addition to the gift giving authority granted to my attorney(s)-in-fact granted herein, I authorize my attorney(s)-in-fact to continue making gifts of my property to carry out my lifetime giving patterns, or to begin such a pattern if deemed prudent, including making gifts to himself. Furthermore, I authorize my attorney(s)-in-fact to elect, in his or her discretion, a "split gift" with my spouse, if I am married, pursuant to section 2513 of the Internal Revenue Code, its successors, or its state law equivalent. I hereby give my consent to any such election and authorize my agent to sign, on my behalf, an affidavit or other proof necessary to effectuate such election;

5. Authority To Make Statutory Elections: I authorize my attorney(s)-in-fact to execute all statutory elections and disclaimers of whatsoever kind or nature, including, but not limited to, qualified disclaimers to effect tax savings, disclaimers to defeat the interests of any and all creditors, and disclaimers to pass properties to successors, even if my attorney-in-fact is such a successor or stands to benefit himself or herself when executing such statutory election or disclaimer;

6. Authority To Purchase Life Insurance: I authorize my attorney(s)-in-fact to purchase and/or amend life insurance policy(ies) including, but not limited to changing beneficiary(ies) or ownership to himself or herself, thereof;

7. Authority As To Debts: I authorize my attorney(s) in fact to forgive and collect debts, including forgiving any debt owed to my attorney-in-fact;

8. Authority As To Insurance: I authorize my attorney(s)-in-fact to deal with any and all insurance policies I may own or may be qualified to purchase, including but not limited to the following types: life, medical, disability, long term health care for home care and/or nursing home care, homeowners and vehicle. Such power shall include but shall not be limited to the purchase and/or cancellation of any such policy or the liquidation of such policy; and the change of ownership or beneficiary designations of any such policy, including the authority to change the ownership of such policy and/or the beneficiary of any such policy to my attorney(s)-in-fact;

9. Authority As To Safe Deposit Box(s): I authorize my attorney(s)-in-fact to remove the contents of any and all safety deposit boxes in my name, and distribute the contents thereof to my spouse and/or lineal descendants and their spouses, and/or to beneficiaries set forth in my Last Will and Testament;

10. Any gift of my property may be transferred in cash or in kind, and may pass outright to the recipient or may be transferred to a custodian under the Uniform Transfer to Minors Act which may be established by my agent(s), and/or to my attorney-in-fact;

11. In making gifts of my property, my "best interest" shall include gifts which would be likely to cause a reduction in estate or gift tax due or which would carry out a plan for the protection of my assets against the costs of potential future nursing home care and other future health care needs; in the foreseeable future, and any such gifts may be made to my attorney(s)-in-fact in any amount;

12. Authority to Purchase an Annuity: I authorize my attorney(s)-in-fact to purchase and/or enter into an annuity contract with third parties, including my attorney(s)-in-fact;

13. Authority For Banking Transactions: I authorize my attorney(s)-in-fact to establish, withdraw funds from, liquidate and/or transfer any and all stocks, bonds and/or accounts with any financial institution including but not limited to banks, brokerage firms and/or insurance companies; and to name and/or change any owner and/or co-owner and/or beneficiary and/or any Transfer on Death beneficiary designation to or for the benefit of any of my attorney(s)-in-fact;

14. Authority As To Retirement Benefits: I authorize my attorney(s)-in-fact to make all necessary decisions and elections, of whatsoever kind and nature, regarding my Social Security benefits and any annuity, pension or other retirement plan(s) or fund(s), or similar type of plans, that I may possess, including, but not limited to, lump-sum payouts, installment payouts, roll-overs, contributions, change of ownership, beneficiary designations or waiving non-employee spousal rights (even if such action benefits my agent).

(d) ACCEPTANCE BY THIRD PARTIES:

I agree to indemnify the third party for any claims that may arise against the third party because of reliance on this Statutory Gifts Rider.

(e) SIGNATURE OF PRINCIPAL AND ACKNOWLEDGMENT:

In Witness Whereof I have hereunto signed my name on the 25th day of January, 2017

PRINCIPAL signs here: ====> Phyllis [redacted]

Phyllis [redacted]

STATE OF NEW YORK)
) ss.:
COUNTY OF SUFFOLK)

On the 25th day of January, in the year 2017, before me, the undersigned, personally appeared Phyllis [redacted] personally known to me or proved to me on the basis of satisfactory evidence to be the person whose name is subscribed to the within instrument and acknowledged to me that she executed the same in her capacity, and that by her signature on the instrument, the individual, or the person upon behalf of which the individual acted, executed the instrument.

George L. Roach
Notary Public

GEORGE L. ROACH
Notary Public, State of New York
No. 02RO4657060
Qualified in Suffolk County
Commission Expires Nov. 30, 2017

(f) **SIGNATURES OF WITNESSES:**

By signing as a witness, I acknowledge that the principal signed the Statutory Gifts Rider in my presence and the presence of the other witness, or that the principal acknowledged to me that the principal's signature was affixed by him or her or at his or her direction. I also acknowledge that the principal has stated that this Statutory Gifts Rider reflects his or her wishes and that he or she has signed it voluntarily. I am not named herein as a permissible recipient of gifts.

George L. Roach
Signature of witness 1

1-25-14
Date

GEORGE L. ROACH
Print Name

162 Terry Rd.
Address

Smithtown, NY 11787
City, State, Zip code

[redacted]
Signature of witness 2

11/25/2017
Date

JAMIE [redacted]
Print Name

[redacted]
Address

St. James N.Y. 11780
City, State, Zip code

(g) This document prepared by: Jeanette Grabie, Esq.
Attorney at Law
Grabie & Grabie, LLP
162 Terry Road
Smithtown, NY 11787
631-360-5600

THE VILLAGE BEACON RECORD

MOLST can ensure end-of-life wishes are followed

MOLST does not replace health care proxies and living wills, but supplements them

Last month New York State Governor David A. Paterson signed into law a bill that helps to ensure that a person's end-of-life wishes are followed whether the person is at home, in a hospital, in a nursing home or in any other setting.

The new law makes permanent and statewide a program piloted in Monroe and Onondaga counties called Medical Orders for Life Sustaining Treatment. MOLST contains medical orders, signed by a patient's physician, that document what kind of care the patient wants at the end of life.

The MOLST form is kept with the patient at all times so that whenever the patient moves — from home to hospital and vice versa, from hospital to hospital, changes rooms within a hospital, etc. — the instructions move with the patient. Patients fill out the MOLST form after discussing alternative treatments with their physician. The form is bright pink so that it is easily recognizable by paramedics and others — and difficult to lose. It is honored by all sites of care in the state.

Amongst the wishes indicated, the MOLST form says whether the patient wants to be resuscitated or intubated, kept home or sent to the hospital, given medications or not and which medications if any. MOLST is based on a national model that has been shown to assure that seriously ill patients' wishes are followed. New York is one of six states with a state-approved program.

Before MOLST, the only non-hospital medical order emergency medical service workers could directly follow was a do-not-resuscitate order, which said whether the patient wanted lifesaving treatment for a cardiac or respiratory arrest.

"Having MOLST available on a statewide basis is a major step for both patients and their families," said Michael Rosenberg MD, president of the Medical Society of the State of New York. "For the first time all New Yorkers will have the comfort of knowing that the wishes of those who are terminally ill can be clearly articulated and that health care providers will have real guidance as to what the patient's wishes are at the end of life."

Those who think that a MOLST would be appropriate for them or a loved one should ask their doctor to obtain and fill out the pink MOLST form. Additional information about MOLST and end-of-life care can be obtained online by a website developed by Excellus at www.compassionandsupport.org.

MOLST does not replace health care proxies/living wills

The MOLST form is only for seriously ill patients and does not replace or serve the same function as a health care proxy and/or living will, which are documents that all adults should have, regardless of whether they are healthy or ill. The differences are as follows:

A health care proxy designates an "agent" to make health care decisions on behalf of someone who is unable to make those decisions because of a physical or mental condition. All healthy adults should have a health care proxy in case they are suddenly incapacitated and unable to think clearly and/or express their wishes. Patients who sign a MOLST form know they are dying and are able to decide how they want to spend their remaining time.

Health care proxy statements assign health care decisions to a living person who can decide what type of care the patient should receive, based on the particular circumstances, if the patient becomes incapacitated. The proxy statement also states whether a patient wants to receive nutrition and liquids. Ideally, the patient discussed various care alternatives with the proxy before becoming incapacitated. Although the authority of a proxy ends with the patient's death, the health care proxy statement can also indicate the patient's preference for organ donation. To be valid, a health care proxy must have the signature of two live witnesses, but a lawyer does not have to be involved.

For more information about health care proxies in New York State and to obtain a downloadable sample form, go to the NYS Department of Health's Health Care Proxy web section at www.nyhealth.gov/professionals/patients/health_care_proxy/intro.htm

The MSSNY advises all adults, healthy or ill, to at least have a health care proxy. MSSNY recommends all New Yorkers near the end of life to also have a MOLST. For some, it is advisable to have all three.

A living will is a static document that specifies what type of treatment a person would like to receive if the person develops a terminal, irreversible condition that prevents the person from communicating these wishes. A living will is not recognized as a legally binding document in New York State, but it does provide the "clear and convincing evidence" needed to have a person's wishes carried out. A lawyer must be involved in the preparation of a living will.

Although there is no specific form for a living will, information about living wills can be obtained from the NY

Continued on page B6

Continued from page B5

Bar Association's website at www.nysba.org/Content/NavigationMenu/PublicResources/LivingWillHealthCareProxyForms/Living_Will_and_Heal.htm.

Who should have which form

An objective comparison of the advantages and disadvantages of a health care proxy and a living will is available on the NYS Attorney General's website at www.seniorlaw.com/livwill-hcp.htm. The NYS-DOH web section on Planning Health Care in Advance also explains and compares the differences at www.health.state.ny.us/nysdoh/hospital/patient_rights/en/planning.htm.

Because each serves a different function and satis es different needs, it is legally acceptable to have all three documents. The MSSNY advises all adults, healthy or ill, to at least have a health care proxy. MSSNY recommends all New Yorkers near the end of life to also have a MOLST. For some, it is advisable to have all three.

This information is provided by the Medical Society of the State of New York. For more health-related information and referrals to physicians in your community, contact your local county medical society at 851-1400 (phone), 851-1212 (fax) or stuscms@aol.com (email).

SEND FORM WITH PATIENT/RESIDENT WHENEVER TRANSFERRED OR DISCHARGED

MOLST

Medical Orders for Life-Sustaining Treatment

Do-Not-Resuscitate (DNR) and other Life-Sustaining Treatments (LST)

This is a Physician's Order Sheet based on this patient/resident's current medical condition and wishes. It summarizes any Advance Directive. If Section A is not completed, there are no restrictions for this section. When the need occurs, *first follow* these orders, then contact physician. Review the entire form with the patient. Any section not completed implies full treatment for that section. ***WARNING**: If patient lacks medical decision-making capacity as a result of mental retardation or developmental disability or has a legal guardian, specific, mandatory procedures need to be followed. Review information and seek legal counsel.*

Last Name/First/Middle Initial of Patient/Resident
Address
City/State/Zip
Patient/Resident Date of Birth (mm/dd/yyyy)
Gender ☐ M ☐ F
Unique Patient Identifier (Last 4 SSN)

This form should be reviewed and renewed periodically, as required by New York State and Federal law or regulations, and/or if:

- The patient/resident is transferred from one care setting or care level to another, or
- There is a substantial change in patient/resident health status (improvement or deterioration), or
- The patient/resident treatment preferences change

Section A

Check One Box Only

RESUSCITATION INSTRUCTIONS (ONLY for Patients in Cardiopulmonary Arrest):

(If patient/resident has no blood pressure, no pulse and no respiration) This form can be used in all settings, including community.

☐ **Do Not Resuscitate (DNR)*/Allow Natural Death** *[DNR = No CPR, endotracheal intubation or mechanical ventilation]

☐ **Full Cardio-Pulmonary Resuscitation (CPR)** [No Limitations; accepts intubation and mechanical ventilation]

* For incapacitated adults; and/or for therapeutic or medical futility exceptions; and/or for residents of OMH, OMRDD or correctional facilities, also complete relevant sections of Supplemental DNR Documentation Form for Adults. For residents of OMRDD without capacity in the community, also complete NYSDOH Nonhospital DNR form. For minor patients, also complete Supplemental DNR Documentation Form for Minors.

Section B

Patient/ Resident/ Health Care Agent or Surrogate Decision-Maker Consent for Section A

Complete one of the subsections of Section B

DNR (CPR) CONSENT OF PATIENT/RESIDENT WITH DECISION-MAKING CAPACITY:

Section A reflects my treatment preferences.

Patient/Resident Signature ☐ Check if verbal consent *	Print Patient/Resident Name	Date
Witness of Patient/Resident Signature or Verbal Consent	Print Witness Name	Date
Witness of Patient/Resident Signature or Verbal Consent	Print Witness Name	Date

*Patient with capacity can provide verbal consent in the presence of two adult witnesses. Written consent requires only one witness signature. If verbal consent, one witness must be a physician. In facility, physician must be affiliated with the facility, e.g. resident physician qualifies.

DNR (CPR) CONSENT OF HEALTH CARE AGENT (HCA) OR SURROGATE DECISION-MAKER FOR PATIENT / RESIDENT WITHOUT DECISION-MAKING CAPACITY: This document reflects what is known about the patient/resident's treatment preferences. For Patient/Resident without decision-making capacity, or when medical futility or therapeutic exception is used, Supplemental MOLST Documentation Form MUST be completed and should always accompany this MOLST Form. If patient/resident has a legal and valid DNR previously completed while patient/resident had capacity, attach to MOLST. ☐ **Prior DNR form attached** ☐ **Supplemental Documentation Form completed**

HCA/Surrogate Signature ☐ Check if verbal consent	Print Name	Date

Relationship to Patient/Resident: _____

Witness Signature	Print Witness Name	Date

(Must witness HCA/surrogate signature or verbal/telephone consent)

Section C

Physician Signature for Section A and B

Physician Signature for Sections A and B:

Physician Signature	Print Physician Name	Date

(Must Witness Patient/Resident Signature or obtain Verbal Consent. Resident physician signature must be co-signed by licensed physician.)

Physician License #: _____ **Physician Phone/Pager #:** _____

It is the responsibility of the physician to determine, within the appropriate period, (see below) whether this order continues to be appropriate, and to indicate this by a note in the person's medical chart. The issuance of a new form is NOT required, and under the law this order should be considered valid unless it is known that it has been revoked. This order remains valid and must be followed, even if it has not been reviewed within the appropriate time period. The **physician must review these orders** as follows: **Hospital: at least every 7 Days; Nursing Home/Skilled Nursing Facility: at least every 60 Days; Nonhospital/Community Setting: at least every 90 Days**

Section D

ADVANCE DIRECTIVES: Patient/Resident has completed an additional document that provides guidance for treatment measures if he/she loses medical decision-making capacity:

☐ **Health Care Proxy** ☐ **Living Will** ☐ **Other Written Documentation or Oral Advance Directive**

Section E

HIPAA Permits Disclosure of MOLST to Other Health Care Professionals & Electronic Registry as necessary for treatment.

ORDERS FOR OTHER LIFE-SUSTAINING TREATMENT AND FUTURE HOSPITALIZATION: (If patient/resident has pulse and/or is breathing)

Review patient's goals and patient's choice of interventions and then complete orders for appropriate subsections. Blank subsections can be completed at a later date. If patient has decision-making capacity, patient should be consulted prior to treatment or withholding thereof. *After confirming consent of appropriate decision-maker, obtain signature or verbal consent and complete the consent section of Section E, at the bottom of this page.* Physician must sign and date each subsection at the time of completion.

Physician may complete form with patient who has capacity or with Health Care Agent. Include Section E consent.

ADDITIONAL TREATMENT GUIDELINES: (Comfort measures are always provided.)

☐ **Comfort Measures Only** – The patient is treated with dignity and respect. Reasonable measures are made to offer food and fluids by mouth. Medication, positioning, wound care, and other measures are used to relieve pain and suffering. Oxygen, suction and manual treatment of airway obstruction are used as needed for comfort. *Do Not Transfer to hospital for life-sustaining treatment. Transfer if comfort care needs cannot be met in current location.*

☐ **Limited Medical Interventions** - Oral or intravenous medications, cardiac monitoring, and other indicated treatments are provided except as specified in Sections A or F. Guidance about acceptable/unacceptable interventions relevant to this patient/resident may be written under "Other Instructions" below. May consider less invasive airway support (e.g. CPAP, BIPAP). *Transfer to the hospital as indicated.*

☐ **No Limitations on Medical Interventions** - All indicated treatments are provided except as specified in Sections A. *Transfer to the hospital is indicated, including intensive care.*

MD Signature: *Date:*

Physician may complete form for incapacitated patients without Health Care Agent only with clear and convincing evidence. Include Section E consent.

ADDITIONAL INTUBATION AND MECHANICAL VENTILATION INSTRUCTIONS: If patient/resident chooses DNR, review all options if patient/resident has progressive or impending pulmonary failure without acute cardiopulmonary arrest. If patient chooses full CPR, review options of trial and long-term intubation & mechanical ventilation:

☐ **Do Not Intubate (DNI)**
(Review available symptomatic treatment of dyspnea: oxygen, morphine, etc.)

☐ **A trial period of intubation and ventilation** ☐ **A trial of BIPAP** ☐ **A trial of CPAP**
(Discuss duration of trial and document in other instructions.)

☐ **Intubation and long-term mechanical ventilation, if needed**

MD Signature: *Date:*

FUTURE HOSPITALIZATION / TRANSFER: (For long-term care residents and home patients)

☐ **No hospitalization unless pain or severe symptoms cannot be otherwise controlled.**

☐ **Hospitalization with restrictions outlined in Sections A and E.**

MD Signature: *Date:*

Physician should consult legal counsel for MR/DD patients without capacity. See Surrogate's Court Procedure Act §1750-b.

ARTIFICIALLY ADMINISTERED FLUIDS AND NUTRITION: (If Health Care Agent makes decision, it must be based on reasonable knowledge of patient/resident's wishes.)

☐ **No feeding tube** (offer food/fluids as tolerated) ☐ **No IV Fluids** (offer food/fluids as tolerated)

☐ **A trial period of feeding tube** ☐ **A trial of IV fluids**

☐ **Long-term feeding tube, if needed**

MD Signature: *Date:*

ANTIBIOTICS:

☐ **No antibiotics** (except for comfort) ☐ **Antibiotics**

MD Signature: *Date:*

OTHER INSTRUCTIONS: (May include additional guidelines for starting or stopping treatments in sections above or other directions not addressed elsewhere.)

MD Signature: *Date:*

Section E Consent

CONSENT FOR SECTION E OF PERSON NAMED IN SECTION B: Significant thought has been given to life-sustaining treatment. Patient/resident preferences have been expressed to the physician and this document reflects those treatment preferences. As the medical decision-maker, I confirm that the orders documented above in Section E reflect patient/resident's treatment preferences.

Signature ☐ Check if verbal consent Print Name Date

SEND FORM WITH PATIENT/RESIDENT WHENEVER TRANSFERRED OR DISCHARGED

RENEW / REVIEW INSTRUCTIONS

MOLST (DNR and Life-Sustaining Treatment)

This form should be reviewed and renewed periodically, as required by New York State and Federal law or regulations, and/or if:

- **The patient/resident is transferred from one care setting or care level to another, or**
- **There is a substantial change in patient/resident health status (improvement or deterioration), or**
- **The patient/resident treatment preferences change**

Last Name/First/Middle Initial of Patient/Resident
Address
City/State/Zip
Patient/Resident Date of Birth (mm/dd/yyyy)
Gender ☐ M ☐ F
Unique Patient Identifier (Last 4 SSN)

How to Complete the MOLST Form

- **MOLST must be completed by a health care professional, based on patient preference and medical indications.**
- **Follow the 8-Step MOLST Protocol found at www.CompassionandSupport.org.**
- **MOLST must be signed by a NYS licensed physician to be valid. Verbal orders are acceptable with follow-up signature by a physician in accordance with facility/community policy.**
- **If patient/resident has a legal and valid DNR previously completed while patient/resident had capacity, attach to MOLST.**
- **Use of original form is strongly encouraged. Photocopies, FAXes and an electronic representation of the original signed MOLST are legal and valid.**

How to Review MOLST Form:

Step 1: Review Sections A through E

Step 2: Complete Section F below:

2a. If no changes, sign, date and check the "No Change" box.

2b. For additions to Section E "optional" directives, complete the relevant subsections(s) after securing consent from the appropriate decision-maker, sign and date subsection(s) in Section E. Then sign, date and check "Changes-Additions only" in box below.

2c. For substantive changes, (i.e. reversal of prior directive), write "VOID" in large letters on pages 1 and 2, and complete a new form. Check box marked "FORM VOIDED, new form completed". (RETAIN voided MOLST form in chart or medical record, or as required by law.)

2d. If this form is voided and no new form is completed, full treatment and resuscitation will be provided. Write "VOID" in large letters on pages 1 and 2 and check box marked "FORM VOIDED, no new form." (RETAIN voided MOLST form in chart or medical record, or as required by law.)

For detailed information about the MOLST Program, view www.CompassionandSupport.org.

Section F *(Review of this Form)*

Review of this MOLST Form

Date	Reviewer's Name and Signature	Location of Review	Outcome of Review
			☐ No Change ☐ Changes – Additions only ☐ FORM VOIDED, new form completed ☐ FORM VOIDED, *no* new form
			☐ No Change ☐ Changes – Additions only ☐ FORM VOIDED, new form completed ☐ FORM VOIDED, *no* new form
			☐ No Change ☐ Changes – Additions only ☐ FORM VOIDED, new form completed ☐ FORM VOIDED, *no* new form
			☐ No Change ☐ Changes – Additions only ☐ FORM VOIDED, new form completed ☐ FORM VOIDED, *no* new form
			☐ No Change ☐ Changes – Additions only ☐ FORM VOIDED, new form completed ☐ FORM VOIDED, *no* new form

 Continue Section F on Page 4

Section F *(Review of this Form)*

Review of this MOLST Form *(Con't from Page 3)*

Date	Reviewer's Name & Signature	Location of Review	Outcome of Review
			☐ No Change ☐ Changes – Additions only ☐ FORM VOIDED, new form completed ☐ FORM VOIDED, ***no*** new form
			☐ No Change ☐ Changes – Additions only ☐ FORM VOIDED, new form completed ☐ FORM VOIDED, ***no*** new form
			☐ No Change ☐ Changes – Additions only ☐ FORM VOIDED, new form completed ☐ FORM VOIDED, ***no*** new form
			☐ No Change ☐ Changes – Additions only ☐ FORM VOIDED, new form completed ☐ FORM VOIDED, ***no*** new form
			☐ No Change ☐ Changes – Additions only ☐ FORM VOIDED, new form completed ☐ FORM VOIDED, ***no*** new form
			☐ No Change ☐ Changes – Additions only ☐ FORM VOIDED, new form completed ☐ FORM VOIDED, ***no*** new form
			☐ No Change ☐ Changes – Additions only ☐ FORM VOIDED, new form completed ☐ FORM VOIDED, ***no*** new form
			☐ No Change ☐ Changes – Additions only ☐ FORM VOIDED, new form completed ☐ FORM VOIDED, ***no*** new form
			☐ No Change ☐ Changes – Additions only ☐ FORM VOIDED, new form completed ☐ FORM VOIDED, ***no*** new form
			☐ No Change ☐ Changes – Additions only ☐ FORM VOIDED, new form completed ☐ FORM VOIDED, ***no*** new form
			☐ No Change ☐ Changes – Additions only ☐ FORM VOIDED, new form completed ☐ FORM VOIDED, ***no*** new form
			☐ No Change ☐ Changes – Additions only ☐ FORM VOIDED, new form completed ☐ FORM VOIDED, ***no*** new form

GRABIE & GRABIE, LLP

Attorneys at Law

JEANETTE GRABIE
Kenneth F. Grabie (1945-2007)
GEORGE L. ROACH
JANNA P. VISCONTI
DENNIS MCCOY
MICHAEL C. MCCARTHY
DENISE SNOW
JENNIFER RAGUSO

162 Terry Road
Smithtown, NY 11787
631-360-5600
Facsimile 631-360-3370
Grabie@ElderLawLongIsland.com

February 17, 2017

Claire D.[redacted]
[redacted]
Port Jefferson, NY 11777

Re: Estate Planning

Dear Ms.[redacted]

By signing this agreement and sending payment as specified below, you are confirming that you are retaining this office to perform the following services:

1. Prepare and supervise the signing of a **Durable Power of Attorney** for you in which Emily A.[redacted] will be the primary agent and Ann B.[redacted] will be the successor agent.

2. Prepare and supervise the signing of a **Health Care Proxy and Living Will** for you in which Emily A.[redacted] will be the primary agent and Ann B.[redacted] will be the successor agent.

3. Prepare and arrange for the recording of a **deed** transferring your property located at [redacted], Port Jefferson, NY 11777 to your daughters, Emily A. [redacted] and Ann B. [redacted], while reserving a life estate for you in the entire premises.

It is important that after signing this deed, you notify your insurance broker as to the change in ownership and that your homeowner's policy is amended accordingly.

WARNING:

Please be advised that the legal advice and planning suggestions we provide are based on our best judgment, experience, and analysis of current law. You must be aware that law is always subject to judicial, legislative, and administrative changes and interpretation. As such, there exists the possibility that the intent of our advice and direction may not be fully realized, and we cannot guarantee the results of our representation.

LEGAL FEES:

The legal fee for the above services will be $1,200, plus a $750 deed preparation and title company fee to record the deed with the county for a total fee of $1,950, less the $450 consultation fee you paid for a balance of $1,500 payable upon the signing of this retainer. Not included in this retainer are any services other than those stated above. Any further services would require a new retainer and additional fees.

IRS Circular 230 Disclosure: To ensure compliance with requirements imposed by the IRS, we inform you that any U.S. Federal tax advice contained in this communication (including any attachments) is not intended or written to be used and cannot be used for the purpose of (1) avoiding penalties under the Internal Revenue Code; or (2) promoting, marketing or recommending to another party any transaction or matter addressed herein. If you would like an opinion upon which you can rely to avoid penalties, please contact the sender to discuss.

Please note that pursuant to Part 137 of the Rules of the Chief Administrator of the Courts, where a fee dispute arises, you may have the right to arbitration. By signing this retainer both the attorney and client(s) are agreeing that the arbitration referred to above shall be the sole remedy available to either party in the event of a fee dispute.

If the above is acceptable, please sign where indicated and return one signed copy to this office. I look forward to being of assistance.

Very truly yours,

Dennis McCoy

ACCEPTED:

Claire D. [redacted] 2-17-17

Claire D. [redacted] DATE

DM:jp

GRABIE & GRABIE, LLP

Attorneys at Law

JEANETTE GRABIE
Kenneth F. Grabie (1945-2007)
GEORGE L. ROACH
JANNA P. VISCONTI
DENNIS MCCOY
MICHAEL C. MCCARTHY
DENISE SNOW
JENNIFER RAGUSO

162 Terry Road
Smithtown, NY 11787
631-360-5600
Facsimile 631-360-3370
Grabie@ElderLawLongIsland.com

February 11, 2017

Carol M.[redacted]
[redacted]
Sayville, NY 11782

Re: Estate Planning

Dear Ms. [redacted]

By signing this agreement and sending payment as specified below, you are confirming that you are retaining this office to perform the following services:

1. Prepare and supervise the signing of an **Irrevocable Living Trust** to be named the "Carol M.[redacted] Irrevocable Trust. " Thomas A.[redacted] will be the primary trustee.

   a. We will prepare and arrange for the recording of a **deed** transferring the real property you own into your irrevocable trust while reserving the rights of a life tenant for you within the trust. This transfer will create a 5-year period of ineligibility for Chronic Care (Nursing Home) Medicaid for you.

   b. You will not be able to sell the house without the consent of the trustee of your irrevocable trust.

   c. The Trustee will be authorized to name a successor trustee in a separate, notarized writing.

   d. You will have a right to live in the house and you will continue to be responsible for all expenses. Any tax exemptions currently in place will continue. If you do sell the house during your lifetime, the proceeds from the sale will remain in the trust. Upon the termination of the trust, the property will be distributed in accordance with the terms of the trust.

   e. Please be advised that most banks will not approve a mortgage, reverse mortgage or refinance of property held by an irrevocable trust.

   f. It is also important that after signing the deed you notify your insurance broker as to the change in ownership and that your homeowner's policy is amended accordingly. The trust should be added to the policy as **additional insured party.**

g. At this time, only your real property will be titled into the trust. If the trust ever holds any other assets (i.e., if your home is sold in the future), the following rules shall apply to those non-real estate assets held by the trust.

i. Funds held in the trust, for the purpose of this explanation, include, but are not limited to, bank accounts, brokerage accounts, stocks, bonds, annuities, etc. that are titled into the trust. These funds will be referred to as the "principal" in the trust. Real estate is also technically trust principal, but it does not generate income unless rented. If the real estate is sold, the net proceeds can be invested and can generate interest and dividends.

ii. Once titled into the trust you may ever withdraw the trust principal. If the trust principal generates interest and dividends, the trustee will be required to pay the income to you.

iii. The trusts will have a "back door provision" in which the trustee may withdraw principal and distribute same to any of the remainder beneficiaries, unless such distribution could disqualify any of said beneficiaries from receiving government benefits. Once distributed, this money may be used for anyone's benefit, including yours. However, any principal withdrawn from the trust cannot be given directly to you or deposited into your bank accounts.

h. Upon your death, the net trust assets in the trust will be distributed to your son Thomas A[redacted] per stirpes. (If Thomas were to predecease you, his children would inherit the assets in the trust.)

i. Your trust will include a "limited power of appointment" so that you can change your beneficiaries if you choose.

j. The assets in the trust will not afford the maximum protection against long-term health care costs for a period of five years beginning one month after the last transfer is made into the trust. Upon your death, the net trust assets in the trust will be distributed to your son Thomas A[redacted], per stirpes, according to the terms of the trust.

2. Prepare and supervise the signing of a **Health Care Proxy and Living Will** for you in which Thomas A.[redacted] will be the agent.

3. If you do not currently have a valid Power of Attorney, we will prepare and supervise the signing of a **Durable Power of Attorney** for you in which Thomas A.[redacted] will be the agent.

The legal fee for the above services will be $2,500, plus a $470 title company fee to record the deed, for a total fee of $2,970, payable upon the signing of this retainer. Not *included in this* retainer are any services other than those stated above. Any further services would require a new retainer and additional fees.

IRS Circular 230 Disclosure: To ensure compliance with requirements imposed by the IRS, we inform you that any U.S. Federal tax advice contained in this communication (including any attachments) is not intended or written to be used and cannot be used for the purpose of (1) avoiding penalties under the Internal Revenue Code; or (2) promoting, marketing or recommending to another party any transaction or matter addressed herein. If you would like an opinion upon which you can rely to avoid penalties, please contact the sender to discuss.

Please note that pursuant to Part 137 of the Rules of the Chief Administrator of the Courts, where a fee dispute arises, you may have the right to arbitration. By signing this retainer both the attorney and client(s) are agreeing that the arbitration referred to above shall be the sole remedy available to either party in the event of a fee dispute.

If the above is acceptable, please sign where indicated and return one signed copy to this office. I look forward to being of assistance.

Very truly yours,

Jeanette Grabie

ACCEPTED:

Carol M. [redacted] 2-17-17
Carol M. [redacted] DATE

JG:dv

GRABIE & GRABIE, LLP

Attorneys at Law

JEANETTE GRABIE
Kenneth F. Grabie (1945-2007)
GEORGE L. ROACH
JANNA P. VISCONTI
DENNIS MCCOY
MICHAEL C. MCCARTHY
DENISE SNOW
JENNIFER RAGUSO

162 Terry Road
Smithtown, NY 11787
631-360-5600
Facsimile 631-360-3370
Grabie@ElderLawLongIsland.com

February 11, 2017

Carol M. [redacted]
[redacted]
Sayville, NY 11782

Re: Community Medicaid

Dear Ms. [redacted]

By signing this agreement and sending payment as specified below, you are confirming that you are retaining this office to perform the following services:

1. This office will represent you with respect to an application for Community Medicaid. You or your family will work directly with our Medicaid staff. Based on the information you provided, we anticipate that you will be Medicaid eligible. However, it will be necessary for you (or your son) to follow our directions regarding the transfer of assets. Please note that you may retain only $14,850 in your name. It will be you and your family's responsibility to provide this office with whatever documentation we request. To the extent that banks or other financial documents are not readily available to you, you are authorizing this office to obtain the documents from the respective banks or financial institutions.

2. The original application will be done as an immediate need application with the Department of Social Services. Shortly thereafter, you will be required to choose a Managed Long Term Care agency to manage your home care services. This will will result in one or two additional assessments in the home. We will arrange for the representatives from both the local Department of Social Services and the Managed Long Term Care Agency to conduct the assessments and to have an attorney present for the assessments.

3. Further, the law provides that you may keep only $845 of your monthly income plus the cost of health insurance. The income above this amount is called the "overage." If the overage is neither offset by medical bills nor deposited into a Pooled Trust Account (explanation follows), it must then be paid to the Department of Social Services on a monthly basis for as long as you are receiving Medicaid paid services. Therefore, this office will represent you with respect to establishing a Pooled Trust agreement with NYSARC. In order to qualify for this trust so that your Medicaid overage may be used for your non-medical expenses, New York State will have to determine that you are disabled according to Social Security Disability standards. As such, both you and your doctor will need to complete medical forms for submission to the State. If the Pooled Trust is approved by the Department of Social Services, then the monthly overage, less the NYSARC fee, will be deposited into the Pooled Trust to be used for your benefit. Any funds remaining in this Trust at the time of your death will be paid to NYSARC. The initial deposit into the NYSARC trust must be made by bank check or money order and it will be submitted with the pooled trust application. This office will advise you as to the amount of the initial deposit. Checks thereafter may be personal checks. The checks will be made out to the "NYSARC Community Trust FBO Carol M.[redacted]" Please note that the first month's deposit is retained by NYSARC and cannot be used toward the beneficiary's expenses.

The legal fee for the above services will be $9500.00, less the $450 consultation fee you paid for a balance of $9050.00, payable upon the signing of this retainer. An attorney's presence at up to three nurse assessments are included in the cost of these services. If more than three nurse assessments are required there will be an additional fee due of $1000 to have an attorney present at an additional assessment.

If a fair hearing becomes necessary to secure or maintain services, there will be an additional fee and a new retainer agreement will have to be signed. We anticipate that the fee for representation at a fair hearing will be no more than $5000.00.

If the Medicaid application is discontinued for any reason, including death, the fees paid will be applied as follows: The minimum fee is fifty percent (50%) of the legal fee due under this retainer agreement. The time expended on the matter, including the full time spent for the initial consultation, will be charged at the hourly rate of $450 per hour for attorneys and $225 per hour for support staff. To the extent that the total time expended results in a fee that exceeds fifty percent (50%) of the legal fee, this office will retain that difference and refund the remainder.

Charges incurred with banks or other agencies to produce this documentation, and overnight mail charges, if any, are not included in the cost of legal services.

Only the services listed above are included in this agreement. In the event the application

is rejected for any unforseen reason and an administrative appeal (fair hearing) is undertaken, that representation will require a separate retainer and an additional legal fee. Additionally, after Medicaid approval, the Department of Social Services requires annual recertification. This agreement does not include representation for the recertification.

It is critical that your estate avoid probate after your death. In order to accomplish this, you must make sure that all your assets are owned jointly with another person or name another person as a beneficiary. In addition, all life insurance policies and IRA's should name specific beneficiaries. Many people name their closest relatives as beneficiaries or joint owners, but the choice is up to you. It is <u>not</u> sufficient to name your "estate" as beneficiary. This is important because Medicaid will put a lien on any assets that have to go through probate after your death.

IRS Circular 230 Disclosure: To ensure compliance with requirements imposed by the IRS, we inform you that any U.S. Federal tax advice contained in this communication (including any attachments) is not intended or written to be used and cannot be used for the purpose of (1) avoiding penalties under the Internal Revenue Code; or (2) promoting, marketing or recommending to another party any transaction or matter addressed herein. If you would like an opinion upon which you can rely to avoid penalties, please contact the sender to discuss.

Please note that pursuant to Part 137 of the Rules of the Chief Administrator of the Courts, where a fee dispute arises, you may have the right to arbitration. By signing this retainer both the attorney and client(s) are agreeing that the arbitration referred to above shall be the sole remedy available to either party in the event of a fee dispute.

If the above is acceptable, please sign where indicated and return one signed copy to this office. I look forward to being of assistance.

Very truly yours,

Jeanette Grabie

ACCEPTED:

Carol M. [redacted] 2-17-17

Carol M. [redacted] Date

JG:dv

SURROGATE'S COURT OF THE STATE OF NEW YORK
COUNTY OF SUFFOLK

In the Matter of the Will of CHARLES J. [redacted] Deceased	STAPLES AFFIDAVIT File No.

STATE OF NEW YORK)
) SS:
COUNTY OF SUFFOLK)

John M. [redacted], being duly sworn, deposes and states:

1. I reside at [redacted] Royal Lane, Northport, NY 11768.

2. I am Decedent's son.

3. I make this affidavit to explain the presence of staple holes at the top of the Last Will and Testament of Charles J. [redacted].

4. I removed the staples from the will to make a photocopy.

5. I was unaware of the problem that removing the staples presents in these circumstances.

6. No pages were added, deleted or substituted during the time the staples were removed from the document.

John M. [redacted]

Sworn to before me this 1
day of February, 2013

Notary Public

VITO M STEA
Notary Public - State of New York
NO. 01ST6236460
Qualified in Suffolk County
My Commission Expires 2/27/201

NYSBA WINTER 2017 | VOL. 27 | NO. 1

Elder and Special Needs Law Journal

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

www.nysba.org/Elder

Overview of the NYSBA Elder Law and Special Needs Section Membership Services Committee

By Sal Di Costanzo

The Membership Services Committee is a standing committee of the Elder Law and Special Needs Section whose mission is to attract new members and retain existing members of the Section. For attorneys, the committee acts as a liaison between other Section committees and other sections of the NYSBA to cross pollinate among existing attorneys who are members of the Bar. This is accomplished through networking events, new member initiatives and CLE programs. The committee also recognizes that cost is a primary concern of many members, especially newly admitted attorneys, thus a significant effort is put forth to reduce membership related costs where feasible.

From an outreach perspective, the committee works in tandem with the NYSBA to educate law students and attract them to the profession. This is largely accomplished through coordinated law school presentations and other events focused on introducing upcoming attorneys to the Section. Opportunities are created for law students to attend Section related events as an introduction to the Section and its related activities. The Section also monitors members who have resigned from the Section, with the expectation of gathering useful information to renew their interest and prevent further withdrawals.

The Section, through the NYSBA, offers valuable resources for its members. One of the goals of the Section is to create awareness of these resources so that members of the Section can reap the benefits of their investment in the Section.

An Elder Law Attorney's Experience in Placing a Parent in a Nursing Home

By Rick Marchese

The call came in on Monday evening around 8:00 p.m. from my brother Steve. My mother had fallen at her home (for the fifth time in three months) and could not get up off of the floor. My brother was frantic because Mom was crying and yelling and he could not calm her down at all. For the last three years my Mom had slowly been going downhill cognitively, with significant short-term memory deficits and very erratic emotional swings. Interactions that occurred ten minutes ago were quickly forgotten, and her inability to remember conversations, meetings, really anything at all was getting dangerous. Also, the glass or two of wine she used to have every day had turned into four or five glasses, not because she wanted to drink a lot, but because she continually forgot that her glass had previously been full, and wanted another glass assuming that it was her first. My brother, who works full-time and lived with my mother, was increasingly becoming very stressed out, and worried about her erratic behavior. As a family, my brothers and my sister all felt we were actors in a play that would not end well.

Mom was in a very ornery and ugly mood when my sister and I arrived. She would not get off the floor and would not let any of us touch or help her at all, telling us to "get out of my house and leave me alone!" We told her we were not leaving, and pleaded with her to let us assist her, all to no avail. We called for an ambulance. Try as they might, the EMTs also could not get her to move. She started yelling and fighting with the ambulance personnel who in turn called the police. Great, I thought, the more the merrier! Two incredibly patient police officers spoke for ten minutes without any success. She would not move and refused all assistance. Finally, the officers lifted my Mom onto a stretcher (she was actually kicking at one of the officers who chuckled about my 89-year-old mother resisting arrest) and then moved her into the ambulance. My sister, who is very close to my mother, was crying, and I just looked at my brother and we sort of knew that this was it. My journey as an elder law attorney going through the nursing home placement process for my mother, something that I had feared for many months, was about to begin.

As my Mom arrived at the hospital I huddled with my siblings and we all came to the same conclusion. It was unsafe for mom to live at home any longer. Nursing home placement, unfortunately, was the only remaining choice for her care. She was well past assisted living, and in any event could never afford it on her very limited income. This was a very difficult and emotional decision for all of us. I think as elder law practitioners we sometimes, in counseling clients, forget about the emotional catharsis that spouses and/or children go through when the decision is made to place a loved one in a nursing home. As legal practitioners, we are rightfully thinking about planning and preservation of assets and making sure legal documents are in order, creating trusts, etc., but I can assure you that none of that was on my mind at all when my siblings and I came to the decision that this was it. We are a very close family, and at the heart of it, we all felt (I know I did) that we had let Mom down. That feeling has persisted to this day. Intellectually you know that a nursing home is the safest and only option, but emotionally it is a hard pill to swallow.

Rick Marchese

Mom was medically checked at the hospital. No broken bones, but significant bruises, and the attending doctor indicated that she would be kept for a day or two to make sure that she was fine, and that he was fully supportive of the decision that she could not safely be discharged home. Of course, he added as an aside to me, we are not admitting her; she will be held in observation. Now I know the importance of the distinction between observation and admission for Medicare reimbursement purposes, but I can tell you how powerless one feels when a doctor is telling you "that's how it will be." Who am I to argue with the doctor, especially when I believe that he was probably correct in that an admission was not warranted? I just basically went along and said "fine." Afterward, I thought about all of the times I have counseled my clients to be proactive and to vigorously advocate for an admission with the doctors and the social workers, and here I was just meekly assenting to their decision. Again, when you are caught up in the moment, your mind as a family member is not on money or legalities but just on facing forward and deciding what is best for your loved one. I was frankly relieved that the doctor was not going to allow her to go home, and that he was supportive of the decision to send Mom to a skilled nursing facility.

We now moved on to the skilled nursing facility placement merry-go-round. Mom actually had little, if any, assets. She was basically Medicaid eligible from day one. How to get her into a good nursing home? The discharge planner at the hospital dutifully produced a list of twenty area nursing homes and told us to "pick five," and she would start making calls to these facilities. My family naturally looked to me for guidance. I knew that as a straight Medicaid patient all of the good facilities on the list would decline the admission, and my head was spinning with the prospect of sending her to one of the "problematic homes" that we often talk about at the firm.

Here, my experience as an elder law attorney actually paid off, not as an attorney, but as an individual acting as an attorney who had made a lot of contacts with geriatric care managers during the course of my work. Now was the time for me to call in some favors. Miraculously, one of my contacts was able to get my mother placed in a fine nursing home in the area, which normally would never have occurred for a client in a similar financial position. Again, a sigh of relief.

I thought about the fact, as most of us who practice elder law do, that money really dictates the opportunity for, and quality of, care for our clients. I always think that there has to be a better way. This transition process from hospital to nursing home is fraught with tension as home after home gets crossed off of the "list," which leaves anxious family members wringing their hands. How can we allow our elderly clients and their supportive family members to be subjected to a process that encapsulates all of their efforts to keep mom or dad at home, and avoid nursing home placement, to this dreaded "list"? I think we owe it as practitioners to put our heads together to see if we can advocate for a better solution in this transition process.

My mother was transported to the nursing home and informally admitted until I signed all of the paperwork (I am her authorized agent, her Power of Attorney). After the admission, I knew enough to ask for a care plan meeting, which my entire family attended, and which was very helpful in getting us to feel more assured that this was the right place for my mother. After the meeting I went to the admissions office to sign the application for my mother. At that point, I was just so happy and relieved that my Mom had ended up in a safe place, and very thankful for my friend's efforts, and thankful for the nursing home accepting her, that I frankly just signed everything that was put in front of me. I had to stop myself and say, "Wait a minute, I should be reading this, this is what I tell my clients to do, **read the paperwork and sign everything as Power of Attorney!!**" I made a mental note to myself to be more understanding of my clients who go ahead and sign admission paperwork after I have told them to let me review it first, or to be very careful and sign "Power of Attorney" after their name. A lot of families find themselves in the situation that I did, where you feel relieved, and that you're nearing the end of your emotional rollercoaster. You will sign anything to make sure things go smoothly at the nursing home. It's funny how your role as an attorney slips away when you are acting as a son, daughter, spouse, or significant other of a loved one facing a health care crisis. At least that is how it happened (with me).

My Mom has now been at the nursing home a little over three months. Her mood swings continue but she is in a safe place. Her forgetfulness is increasing and her memory deficits are significant. Still, she enjoys our visits (and I enjoy visiting her) and things are so much better for everyone now that she is settled. My mom thinks the home is a hospital (or an apartment building depending on which day you talk to her). Do we tell her it's a nursing home? Do we tell her that she can't go home, and that the home in which all of us grew up has to be sold? These were questions that were left unanswered, actually for several months, while my Mom adjusted to her new setting.

My Mom is a staunch Roman Catholic. She stopped attending Mass at home, despite our offers to take her to church, and had not taken communion in years. The nursing home does have Mass every Sunday and I thought, "Hey, this is great; my Mom will finally be able to go to church again." Two weeks after her admission I visited my mother on a Sunday morning around 11:00 a.m. I found her in her room watching television. She seemed content, and we spent some good quality time reminiscing about events that had happened forty or fifty years ago—her long-term memory remaines fairly good. I then asked her if she had gone to Mass that morning. She looked at me and said, "Oh Rick, I knew that Mass was this morning and that I could take communion, but I heard that the Pope was here, and I didn't want to see the Pope." She looked at me and squeezed my hand and said "Rick, was that all right"? I told her, "Mom, that's totally fine; you know, I didn't want to see the Pope either."

I believe what my experience has taught me is to be more compassionate and understanding of my clients who are facing long-term care placement decisions for their loved ones. Of course, I go through all of the legal and financial planning with clients, draw up the appropriate documents, get them on the right path, and do what I do to help them navigate through the system. I think that often clients who are in the position I was facing are also looking for somebody to listen to their concerns, understand how they have reached this critical points in their lives, and be supportive of their decisions. If we can all remember to do those three things, and advocate as much as possible for a humane, safe, and dignified transition process to a nursing home, we will all be better attorneys for it.

Richard A. Marchese of Woods Oviatt Gilman LLP, Rochester, is a Partner in the firm's Elder Law and Health Care Practice Group responsible for handling all elder law and health care issues. He concentrates his practice in Medicaid and Estate planning, Social Security, Medicare and Medicaid eligibility and recovery matters, asset protection, issues of spousal support, and the use of trusts in Medicaid planning. Mr. Marchese also provides counsel to health care providers in matters of compliance with federal and state regulations, defense of government audits and investigations, voluntary self-disclosures, corporate compliance and professional licensure issues.

Prior to joining the firm, Mr. Marchese served for over fifteen years as Chief Counsel to the Monroe County, N.Y. Department of Social Services, advising the Chronic Care, Home Care and Adult Protective units at that agency. He was the director of the Monroe County Provider Fund, Waste and Abuse Demonstration Project, and he now represents Medicaid providers in matters of compliance with government regulations and defense against government audits.

Factors to Consider When Converting Excess Resources Into an Income Stream for Purposes of the Institutional Medicaid "Snapshot"

By Regina Kiperman and Naomi Levin

Jack and Alice are married. Jack is 80 years old. He is sick, requires institutional care, and is about to enter a nursing home. (Jack is the "Institutionalized Spouse.") Alice is 75 years old. (Alice is the "Community Spouse.") Jack and Alice have a house, free and clear of mortgage and $750,000 worth of investable assets, generating de minimis annual income in the form of dividends (estimated at $4,000 a year). Each spouse also has their own separate IRA in payout status. The Institutional Spouse's required minimum distribution is $750 a month. The Community Spouse's required minimum distribution is $200 a month. The Institutional Spouse receives $2,000 a month from Social Security while the Community Spouse receives $510 a month from Social Security.

Jack and Alice come to you for Medicaid planning. You know that transfers between spouses are exempt.[1] If Jack transfers all of his assets to Alice, Jack can thereafter apply and be eligible for Medicaid. You also know that the Community Spouse may execute a "Spousal Refusal" advising the Local Department of Social Services ("DSS") that the community spouse refuses to fulfill his/her obligations, as the legally responsible relative, to support the institutionalized spouse.[2] DSS will provide the necessary medical assistance to the institutionalized spouse, notwithstanding the community spouse's refusal to contribute to the cost of the institutionalized spouse's care. However, the filing of the "spouse refusal" may create an implied contract with DSS, authorizing DSS to commence a claim for spousal contribution from the community spouse for the cost of care paid by DSS for the benefit of the institutionalized spouse.[3] [4] When initiating a claim for spousal contribution, DSS will look to the community spouse's income and/or resources in excess of applicable limits.

Current laws permit the Community Spouse to retain monthly income up to the amount of the minimum monthly maintenance needs allowance ("MMMNA"), and resources up to the amount of the community spouse resource allowance ("CSRA").[5] The MMMNA[6] and CSRA[7] are exempt from recovery by DSS and are adjusted annually to account for increases in cost of living.[8] Income and resources above the MMMNA and CSRA may be subject to a contribution claim from DSS. Currently, New York State limits its claims for spousal income contribution to twenty-five percent (25%) of the Community Spouse's income in excess of the MMMNA.[9] (The amount sought for contribution may be reduced if the Community Spouse can demonstrate a need for an increased income allowance, and therefore an increase in the MMMNA.)[10]

You know that the Community Spouse can have a Federal CSRA of $119,220 (and an MMMNA of $2,980.50) in 2016.[11] Thus, if Jack keeps $14,000 in his own name and transfers the balance to Alice, the first $119,220 in 2016 can be held free and clear of any contribution claims. Unlike the contribution claims for income, however, there is no limit on how much DSS can request for contribution of excess resources over and above the CSRA. Therefore, you are left wondering what can you do to protect your client's excess resources? Put another way, should you convert the excess resources into income so that you can mitigate the amount of money subject to contribution to just 25% of the income over the MMMNA?

You have heard suggestions regarding converting the excess resources over the CSRA into an income stream by using either a Promissory Note[12] or Medicaid Compliant Annuity[13] before filing the Medicaid application.[14] The goal of this approach is to provide a snapshot that minimizes, if not completely eliminates, the excess resources. Instead, the result of the conversion of the excess resource into an income stream will be that the snapshot will show a higher income stream (which is exposed to a maximum contribution claim of 25%). Should you employ this technique, you wonder?

This tool may not always be the optimal approach for your clients. Therefore, before you engage this method, you should conduct a cost/benefit analysis and consider the following.

1. Effect of the conversion on potential spousal impoverishment budgeting

When a community spouse earns less than the MMMNA, once Medicaid eligibility has been established for the institutional spouse, the community spouse can request spousal impoverishment budgeting wherein the institutional spouse's income is allocated to the community spouse such that the community spouse's income is brought up to the MMMNA.[15] The amount of income allocated is referred to as the Community Spouse Monthly Income Allowance ("CSMIA").

In our example, Alice's total monthly income (from Social Security, dividends, and her IRA distribution) does not equal or exceed the 2016 MMMNA of $2,980.50. Therefore, after Jack is determined eligible for institutional Medicaid, Alice may request that a portion of Jack's income be allocated to Alice. (In this instance, Jack can have almost $2,000 allocated to herself from Jack's income). However, if Alice converts all of her excess resources (approximately $650,000) into an income stream, it is very likely that the additional income will push her total monthly income over the MMMNA, and she will no longer be eligible to receive a CSMIA from Jack's income. Instead, Jack's income may be paid to the nursing home. Furthermore, the DSS may bring a contribution claim, requesting a contribution of 25% of Alice's income in excess of the MMMNA.

It may make sense to ask yourself the following questions: Is the Community Spouse eligible for minimum monthly maintenance needs allowance ("MMMNA") from the Institutionalized Spouse? If so, will the creation of the promissory note completely eliminate the amount of the MMMNA? Will it reduce the amount of the MMMNA? Is the Community Spouse better off receiving the MMMNA from the Institutional Spouse and possibly using some of the MMMNA as a negotiation tactic with DSS?

2. What is your client's risk tolerance?

A client who prefers certainty may find limiting potential liability to 25% of their income in excess of the MMMNA quite appealing. Indeed, risk-averse clients may prefer to have a calculation of their exact liability and may even want to make a voluntary contribution,[16] rather than waiting for Medicaid to file the claim.

Clients who are more risk tolerant may want to take their chances. In our example, Alice, who will ultimately seek spousal budgeting, may be better off not converting her excess resources on the theory that DSS may see her relatively lower income and overlook her excess resources. Alice, if she is more risk tolerant, may choose to wait to see what, if any steps, DSS takes.

3. What is the term of the note?

A non-qualified annuity or promissory note must be actuarially sound as determined in accordance with actuarial publications of the Office of the Chief Actuary of the Social Security Administration.[17] The longer the term of the note, the lower the income. At the end of the day you are tying up your client's funds. The question is—for how long?

Factors to consider include:

- What are the actuarial life expectancies of the spouses?
- What are the realistic life expectancies of the spouses (based on the health/medical conditions of your specific clients)?[18]

For example, if the institutional spouse is terminal and has less than six months to live, perhaps the community spouse may not want to enter into an irrevocable agreement restricting access to resources for a period of time greater than six months. In situations such as these, it may be important to speak with the institutional spouse's care-team, as well as to check the actuarial life expectancy tables to understand the term of the note.

Reverting back to Jack and Alice, Alice's life expectancy (at age 75) is 12.76 while Jack's is 9.58. A note for the term of Alice's life expectancy would be "actuarially sound," but might result in income payments beyond Jack's life (and need for Medicaid benefits). Would Alice prefer to have her assets returned to her more quickly? Does the existence of the note and income stream create future problems for Alice's own future Medicaid eligibility and planning, or for her estate?

4. How much of the community spouse's resources should be converted into an income stream?

Should the community spouse convert all of her excess resources into an income stream? Should she convert more than her excess? Or perhaps she should only convert some of the excess.

Consider your client's needs and wishes. Does the community spouse need access to large amounts of money in the near future, or can she meet all of her needs with an income stream? Consider both anticipated and unanticipated needs that might arise, including things like vacations, home improvements, education for grandchildren, and medical emergencies.

5. Is there a correlation in your region between a lower "excess resource" amount and the chance that your local DSS will pursue a contribution claim?

Speak to your colleagues, the local DSS, and review any fair hearings. Perhaps there is a trend in Suffolk County such that Suffolk County pursues everything. Alternatively, perhaps there is a trend in Rockland County that DSS does not pursue anything.

If the chances of contribution pursuit are low, then it may not be worth converting.

6. How much over the CSRA is the community spouse going to be?

(This question also ties into risk tolerance and knowledge of your local DSS.) If the community spouse will only be $50,000 over the CSRA, perhaps there is a significantly smaller likelihood that the DSS may request a con-

tribution. If so, perhaps converting the excess resource into an income stream is not the ideal solution.

7. What are the transaction costs involved in converting the excess resources into an income stream?

In addition to increased legal fees and possible accountant costs for allocating the income and interest earned on the income, do you have to pay for the creation of the note or the annuity?

8. What types of investments are being exchanged/liquidated to get the fixed income?

Will the community spouse face capital gains taxes on the liquidation of the resources in order to convert it into an income stream? If so, are the taxes due larger or smaller than a possible contribution claim?

If the assets to be sold/liquidated are all stocks with a low basis, then it may not be worth converting. If the assets are just cash sitting in a bank account and the client is looking for something to do with the funds anyway, then this may be a different conversation to have.

In sum, although the concept of converting excess resources into an income stream is an excellent yet complex tool, it is important to consider the above factors prior to utilizing this tool as in some cases, this may not be the ideal tool to accomplish all of the client's goals.

Endnotes

1. *See* New York Social Services Law ("NY SSL") §366.5(e)(4)(ii)(A).
2. *See* NY SSL §366.3(a).
3. The implied contract is only created if the spouse has sufficient income and resources at the time that Medicaid is provided. *See Commissioner of the Dep't of Soc. Servs. v. Spellman*, 672 N.Y.S.2d 298 (1st Dept. 1998).
4. *See* NY SSL §366.3(a).
5. *See* Medicaid Reference Guide at p. 277.
6. *See* NY SSL §366-c.2(h); 18 NYCRR 360-4.10(a)(8).
7. *See* NY SSL §366-c.2(d); 18 NYCRR 360-4.10(a)(4)(ii).
8. *Commr. of the Dept. of Social Servs. of the City of N.Y. v Scola*, 2011 NY Slip Op. 33019[U] [Sup Ct., NY County 2011].
9. 18 NYCRR 360-4.10(b)(5).
10. NY Social Services law 366-c.8(b) and NY Social Services Law 366-c.8(c); 18 NYCRR 360-4.10(b)(6) and 18 NYCRR 360-4.10(c)(7).
11. GIS 15 MA/21.
12. NY Social Services Law 366.5(e)(3)(iii); 06 OMM/ADM-5, GIS 06 MA/016 and Medicaid Reference Guide Page 334 (updated June 2010).
13. 18 NYCRR 366.5(e)(3)(i); *see also* 06 OMM/ADM-5, GIS 06 MA/016, and Medicaid Reference Guide pages 452-54 (updated January 2011).
14. 1-7 Bender's New York Elder Law § 7.03(2) (2015).
15. 18 NYCRR 360-4.10(b)(4); Medicaid Reference Guide page 276 (updated November 2007).
16. Medicaid Reference Guide at 277 (November 2007).
17. NY SSL 366.5(e)(3)(iii); 06 OMM/ADM-5, GIS 06 MA/016 and Medicaid Reference Guide, Page 334 (updated June 2010).
18. The longer the term of the note, the lower the income. At the end of the day you are tying up your client's funds. The question is—for how long?

Regina Kiperman is a Partner and Naomi Levin is an Associate with Grimaldi & Yeung, LLP. Regina focuses on Probate and Estate Administration, Estate Litigation, Elder Law (including guardianship and Medicaid planning), and Estate Planning. Naomi focuses on Elder Law, Estate Planning, and Guardianship.

To Whom It May Concern:

Please accept the application of my spouse,_____, for Medicaid. Although information on my resources and income are being provided on the application, I am not applying for Medicaid for myself. I am unable to contribute anything from my income and resources toward the cost of my spouse's medical care.

Please consider my spouse's application solely on the basis of their income and resources. On the basis of New York Social Services Law Section 366 (3) (a), I understand that it is my spouse's right to obtain Medicaid even though I find it necessary to refuse to contribute my own funds toward my spouse's care.

Signed:_____

Dated:_____

Loan Programs for Properties in Irrevocable Trust? How to Navigate Through Trust Lending Options

By Britt Burner and Frank Melia

All too often we have clients asking if they can get a reverse mortgage or line of credit even if their home has been placed into an irrevocable grantor trust for Medicaid protection purposes. Their home may be the only asset that they have equity in, especially if they have outlived their savings. Frank Melia, CMPS of Quontic Bank, sat down with me to explain options for clients that need to access the equity in their homes.

Q When a trust owns the home can a client get the same type of loan as when he or she owns the home outright in his or her sole name?

A No. Conventional mortgage financing guidelines ask for ownership to be in an individual(s) name. Any other type of ownership has historically not qualified for conforming/conventional mortgage financing. When an individual purchases or refinances a home we usually receive a Fannie Mae or Freddie Mac guideline-driven mortgage. Once you transfer ownership to an LLC, corporation, or trust you no longer qualify for conventional financing. Loans to these types of entities are known as "portfolio loans."

Q How do you determine what lending options are available to potential borrowers?

A Our bank guidelines include looking at occupants/grantors, beneficiaries, and trustees as potential guarantors. Property type, location of property, and valuation also determine what type of lending options we can offer. We prefer to look at the occupants/grantors as our loan program guarantors. With different lending options available we can recommend the proper lending terms for the individual situation and family needs.

Q What are some creative solutions you have come up with to access the equity an individual has in his or her home?

A We have offered mortgage financing with 5/1 ARM Terms for trustees of an irrevocable trust who were looking to purchase more four-family investment properties. We also have offered financing with Home Equity Conversion Mortgage ("HECM") line of credit terms to provide funds for private pay home care providers. Quontic

Britt Burner

Frank Melia

Bank can approve a reverse mortgage for a property transferred into an irrevocable trust and the line of credit option works well with most Medicaid planning strategies. I personally review the trusts for our bank and I find most trusts do receive approval.

A majority of the loans families have decided to use to satisfy their needs include a Home Equity Conversion Mortgage Line of Credit ("HECM LOC") so there is liquidity to the beneficiaries of trust assets. There are less stringent income and credit guidelines to get approval with a reverse mortgage. A reverse mortgage is also a non-recourse loan so no credit reporting is necessary and heirs of the estate will never owe more than the property's value once the borrower passes.

Q What can we do as attorneys to protect our clients' ability to access these types of loans?

A When a family sits down with their attorney to discuss the family's legacy and their need to protect what they have worked so long for, it makes sense to include verbiage in your trust document to ensure as many future lending options as possible. In order for us to approve lending for a property held in trust we need certain language in the trust including that the grantor is a lifetime income beneficiary. Our bank offers a review of any revocable and irrevocable trusts and will recommend additions or special language needed to ensure lending option approvals.

Q What if only a small amount of equity is needed from the property?

A A good example of this is the homeowner who needs a small amount of money to address a home improvement. Usually it is an amount no greater than $20,000 and it is a typical home improvement project including a new roof, kitchen or bathroom, or a new boiler or heating system. Lending programs have costs with closing and when the amount needed is relatively small in comparison to the home's value we can recommend quicker options including credit card financing, personal loans, or other bank products.

Q What are some of the worst case scenarios you have seen regarding lending to homes owned by a trust?

A We have spoken with families who have had an irrevocable trust for over 10 years who were told they must transfer title back into their individual names in order to get financing because their bank would not lend to trust-owned properties. We even had a family go to a different bank that recommended the transfer to their individual names, and then the bank denied the financing anyway. A consultation with us and a simple review of your trust document can save a lot of headaches and money for many families.

In most cases the family home is the largest asset. As our clients are living longer they may find themselves running out of liquid assets. It is useful for attorneys to be aware of ways to access the equity in the home.

Britt Burner manages the Manhattan office of Nancy Burner & Associates, P.C. Britt is a member of the Executive Committee of the New York State Bar Association Elder Law and Special Needs Planning Section as a Vice-Chair of the Legislative Committee and previously as a Vice-Chair of the Medicaid Committee.

Frank Melia entered the financial services industry in 1990 and worked as a financial advisor until the year 2000. Residential & Commercial Lending have been Frank's focus for the past 16 years. Frank regularly appears on the AM970 Radio show *Ask the Lawyer with Mike Connors* as a reverse mortgage expert. Frank works with some of the most respected and highly regarded professionals in their respective fields which include, Estate/Elder Care planning attorneys and law firms, financial planners, bankers and CPA/accounting Firms. Frank received his Certified Mortgage Planning Specialist designation in 2007 and offers mortgage planning services including purchase and refinance loans, reverse mortgages, commercial financing and construction loans. Frank can be reached at fmelia@quonticbank.com.

New York NAELA Niche

By Robert P. Mascali

Some Very Important Wins Leading Into an Uncertain 2017

The past year has seen a number of significant national developments in the areas of elder law and special needs planning and the National Academy of Elder Law Attorneys (NAELA) with the New York Chapter has been involved in many of them.

Robert P. Mascali

Special Needs Trust Fairness Act

On December 7, 2016 the United States Senate approved the 21st Century Cures Act (H.R.34) by an overwhelming majority and President Obama signed it into law on December 13th resulting in the elimination of the discriminatory provision that prevented a competent individual with disabilities from being able to establish his/her own Special Needs Trust (SNT) under 42 U.S.C. 1396p(d)(4)(A). The insertion of the two words "the individual" in addition to parent, grandparent, guardian or a court, as to who is able to establish such a trust, has ended years of delay and frustration for individuals with disabilities and those representing and advocating for them and their families.

The discussion as to whether the original statute that prevented the individual from establishing this type of trust while permitting it for pooled trusts under 1396p(d)(4)(C) was a drafting oversight, the result of personal beliefs or a vestige of the culture at the time is now happily confined to the archives. The important consequence of this statutory change is that beneficiaries with mental capacity can now establish and fund their own SNT without any undue difficulty or delay. The movement for this change has been supported by NAELA from the very beginning and in a statement NAELA President Catherine Anne Seal called the passage "a monumental moment for NAELA advocacy", while at the same time calling out for special recognition a number of NAELA members including Michael Amoruso and Howie Krooks, two past presidents of NY NAELA, and the NYSBA Elder Law and Special Needs Section.

ABLE Act

While the federal law (Achieving a Better Life Experience Act) was enacted at the end of 2014 it required the individual states to take the steps necessary to implement the law within their own state. Currently, ten states have implemented ABLE—Alabama, Florida, Ohio, Nebraska, Tennessee, Michigan, Oregon, Kentucky, Rhode Island and Virginia, and all of these states except for Florida permit accounts to be opened by non-residents (see www.ablenrc.org for updates on state implementation of ABLE). The effort to enact and implement ABLE in New York was stalled due to bureaucratic and legislative inertia but finally this past legislative session, due in part through the persistence of NY NAELA, the legislature passed and Governor Cuomo signed the bill so that implementation in New York may be only a short time away...hopefully in 2017.

Medicare Observation Status

This past year the issue of "obervation status" and Medicare came to a head. As a result, and beginning August 6, 2016, the Notice of Observation Treatment and Implication for Care Eligibility Act (NOTICE Act) required hospitals to provide written and oral notice, within 36 hours, to patients who are in observation or other outpatient status for more than 24 hours. The notice must explain the reason that the patient is an outpatient (and not an admitted inpatient) and describe the implications of that status both for cost-sharing in the hospital and for subsequent "eligibility for coverage" in a skilled nursing facility (SNF). The Center for Medicare Advocacy (Center) has written extensively about patients in hospitals who receive medically necessary care, tests, treatment, and medications ordered by their physicians but are in observation status or are otherwise called outpatients, rather than admitted inpatients.

The consequences for these patients are generally not medical. CMS confirmed that physicians can order whatever care their patients need, regardless of whether they are labeled inpatients or outpatients. A primary consequence for patients of the inpatient/outpatient Medicare billing distinction is financial: Medicare will not pay for post-hospital care in a SNF unless a patient is classified as an inpatient for at least three consecutive days, not counting the day of discharge. Observation status and outpatient status are not inpatient and they do not qualify a patient for Medicare Part A coverage of SNF care. After the completion of the regulatory process and considerable delay, CMS has issued the final form of the required notice. It is referred to as The MOON (Medicare Outpatient Observation Notice) and it is a standardized notice to inform beneficiaries

(including Medicare health plan enrollees) that they are an outpatient receiving observation services and are not an inpatient of the hospital or (CAH). Medicare Outpatient Observation Notice (MOON) and accompanying form instructions are available online at the CMS website (see https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2016-Fact-sheets-items/2016-12-08-3.html for the fact sheet and at https://www.cms.gov/Medicare/Medicare-General-Information/BNI/index.html?redirect=/bni for the forms. Manual instructions are to be made available in early 2017. All hospitals and critical access hospitals (CAHs) are required to provide the MOON beginning no later than March 8, 2017.

While we can savor these victories from 2016, there is considerable concern for the prospects for the elderly and individuals with disabilities as 2017 arrives. Both National NAELA and the NY Chapter will keep our colleagues advised as to developments on the national stage. There was a special webinar on January 10, 2017 at 1:00PM ET-NAELA "Strategy for the New Congress."

Robert P. Mascali is currently the president of the New York Chapter of NAELA. He is a senior consultant at the Center for Special Needs Trust Administration, Inc. which is a national nonprofit organization that administers supplemental needs trusts. Mr. Mascali is responsible for the New York and New England markets for The Center. Mr. Mascali is a member of the New York State Bar Association and its Elder Law and Special Needs and the Trusts and Estates sections. He serves on the Executive Committee and is Co-Vice Chair of the Special Needs Planning and the Legislation Committees of the Elder Law and Special Needs Section. He is also a member of Massachusetts NAELA.

MEDICAID UPDATE

Richard A. Marchese, Esq.
Woods Oviatt Gilman LLP
2 State Street 700 Crossroads Building
Rochester, NY 14614
585-987-2859
rmarchese@woodsoviatt.com

WOODS OVIATT GILMAN

The art of representing people

What is the Medicaid Program?

- US Supreme Court- the Medicaid statute is "among the most intricate ever drafted by Congress," with a "Byzantine construction" that is "almost unintelligible to the uninitiated." *Schweiker v. Gray Panthers*, 453 U.S. 34, 43 (1981).

WOODS OVIATT GILMAN LLP
The art of representing people

What is the Medicaid Program?

- A "virtually impenetrable thicket of legalese and gobbledygook"- *Lamore v. Ives*, 977 F. 2d 713, 716 (5th Cir. 1992)
- "An aggravated assault on the English language, resistant to attempts to understand it." – *Friedman v. Berger, 409* F. Supp. 1225,1226 (S.D.M.Y. 1976).

WOODS OVIATT GILMAN LLP
The art of representing people

A "serbonian bog." (A bog in which entire armies have sunk- John Milton)

WOODS OVIATT GILMAN LLP
The art of representing people

GIS 16 MA/18

- Effective January 1, 2017:
- MMMNA - $3,022.50
- Maximum CSRA- $120,900 (minimum remains $74,820)
- "Medically Needy" Resource level remains at $14,850
- SSI resource level remains at $2,000 ($3,000 for couples)

GIS 16 MA/18

- Community Medicaid income level remains at $825 per month
- Personal needs allowance for waiver participants subject to spousal budgeting is $384 per month
- Home equity limit increased to $840,000

2017 Medicaid Regional Rates for Calculating Transfer Penalty

- Applicable to applications filed after January 1, 2017 as per GIS MA/016
- Central - $9,551
- Northern Metropolitan- $12,198
- Northeastern- $10,242
- New York City- $12,157
- Long Island- $12,811
- Western- $10,078
- Rochester- $11,237

GIS 16 MA/015 - 2016 Update to the Actuarial Life Expectancy Table

- the life expectancy table issued by SSA is required to be used in evaluating whether an annuity purchased by or on behalf of an applicant/recipient on or after February 8, 2006 is actuarially sound. The table is also used in determining whether the repayment term for a promissory note, loan or mortgage is actuarially sound.
- Effective 12/09/16

CMS final nursing home rule bans pre-dispute arbitration agreements

- CMS Final Rule issued September 28,2016 "Reform of Requirements for Long-Term Care facilities.
- To become effective November 28, 2016
- One of new requirements prohibits nursing homes receiving Medicare/Medicaid funds from entering into pre-dispute binding arbitration agreements with any resident nor requiring a resident to sign an arbitration agreement as a condition of admission.

CMS final nursing home rule bans pre-dispute arbitration agreements

- American Health Care Association (AHCA) brought suit against CMS over the new arbitration regulation.
- Preliminary Injunction issued on November 7,2016 by U.S. Dist. Ct. for Northern Dist. Of Mississippi in *AHA et al. v Burwell and Slavitt*, Civil Action No. 3:16-CV-00233.
- CMS Memorandum December 9, 2016 suspends enforcement until injunction lifted.

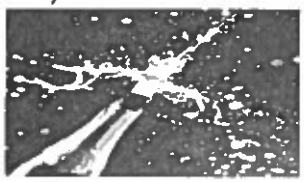
Nursing Home Arbitration Suit

- U. S. Supreme Court has agreed to weigh in on validity of nursing home arbitration agreements- cert. granted on October 28, 2016 in in *Kindred Nursing Centers, et al. V. Clark, Janis E., et al.*
- Appeal from decision from the Supreme Court of Kentucky (478 S.W.3d 306). that struck down the arbitration agreements at issue.
- To be argued on February 22, 2017.

WOODS OVIATT GILMAN
The art of representing people

Special Needs Trust Fairness Act signed into law

- On Dec. 13, 2016, President Obama signed the 21st Century Cures Act (H.R.34 — 114th Congress (2015-2016)). Section 5007 of the Act, titled "Fairness in Medicaid Supplemental Needs Trusts" incorporates language from the Special Needs Trust Fairness Act of 2015 by adding two words ("the individual") to the existing statute.



WOODS OVIATT GILMAN
The art of representing people

Special Needs Trust Fairness Act

- Remarkably, the SSA issued an Emergency Message- EM-16053, effective for SNTs established after December 13, 2016 (adding "the individual" to list of entities/persons that may establish a self-settled SNT.
- NY NAELA and this Elder Law Section are working to have the State statute (SSL 366) amended to conform with the new federal amendment.

Special Needs Trust Fairness Act

- Can we proceed to have a beneficiary create their own trust, or do we have to wait until New York amends the Social Services Law?
- Proposed amendment to SSL 366(2)(b)(2)(iii) simply adds the words *"by the individual" to list of those individuals/entities who are allowed to cerate a self-settled SNT.*

SSL 366 (2)(b)(2)(iii) *Notwithstanding the provisions of clauses (i) and (ii) of this subparagraph, in the case of an applicant or recipient who is disabled, as such term is defined in section 1614(a)(3) of the federal social security act, the department must not consider as available income or resources the corpus or income of the following trusts which comply with the provisions of the regulations authorized by clause (iv) of this subparagraph: (A) a trust containing the assets of such a disabled individual which was established for the benefit of the disabled individual while such individual was under sixty-five years of age* ***by the individual,*** *a parent, grandparent, legal guardian, or court of competent jurisdiction, if upon the death of such individual the state will receive all amounts remaining in the trust up to the total value of all medical assistance paid on behalf of such individual;*

Asset Verification System

- Section 1940 of the Social Security Act requires states to implement a system for verifying assets to determine Medicaid Eligibility for SSI-Related Individuals.
- A/Rs will now be required to provide authorization for the state to obtain records from financial institutions.
- Districts have received a draft ADM for comment and review.

WOODS OVIATT GILMAN LLP
The art of representing people

AVS

- Will electronically verify accounts held in banking institutions and conduct searches of real property owned by the A/R and the A/R's spouse.
- For chronic care applications, the AVS will provide information for the 60 month look-back period, including accounts that were closed during that time period.
- State will then presumably flag for the LSDS transactions that could be potential disqualifying transfers.

AVS

- Only applies at this time to financial institution accounts.
- "Late" AVS responses
  - What happened if LSDS determines eligibility before receiving a response back from the State? Will eligibility be re-determined based upon new information form AVS?

  How does the AVS change our practice?

National Case law Review

- *Shackelford v. Lake*, 2016 U. S. Dist. Lexis 164199 (U.S.D.C. Western Dist. Of Oklahoma, Nov. 29, 2016)
  - When is a Medicaid plan a "scheme"?
  - Applicant for Medicaid created an LLC with an operating agreement "restricting" her interest in the LLC.
  - Deemed a transfer of assets.

National Case Law Review

- *In re Estate of Skinner*, 787 S.E.2d 440 (NC Ct. of Appeals, 2016).
- Action to remove spouse as Trustee of his wife's special needs trust.
  - Interpretation of the "sole benefit" rule.
  - Fact that spouse of trust beneficiary lived in house owned by trust, and used furniture and appliances, does not violate the "sole benefit" rule.

National Case Law Review

- *Mahannah v. State of Illinois*, 2016 IL App (4th) 150838-U.
- Son filed Medicaid application for his mother.
- Two weeks prior to application, mother had purchased a single premium whole life insurance policy for $164,000,which, upon mother's death, paid the son $1,474 per month for ten years.

National Case Law Review

- Ct. held that the purchase of single premium life insurance policy is "substantially similar to an annuity". The purchase cannot be described as "actuarially sound" because benefits are not paid until death.
- Purchase of the policy is therefore a non-allowable transfer of assets for less than fair market value.

New York State Case Law Review

Transfer Rebuttal cases

- *Matter of Collins v Zucker*, 2016 N.Y. Slip Op 07897, App. Div. LEXIS 7738 (3rd dept. 11/23/16).
- **Great advocacy (and facts)**
- But..... see
- *Burke v Zucker*, 2016 N.Y. Slip Op 08737, App. Div. LEXIS 8521 (4th Dept. 12/23/16).

  and
- *Matter of Krajewski v Zucker*, 2016 N.Y. App. Div. LEXIS 8150 (3rd. Dept. 12/8/16)

WOODS OVIATT GILMAN LLP
The art of representing people

New York State Case Law

- *Wayne Health Care DeMay Living Ctr. v Estate of Gaudio,* 2016 N.Y. Misc. LEXIS 3053 (Sup. Ct. Wayne Co., 8/16/16).
- Common law Doctrine of Necessaries is (unfortunately) alive and well- at least in Wayne County!
- "Under the traditional doctrine, a creditor seeking to recover from a husband necessaries furnished to a wife has the burden of proving that the necessaries were furnished on the credit of the husband…"
- Summary Judgment granted to Plaintiff nursing facility.

New York State Case Law

- *Woods v. Tompkins Cnty.*, 2016 U.S. Dist. LEXIS 127852 (5:16-CV-0007, U. S. Dist. Ct. Northern Dist. of NY, 9/20/16).
- Interpretation of *Olmstead* and the Americans with Disabilities Act (" ADA")- *"risk of institutionalization is per se discrimination based on disability."*
- *No need to exhaust administrative remedies when a case is brought under Title II of the ADA.*

New York Case Law

- *Matter of Kroll v New York State Dept. of Health*, 39 N.Y.S.3d 183 (2nd Dept., 10/05/16).
- Grandfather created a trust for grandson (now 20 years old, disabled, receiving SS and Medicaid, living with parents).
- Under terms of Trust, grandson has right to withdraw principal upon reaching age 21.
- Trustees appoint principal to a new SNT (decanting) prior to beneficiary turning 21.

New York Case Law

- *Kroll* (cont.)
- DOH argues that it must be a payback trust because the original trust contained the assets of the grandson.
- Court disagreed with DOH:- beneficiary had no vested rights in Trust at time of the decanting, and grandfather funded the Trust.
- Court approved the decanting, affirming the Surrogate below. Decanting allowed, payback provision not required.

Fair Hearing decisions

- *FH#7292419J*- Erie County, 8/10/16
- Interpretation of Entrance Fee for CCRC- a "loan" or a "gift"?
- Son paid $195,457 of his own money to the CCRC to meet his mother's "Entrance fee" obligation.
- Mother designates in writing her son as the recipient of any refund due under the terms of the Agreement "as a result of my death."

WOODS OVIATT GILMAN LLP
The art of representing people

Fair Hearing Decisions

06 OMM/ADM-5, p. 26- an individual's entrance fee in a continuing care retirement community or life care community shall be considered a resource to the extent that:

- the individual has the ability to use the entrance fee, or the contract provides that the entrance fee may be used, to pay for care should other resources or income of the individual be insufficient to pay for such care;
- the individual is eligible for a refund of any remaining entrance fee when the individual dies or terminates the continuing care retirement community or life care community contract and leaves the community; and
- the entrance fee does not confer an ownership interest in the continuing care retirement community or life care community.

WOODS OVIATT GILMAN LLP
The art of representing people

Fair Hearing Decisions

- *FH#7292419J-* Erie County, 8/10/16 (cont.)
- Mother argues that she effectively assigned her right to receive a refund of the entrance fee to her son, thereby creating a legal impediment to using the funds for skilled nursing care.
- No written evidence of a loan.
- Ruling- entrance fee is indeed a resource of the mother- must be spent down before applying for Medicaid.

Fair Hearing Decisions

- *FH# 7374309Y-* NYC/ 10/21/16
- *Homefirst, a MMLTC,* couches a discontinuance of 24/7 live-in personal care services as a denial of services.

Fair Hearings

- FH# 7353679K- NYC, 9/1/16
- Having Mom around is not a safe "back-up" plan to justify the MMLTC approving less than 24/7 care.
- ALJ cites the NYS Medicaid guidelines for authorization of private duty nursing services- "back up" non-medical caregivers are not expected to provide and render complex nursing care.

WOODS OVIATT GILMAN LLP
The art of representing people

Fair Hearings

- FH#7098431R, Westchester County, 10/14/16
- Excellent transfer rebuttal decision- pattern of gifting established.
- Checks written in 2010 for $10,000.00 to each of her eight children.
- Appellant "financially independent" before and after she entered a SNF.

WOODS OVIATT GILMAN LLP
The art of representing people

Fair Hearings

- FH# 7110582N- Cattaraugus County, 12/13/16
- Court Ordered Child support garnished from recipient's Social Security is not deducted from the NAMI.
- 18 NYCRR 360-4.6.
- *Himes v. Sullivan*, 999 F.2d 684 (2nd. Cir., 1993).

Fair Hearings

- FH# 7368958K- Oneida County, 10/19/16
- Community spouse budgeting still allowed when spouse of SNF recipient is residing in an Assisted Living Facility.
- Agency insisted on non-spousal budgeting- Agency reversed.

Fair Hearings

- FH# 7361762Z- Erie County, 11/22/16
- **BEWARE THE USE OF TEMPLATES!!**
- **Spousal refusal affidavit submitted with application pertained to a "third party."**
- **Agency declined to honor it, issued decision denying application for excess resources.**
- **Agency stated that it was not their place to give legal advice.**
- **Correct spousal refusal affidavit submitted at hearing.**

Fair Hearings

- FH# 7361762Z- Erie County, 11/22/16 (cont.)
- Agency upheld!
- **BEWARE THE USE OF TEMPLATES!!**

Fair Hearings

- FH# 7273600L, Nassau County, 9/2/16
- When is a wheelchair ramp a "medical necessity"- according to this MMLTC, virtually never!
- Appellant requires assistance with all ADLs, relies on wheelchair for ambulation, receives 24 hour split shift personal care services.
- One exit from house.
- Appellant had not left his home for over a year.
- Agency reversed- good advocacy!

WOODS OVIATT GILMAN
The art of representing people

Fair Hearings

- FH# 7277126R- Putnam County, 8,22/16
- Single Premium Immediate Life Annuity is the appropriate benchmark to use when seeking to raise the CSRA.
- Spouse had income well below MMMNA- wanted to retain all of her excess resources.
- May only be done, as per regulations, at a Fair hearing.

WOODS OVIATT GILMAN
The art of representing people

Fair Hearings

- FH# 7244675Q, Onondaga County, 7/5/16
- Caregiver child exception to transfer penalty provisions is lost if the A/R moves to an assisted living facility prior to moving to a SNF.
- Mother deeded home to daughter in 2012 daughter had lived with her for well over two years.
- Mom transferred to an assisted living facility in 2013- eventually places in a SNF in 2015.
- Agency upheld- must reside with parent for at least two years immediately before the parent enters a SNF.

Fair Hearings

- FH #7206285Q- Suffolk County, 9/29/16
- **Beware of returning Gifts!!!** How the gifts are returned, from whom the gifts are returned and, and to whom the gifts are returned is critical.
- H& W create two separate Irrevocable Medicaid Trusts in July 2008. Trust funded in 2009 and 2010.
- Trustees are children (who are also the beneficiaries).

Fair Hearings

- FH #7206285Q- Suffolk County, 9/29/16 (cont.)
- Medicaid app- April 2014.
- To avoid transfer penalty- children/trustees return $ in trust to children, who in turn pay $ back to parents-Trust presumably had a "trap door" provision allowing distributions of principal to children.

Fair Hearings

- FH #7206285Q- Suffolk County, 9/29/16 (cont.)
- 96 ADM-8: "*Transferred assets shall be considered to be returned if the person to whom they were transferred…uses them to pay for nursing facility services for the A/R or provides the A/R with an equivalent amount of cash or other liquid assets.*"
- *Agency Upheld.*

Thank You!

Richard A. Marchese, Esq.
Woods Oviatt Gilman LLP
2 State Street 700 Crossroads Building
Rochester, NY 14614
585-987-2859
rmarchese@woodsoviatt.com

WOODS OVIATT GILMAN
The art of representing people

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-26-12
Baltimore, MD 21244-1850

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES
CENTER FOR MEDICAID & CHIP SERVICES

CMCS Informational Bulletin

DATE: December 2, 2016

FROM: Vikki Wachino
Director
Center for Medicaid and CHIP Services

SUBJECT: 2017 SSI and Spousal Impoverishment Standards

This CMCS informational bulletin is to provide an update on the 2017 Supplemental Security Income (SSI) and Spousal Impoverishment Standards.

Certain Medicaid income and resource standards are adjusted beginning each January in accordance with changes in the SSI federal benefit rate (FBR) and the Consumer Price Index (CPI). Many states offer, for example, categorical eligibility to individuals who are not receiving SSI but who meet the financial eligibility requirements of the program, as authorized by 1902(a)(10)(A)(ii)(I) of the Social Security Act ("the Act"). Similarly, most states have adopted the "special income level" institutional eligibility category authorized under Section 1902(a)(10)(A)(ii)(V) of the Act, the maximum income standard for which is 300% of the SSI FBR. Additionally, certain eligibility standards relating to coverage of long-term services and supports, including the home equity limitation in Section 1917(f) of the Act and elements of the spousal impoverishment statute in Section 1924, are increased each year based on increases in the CPI for All Urban Consumers (CPI-U).

Included with this informational bulletin is the *2017 SSI and Spousal Impoverishment Standards* chart that displays the new standards. These standards are also available on Medicaid.gov at http://medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Eligibility/Spousal-Impoverishment-Page.html. Please update your standards in accordance with this information for the provisions that become effective on January 1, 2017.

If you have any questions or need additional information, please contact Gene Coffey at 410-786-2234 or Gene.Coffey@cms.hhs.gov.

2017
SSI and Spousal Impoverishment Standards

Supplemental Security Income (SSI)

Effective 1-1-17

	SSI Federal Benefit Benefit Rate (FBR)	SSI Resource Standard	Income Cap Limit (300%)	Earned Income Break Even Point	Unearned Income Break Even Point
Individual	735.00	2,000.00	2,205.00	1,555.00	755.00
Couple	1,103.00	3,000.00	N/A	2,291.00	1,123.00

Substantial Gainful Activity (SGA) Limit: 1,170.00 (Blind SGA: 1,950.00)

CPI Increase for 2017: 1.5%
CPI Increase, Since September 1988: 101.5%

Spousal Impoverishment

Effective 1-1-17 Unless Otherwise Noted

Minimum Monthly Maintenance Needs Allowance (MMMNA):
(Effective 7-1-16)

2,002.50	All States (Except Alaska and Hawaii)
2,502.50	Alaska
2,302.25	Hawaii

Maximum Monthly Maintenance Needs Allowance: 3,022.50

Community Spouse Monthly Housing Allowance:
(Effective 7-1-16)

600.75	All States (Except Alaska and Hawaii)
750.75	Alaska
690.68	Hawaii

Community Spouse Resources:

Minimum Resource Standard: 24,180.00
Maximum Resource Standard 120,900.00

Home Equity Limits:

Minimum: 560,000.00
Maximum: 840,000.00

TO:	Local District Commissioners, Medicaid Directors
FROM:	Judith Arnold, Director Division of Eligibility and Marketplace Integration
SUBJECT:	Medicaid Regional Rates for Calculating Transfer Penalty Periods for 2017
EFFECTIVE DATE:	January 1, 2017
CONTACT PERSON:	Local District Support Unit Upstate (518) 474-8887 NYC (212) 417-4500

The purpose of this General Information System (GIS) message is to inform local departments of social services of the year 2017 Medicaid regional rates which must be used when calculating a transfer of assets penalty period for coverage of nursing facility services. This is in accordance with 96 ADM-8, "OBRA '93 Provisions on Transfers and Trusts" and 06 OMM/ADM-5, "Deficit Reduction Act of 2005 – Long-Term Care Medicaid Eligibility Changes." These rates are based on average private pay nursing home costs in each of the seven regions in the State. Districts must use the regional rate in effect as of the date of application or the date of request for an increase in coverage for the region in which the facility is located.

Central $9,511

Broome	Jefferson	Oswego
Cayuga	Lewis	St. Lawrence
Chenango	Madison	Tioga
Cortland	Oneida	Tompkins
Herkimer	Onondaga	

Northeastern $10,242

Albany	Fulton	Saratoga
Clinton	Greene	Schenectady
Columbia	Hamilton	Schoharie
Delaware	Montgomery	Warren
Essex	Otsego	Washington
Franklin	Rensselaer	

Western $10,078

Allegany	Niagara
Cattaraugus	Orleans
Chautauqua	Wyoming
Erie	
Genesee	

Northern Metropolitan $12,198

Dutchess	Ulster
Orange	Westchester
Putnam	
Rockland	
Sullivan	

New York City $12,157

Bronx	Queens
Kings (Brooklyn)	Richmond (Staten Island)
New York (Manhattan)	

Long Island $12,811

Nassau
Suffolk

Rochester $11,237

Chemung	Seneca
Livingston	Steuben
Monroe	Wayne
Ontario	Yates
Schuyler	

TO:	Local District Commissioners, Medicaid Directors
FROM:	Judith Arnold, Director Division of Eligibility and Marketplace Integration
SUBJECT:	2016 Update to the Actuarial Life Expectancy Table
ATTACHMENT:	2016 Life Expectancy Table
EFFECTIVE DATE:	Immediately
CONTACT PERSON:	Local District Support Unit Upstate (518) 474-8887 NYC (212) 417-4500

The purpose of this General Information System (GIS) message is to provide local departments of social services with the updated life expectancy table issued by the Office of the Chief Actuary of the Social Security Administration (SSA).

As advised in Administrative Directive 06 OMM/ADM-5, "Deficit Reduction Act of 2005 – Long-Term Care Medicaid Eligibility," the life expectancy table issued by SSA is required to be used in evaluating whether an annuity purchased by or on behalf of an applicant/recipient on or after February 8, 2006 is actuarially sound. The table is also used in determining whether the repayment term for a promissory note, loan or mortgage is actuarially sound.

The life expectancy table that was attached to 06 OMM/ADM-5 as Attachment VIII, is being updated to reflect the current information obtained from the Office of the Chief Actuary of the Social Security Administration. The revised life expectancy table is provided as an attachment to this GIS. Effective with the release of this GIS, districts must use the revised table.

Please direct any questions to your local district support liaison.

2016 Life Expectancy Table

Age	Male Life Expectancy	Female Life Expectancy	Age	Male Life Expectancy	Female Life Expectancy
0	76.28	81.05	30	47.82	52.01
1	75.78	80.49	31	46.89	51.04
2	74.82	79.52	32	45.96	50.08
3	73.84	78.54	33	45.03	49.11
4	72.85	77.55	34	44.10	48.15
5	71.87	76.56	35	43.17	47.19
6	70.88	75.57	36	42.24	46.23
7	69.89	74.58	37	41.31	45.28
8	68.90	73.58	38	40.38	44.33
9	67.90	72.59	39	39.46	43.37
10	66.91	71.60	40	38.53	42.43
11	65.92	70.60	41	37.61	41.48
12	64.92	69.61	42	36.70	40.54
13	63.93	68.62	43	35.78	39.60
14	62.94	67.63	44	34.88	38.66
15	61.96	66.64	45	33.98	37.73
16	60.99	65.65	46	33.08	36.81
17	60.02	64.67	47	32.19	35.89
18	59.05	63.68	48	31.32	34.97
19	58.09	62.70	49	30.44	34.06
20	57.14	61.72	50	29.58	33.16
21	56.20	60.75	51	28.73	32.27
22	55.27	59.77	52	27.89	31.38
23	54.33	58.80	53	27.05	30.49
24	53.40	57.82	54	26.23	29.62
25	52.47	56.85	55	25.41	28.74
26	51.54	55.88	56	24.61	27.88
27	50.61	54.91	57	23.82	27.01
28	49.68	53.94	58	23.03	26.16
29	48.75	52.97	59	22.25	25.31

2016 Life Expectancy Table

Age	Male Life Expectancy	Female Life Expectancy	Age	Male Life Expectancy	Female Life Expectancy
60	21.48	24.46	90	4.03	4.80
61	20.72	23.62	91	3.74	4.45
62	19.97	22.78	92	3.47	4.13
63	19.22	21.95	93	3.23	3.84
64	18.48	21.13	94	3.01	3.57
65	17.75	20.32	95	2.82	3.34
66	17.03	19.52	96	2.64	3.12
67	16.32	18.73	97	2.49	2.93
68	15.61	17.95	98	2.36	2.76
69	14.92	17.18	99	2.24	2.60
70	14.24	16.43	100	2.12	2.45
71	13.57	15.68	101	2.01	2.30
72	12.92	14.95	102	1.90	2.17
73	12.27	14.23	103	1.80	2.03
74	11.65	13.53	104	1.70	1.91
75	11.03	12.83	105	1.60	1.78
76	10.43	12.16	106	1.51	1.67
77	9.85	11.50	107	1.42	1.56
78	9.28	10.86	108	1.34	1.45
79	8.73	10.24	109	1.26	1.35
80	8.20	9.64	110	1.18	1.26
81	7.68	9.05	111	1.11	1.17
82	7.19	8.48	112	1.04	1.08
83	6.72	7.94	113	0.97	1.00
84	6.27	7.42	114	0.90	0.92
85	5.84	6.92	115	0.84	0.85
86	5.43	6.44	116	0.78	0.78
87	5.04	5.99	117	0.72	0.72
88	4.68	5.57	118	0.67	0.67
89	4.34	5.17	119	0.61	0.61

TO:	Local District Commissioners, Medicaid Directors
FROM:	Judith Arnold, Director Division of Eligibility and Marketplace Integration
SUBJECT:	2017 Medicaid Levels and Other Updates
EFFECTIVE DATE:	January 1, 2017
CONTACT PERSON:	Local District Support Unit Upstate (518) 474-8887 NYC (212) 417-4500

The purpose of this General Information System (GIS) message is to advise local departments of social services (LDSS) of the levels and figures used in determining Medicaid eligibility effective January 1, 2017.

Due to a 0.3 percent cost of living adjustment (COLA) for Social Security Administration (SSA) payments effective January 1, 2017, several figures used in determining Medicaid eligibility must be updated. Since the increase to the Supplemental Security Income (SSI) benefit levels was relatively small, the Medically Needy Income and Resource Levels will remain the same.

Due to the low COLA and a statutory "hold harmless" provision designed to ensure that a beneficiary's Social Security benefit is not lower in January than it was in December due solely to the increase in Medicare Part B premiums, Medicare Part B premiums will vary depending on the amount of an individual's Social Security benefit in 2017. Medicare Part B premiums will increase by the amount of the individual's Social Security COLA. The net result of the COLA increase for many Medicaid recipients will be a $0 change in net available monthly income.

Since information concerning the manner in which Medicare Part B premiums would be impacted by the COLA was not received in time to make the necessary changes for the scheduled Mass Re-Budgeting (MRB) upstate, it was decided not to perform the MRB. While the MRB will not occur, the MBL tables and figures will be updated to reflect the 2017 figures. The updated MBL tables for upstate will be available December 5, 2016 and for New York City on December 9, 2016.

A chart with the new Medicaid levels is attached. MBL will be programmed to use these figures when a "From" date of January 1, 2017, or greater is entered.

Note: Budgets with a "From" date of January 1, 2017, or later, that utilize an FPL, must be calculated with the 2016 Social Security benefit amount and Medicare Part B premium until the 2017 FPLs are available on MBL. Upstate districts should separately identify these cases for re-budgeting once the 2017 FPLs are available as these cases will not be included in Phase Two of Mass Re-budgeting. In New York City, the 2016 Social Security benefit amounts and Part B premium should be used until Phase Two of Mass Re-budgeting. Upstate districts are instructed to update Social Security benefit amounts and Medicare Part B premiums for budgets that do not utilize a FPL at next contact or recertification, whichever occurs first.

The following figures are effective January 1, 2017.

1. Medically Needy Income and Resources Levels.

HOUSEHOLD SIZE	MEDICALLY NEEDY INCOME LEVEL		RESOURCES
	ANNUAL	MONTHLY	
ONE	9,900	825	14,850
TWO	14,500	1,209	21,750
THREE	16,675	1,390	
FOUR	18,850	1,571	
FIVE	21,025	1,753	
SIX	23,200	1,934	
SEVEN	25,375	2,115	
EIGHT	27,550	2,296	
NINE	29,725	2,478	
TEN	31,900	2,659	
EACH ADD'L PERSON	2,175	182	

2. The Supplemental Security Income federal benefit rate (FBR) for an individual living alone is $735/single and $1,103/couple.
3. The allocation amount is $384, the difference between the Medicaid income level for a household of two and one.
4. The 249e factors are .968 and .159.
5. The SSI resource levels remain $2,000 for individuals and $3,000 for couples.
6. The State Supplement is $87 for an individual and $104 for a couple living alone.
7. The Medicare Part A Hospital Insurance Base Premium is $227/month for people having 30-39 work quarters and $413/month for people who are not otherwise eligible for premium-free hospital insurance and have less than 30 quarters. The standard Medicare Part B monthly premium for beneficiaries with income less than or equal to $85,000 is $134.
8. The Maximum federal Community Spouse Resource Allowance is $120,900.
9. The Minimum State Community Spouse Resource Allowance is $74,820.
10. The community spouse Minimum Monthly Maintenance Needs Allowance (MMMNA) is $3,022.50.
11. Maximum Family Member Allowance is $668 until the FPLs for 2017 are published in the Federal Register.
12. Family Member Allowance formula number remains $2,003 until the FPLs for 2017 are published in the Federal Register.
13. Personal Needs allowance for certain waiver participants subject to spousal impoverishment budgeting is $384.
14. Substantial Gainful Activity (SGA) is: Non-Blind $1,170/month, Blind $1,950/month and Trial Work Period (TWP) $840/month.
15. SSI-related student earned income disregard limit of $1,790/monthly up to a maximum of $7,200/annually.
16. The home equity limit for Medicaid coverage of nursing facility services and community-based long-term care is $840,000.
17. The special income standard for housing expenses that is available to certain individuals who enroll in the Managed Long Term Care program (See 12 OHIP/ADM-5 for further information) vary by region. For 2017, the amounts are: Northeastern $471; Central $412; Rochester $419; Western $367; Northern Metropolitan $892; Long Island $1,285; and New York City $1,171.

Please direct any questions to the Local District Support Unit at 518-474-8887 for Upstate and 212-417-4500 for NYC.

NEW YORK STATE | Department of Health | Office of Health Insurance Programs

NEW YORK STATE INCOME AND RESOURCE STANDARDS FOR NON-MAGI POPULATION
EFFECTIVE JANUARY 1, 2017

HOUSE HOLD	MEDICAID INCOME LEVEL		100% FPL		120% FPL		133% FPL		135% FPL		150% FPL		185% FPL		200% FPL		250% FPL		RESOURCES	
SIZE	ANNUAL	MONTHLY	ANNUAL	MONTHLY	ANNUAL	MONTHLY	ANNUAL	MONTHLY	ANNUAL	MONTHLY	ANNUAL	MONTHLY	ANNUAL	MONTHLY	ANNUAL	MONTHLY	ANNUAL	MONTHLY		
ONE	9,900	825	11,880	990	14,256	1,188	15,801	1,317	16,038	1,337	17,820	1,485	21,978	1,832	23,760	1,980	29,700	2,475	14,850	1
TWO	14,500	1,209	16,020	1,335	19,224	1,602	21,307	1,776	21,627	1,803	24,030	2,003	29,637	2,470	32,040	2,670	40,050	3,338	21,750	2
THREE	16,675	1,390	20,160	1,680			26,813	2,235			30,240	2,520	37,296	3,108	40,320	3,360				3
FOUR	18,850	1,571	24,300	2,025			32,319	2,694			36,450	3,038	44,955	3,747	48,600	4,050				4
FIVE	21,025	1,753	28,440	2,370			37,826	3,153			42,660	3,555	52,614	4,385	56,880	4,740				5
SIX	23,200	1,934	32,580	2,715			43,332	3,611			48,870	4,073	60,273	5,023	65,160	5,430				6
SEVEN	25,375	2,115	36,730	3,061			48,851	4,071			55,095	4,592	67,951	5,663	73,460	6,122				7
EIGHT	27,550	2,296	40,890	3,408			54,384	4,532			61,335	5,112	75,647	6,304	81,780	6,815				8
NINE	29,725	2,478	45,050	3,755			59,917	4,994			67,575	5,632	83,343	6,946	90,100	7,509				9
TEN	31,900	2,659	49,210	4,101			65,450	5,455			73,815	6,152	91,039	7,587	98,420	8,202				10
EACH ADD'L PERSON	2,175	182	4,160	347			5,533	462			6,240	520	7,696	642	8,320	694				+

SPOUSAL IMPOVERISHMENT	INCOME	RESOURCES
Community Spouse	$3,022.50	$120,900
Institutionalized Spouse	$50	$14,850
Family Member Allowance	$2,003 (150% of FPL for 2) is used in the FMA formula the maximum allowance is $668	N/A

SPECIAL STANDARDS FOR HOUSING EXPENSES					
REGION	Amount	REGION	Amount	REGION	Amount
Central	$412	Northeastern	$471	Northern Metropolitan	$892
Rochester	$419	Long Island	$1,285		
Western	$367	New York City	$1,171		

*In determining the community resource allowance on and after January 1, 2016, the community spouse is permitted to retain resources in an amount equal to the greater of the following $74,820 or the amount of the spousal share up to $120,900. The spousal share is the amount equal to one-half of the total value of the countable resources of the couple as of the beginning of the most recent continuous period of institutionalization of the institutionalized spouse on or after September 30, 1989.

Revised December 6, 2016

NEW YORK STATE | Department of Health | Office of Health Insurance Programs

MAGI POPULATION						
CATEGORY	INCOME COMPARED TO	HOUSEHOLD SIZE		RESOURCE LEVEL		SPECIAL NOTES
		1	2	1	2	
PRESUMPTIVE ELIGIBILITY FOR PREGNANT WOMEN	223% FPL	N/A	2,978	NO RESOURCE TEST		Qualified provider makes the presumptive eligibility determination. Cannot spenddown to become eligible for presumptive eligibility.
PREGNANT WOMEN	223% FPL	N/A	2,978	NO RESOURCE TEST		A woman determined eligible for Medicaid for any time during her pregnancy remains eligible for Medicaid coverage until the last day of the month in which the 60th day from the date the pregnancy ends occurs, regardless of any change in income or household size composition. It the income is above 223% FPL the A/R must spenddown to the Medicaid income level. The baby will have guaranteed eligibility for one year.
CHILDREN UNDER ONE	223% FPL	2,208	2,978	NO RESOURCE TEST		If the income is above 223% FPL the A/R may apply for CHPlus or if chooses to spenddown, must spenddown to the Medicaid level. One year guaranteed eligibility if mother is in receipt of Medicaid on delivery. Eligibility can be determined in the 3 months retro to obtain the one year extension.
CHILDREN AGE 1 THROUGH 5	154% FPL	1,525	2,056	NO RESOURCE TEST		If income is above 154% FPL the A/R may apply for CHPlus or if chooses to spenddown, must spenddown to the Medicaid level.
CHILDREN AGE 6 THROUGH 18	110% FPL	1,089	1,469	NO RESOURCE TEST		If income is above 154% FPL the A/R may apply for CHPlus or if chooses to spenddown, must spenddown to the Medicaid level.
	154% FPL	1,525	2,056			
PARENTS/CARETAKER RELATIVES	138% FPL	1,367	1,843	NO RESOURCE TEST		If income is above 138% FPL the A/R may apply for APTC or if chooses to spenddown, must spenddown to the Medicaid Level.
19 AND 20 YEAR OLDS LIVING WITH PARENTS	138% FPL	1,367	1,843	NO RESOURCE TEST		If income is above 155% FPL the A/R can apply for APTC or if chooses to spenddown, must spenddown to Medicaid level.
	155% FPL	1,535	2,070			
SINGLE/CHILDLESS COUPLES AND 19 AND 20 YEARS LIVING ALONE	100% FPL	990	1,335	NO RESOURCE TEST		S/CCs cannot spenddown , but can apply for APTC. 19 and 20 year olds if income over 138% may apply for APTC or if chooses to spenddown, must spenddown to the Medicaid level.
	138% FPL	1,367	1,843			
FAMILY PLANNING PROGRAM	223% FPL	2,208	2,978	NO RESOURCE TEST		Eligibility determined using only applicant's income.

NEW YORK STATE | Department of Health | Office of Health Insurance Programs

NON-MAGI POPULATION						
CATEGORY	INCOME COMPARED TO	HOUSEHOLD SIZE		RESOURCE LEVEL		SPECIAL NOTES
		1	2	1	2	
UNDER 21, ADC-RELATED	MEDICAID LEVEL	825	1,209	NO RESOURCE TEST		
SSI-RELATED	MEDICAID LEVEL	825	1,209	14,850	21,750	Household size is always one or two.
Qualified Medicare Beneficiary (QMB)	100%FPL	990	1,335	NO RESOURCE TEST		Medicare Part A & B, coinsurance, deductible and premium will be paid if eligible.
COBRA CONTINUATION COVERAGE	100%FPL	990	1,335	4,000	6,000	A/R may be eligible for Medicaid to pay the COBRA premium.
AIDS INSURANCE	185%FPL	1,832	2,470	NO RESOURCE TEST		A/R must be ineligible for Medicaid, including COBRA continuation.
QUALIFIED DISABLED & WORKING INDIVIDUAL	200%FPL	1,980	2,670	4,000	6,000	Medicaid will pay Medicare Part A premium.
SPECIFIED LOW INCOME MEDICARE BENEFICIARIES (SLIMBS)	OVER 100% BUT AT OR BELOW 120% FPL	990	1,335	NO RESOURCE TEST		If the A/R is determined eligible, Medicaid will pay Medicare Part B premium.
		1,188	1,602			
QUALIFIED INDIVIDUALS (QI-1)	BETWEEN 120% BUT	1,188	1,602	NO RESOURCE TEST		If the A/R is determined eligible, Medicaid will pay Medicare Part B premium.
	LESS THAN 135% FPL	1,337	1,803			
MEDICAID BUY-IN PROGRAM FOR WORKING PEOPLE WITH DISABILITIES (MBI-WPD)	250%	2,475	3,338	20,000	30,000	Countable retirement accounts are disregarded as resources effective 10/01/11.

Social Security

Emergency Message

Identification Number:	**EM-16053**
Intended Audience:	All RCs/ARCs/ADs/FOs/TSCs/PSCs/OCO/OCO-CSTs /ODAR
Originating Office:	
Title:	**Information Regarding a Change in Supplemental Security Income (SSI) Special/Supplemental Needs Trust Policy– Permanent Instructions Will Follow Shortly**
Type:	EM - Emergency Messages
Program:	**Title XVI (SSI)**
Link To Reference:	SI 01120.203

Retention Date: June 16, 2017

A. Purpose

This EM provides important information regarding a change in SSI trust policy as a result of the 21st Century Cures Act (P.L. 114-255).

B. Background

On **December 13, 2016**, the President signed into law the 21st Century Cures Act. Section 5007 of this Act allows individuals to establish their own special needs trusts and qualify for the exception to resource counting under Section 1917(d)(4)(A) of the Social Security Act.

C. Policy for trusts established before 12/13/16

For special needs trusts under Section 1917(d)(4)(A) of the Social Security Act

established prior to December 13, 2016, the resource counting provisions of Section 1613 (e) do not apply to a trust:

- Which contains the assets of an individual under age 65 and who is disabled; and
- Which is **established for the benefit of such individual through the actions of a parent, grandparent, legal guardian or a court**; and
- Which provides that the State(s) will receive all amounts remaining in the trust upon the death of the individual up to an amount equal to the total medical assistance paid on behalf of the individual under a State Medicaid plan.

NOTE: This law does not affect special needs trusts established prior to December 13, 2016.

D. Policy for trusts established on or after 12/13/16

Effective with special needs trusts established on or after December 13, 2016, the resource counting provisions of the SSI trust statute do not apply to a trust **established through the actions of the individual, a parent, grandparent, legal guardian, or a court**. The other requirements in section C. above continue to apply.

Direct all program-related and technical questions to your Regional Office (RO) support staff. RO support staff may refer questions, concerns or problems to their Central Office contacts.

EM-16053 - Information Regarding a Change in Supplemental Security Income (SSI) Special/Supplemental Needs Trust Policy-- Permanent Instructions Will Follow Shortly - 12/13/2016

BY DANIEL G. FISH

Promissory Notes: More Certainty Now in Post-DRA Plans

The Deficit Reduction Act (DRA) was enacted so recently, February 2006, that we are only now seeing the first interpretations. A trio of recent New York state administrative fair hearing decisions[1] has affirmed the use of DRA-compliant promissory notes for individuals who are in imminent need of long-term care services.

Triggering Penalty Period

Elder law attorneys are frequently sought out at a moment of crisis; when a person has just entered a nursing home and wants to preserve assets. Under the pre-DRA rules the applicant could make a gift of half of his or her assets, trigger the running of the penalty period, and use the remaining assets to pay privately to the nursing home during the penalty period. This was known in the vernacular as the "rule of halves."

The DRA eliminated the "rule of halves" by changing the point at which the penalty period begins to run. Post-DRA, the penalty period does not begin until three conditions are met: a gift is made, the applicant is in need of long-term care services and is determined "otherwise eligible." "Otherwise eligible" means that the Medicaid application would have been approved except for the uncompensated transfer. This requires that the applicant's countable resources be less than $4,200 (2007) and the monthly private pay cost of the nursing home exceeds the applicant's income. The applicant is required to file an application and have it rejected on the sole basis of the uncompensated transfer. When the penalty period is over, the applicant is required to file a second application.

The "rule of halves" no longer works because at the time of the gift, the penalty period is not triggered since the individual still has control over the half of the assets that were not transferred. The penalty period will not start to run until the individual has spent down those resources. However, the individual will not have assets to pay privately for the nursing home care through the penalty period that has just commenced. With the elimination of the "rule of halves" by the DRA, elder law attorneys have explored other options for Medicaid planning such as promissory notes, personal service contracts and annuities. It appears that the use of the promissory note is one of the most likely to succeed.

The DRA compliant promissory note permits the protection of assets for individuals who are currently in nursing homes. The applicant makes a gift of half of his or her assets. Simultaneously, the applicant lends the excess resources (those above $4,200) pursuant to a promissory note which will produce an income stream for the applicant. The applicant is now eligible in all respects other than the gift. The individual files a Medicaid application that is denied on the sole basis of the transfer. Ironically, the denial is good news because it serves as formal notification that the penalty period has commenced. The monthly repayments under the note are used to pay for the cost of the nursing home during the penalty period. When the penalty period expires, the applicant can file a second Medicaid application that should be approved.

Promissory Notes

The DRA allows the use of the promissory note but requires that it (1) be actuarially sound, (2) provide for equal payments with no balloon payments, (3) prohibit the cancellation of the note upon the death of the maker and (4) be non-negotiable. The DRA contains no provision regarding the rate of interest that the note carries.

Fact Pattern

On Oct. 19, 2006, Geraldine executed a promissory note with a close family member, in the principal sum of $40,000. The interest rate was set at five percent. The payments were all of equal amount ($8,100.20) and were to be made in five monthly payments. The note was not cancelable upon the death of the lender. When she made the loan, Geraldine's resources fell below the Medicaid level.

Geraldine applied for nursing home Medicaid on Nov. 14, 2006, hoping that the application would be denied on the basis of the gift only and finding her otherwise eligible. The Albany County Department of Social Services denied the application on another ground, claiming that the note was an available resource which placed her resources above the allowable Medicaid level. (At the fair hearing the agency also argued that it was an uncompensated transfer.) She requested a fair hearing to challenge that determination.

Fair Hearing Decisions

The three fair hearing decisions concluded that promissory notes which meet the requirements of the DRA are legitimate and must be recognized by the local Medicaid agency. The decisions presented identical issues of law and can be read as one. All three applicants with promissory notes filed Medicaid applications in Albany County and they were all denied on the same day. Their fair hearings were consolidated and argued on the same day, by the same counsel, before the same administrative law judge. The decisions were all rendered on the same day. The decision[] rejected every one of the numerous arguments that the Albany County Department of Social Services raised.

The decision rejected the agency claim that the note was not actuarially sound because the repayment period, at six months, was too short. The tables of the Office of the Chief Actuary of the Social Security Administration calculated Geraldine's life expectancy at 6.4 years. Actuarial soundness is a restriction on a repayment period beyond the life expectancy of the lender. Actuarial soundness can only be breached by a repayment period that is too long, not by a shorter term.

The decision rejected the claim by the agency that the

Elder law attorneys are frequently sought out at a moment of crisis; when a person has just entered a nursing home and wants to preserve assets. Under the pre-DRA rules the applicant could make a gift of half of his or her assets, trigger the running of the penalty period, and use the remaining assets to pay privately to the nursing home during the penalty period. This was known in the vernacular as the "rule of halves."

The DRA eliminated the "rule of halves" by changing the point at which the penalty period begins to run. Post-DRA, the penalty period does not begin until three conditions are met: a gift is made, the applicant is in need of long-term care services and is determined "otherwise eligible." "Otherwise eligible" means that the Medicaid application would have been approved except for the uncompensated transfer. This requires that the applicant's countable resources be less than $4,200 (2007) and the monthly private pay cost of the nursing home exceeds the applicant's income. The applicant is required to file an application and have it rejected on the sole basis of the uncompensated transfer. When the penalty period is over, the applicant is required to file a second application.

The "rule of halves" no longer works because at the time of the gift, the penalty period is not triggered since the individual still has control over the half of the assets that were not transferred. The penalty period will not start to run until the individual has spent down those resources. However, the individual will not have assets to pay privately for the nursing home care through the penalty period that has just commenced. With the elimination of the "rule of halves" by the DRA, elder law attorneys have explored other options for Medicaid planning such as promissory notes, personal service contracts and annuities. It appears that the use of the promissory note is one of the most likely to succeed.

The DRA compliant promissory note permits the protection of assets for individuals who are currently in nursing homes. The applicant makes a gift of half of his or her assets. Simultaneously, the applicant lends the excess resources (those above $4,200) pursuant to a promissory note which will produce an income stream for the applicant. The applicant is now eligible in all respects other than the gift. The individual files a Medicaid application that is denied on the sole basis of the transfer. Ironically, the denial is good news because it serves as formal notification that the penalty period has commenced. The monthly repayments under the note payments with no balloon payments, (3) prohibit the cancellation of the note upon the death of the maker and (4) be non-negotiable. The DRA contains no provision regarding the rate of interest that the note carries.

Fact Pattern

On Oct. 19, 2006, Geraldine executed a promissory note with a close family member, in the principal sum of $40,000. The interest rate was set at five percent. The payments were all of equal amount ($8,100.20) and were to be made in five monthly payments. The note was not cancelable upon the death of the lender. When she made the loan, Geraldine's resources fell below the Medicaid level.

Geraldine applied for nursing home Medicaid on Nov. 14, 2006, hoping that the application would be denied on the basis of the gift only and finding her otherwise eligible. The Albany County Department of Social Services denied the application on another ground, claiming that the note was an available resource which placed her resources above the allowable Medicaid level. (At the fair hearing the agency also argued that it was an uncompensated transfer.) She requested a fair hearing to challenge that determination.

Fair Hearing Decisions

The three fair hearing decisions concluded that promissory notes which meet the requirements of the DRA are legitimate and must be recognized by the local Medicaid agency. The decisions presented identical issues of law and can be read as one. All three applicants with promissory notes filed Medicaid applications in Albany County and they were all denied on the same day. Their fair hearings were consolidated and argued on the same day, by the same counsel, before the same administrative law judge. The decisions were all rendered on the same day. The decision[] rejected every one of the numerous arguments that the Albany County Department of Social Services raised.

The decision rejected the agency claim that the note was not actuarially sound because the repayment period, at six months, was too short. The tables of the Office of the Chief Actuary of the Social Security Administration calculated Geraldine's life expectancy at 6.4 years. Actuarial soundness is a restriction on a repayment period beyond the life expectancy of the lender. Actuarial soundness can only be breached by a repayment period that is too long, not by a shorter term.

The decision rejected the claim by the agency that the

ELDER LAW

Promissory Notes: More Certainty Now in Post-DRA Plans

Continued from page 3

note was a "sham," that it was a gift transferred at less than fair market value for the sole purpose of qualifying for Medicaid. It accepted Geraldine's position that the note was a "prudent financial investment."

The decision rejected the claim that the note was negotiable and accepted a written opinion from an economist who concluded that the "Note is worthless as a present asset due to the fact that there is no secondary market on which the appellant could resell it."

The decision rejected the claim by the agency that the rate of interest, at 5 percent was too low, finding that a certificate of deposit would bear a similar or lesser interest rate.

After finding that the note in question met the requirements of the DRA the decision finds: "The DRA has specific criteria that if interpreted correctly, can guide individuals in deciding if a Note is an uncompensated transfer. The Note with a value of $40,000, executed by parties that have a close family relationship, with an interest rate of 5 percent, is reasonable for any type of promissory note."

Conclusion

The great constant in the elder law practice is the desire of clients for certainty. Centenarians, nonagenarians, octogenarians and septuagenarians seek reassurance from counsel as to how their application will be treated. These three fair hearing decisions will help point the way to planning options that are likely to be approved by local Medicaid agencies. These fair hearing decisions are not binding but they are an indication that the dust is beginning to settle and practitioners may begin to make recommendations with greater assurance in the post-DRA world.

1. *Matter of Mary*, Fair Hearing #4733465H; *Matter of Anna*, Fair Hearing #4733471N; *Matter of Geraldine*, Fair Hearing #4733466Z

Protecting Assets in a Crisis: Promissory Note Planning

The Deficit Reduction Act of 2005 severely restricted Medicaid asset protection planning (see the Deficit Reduction Act section of this Guidebook). The law was aimed at eliminating transfer of asset strategies at the so-called "crisis" phase, that is, last minute transfers of assets just prior to or immediately after an individual's placement in a nursing home. However, the federal law left open one planning strategy in particular – planning via a promissory note.

With the promissory note strategy, it is still possible to protect one-half of an individual's assets, even if s/he is already in a nursing home. It works as follows: the nursing home resident transfers all of his/her funds (less the Medicaid-permissible resource allowance) to an individual/family member. The person receiving the funds signs a note promising to pay back approximately one-half of the monies transferred (the loaned assets), plus interest, to the nursing home resident on a monthly basis. The monthly amount to be paid back to the resident is calculated using the nursing home daily rate less the resident's monthly income. Upon payment of the monthly amount to the resident, the resident writes a check for the same amount to the nursing home. The note repayment amount, together with the resident's income, covers payment to the nursing home during the penalty period (number of months) incurred by the transfer of the other one-half of the assets (the gifted assets). The loan payments are calculated to end at the same time that the penalty period on the gifted assets ends, thereby making the nursing home resident Medicaid eligible on that date. The family member(s) will keep one-half of the assets (the gifted assets) free and clear.

Promissory Note planning is a complex strategy and every detail must be carefully calculated and followed for the strategy to work. Be sure to consult with your Elder Law attorney to ensure your plan is properly implemented.

Planning in advance is always recommended but clients can take comfort in the fact that not all will be lost if a loved one has not planned early enough.

Protecting the Family Home

For many families, the family home is the largest asset. Many people are concerned about losing their home, and rightfully so. With the rising cost of health care, how can you protect your home?

There are many ways to protect your home, each of which has Medicaid planning consequences and tax consequences.

Outright Transfer
You may give your home to another individual, such as a spouse or child, by signing a new deed in that person's name. This will assure that Medicaid can never place a lien on your home and that the value of your home will not be countable as part of your estate assets, thereby potentially reducing estate taxes. However, you may lose your real estate tax exemptions, such as enhanced STAR or Veterans' deductions, and you have no guarantee that you can continue to reside in the house. Further, the new owner may incur significant tax disadvantages, particularly if the house is not that person's primary residence. There will also be a Medicaid penalty period based upon the transfer of the entire value of the house.

The Life Estate
You may give your home to another individual and retain a life estate. The retained life estate means that you have all rights and obligations regarding the property during your lifetime. For example, you have the right to reside in the home for life. You will also be responsible for all up-keep and taxes and you will keep all real estate tax exemptions. Upon your death, the property will pass to your designated beneficiary automatically (i.e. without the probate of your Will). The transfer of the home with a life estate protects the home from Medicaid as a lien can never be asserted against the home. Further, the penalty period assessed on the transfer will be reduced for Medicaid planning purposes. The life estate has a multitude of tax ramifications that must be considered (see the Life Estate section of this Guidebook).

Irrevocable Trust
You may transfer your home to a Trust. An irrevocable trust will protect the home from Medicaid after five years has passed. Like the life estate, you will keep your real estate tax exemptions. Your heirs will get certain tax advantages and will inherit the home without the need for probate of your Will. Unlike the life estate, the house may be sold without losing any capital gains exclusions.

Each method of transfer has tax consequences and Medicaid consequences. Make sure you seek legal counsel before taking any action.

approximate number. In order to meet the "otherwise eligible" requirement, all excess resources will have to be transferred. A Medicaid application must be filed by the nursing home resident once the assets are transferred. Assuming no previous transfers or any other factors that would affect eligibility, the applicant should be "otherwise eligible", and have the penalty period calculated for the entire transfer.

The transferee will then begin paying the applicant's nursing home bill on a monthly basis. The original calculations would determine how many months will have to be paid. The monthly payment to the nursing home from the transferred funds would reduce the amount transferred by the amount repaid, and therefore reduce the penalty period, to match the period covered by the payments. It would then be necessary to file a second application to have the local Medicaid agency recalculate and reduce the penalty and determine the applicant's eligibility.

The N.Y.S. Administrative Directive appears to indicate that partial returns will not shorten the Medicaid transfer penalty period.[31] It is the authors' belief that the partial return of assets rule under OBRA 1993 was not changed or altered by the DRA. Clients should be advised that a shortening of the Medicaid transfer penalty period by a partial pay back may be challenged by the local Medicaid agency. In such event, the client may have to appeal that adverse determination by a fair hearing and subsequent court proceeding.

U. **DRA Compliant Promissory Note.** Another planning technique to protect a portion of the assets under the DRA is a combination of a partial gift and the use of a DRA compliant promissory note. Like the partial pay back, it will be necessary to first calculate the rule of halves amount, to determine the approximate amount to be transferred, and the amount to be "returned" via the promissory note. The approach behind the promissory note is that after calculating the amount to be transferred, the individual (Medicaid applicant) will then loan the balance by signing a promissory note for that amount with interest. The promissory note must be irrevocable and non-assignable and will have to be actuarially sound, provide for equal monthly payments, with no balloon payments, and the note may not be forgiven at death. The entire amount must be paid back within the life expectancy period of the Medicaid applicant.

Since the promissory note payment will be treated as income, it is necessary to calculate all of the applicant's other income. How much the promissory note will pay monthly depends on the private pay rate of the nursing home. The combined amount of income and note payment must be below the private pay rate.

---

[31] N.Y.S. Department of Health, Administrative Directive: 06 OMM/ADM-5.

Several fair hearing decisions have upheld the use of the DRA compliant promissory notes.[32] The process of preparing a DRA transfer using a promissory note is multistage.

1) Determine the total excess asset level.

2) Determine the monthly private pay rate of the nursing home. This figure should include extras such as drugs, therapy or oxygen.

3) Determine the applicable transfer rate.

4) Determine the life expectancy of the resident using an actuarial table such as the one used by Social Security.

5) Calculate the amount to be gifted and the amount to be used as the loan under the promissory note (rule of halves amount).

6) Determine total net income of the resident. (Deduct the $50 monthly allowance, plus health insurance premiums.

7) Calculate the penalty period for the amount to be transferred pursuant to the rule of halves calculation.

8) Divide the balance not to be gifted by the number of penalty months, and add the available net income to this amount and add prevailing interest rate (such as 5% interest per annum).

9) If the total is below the nursing home private pay rate, then this becomes the monthly promissory note payment. Any shortfall will have to be paid from the transferred funds.

10) If the total exceeds the private pay rate, an adjustment must be made. The adjustment may include lengthening the term of the note and/or adjusting the amount of the gift.

11) It is necessary to be certain that the term of the note does not exceed the patient's life expectancy. It is also necessary to be sure that the promissory note is actuarially sound, meaning that payment in full does not exceed the patient's life expectancy; that it makes equal monthly payments, no balloon payments and no deferral of payments. The note may not be cancelled upon the death of the maker. To arrive at a promissory note figure that is actuarially sound and is below the private pay rate after factoring in the resident's own income may require multiple calculations, all of which are necessary to achieve a workable result.

12) The next step is the submission of the Medicaid application. The application will reveal the gift as well as the promissory note. This should result in a denial together with a calculation of the penalty period. The patient should be eligible when both the penalty period and the promissory note payments end.

13) The final step is the submission of a second Medicaid application, which should be approved, if all of the calculations were

---

[32] 4819798, Edward H; M.K. F.H. 4733465H, F.H. 4733471N; A.G.; F.H. 4733466Z-G.A.

correct. Some local Medicaid agencies may accept updated documentation for the period of ineligibility instead of a second Medicaid application. The promissory note payments to the nursing home, plus the additions each month from the gifted funds will cover the Medicaid transfer penalty period on the Medicaid transfer penalty period for the gifted amount. This should result in the fulfillment of the promissory note coinciding with the end of the reduced Medicaid transfer penalty period. Any difference between the payment to the nursing home and the actual payment due will have to be paid from the transferred funds.

V. **Long Term Care Insurance--Partnership Policies.** The DRA[33] permits all States to enter into the Partnership Program--Long Term Care Insurance Plan. OBRA 1993 had previously limited the Partnership Program to the four States that already joined in 1993 (New York, California, Indiana and Connecticut). Pursuant to this legislation, which adopts model regulations for the Program, all States are allowed to join providing they meet the Federal requirements. Each State's plan is submitted to and approved by the Secretary of Health and Human Services ("HHS").

Reciprocal recognition among Partnership States is authorized, and the Secretary of HHS was required to establish standards for uniform reciprocal recognition of such policies no later than January 1, 2007. The Secretary must report annually to Congress on the Partnership Program. Prior to this legislation, the owner of a Partnership Policy could apply for Medicaid benefits only in the State of purchase. This portability feature will create greater flexibility.

New York State has determined that the DRA annuity requirements do not apply to owners of Partnership Long Term Care Insurance Policies. It is the state's position that since resources would not be an eligibility factor, and since an annuity is a resource, the annuity requirements do not apply.

As to the dollar for dollar partnership policies, annuities will be counted but only to the extent that assets exceed the dollar for dollar limit.[34]

NOTE: This outline is based on an excerpt from *New York Elder Law and Special Needs Practice by Vincent J. Russo and Marvin Rachlin*, West Group, 800-328-4880.

---

[33] 42 U.S.C.A. §1396p(b).

[34] GIS 07 MA/020.

RESOURCES
TRANSFER OF ASSETS

ALL CATEGORIES EXCEPT S/CC

the eligibility determination. This policy applies to applications filed on or after August 1, 2006 for nursing facility services, including requests for an increase in coverage for nursing facility services.

Assets Transferred to Purchase Loans, Promissory Notes and Mortgages:

Applications filed on or after August 1, 2006 for Medicaid coverage of nursing facility services, including requests for an increase in coverage for nursing facility services, if an A/R or the A/R's spouse purchases a loan, promissory note or mortgage, the funds used are to be treated as a transfer for less than fair market value, unless the note, loan or mortgage:

- Has a repayment term that is actuarially sound;
- Provides for payments to be made in equal amounts during the term of the loan, with no deferral and no balloon payments made; and
- Prohibits the cancellation of the balance upon the death of the lender.

The third bullet means that if the A/R (or A/R spouse) passes away before the outstanding balance of the loan, promissory note or mortgage is paid in full, the borrower must pay back the amount owed to the deceased's estate. If a loan, note, or mortgage does meet the above requirements, the outstanding balance due as of the date of the individual's application for nursing facility services is a transfer for less than the fair market value.

Assets Transferred for Personal Services

In situations where assets have been transferred to a family member in exchange for services to be provided by the family member for the lifetime of the applicant, the personal service contract, also known as a caregiver arrangement must be evaluated to determine if the applicant received or will receive fair market value (FMV) for the transferred resources. A personal service contract or caregiver arrangement is a formal written agreement between two or more parties in which one or more of those parties agree to provide personal and/or managerial services in exchange for compensation paid by the party receiving the services.

NON-NEGOTIABLE
PROMISSORY NOTE

$63,422.00
Islandia, New York

January 24, 2007

FOR VALUE RECEIVED, _____ (the "Promisor") hereby promises to pay to the order of _____ (the "Promisee"), Insert Address_____, the principal amount _____($_____), together with the interest thereon from the date hereof until payment in full at five percent (5 %) per annum. This note is payable in __ (__) equal monthly installments of principal and interest in the amount of_____ ($_____) each, commencing on _____and continuing on the twenty-fourth day of each month thereafter, to and including _____, with a final payment of _____ ($_____), together with any other unpaid principal and interest due thereon, if any, on _____.

All payment of principal and interest shall be made in lawful money of the United States of America to the Promisee at Promisee's address indicated herein or elsewhere as the Promisee may direct the Promisor.

Except as otherwise specifically provided herein, all notices, requests, demands or other communications to the Promisee or the Promisor shall be deemed to have been given or made when mailed certified mail return receipt requested, if to the Promisee, to the Promisee at _____ or if to the Promisor, to the Promisor at _____or such other address as either the Promisee or the Promisor shall hereafter specify to the other in writing.

This Note has been executed and delivered in, and shall be governed by and construed in accordance with, the laws of the State of New York.

This Note is non-negotiable and may not be assigned by Promisor or Promisee. The Promisor shall make payments only to the Promisee, or, in the event of Promisee's death, to the legal representative of Promisee's estate.

This Note shall not be cancelled upon the death of the Promisee and all remaining payments hereunder shall be made to the legal representative of Promisee's estate.

Witness:

_____ _____

NON-NEGOTIABLE PROMISSORY NOTE

Smithtown, New York

FOR VALUE RECEIVED, I, Shirley [redacted] (hereafter, the "Promisor") hereby promise to pay to the order of Joan [redacted] (the "Promisee"), at the Grandell Rehab. & N.C. , 645 W Braodway, Long Beach, New York 11561, the principal amount of Fifty One Thousand, Eight Hundred and Thirty Eight Dollars and Ninety Eight Cents ($51,838.98), together with the interest thereon from the date hereof until payment in full at ten percent (10 %) per annum. This note is payable in sixteen (16) equal monthly installments of principal and interest in the amount of Three Thousand, Four Hundred and Seventy Four Dollars and Nineteen Cents ($3,474.19) each, commencing on July 28, 2010 and continuing on the 28th day of each month thereafter, to and including the last payment on October 28, 2011.

All payment of principal and interest shall be made in lawful money of the United States of America by the Promisor to the Promisee at Promisee's address indicated herein or elsewhere as the Promisee may direct the Promisor.

Except as otherwise specifically provided herein, all notices, requests, demands or other communications to the Promisee or the Promisor shall be deemed to have been given or made when mailed, certified mail return receipt requested, if to the Promisee, to the Promisee at the Grandell Rehab. & N.C. , 645 W Braodway, Long Beach, New York, 11561, or if to the Promisor, to the Promisor at 5631 South 41st Street, Greenfield, Wisconsin 53221, or such other address as either the Promisee or the Promisor shall hereafter specify to the other in writing.

Payments will be made by the Promisor to the Promisee in the amounts stated and on the dates stated in the first paragraph of this instrument. There is no requirement that this note be presented for payment in order for payment to be due on the stated dates.

Payments due under this promissory note cannot be accelerated, cancelled, or delayed, for any reason. Nevertheless, the amount of payment due and the dates when payments are due as provided for herein, shall not be increased and no penalties or additional interest payments shall be added to any outstanding payment, due to the failure on the part of the Promisor to meet her obligations under this note. The remaining principal due under this note shall not become due as a result of any missed payments, and only the missed payments will be due in the event that any payments are not made.

The Promisor will make payments only to the Promisee or to her legal agent under a valid Power of Attorney or to the executor or administrator of her estate. Presentment of this note for payment by any other individual or entity will not be honored.

This Note has been executed and delivered in, and shall be governed by and construed in accordance with, the laws of the State of New York.

This Note is non-negotiable, non-assignable and non-transferrable. This note cannot be canceled due to the death of the Promisee.

_____

Shirley [redacted] Promisor

Joan [redacted] Promisee

STATE OF NEW YORK)
COUNTY OF) SS.:

On the day of , 2010, before me, the undersigned, personally appeared **Joan** [redacted], personally known to me or proved to me on the basis of satisfactory evidence to be the individual whose name is subscribed to the within instrument and acknowledged to me that she executed the same in her capacity, and that by her signature on the instrument, the individual or the person on behalf of which the individual acted, executed the instrument.

_____
Notary Public

STATE OF)
COUNTY OF) SS.:

On the day of , 2010, before me, the undersigned, personally appeared **Shirley [redacted]**, personally known to me or proved to me on the basis of satisfactory evidence to be the individual whose name is subscribed to the within instrument and acknowledged to me that she executed the same in her capacity, and that by her signature on the instrument, the individual or the person on behalf of which the individual acted, executed the instrument.

_____
Notary Public

Non-Negotiable Promissory Note

Date: May 15, 2012

The undersigned, _____ ("Borrower") promises to pay to _____ ("Lender") the principal sum of Two Hundred Eighty-Eight Thousand Eight Hundred Sixty-Two Dollars and Eight Cents ($288,862.08), together with interest thereon at the rate of one and 75/100 percent (1.75%), under the following terms and conditions.

The repayment terms of this Note are as follows:

- Borrower shall repay the loan in equal monthly installments in the amount of $24,300.63 ("Payment Amount") due on the 15th of each month commencing June 15, 2012 and the balance of the principal and accrued interest is due and payable in full on May 15, 2013 ($24,265.26 principal plus interest of $35.37) at the Lender's address of _____, New York, or such other place designated by the Lender.
- It is expressly understood that deferral, acceleration and/or balloon payments are strictly prohibited under this Note.
- It is intended that the payment terms of this Note are actuarially sound under the Deficit Reduction Act of 2005 since the repayment by the Borrower will occur within the Lender's life expectancy under the SSA Tables and therefore, not a Medicaid transfer of assets by the Lender.
- It is expressly understood that this Note prohibits the cancellation of the balance upon the death of the Lender and all remaining payments shall be made to Lender's estate.

This Note is non-negotiable, non-assignable and not otherwise transferable by the Lender. The Borrower shall not have any obligation to make any payments under this Note to anyone other than Lender or Lender's estate.

Borrower shall not have the right to prepay interest and/or principal in whole or in part. The Lender has no right to demand prepayment of the interest, or any part thereof, nor may Lender accelerate the payment of principal for any reason.

This Note shall be governed under the terms of the State of New York.

IN WITNESS WHEREOF, _____ has executed this instrument on the date first above written.

_____

_____,Borrower

Genworth New York Partnership Plus

Date: 02/07/2011

PREMIUM CALCULATION

State: **NY**

Prepared for: **George Roach**

Birthdate:
Age: **59**

Barry Brown

Phone 631-345-6355
Cell 631-804-3959
Email
BGBROWN66@OPTONLINE.NI

Policy Benefits You Have Chosen

Underwriting Class	**Preferred**
Plan Type	**Total Asset** ←
Daily Benefit	**$250** ←
Home Health Care	**50%**
Facility Benefit Period	**3 years** ←
HHC Benefit Period	**6 years**
Pool of Money	**$273,750.00**
Inflation Protection	**5% Compound** ←
Elimination Period	**90 days**
Nonforfeiture Option	**No**
Premium Waiver	**Yes**
Survivorship Benefit	**No**
Independent Caregiver	**No**
Return of Premium	**No**
Monthly Home Care	**No**
Full Daily Max Ben	**No**
Marital Discount	**Single**
Small Business Discount	**No**
Payment Option	**Lifetime**
Modal Factor	**Annual**

Premium for These Choices: **$2,198.10** ←

Genworth New York Partnership Plus is a tax-qualified plan with a pooled facility and home/community care benefit.

Genworth New York Partnership Plus

Inflation Protection - 5% Compound

Compound inflation protection provides an automatic annual increase in your policy's Daily Benefit and Lifetime Benefit. The annual increase is 5% of your current Daily Benefit. This amount is added to your benefit each year.

Long-term care costs have increased in the past, and are likely to continue to increase in the future. Inflation protection increases your benefits to compensate for these increased costs.

Cost increases are compounded over time; the increase each year is a percentage of last year's cost. Compound Inflation Protection increases your benefits each year by a percentage of the previous year's benefit, and thus is more likely to keep up with long-term care costs, compared to other forms of inflation protection.

Client's Name: George Roach **Age: 59**

Underwriting Class	**Preferred**	Premium Waiver	**Yes**
Plan Type	**Total Asset**	Survivorship Benefit	**No**
Daily Benefit	**$250**	Independent Caregiver	**No**
Home Health Care	**50%**	Return of Premium	**No**
Facility Benefit Period	**3 years**	Monthly Home Care	**No**
HHC Benefit Period	**6 years**	Full Daily Max Ben	**No**
Pool of Money	**$273,750.00**	Marital Discount	**Single**
Inflation Protection	**5% Compound**	Small Business Discount	**No**
Elimination Period	**90 days**	Payment Option	**Lifetime**
Nonforfeiture Option	**No**	Modal Factor	**Annual**

Age	Daily Benefit	Lifetime Benefit	Premium
59	$250.00	$273,750.00	$2,198.10
62	$289.41	$316,899.80	$2,198.10
65	$335.02	$366,851.20	$2,198.10
68	$387.83	$424,676.20	$2,198.10
→ 71	$448.96	$491,615.90	$2,198.10
74	$519.73	$569,106.90	$2,198.10
77	$601.66	$658,812.40	$2,198.10
→ 80	$696.49	$762,657.80	$2,198.10
83	$806.28	$882,871.80	$2,198.10
86	$933.36	$1,022,034.00	$2,198.10
→ 89	$1,080.49	$1,183,133.00	$2,198.10

PREMIUM IS CONSTANT

LTCR
LONG-TERM CARE RESOURCES

100 Falls Summit Road
Hendersonville, NC 28739

Phone: (828) 595-9412
Cell: (631) 804-3959
Customer Service Center: (877) 333-5827
Email: barrybrown3959@gmail.com
Website: www.ltciresources.com

Barry Brown
LTC Specialist

Genworth Financial
Genworth Life of New York
PO Box 40005
Lynchburg, VA 24506

002 01045 001045

Important Notice Regarding Partnership Reciprocity

June 12, 2013
from Genworth Life Insurance Company of New York

Insured
George L Roach

Policy number
VBA7032059

Agent
Barry Brown
66 Ethan Cir
Middle Island, NY 11953-2644

Customer service
888 557.5524
M-Th: 8:30 - 8PM ET
F: 9 - 8PM ET
genworth.com

GEORGE L ROACH
122 MC CALL AVE
WEST ISLIP, NY 11795

100000:101045045

Dear George L Roach,

The following information is provided by the New York State Partnership for Long Term Care. It concerns asset disregard reciprocity among New York State and other Partnership states. This information applies to your New York State Partnership Long Term Care insurance policy/certificate:

Please keep this important notice with your policy/certificate

Reciprocity is intended to permit asset disregard to be used in any participating Partnership state.

New York State Total Asset Protection policies/certificates will be considered Dollar for Dollar Asset Protection policies/certificates in reciprocal states. In Dollar for Dollar Asset Protection plans policyholders/certificate holders may apply for Medicaid without regard to resources (assets) equal to the amount of insurance benefits paid out under his/her Partnership insurance plan as long as the policy/certificate minimum duration period is satisfied. A Total Asset Protection policyholder/certificate holder returning to New York State will once again be eligible for total asset protection while residing in New York State.

The New York State Department of Financial Services regulates the insurance industry in New York and is responsible for handling consumer complaints regarding individual and group insurance policies approved by New York. Partnership policies approved by other states are under the jurisdiction of that state's regulator and any concerns regarding policy/certificate benefits, premium rates, insurer solvency, insurer licensure and consumer complaints are under the regulatory oversight of the approving state.

State participation with the federal reciprocity standards is voluntary. In order for a Medicaid Extended Coverage applicant to be eligible for the asset disregard, both the State in which the individual is applying, and the State in which the Partnership insurance was purchased, must be participating in the reciprocity standards at the time the individual applies for Medicaid.

States can choose to opt out of Partnership and/or reciprocity at will. This means that New York State Partnership insureds may not be eligible for Medicaid asset disregard in other states, due to the state's withdrawal.

Also, some states may choose not to offer Partnership insurance, or to participate in federal reciprocity standards, at any time. This means the New York State Partnership insureds are not eligible for Medicaid asset disregard in those states, and that insureds with long term care insurance from those states are not eligible for Medicaid asset disregard in New York State.

Only New York State Partnership policies/certificates will be eligible for the New York State long term care insurance tax credit.

NYS Partnership Participating Insurers Offering Individual Policies as of December 2012*

Genworth Life Insurance Company of New York
888-436-9678
www.genworth.com

John Hancock Life & Health Insurance Company
800-377-7311
www.johnhancockltc.com

Massachusetts Mutual Life Insurance Company
800-272-2216
www.massmutual.com

MedAmerica Insurance Company of New York
800-544-0327
www.MedAmericaLTC.com

New York Life Insurance Company
800-635-8257
www.newyorklife.com

*The list of participating insurers is subject to change. We recommend visiting our website, **www.nyspltc.org** for any updates or changes to this list. For information about group coverage offerings, please see our website or inquire with your insurer directly.

12/12

New York State Partnership for Long-Term Care

An option for asset protection for New Yorkers.
www.nyspltc.org

What is the Partnership?

The NYS Partnership for Long-Term Care (NYSPLTC) is a unique Department of Health program combining private long-term care insurance and Medicaid Extended Coverage (MEC). Its purpose is to help New Yorkers financially prepare for the possibility of needing nursing home care, home care, or assisted living services someday. The program allows New Yorkers to protect their assets (depending on the insurance plan purchased), if their long-term care needs extend beyond the period covered by their Partnership LTC insurance policy.

What does this mean to you?

If you buy NYSPLTC insurance and use the benefits according to the conditions of the program, you can apply for MEC, which may assist in paying for your ongoing care. Unlike regular Medicaid, MEC allows you to protect some or all of your assets, depending on whether you select a Dollar for Dollar Asset Protection plan or a Total Asset Protection plan. However, MEC does require that you contribute your income to the cost of your care according to Medicaid income rules.

How is the NYS Partnership a win-win situation?

NYSPLTC helps New Yorkers pay for their long-term care without having to "spend down" their assets, as they would have to do if they relied totally on Medicaid to pay for their long-term care. By allowing New Yorkers to keep what they've worked hard to acquire, and reducing Medicaid costs for the State, NYSPLTC provides a win-win scenario for everyone.

Who should consider a NYS Partnership policy?

NYSPLTC insurance allows you to choose the care and care setting that meets your care needs, while avoiding financial hardship. A Partnership policy is ideal for someone who will not be able to afford the high cost of long-term care but who can afford the reasonable cost of long-term care insurance. The purpose of NYSPLTC is to protect personal resources by insuring yourself against the future catastrophic cost of long-term care. Therefore, if you have accumulated some wealth by saving, investment, or growth of value, you may be a good candidate for NYSPLTC insurance. Remember you must continue to pay the premiums and may also be responsible for certain out-of-pocket expenses beyond your policy coverage.

Why consider a NYS Partnership policy today?

Give yourself and your family peace of mind. As long-term care costs increase, quality long-term care insurance is a sensible way to protect your financial and personal independence. The Partnership Program will provide MEC benefits once the Private benefit period has been exhausted. Your income will be used for your care, but your assets are protected.

What if I move out of NYS?

The Private portion of your partnership policy can be used in any of the 50 states. New York now has a reciprocity agreement with other Partnership states. If you move to a state that has a reciprocity agreement at the time that you apply for MEC, you will be able to protect your assets. The assets protected in a reciprocal state will only be under the terms of a "Dollar for Dollar" policy but you may return to New York to protect all of your assets if you have a Total Asset plan. Please note that a state can opt out of reciprocity at any time and only those who are currently receiving Medicaid services will be exempt from new regulations (grandfathered). Medicaid eligibility and services are determined on a state-by-state basis.

What are the benefits?

All Partnership policies have the following basic benefits.*

- Nursing home care, home care, and assisted living services.
- 3.5% or 5% annual compounded inflation protection required at purchase ages 79 and younger.
- Care management services.
- 14 days of respite care per year.
- Nursing home bed reservation, 20 days per year.
- 60 day grace period to ensure the premium is paid if you have designated someone to be notified when you fail to pay your premium on time.
- Hospice care.
- Coverage of alternate level of care status in a hospital while awaiting nursing home placement or at-home services.
- Review of denied benefit authorization requests.
- Guaranteed renewable.

*Additional benefits are available.

For more detailed information see the consumer booklet or contact the Partnership office.

Which plan is best for you?

Total Asset Protection Plans
All assets protected. Recommended for those with substantial wealth accumulation and for those who purchase policies at a younger age.

OR

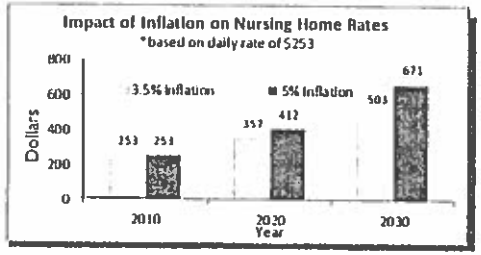
Dollar for Dollar Asset Protection Plans
Asset protection is equal to the amount of benefits paid from the policy. Recommended for those with fewer assets. Policies may be more affordable.

Partnership Plans	Years of Coverage		Daily Benefit*	
	Nursing Home	Home Care	Nursing Home	Home Care
Total Asset 50**	2 Years	4 Years	$265	$133
Total Asset 50**	3 Years	6 Years	$265	$133
Total Asset 100	4 Years	4 Years	$265	$265
Dollar for Dollar 50**	1.5 Years	3 Years	$265	$133
Dollar for Dollar 100	2 Years	2 Years	$265	$265

* These daily benefits are the 2013 minimums.

**Two home care days are equal to one nursing home day and the home care daily benefit is equal to one half of the nursing home daily benefit.

Note: A larger daily benefit may be purchased. A greater number of years of coverage may be available in each plan.



How much does it cost?

The cost of your premiums will depend on your age, coverage and the type of asset protection you choose. The premiums will not increase due to changes in your health or age. Premiums may increase only for an entire class of policies, and only with approval of the New York State Department of Financial Services.

For example, average annual premiums for a basic policy* with Total Asset Protection based on purchase age:

Age	Annual Average Premium**
50	$2,947
55	$3,341
60	$3,980
65	$4,863
70	$6,413
75	$9,540

- In areas of the State where long-term care costs are higher, a policy with a larger daily benefit is recommended. Check the costs in your area.
- Policyholders benefit from a New York State income tax credit equal to 20% of insurance premium costs.

*Example based on policy duration: 3 years of nursing home care, 6 years of home care, or a combination of the two.

**Based on 2012 minimum daily benefits of $253 for nursing home care and $127 for home care.

How can I find out more about the NYS Partnership policies?

1. **Visit our website:**
   www.nyspltc.org
2. **Ask your insurance agent, financial advisor or attorney.**
3. **Ask your employer.** For New York State employees, retirees and family members, ask about New York State Public Employee and Retiree Long-Term Care Insurance Plan: 1-866-474-5824 or www.nyperl.net
4. **Call the in-state, toll-free hotline for basic questions about the Partnership policies and to find out which insurance companies offer them:**
   1-866-950-7526
5. **Write:**
   NYS Partnership for Long-Term Care
   NYS Department of Health
   ESP, Corning Tower, Room 1970
   Albany, New York 12237

How can I find out more about Medicaid?

Call your local county Department of Social Services with questions about Medicaid and eligibility rules, or visit the website for the New York State Department of Health.
1-800-541-2831 or www.nyhealth.gov

The New York State Partnership for Long-Term Care: An Underused Asset

By Peter Aronson

The adult child of an elderly woman recently came to my office wanting to do long-term Medicaid planning for his mother. His mother had hoped to save more than $500,000 for her children, the child explained, possibly through an outright transfer or an irrevocable trust. If they did such planning, the child and mother were well aware that they could not apply for Medicaid nursing home coverage for at least five years because of the look-back period.

The child explained that his mom ("Client") had long-term care insurance to pay for care in the interim. I asked the child if the policy was part of New York State's Partnership for Long-Term Care. The child did not know, saying he had not heard of such a plan.

I reviewed the plan and it turned out it was part of New York State's Partnership for Long-Term Care ("NYS Partnership"), purchased by the client in 1998. The client selected the best option, the so-called total asset protection plan called 3/6/50. This is how her plan works: once she receives home care for six years, or nursing home care for three years, or a combination of the two that equals 1,095 days of care (calculated by receiving one day for each day of nursing home care and ½ day for each day of home care), the client will be eligible for *Medicaid Extended Coverage* with full asset protection.[1] This means she will receive Medicaid regardless of her assets. She will not have to do any Medicaid planning. She will not have to transfer any assets. After she uses up her allotted days under her long-term care policy, she will be eligible for full Medicaid coverage to pay for home care and/or nursing home care, should she need it. Her assets will be exempt.

However, Medicaid Extended Coverage does have income limitations. For a couple, the spousal impoverishment minimum monthly maintenance needs allowance ("MMMNA") applies, which in 2012 is $2,841. For community-based single individuals, like my client, they may keep half that amount, or $1,420.50 in 2012. If the individual is in a nursing home, they may keep only $50 a month. The amount of income exceeding those amounts must be paid to Medicaid as a spend-down.[2] But another advantage to participating in Medicaid Extended Coverage is that the Medicaid asset transfer rules *do not apply, thus my client can transfer assets away and not suffer a penalty period.* This means that she can transfer away certain income-producing assets (i.e., a brokerage account or income-producing real estate), thereby lowering her income and reducing the amount she will have to pay to Medicaid, should she need it. "In other words, as a Participating Consumer, you will not lose eligibility for Medicaid Extended Coverage because your income decreases after transferring an income-generating resource."[3]

The NYS Partnership is a terrific option for my client because her monthly income is moderate and it falls far below the cost of her monthly home care. And clearly this is a terrific option for many other New Yorkers, particularly those who are younger, because the younger the purchaser, the less expensive the cost of the policy. (The average age of a purchaser for a NYS Partnership plan is approximately 60.) However, for clients who have monthly income that exceeds the monthly cost of their home care or nursing home care, they are not eligible to receive the Medicaid Extended Coverage. Therefore, these individuals would not make good candidates for a NYS partnership plan. These individuals could explore other long-term care insurance options outside the NYS Partnership.

My client had the foresight to purchase the policy years ago and now has private long-term care insurance for up to six years. During this period, depending on the policy an individual purchases, the private reimbursement rate can range from $126.50 to $200 per day for home care or residential care (i.e. assisted living) or $253 to $400 per day for nursing home care.

Needless to say, in the case outlined above, my client and her children were extremely happy when told no asset transfers were necessary. This case raised the issue for me: Why don't more New Yorkers take advantage of the NYS Partnership? I practice in New York City, and I have found that most of my clients have never heard of the program. For clients who have substantial assets, but a fixed monthly income that will be less than the estimated cost of future care, and are under seventy years old, I believe the partnership plan is a viable option, one that certainly should be explored by many more individuals than now consider it. One thing that must be emphasized to clients is that the annual premium cost of a NYS Partnership plan, if the coverage is identical to a non-partnership plan, may actually cost less. So why shouldn't the client consider a partnership plan? Of course, each client's circumstances are different and the pros and cons must be weighed.

Recent changes to the NYS Partnership are designed to make the plans more attractive to consumers. The changes will be described below.

1. The Facts and Figures

As of June 30, 2011, there were 72,310 active policy holders in the NYS Partnership program.[4] (Approximately 1,000 additional policies are being sold in the state every quarter.) These numbers pale compared to the potential client pool in the state. According to the state's 2010 U.S. Census figures, there are 2,617,000 people over age 65 in New York State, and another 6,535,000 individuals age 40 to 64, for a total of 9,152,000 people age 40 and over in the state.[5] Yet less than one in 100 of those 9,152,000 individuals have a long-term care policy in the NYS Partnership plan.

Equally as surprising, the purchase of policies in counties throughout the state is not close to proportionate with the counties' population. The county with approximately 50 percent more policy holders than any other county in the state is Monroe County (Rochester area), population 744,000, with 9,306 policies. Erie County (Buffalo area), population 918,000, has the second most policyholders with 6,660. Compare Monroe and Erie counties with the five boroughs of New York City, population 8,184,000, with 7,982 policies, or with Nassau and Suffolk Counties, population 2,835,000, with 11,887 policy holders.[6 and 7]

A further look at the totals underlines the emphasis placed on the NYS Partnership in upstate counties: Onondaga County, with a population of 467,000, has 2,854 policyholders, the state's seventh highest total. Saratoga County, with a population of only 219,000, has 2,083 policy holders, the state's ninth highest total, and more than Queens County, with a population 10 times that of Saratoga, with only 2,057 policy holders. Kings County, the state's most populous county with 2,508,000 people, has only 1,472 policy holders.[8 and 9]

Clearly, elder care attorneys and long-term care specialists upstate focus more on the NYS Partnership then their downstate brethren.

According to NYS Partnership long-term care specialists like Sam DePaolo, a licensed broker with Genworth, based in Orange County, and Ira Weiss, a licensed broker based in Staten Island, a lot of brokers don't suggest the NYS Partnership because they simply don't understand the plans and they find it difficult to explain to clients. An excellent resource for brokers and attorneys is the NYS Partnership Website. (http://www.nyspltc.org/).

To find the insurance companies that sell policies in the NYS Partnership plan, go to: http://www.nyspltc.org/insurers.htm.

2. The Beginning and the Options

The NYS Partnership began in New York in 1993 and was among four states at the time to implement a partnership program.

> As an alternative means to fund long-term care, New York State was authorized to establish a partnership for Long-Term Care demonstration program. The program was designed to assist New York State residents in planning for the cost of long-term care and to promote personal responsibility. This program, funded in part by a grant from the Robert Wood Johnson Foundation, promoted the availability of New York State approved long-term care insurance policies issued by participating insurers to residents of New York State.
>
> The goal of the Partnership program is financial independence for consumers through shared responsibility. This means New York State will share with participating consumers in planning for their long-term care expense. If an individual/couple purchases a Partnership for Long-Term Care insurance policy and keeps it in effect, the State will protect them, if otherwise eligible, against the costs of extended care situations through the Medicaid program.[10]

There have been four insurance plan options over the years and a fifth option was just added, to be available in 2013, so there will now be three *total asset protection plans* and two *dollar-for-dollar* plans. The total asset protection plan, as described in my client's case above, means that once the private insurance benefit is exhausted, the individual is eligible for Medicaid coverage regardless of their assets. The dollar-for-dollar plan means that once the private insurance benefit is exhausted, the individual's assets equal to the amount expended under the private insurance benefit will be an exempt asset. In both cases, income rules previously described will apply.

a. Total Asset Protection Plan

The Total Asset Protection plan allows for the disregard of all of the consumer's assets in determining eligibility for Medicaid Extended Coverage. There are two old options for Total Asset Protection and the one new one:

1) Total Asset 50 policies, identified as 3/6/50 policies, provide a minimum benefit of:

   - Three years in a nursing home; or

- Six years of home care.

To be eligible for Medicaid, the policy holder must use benefits equal to *three* years of paid nursing home care or its equivalent, or six years of paid home care or a combination, with one day's credit for one day of nursing home care and a ½ day credit for one day of home care.[11]

2) Total Asset 100 policies, indentified as 4/4/100 policies, provide a minimum benefit of:

   - Four years in a nursing home;
   - Four years of home care; or
   - Four years in a residential care facility, such as an assisted living program.

To be eligible for Medicaid, the policy holder must use benefits equal to *four* years of paid nursing home care or its equivalent. A combination of nursing home care, home care, or care in a residential facility may be used to satisfy this requirement.[12]

3) The *new* Total Asset protection plan, called 2/4/50, will provide a minimum benefit of:

   - Two years in a nursing home;
   - Four years of home care; or
   - Four years of residential care, such as an assisted living program.

To be eligible for Medicaid, the policy holder must use benefits equal to *two* years of paid nursing home care or its equivalent, with a ½ day credit for every day of home care or residential care. A combination of nursing home care, home care, or care in a residential facility may be used to satisfy this requirement.[13]

This will be an attractive plan option for some clients because it is expected to be a less expensive policy than the other options.

b. Dollar-for-Dollar Asset Protection Plan

The Dollar-for-Dollar Asset Protection Plan allows for the disregard of the policy holder's assets up to the amount of benefits paid out by the long-term care plan on behalf of the consumer. There are two options under the Dollar-for-Dollar Asset Protection Plan.

1) Dollar-for-Dollar Asset 50, identified as 1.5/3/50, provides a minimum benefit of:

   - 1½ years in a nursing home; or
   - Three years of home care, where two days of home care equals one nursing home day.

To be eligible for Medicaid, the policy holder must use benefits equal to 1½ years of paid nursing home care, or, three years of home care, or a combination of the two, where one day of nursing home care counts as one day and one day of home care counts as a ½ of a day.[14]

2) Dollar-for-Dollar Asset 100, identified as 2/2/100, provides a minimum of:

   - Two years in a nursing home; or
   - Two years of home care; or
   - Two years in a residential care facility, such as an assisted living program.

To be eligible for Medicaid, the policy holder must use benefits equal to two years of nursing home care, or a combination of nursing home care, home care and care in a residential care facility. A participating consumer may buy a partnership policy that exceeds the minimum required, but there are restrictions.[15]

Here's a summary of some key elements of the NYS Partnership plan:

- Insurance companies will notify policy holders approximately 90 days before they are eligible for Medicaid;
- There is no age restriction for participating in the NYS Partnership plan;
- In the Total Asset Protection Plan, if the policy holder is married, the spouse's resources are not counted when determining Medicaid eligibility for the policy holder;
- In the Total Asset Protection Plan, because a policy holder's total resources are exempt, the rules regarding resource transfers, the look-back period and penalty period do not apply;
- In the Total Asset Protection Plan, no lien or estate recovery may occur against a policy holder's property or estate;
- In the Total Asset Protection Plan, annuities purchased by the policy holder or their spouse are exempt;
- In the Total Asset Protection Plan and the Dollar-for-Dollar Plan, the $750,000 Home Equity Rule does not apply;
- Medicaid Extended Coverage imposes income limitations: for a couple, the spousal impoverishment minimum monthly maintenance needs allowance (MMMNA) applies, which in 2012 is $2,841. For community-based single individuals, the covered individual may keep half that amount, or $1,420.50 in 2012. If the individual is in a nursing home, they may keep only $50 a month. The amount of income exceeding those amounts must be paid to Medicaid as a spend-down. However, because Medicaid transfer rules

do not apply, the individual may transfer away certain income-producing assets to reduce his or her spenddown; and

- If an insurance company denies a claim due to failure to meet the insurer's disability standards, the policy holder may request that the NYS Partnership review the denial.[16]

3. 2012 Changes

In addition to adding the fifth plan option of 2/4/50, described above, there are three other important changes to the NYS Partnership.

1) New York State will now participate in reciprocity, although to a limited extent. The change will allow New Yorkers who have purchased a NYS Partnership Plan in New York to relocate to one of 40 other participating states and take advantage of asset protection and receive Medicaid in those states at a dollar-for-dollar level. Reciprocity will not apply for total asset protection. This means that even if an individual purchases a total asset protection plan in New York State and then moves to one of these 40 states, the individual will receive only dollar-for-dollar protection from that other state. Thus, the amount of assets protected will be only the amount expended under the individual's private long-term care plan. (It's important to keep in mind that virtually all the NYS Partnership plans purchased in New York State—98 percent, according to the NYS Partnership—are total asset plans, because consumers want full, not partial, protection for their assets, particularly when the cost of the two types of policies is not that much different).[17]

2) In the past, NYS Partnership policies required that the minimum daily benefit amount be increased annually by an inflation protection factor of 5 percent. The new rule will allow the consumer to choose an inflation protector of 3.5 percent or the 5 percent. The option of the lower inflation protector will lower the cost of the policy.[18]

3) The final change will allow insurance agents to become certified to sell NYS Partnership plans through an on-line training and certification program. For details, see: http://www.nyspltc.org/agents/index.htm.[19]

4. Factors to Consider

While I believe the NYS Partnership is not being fully utilized by New York consumers, clearly it is not a program for everyone. If individuals project a substantial monthly income in their later years when they might need care—in other words, if they believe their monthly income will more than pay for home care or nursing home care and they are unwilling or unable to transfer certain assets to reduce their income—then they would not be eligible for Medicaid coverage, so they would not want to purchase a NYS Partnership plan. The plan also might not make sense for our older clients. For example, a healthy 55-year old can purchase a 3/6/50 total asset protection plan, with $126.50 daily coverage for home care and $253 daily coverage for nursing home care, with 5 percent inflation protection, for approximately $2,600 a year. The cost for a 75-year-old would be approximately $12,000 a year. The older clients will have to evaluate whether it's cost effective for them to purchase a policy. We should emphasize to our younger clients that the NYS Partnership option, or any long-term care insurance option, is much less expensive when purchased at a younger age.

Insurance brokers reported to me in interviews that they have many clients with substantial assets (easily more than $1 million), who project a fixed, moderate income, who are purchasing partnership plans. Some individuals buy the plan for financial need, and some, the brokers say, for equal parts need and peace of mind. As elder care attorneys, we advise clients to be prepared for many scenarios, including catastrophic illness or events, even though these events for the average person are a remote possibility. An example is the all-encompassing durable power of attorney, with a few dozen modifications, to cover a plethora of scenarios, even though most scenarios are unlikely to arise for any particular individual. But we include these modifications just in case. Long-term care insurance falls into this same category. It is there *just in case*.

I believe strongly that as part of our regular client intake, whether our clients are 40 or 70, we should inquire whether the client has long-term care insurance and if not, then, if the client's finances warrant it, we should advise the client on NYS partnership options, as well as other long-term care insurance options. After all, we all have had or heard about the 50-something client who suffers a catastrophic event and needs (or will need) extensive care. Personally, I have had two cases—one client hit by a bicyclist and a second with early-onset Alzheimer's disease—who came to me after the fact. Neither had long-term care insurance and now it is too late to get it. That's why we advise clients on steps to take *just in case*. We should have a list of qualified and reputable long-term care insurance specialists available for referral. (A list of certified agents can be found at: http://www.nyspltc.org/certified_agents/.) We should advise the client that long-term care insurance is a safety net. A safety net that hopefully will never be needed, but one that will be there just in case. It is our job to advise the client on the options, so that the client can make an informed decision.

A NYS Partnership plan is not for everyone, but I believe it is a viable option for a far greater pool of New Yorkers than now consider and purchase a plan.

Endnotes

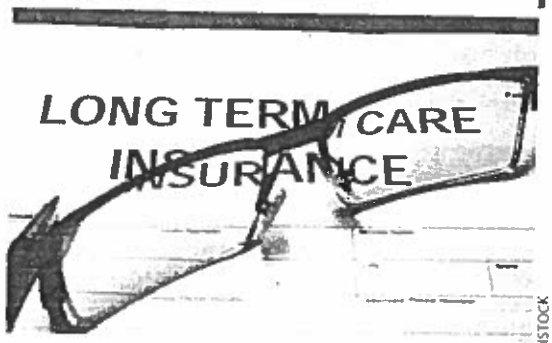
1. NYS Social Services Law, Article 5, Title 11, Section 367-f and 09 OHIP/ADM-3 (July 8, 2009).
2. GIS 10 MA/016 (July 7, 2010), explaining Chapter 58 of the Laws of 2009, amending Section 367-f of the Social Services Law.
3. *See* New York State Partnership for Long-Term Care Consumer Participation Agreement, p. 4, found at http://www.nyspltc.org/publications.htm.
4. *See* www.nyspltc.org/policysales.htm.
5. 2010 U.S. Census.
6. *See* www.nyspltc.org/policysales.htm.
7. 2010 U.S. Census.
8. *See* www.nyspltc.org/policysales.htm.
9. 2010 U.S. Census.
10. *See* 09 OHIP/ADM-3 (July 8, 2009).
11. *Id.*
12. *Id.*
13. *See* Department of Financial Services, State of New York, Third Amendment to 11 NYCRR 39, Insurance Regulation 144, Minimum Standards for the New York State Partnership for Long-Term Care Program (April 26, 2012).
14. *See* 09 OHIP/ADM-3 (July 8, 2009).
15. *Id.*
16. *See* 09 OHIP/ADM-3 (July 8, 2009) and GIS 10 MA/016 (July 7, 2010) (explaining Chapter 58 of the Laws of 2009, amending Section 367-f of the Social Services Law).
17. *See* Department of Financial Services, State of New York, Third Amendment to 11 NYCRR 39, Insurance Regulation 144, Minimum Standards for the New York State Partnership for Long-Term Care Program (April 26, 2012), available at: http://www.dfs.ny.gov/insurance/r_finala/2012_rf144a3t.pdf.
18. *Id.*
19. *Id.*

Peter Aronson operates The Law Office of Peter Aronson PLLC in Manhattan. A solo practitioner who formerly was an associate with Goldfarb Abrandt Salzman & Kutzin LLP, Mr. Aronson focuses on elder law, including Medicaid planning, asset protection, trusts and estates, probate administration, and guardianship work. He services clients throughout the New York metropolitan area. Mr. Aronson is a member of the New York State Bar Association's Elder Law and Trusts and Estates Law Sections. He also serves on the Board of Directors of LiLY (Lifeforce in Later Years), a non-profit organization on the Upper West Side of Manhattan that provides volunteer service to homebound seniors.

The author would like to thank the following individuals for their considerable input and review of this article: Ira Weiss, a licensed broker and long-term care specialist based in Staten Island; Sam DePaolo, a licensed broker and long-term care specialist based in Orange County; and Patrick Breen, a senior analyst with the NYS Partnership.

Watch those insurance premiums

GOOD2KNOW
Peter King



ISTOCK

More than 8 million Americans have purchased long-term care insurance with the expectation it will pay for expensive health care services that Medicare doesn't cover. But if you stop paying the premiums, you could lose all your benefits just when you need them most.

The total number of people who lose their coverage because of nonpayment of premiums is unknown. But a new study from Boston College's Center for Retirement Research suggests that more than 30 percent of long-term care insurance holders lapse on their payments at some point over the life of the policy, potentially losing both the money they paid in premiums and any benefits the plan pays.

Senior research economist Anthony Webb, of the Center for Retirement Research who worked on the report, says there are two main reasons people lapse. One is financial, mainly because the premium becomes too expensive. The second is more worrisome. These are typically people who are suffering cognitive decline and forget to pay their premiums, often just as they are about to need costly medical services. "Cognitive decline causes two things," Webb says. "It increases your risk of going into care and it puts you at elevated risk of not paying your premium."

Insurance companies will not cancel a policy immediately after nonpayment of a premium. The companies generally send three notices, about 30 days apart. If the premium is not paid by the end of this 90-100 day period, the policy can be canceled.

The long-term care industry disputes the Boston College findings. Jesse Slome, executive director of the American Association for Long-Term Care Insurance, says researchers "sensationalized the facts" and that half of all lapses occur during the first five years after the policy is written. "These are not people who are dropping because of cognitive impairments," Slome says. Slome also disputes the finding that 30 percent of people lapse their policies. He says newer policies have added considerable safeguards, such as allowing the policyholder to name another person to get copies of bills and nonpayment notices. Slome says lapse rates have declined over the past decade because of these safeguards.

Whatever the actual number of older adults who forget to pay their premium may be, the take-away from the research is obvious for adult children and healthy spouses of seniors with long-term care policies. "If you spot cognitive decline you really have to keep an eye on their finances and make sure the bills get paid," Webb says.

In short, current long-term-care costs are rising

Long-term care on Long Island is costly and getting more expensive.

The average bill for a semiprivate room in a nursing home in Nassau and Suffolk is $155,125 a year, up 2.4 percent from last year, according to the annual Cost of Care study by long-term-care insurance provider Genworth. The average cost for a Queens nursing home is $144,540. Nationwide, the average cost is $80,300.

A private bedroom in an assisted-living center on Long Island costs $67,500 a year, up 3.4 percent from 2013. And costs are getting higher for those who need help aging in their own homes.

Genworth says the average hourly rate for a home-health aide in Nassau and Suffolk is $22.50, up from $21 last year.

You can compare rates in states and localities around the country at nwsdy.li/costofcare

ending info for the Act 2 generation to Peter King at good2know@cox.net. News about eks in advance. Include photos if available and contact information.

$155,125/YR ÷ 12 = $4,25/DAY

NEWSDAY 5-3-15

ASK THE EXPERT
Lynn Brenner

You need a big estate to get taxed by NYS

New York State has a new estate tax law. What are the new exemption amounts for 2014, 2015 and 2016?

Under the previous law, estates valued at up to $1 million were exempt from New York estate tax. Under the new law, the exempt amount rises annually until 2019. For individuals who died between April 1, 2014, and March 31, 2015, the tax is levied only on estates worth more than $2,062,500.

Your estate is the total value of your assets — your house, car, retirement accounts and life insurance policies — when you die. Very few Americans owe a federal estate tax, which in 2014 applied only to estates worth more than $5.34 million. The tax is indexed to inflation. In 2015, it applies only to the estate of individuals who leave more than $5.43 million; for a married couple, the 2015 federal exemption is worth $10.86 million.

The New York estate tax exemption is $3.125 million between April 1, 2015, and March 31, 2016; $4,187,500 between April 1, 2016 and March 31, 2017; and $5.250 million between April 1, 2017, and Dec. 31, 2018. Starting Jan. 1, 2019, the New York exemption will be indexed to inflation and will equal the federal estate tax exemption.

But there's a complicating factor. If you die before Jan. 1, 2019, leaving an estate worth more than 105 percent of the prevailing exemption, your entire estate is subject to the New York estate tax. In most cases, however, your survivors won't be worse off than if you'd died under the previous law, says Michael W. Alderman, an East Meadow tax accountant, because the old $1 million exemption is built into the new tax rates.

THE BOTTOM LINE If you die before April 1, 2016, New York won't tax your estate unless it's worth more than $3.125 million.

WEBSITES WITH MORE INFORMATION nwsdy.li/exemption and nwsdy.li/estatetaxes

Don't miss deadline to tap retirement assets

Nerdwallet

The IRS defers taxes on many retirement accounts. But at a certain point, the agency wants to start collecting its due.

The way it does so can feel like an abrupt change, especially if you've spent decades considering those accounts off limits. You must start taking required minimum distributions, or RMDs, at age 70½.

RMDs are required from tax-deferred retirement plans: traditional individual retirement accounts, SEP and Simple IRAs, and workplace plans like 401(k)s. They're not required from Roth IRAs.

If you're still working at 70½, you can delay distributions from your employer plan until you retire, unless you own 5 percent or more of the business.

In general, you have to take your allotted distributions by Dec. 31 each year. RMD first-timers — those who turned 70½ just this year — get an extension to April 1.

Procrastinators can take comfort in the fact that they're not alone. Fidelity Investments says that as of Dec. 2, 41 percent of its IRA customers due for RMDs had not taken any. But comfort won't pay the 50 percent penalty the IRS levies on money you don't distribute in time.

Here's what you need to know:

If you're eligible, decide if you want to use an extension. Using it means you'll have to take both this year's and next year's RMD in 2017. That matters because these distributions are taxed as income.

"I've been doing this for 30 years, and I've never seen anyone who benefits from waiting," says Neal Frankle, a certified financial planner and founder of Wealth Resources Group in Westlake Village, California.

However, if you're in a high tax bracket this year and you expect to be in a lower one next year, it might make sense to push this income off.

The amount you need to withdraw is based on an IRS calculation that divides your account balance at the end of the prior year by a life expectancy factor for your age. The RMD will be calculated separately for each retirement account, and account providers typically do the math for you.

But the high percentage of procrastinators means those providers are flooded with RMD requests this time of year. The earlier you get in line, the better, says Maura Cassidy, vice president of retirement at Fidelity. "It might take some time to sell (investments) and settle the amounts needed," she says.

newsday.com NEWSDAY, TUESDAY, DECEMBER 27, 2016

NEWSDAY 12-27-16.

Factors for Calculating your Annual Minimum Taxable Withdrawal (distribution) from 403(b) and other Tax-deferred Savings Accounts

Starting at age 70½ and each year thereafter, you must take minimum taxable distributions (withdrawals) from 403(b) accounts that you own. To determine this amount, divide your 403(b) account balance as of December 31 of each year by the factor next to your age below. The result is the minimum amount of your account that has to be withdrawn by December 31 of the following year. This amount can no longer gain tax-deferred interest within a 403(b), and must be reported on your federal (and possibly state) tax return as ordinary, taxable income. Different factors apply if you have an ***Inherited 403(b).***

Age	Factor	Age	Factor	Age	Factor	Age	Factor
70	27.4	79	19.5	88	12.7	97	7.6
71	26.5	80	18.7	89	12.0	98	7.1
72	25.6	81	17.9	90	11.4	99	6.7
73	24.7	82	17.1	91	10.8	100	6.3
74	23.8	83	16.3	92	10.2	101	5.9
75	22.9	84	15.5	93	9.6	102	5.5
76	22.0	85	14.8	94	9.1	103	5.2
77	21.2	86	14.1	95	8.6	104	4.9
78	20.3	87	13.4	96	8.1	105	4.5

REQUEST April 9, 2002

STATE OF NEW YORK
DEPARTMENT OF HEALTH

CASE # MA0582300
CENTER # Monroe
FH # 3701203H

In the Matter of the Appeal of ,.

Arnold S

from a determination by the Monroe County Department of Social Services

: DECISION
: AFTER
: FAIR
: HEARING

JURISDICTION

Pursuant to Section 22 of the New York State Social Services Law (hereinafter Social Services Law) and Part 358 of Title 18 NYCRR, (hereinafter Regulations), a fair hearing was held on May 1, 2002, in Monroe County, before Katharine Volk, Administrative Law Judge. The following persons appeared at the hearing:

For the Appellant

Mrs. S , Appellant's spouse; Rene Reixach, Esq., Woods, Oviatt, and Gilman; Ms. Propseri, paralegal

For the Social Services Agency

Richard Marchese, Esq. Deputy County Atty; Craig Roth, Senior legal Assistant

ISSUE

Was the Agency's determination to deny the Appellant's application for Medical Assistance on the ground that the Appellant's household has excess resources correct?

FACT FINDING

An opportunity to be heard having.been afforded to all interested parties and evidence having been taken and due deliberation having been had, it is hereby found that:

1. On January 11, 2002, an application for Medical Assistance ("Medicaid") was submitted to the Agency on behalf of the Appellant.

2. The Appellant, age 77 is currently residing in a Residential Health Care Facility; the Appellant's wife, age 77, continues to reside in the community.

3. By CNS Notice dated March 29, 2002, the Agency informed the Appellant of its determination to deny the Appellant's Medical Assistance _ application on the grounds that the Appellant's household has resources in excess of the allowable Medical Assistance standard.

4. The Agency calculated the household's excess resources as follows:

Non-Exempt Resources		Equity Value
Key Bank	Joint	$ 1685.86
Key Bank.	Wife	$10053.04
McDonald Investments	Wife	$24804.15
ING	Wife	$ 1268.27
Nationwide	Wife	$ 844.97
NY Life	Wife	$ 8128.43
329 Sandori Circle	exempt	$ 00.00
ManuLife Annuity/IRA	Wife	$44760.40
Allstate Annuity/IRA	Appellant	$55791.04
	TOTAL	$147,336.16

Community Spouse Resource Allowance	$ 89,820.00
(Resources owed by the Spouse	$ 89,859.26)
Resources available to Appellant ($147,336.16 - $89,820.00)	$ 57,516.16
Resource limit	$ 3,800.00
EXCESS RESOURCES	$ 53,716.16

5. The Appellant is the owner of an AIM lifetime Plus Variable Annuity/IRA, with a value of $55,791.04 as September 21, 2001.

6. The Appellant has been taking periodic payments from his IRA at the rate of $600 monthly.

7. The Appellant's wife is the owner of a ManuLife Annuity/IRA, with value of $44,760; Appellant's spouse has been taking periodic payments from her IRA at the rate of $500.00.

8. On April 9, 2002, the Appellant requested this fair hearing.

APPLICABLE LAW

GENERAL INFORMATION SYSTEM
GIS 98 MA/024

This message is to clarify the Department's policy concerning the treatment of retirement funds for purposes of determining Medicaid eligibility. The clarification reflects the eligibility

requirements of the Supplemental Security Income (SSI) program, however, the clarification applies to all Medicaid applicants/recipients.

Retirement funds are annuities or work-related plans for providing income when employment ends (e.g., pension, disability, or other retirement plans administered by an employer or union). Other examples are funds held in an individual retirement account (IRA) and plans for self employed individuals, sometimes referred to as Keogh plans.

Treatment as a Resource

A retirement fund owned by an individual is a countable resource if the individual is not entitled to periodic payments, but is allowed to withdraw any of the funds. The value of the resource is the amount of money that the individual can currently withdraw. If there is a penalty for early withdrawal, the value of the resource is the amount available after the penalty deduction. Any income taxes due are not deductible in determining the resource's value.

As advised in 90 ADM-36, retirement funds owned by an ineligible or nonapplying community spouse are countable for purposes of determining the total combined countable resources of the couple. However, the retirement funds are not considered available to the institutionalized spouse. The retirement fund owned by the community spouse is counted first toward the maximum community spouse resource allowance.

Periodic Payments

Medicaid A/Rs who are eligible for periodic retirement benefits must apply for such benefits as a condition of eligibility. If there are a variety of payment options, the individual must choose the maximum income payment that could be made available over the individual's life time. (By federal law, if the Medicaid A/R has a spouse, the maximum income payment option for a married individual will usually be less than the maximum income payment option that is available to a single individual.) Once an individual is receiving periodic payments, the payments are counted as unearned income on a monthly basis, regardless of the actual frequency of the payment. For example, if the periodic benefit is received once a year, the amount is to be divided by twelve to arrive at a monthly income amount.

Once an individual is in receipt of or has applied for periodic payments, the principal in the retirement fund is not a countable resource. This includes situations where a Medicaid applicant has already elected less than the maximum periodic payment amount and this election is irrevocable. In such situations, only the periodic payment amount received is counted as income and the principal is disregarded as a resource.

NOTE: Individuals who have met the minimum benefit duration requirement of a New York State Partnership for Long Term Care policy are not required to maximize income from a retirement fund. In addition, non-applying or ineligible spouses/parents cannot be required to maximize income from a retirement fund.

DISCUSSION

The Agency determined to deny the Appellant's application for medical assistance on the grounds that he had excess resources; included in such resources are two IRA's; one owned by the Appellant and one owned by the Appellant's spouse.

The issue in dispute is the Agency's treatment of the couple's two annuities/IRAs.

The Agency argues that the husband's IRA is an available resource in accordance with 18 NYCRR 360-4.4, 88 ADM 30 and under the Medical Reference Guide (MRG) at pages 257. The Agency reasons that since the Appellant is allowed to withdraw any or all of the funds in the IRA, the IRA is a countable resource, despite the fact that that Appellant has elected to receive monthly payments. The Agency argues that the ability to access the funds in the IRA supersedes his election to receive monthly payments from this fund. The Agency notes that Appellant's election to receive $600 monthly is not irrevocable. The Agency asserts that the Appellant is required to pursue all available resources.

The Appellant's attorney argues that the Appellant's IRA and his wife's IRA are not a countable resource as the IRAs are exempt because they are in periodic payment status. The Appellant's attorney points out that Appellant is 77 years old and thus under the Internal Revenue Code, he is in required minimum distribution status, and that Appellant's monthly payment of $600 significantly exceeds the minimum distribution amount. Similarly, the Appellant's wife is 77 years old and is in required minimum distribution status, and that the wife's monthly payment of $500 significantly exceeds the minimum distribution amount.

The Appellant's attorney argues that under the Medical Reference Guide at pages 257 - 258, as well as set forth under GIS 98 MA 024 , once an individual is in receipt of or has applied for periodic payments, the retirement fund is not a countable resource.

The Appellant's attorney notes that the Agency's argument finds some authority under the "old" Medical Assistance Reference Guide (MARG) at pages 249 -250, which policy did not make an exception for exempting retirement plans which were in periodic payment status; the Appellant's attorney notes however that under the current revised Medical Reference Guide (MRG) and consistent with current SSI regulations, and as set forth in the GIS, where a retirement account is in periodic payment status, the principal is not a countable resource.

Alternatively, the Appellant's attorney argues that in the event the husband's IRA is found to be a resource, the entire amount of the Spinell's combined resources should be exempt by increasing the Community Spouse Resource Allowance needed to generate sufficient income to bring the community spouse's income closer to the the Minimum Monthly Maintenance Needs Allowance (MMMNA).

The Agency's determination to include the Appellant's IRA and the wife's IRA as countable resources is not correct is and reversed.

The Department's policy clearly states that a retirement fund owned by an individual is a countable resource if the individual is not entitled to periodic payments but is allowed to withdraw any of the funds. If an individual is in receipt or has elected to receive periodic payments, the retirement fund is not a countable resource. The Agency's treatment of retirement funds was most recently clarified under the GIS 98 MA 024.

The uncontroverted evidence establishes that the two IRAs are in periodic payment status; as such the IRAs are not a countable resource. While an applicant has the duty to pursue all resources, before such duty is imposed, the resource must be in existence. Here, the IRAs are already in periodic payment status, and thus are not countable resources.

Appendix C. Uniform Lifetime Table

Table III
(Uniform Lifetime)

(For Use by:

- **Unmarried Owners,**
- **Married Owners Whose Spouses Are Not More Than 10 Years Younger, and**
- **Married Owners Whose Spouses Are Not the Sole Beneficiaries of Their IRAs)**

Age	Distribution Period	Age	Distribution Period
70	27.4	93	9.6
71	26.5	94	9.1
72	25.6	95	8.6
73	24.7	96	8.1
74	23.8	97	7.6
75	22.9	98	7.1
76	22.0	99	6.7
77	21.2	100	6.3
78	20.3	101	5.9
79	19.5	102	5.5
80	18.7	103	5.2
81	17.9	104	4.9
82	17.1	105	4.5
83	16.3	106	4.2
84	15.5	107	3.9
85	14.8	108	3.7
86	14.1	109	3.4
87	13.4	110	3.1
88	12.7	111	2.9
89	12.0	112	2.6
90	11.4	113	2.4
91	10.8	114	2.1
92	10.2	115 and over	1.9

■

Life Expectancy Table

Age	Male	Female	Age	Male	Female
	Life Expectancy	Life Expectancy		Life Expectancy	Life Expectancy
0	74.14	79.45	30	45.90	50.53
1	73.70	78.94	31	44.96	49.56
2	72.74	77.97	32	44.03	48.60
3	71.77	77.00	33	43.09	47.63
4	70.79	76.01	34	42.16	46.67
5	69.81	75.03	35	41.23	45.71
6	68.82	74.04	36	40.30	44.76
7	67.83	73.05	37	39.38	43.80
8	66.84	72.06	38	38.46	42.86
9	65.85	71.07	39	37.55	41.91
10	64.86	70.08	40	36.64	40.97
11	63.87	69.09	41	35.73	40.03
12	62.88	68.09	42	34.83	39.09
13	61.89	67.10	43	33.94	38.16
14	60.91	66.11	44	33.05	37.23
15	59.93	65.13	45	32.16	36.31
16	58.97	64.15	46	31.29	35.39
17	58.02	63.17	47	30.42	34.47
18	57.07	62.20	48	29.56	33.56
19	56.14	61.22	49	28.70	32.65
20	55.20	60.25	50	27.85	31.75
21	54.27	59.28	51	27.00	30.85
22	53.35	58.30	52	26.16	29.95
23	52.42	57.33	53	25.32	29.07
24	51.50	56.36	54	24.50	28.18
25	50.57	55.39	55	23.68	27.31
26	49.64	54.41	56	22.86	26.44
27	48.71	53.44	57	22.06	25.58
28	47.77	52.47	58	21.27	24.73
29	46.84	51.50	59	20.49	23.89

Age	Male	Female	Age	Male	Female
	Life Expectancy	Life Expectancy		Life Expectancy	Life Expectancy
60	19.72	23.06	90	3.70	4.47
61	18.96	22.24	91	3.45	4.15
62	18.21	21.43	92	3.22	3.86
63	17.48	20.63	93	3.01	3.59
64	16.76	19.84	94	2.82	3.35
65	16.05	19.06	95	2.64	3.13
66	15.36	18.30	96	2.49	2.93
67	14.68	17.54	97	2.35	2.75
68	14.02	16.80	98	2.22	2.58
69	13.38	16.07	99	2.11	2.43
70	12.75	15.35	100	2.00	2.29
71	12.13	14.65	101	1.89	2.15
72	11.53	13.96	102	1.79	2.02
73	10.95	13.28	103	1.69	1.89
74	10.38	12.62	104	1.59	1.77
75	9.83	11.97	105	1.50	1.66
76	9.29	11.33	106	1.41	1.55
77	8.77	10.71	107	1.33	1.44
78	8.27	10.11	108	1.25	1.34
79	7.78	9.52	109	1.17	1.25
80	7.31	8.95	110	1.10	1.16
81	6.85	8.40	111	1.03	1.07
82	6.42	7.87	112	0.96	0.99
83	6.00	7.36	113	0.89	0.91
84	5.61	6.88	114	0.83	0.84
85	5.24	6.42	115	0.77	0.77
86	4.89	5.98	116	0.71	0.71
87	4.56	5.56	117	0.66	0.66
88	4.25	5.17	118	0.61	0.61
89	3.97	4.81	119	0.56	0.56

Improvement Standard and *Jimmo* News

Court Orders Corrective Action Plan for Government's Noncompliance with Settlement in *Jimmo v. Burwell*

In a decision released February 2, 2017, the federal judge overseeing the Settlement Agreement in the Medicare "Improvement Standard" case (*Jimmo v. Burwell*) ordered the Secretary of Health & Human Services to carry out a Corrective Action Plan to remedy the Department's noncompliance with the Settlement. In August, 2016, Chief Judge Christina Reiss, of the District of Vermont, held that the Secretary had not accurately implemented the *Jimmo* Settlement's required Educational Campaign. The Judge ruled that the Secretary failed to explain that a consideration of the need for skilled care, not the potential for improvement, should govern Medicare coverage determinations – for skilled nursing facility, home health, and outpatient therapy. Medicare covers skilled nursing and therapy to maintain or slow decline as well as to improve the patient's condition. Following up on her August decision, the judge has ruled on the content of a Corrective Action Plan.

The judge ruled that the Corrective Action Plan will include a new CMS webpage dedicated to *Jimmo*, a published Corrective Statement disavowing the improvement standard, a posting of Frequently Asked Questions (FAQs), and new training for contractors making coverage decisions. In addition, and significantly, the Court largely adopted the Corrective Statement drafted by plaintiffs, and ordered the Secretary to conduct a new National Call to explain the correct policy.

Judith Stein, Executive Director of the Center for Medicare Advocacy, one of two public interest law firms representing the plaintiffs, said that the Corrective Statement is critical: "With the imprimatur of CMS on the Statement, which specifically notes that the *Jimmo* Settlement represents a 'change in practice,' Medicare adjudicators and providers should have no doubt about what the correct coverage policy is. This should open doors to critically important care for people with long-term, debilitating and chronic conditions." The judge's Order requires the Statement to appear "on the *Jimmo* webpage, in the FAQs, and in the written materials and oral statements the Secretary has agreed to disseminate."

Another of plaintiffs' attorneys, Michael Benvenuto of Vermont Legal Aid, viewed the new National Call as a particularly important component of relief: "The original National Call was riddled with misstatements and confusion. Requiring a new Call should clarify that a maintenance standard, not an improvement standard, controls."

Despite the education provided by CMS in 2013, many Medicare decision-makers and providers have continued to require improvement as a condition of continued coverage. Gill Deford, Litigation Director at the Center for Medicare Advocacy and lead counsel for plaintiffs, observed: "I hope this latest Order finally puts the Improvement Standard to rest. We thought the Settlement Agreement would accomplish that goal, but this Order should finally ensure that elderly and disabled Medicare beneficiaries receive the health care and Medicare coverage that they have always been entitled to."

Cyndi Zagieboylo, CEO of the National Multiple Sclerosis Society, a plaintiff in *Jimmo*, underscored the importance of the case and the new Order, "Rehabilitation therapy is essential for people with multiple sclerosis to maintain the flexibility,

strength, and independence they need to avoid falls or other injuries, and to live their best lives. More and better education about Medicare coverage of these benefits will help ensure that beneficiaries with MS are never again told they cannot get all the rehabilitation therapy they need as their doctors prescribe."

The Secretary is required to certify compliance with the order by September 4, 2017.

Skilled Maintenance Services Are Covered by Medicare.

The Center for Medicare Advocacy is pleased to announce that the Medicare Policy Manuals have been revised.

The revisions, pursuant to the *Jimmo vs. Sebelius* Settlement, clarify that improvement is not required to obtain Medicare coverage. The revisions were published by the Centers for Medicare & Medicaid Services (CMS) on Friday December 6, 2013. They pertain to care in Inpatient Rehabilitation Facilities (IRF), Skilled Nursing Facilities (SNF), Home Health care (HH), and Outpatient Therapies (OPT).

The CMS Transmittal for the Medicare Manual revisions, with a link to the revisions themselves, is posted on the CMS website at http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R179BP.pdf. The CMS *MLN Matters* article is also available on the CMS site under "Downloads" at: http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM8458.pdf

As CMS states in the Transmittal announcing the *Jimmo* Manual revisions:

> **No "Improvement Standard" is to be applied in determining Medicare coverage for maintenance claims that require skilled care.** Medicare has long recognized that even in situations where no improvement is possible, skilled care may nevertheless be needed for maintenance purposes (i.e., to prevent or slow a decline in condition). The Medicare statute and regulations have never supported the imposition of an "Improvement Standard" rule-of-thumb in determining whether skilled care is required to prevent or slow deterioration in a patient's condition. Thus, such coverage depends not on the beneficiary's restoration potential, but on whether skilled care is required, along with the underlying reasonableness and necessity of the services themselves. The manual revisions now being issued will serve to reflect and articulate this basic principle more clearly. [Emphasis in original.]

Per the *Jimmo* Settlement, CMS will now implement an Education Campaign to ensure that Medicare determinations for SNF, Home Health, and Outpatient Therapy turn on the need for skilled care – not on the ability of an individual to improve. For IRF patients, the Manual revisions and CMS Education Campaign clarify that coverage should never be denied because a patient cannot be expected to achieve complete independence in self-care or to return to his/her prior level of functioning.

Background

The *Jimmo* settlement was approved on January 24, 2013 after a fairness hearing, marking a critical step forward for thousands of beneficiaries nationwide. (See the Order Granting Final Approval). The lawsuit was brought on behalf of a nationwide class of Medicare beneficiaries by six individual beneficiaries and seven national organizations representing people with chronic conditions, to challenge the use of the illegal Improvement Standard.

The proposed Jimmo settlement agreement[2] was originally filed in federal District Court on October 16, 2012. The plaintiffs joined with the named defendant, Secretary of Health and Human Services Kathleen Sebelius, in asking the federal judge to approve the settlement of the case. With only one written comment received, and no class members appearing at the fairness hearing to question the settlement, Chief Judge Christina Reiss granted the motion to approve the Settlement Agreement on the record, while retaining jurisdiction to enforce the agreement in the future, as requested by the parties.

With the settlement now officially approved, the Centers for Medicare & Medicaid Services (CMS) is tasked with revising its Medicare Benefit Policy Manual and numerous other policies, guidelines and instructions to ensure that Medicare coverage is available for skilled maintenance services in the home health, nursing home and outpatient settings. CMS must also develop and implement a nationwide education campaign for all who make Medicare determinations to ensure that beneficiaries with chronic conditions are not denied coverage for critical services because their underlying conditions will not improve.

- CMS Transmittal for the Medicare Manual revisions, with a link to the revisions themselves: http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R179BP.pdf.
- CMS *MLN Matters* article (under "Downloads"): http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM8458.pdf
- Updated CMS Fact Sheet, *Jimmo v. Sebelius*
- MLN Connects National Call for providers and suppliers held (December 19, 2013)
- *The New York Times* exclusive: "Settlement Eases Rules for Some Medicare Patients", by Robert Pear
- *The New York Times* editorial: "A Humane Medicare Rule Change"
- Bloomberg BNA Article by Center Executive Director Judith Stein (.pdf format): "Jimmo Settlement Invalidates Improvement Mandate for Medicare Coverage"

- Court Orders Corrective Action Plan for Government's Noncompliance with Settlement in *Jimmo v. Burwell* February 2, 2017
- Jimmo v. Sebelius October 13, 2016
- Judge Orders Medicare Agency to Comply with Settlement in "Improvement Standard" Case and Provide More Education August 18, 2016
- *Jimmo v. Sebelius* Plaintiffs Return to Court to Urge Enforcement March 2, 2016
- Practice Tip: Orders Needed for Maintenance Skilled Care October 7, 2015
- The Jimmo Implementation Council June 25, 2015
- *Jimmo* Class Members Can Now Have Their Coverage Denials Re-Reviewed January 30, 2014
- One-Year Anniversary of Medicare Improvement Standard Settlement Brings Victories, and Ongoing Struggle, for Beneficiaries January 27, 2014
- Medicare Policy Manuals Revised as Required by Jimmo Settlement January 9, 2014
- Improvement Standard Update: CMS Revises Medicare Policy to Ensure Coverage for Skilled Maintenance Care December 9, 2013

- Coverage for People with Chronic Conditions

Practice Tips

- Orders Needed for Maintenance Skilled Care
- *Are We Addicted to Improvement?* (Cindy Krafft – .pdf)
- Medicare Maintenance Therapy Documentation (Good Shepherd Rehabilitation – .pdf)

For older articles, please see our archive.

The case filing of the class action lawsuit received extensive coverage in the media, including articles by the *Associated Press*, *Chicago Tribune*, *Detroit Free Press* and *The Hill*. A more complete list media coverage is available as well.

Help us Implement Jimmo: Donate Now!

---

[1] *Jimmo v. Sebelius*, No. 11-cv-17 (D.Vt.), filed January 18, 2011.
[2] The proposed settlement is at www.medicareadvocacy.org/wp-content/uploads/2012/12/Jimmo-Settlement-Agreement-00011764.pdf
[3] http://www.nytimes.com/2012/10/24/opinion/a-humane-medicare-rule-change.html?partner=rssnyt&emc=rss. *See also* Robert Pear, "Accord to Ease Medicare Rules in Chronic Cases; Longtime Policy Ends," *The New York Times*, page 1 (Oct. 23, 2012), http://www.nytimes.com/2012/10/23/us/politics/settlement-eases-rules-for-some-medicare-patients.html.

- Info by Topic
  - Affordable Care Act (ACA)
  - Ambulance Coverage
  - Antipsychotic Drugs
  - Appeal Steps
  - Basic Introduction to Medicare
  - Chronic Conditions
  - Connecticut Consumer's Guide
  - Coverage & Appeals
  - Coverage for People with Disabilities
  - Dental/Oral Health

- Discharge Planning
- Durable Medical Equipment (DME)
- Eligibility & Enrollment
- Glossary of Terms
- Hearing Care and Audiology
- Home Health Care
- Hospice
- Hospital
- Improvement Standard and *Jimmo*
- LGBT (Lesbian, Gay Bisexual and Transgender) Persons & Health: Available Resources
- Long Term Care Commission
- Long Term Care Hospitals
- Medicare Advantage
- Medicare "Reform"
- Medicare Savings Programs
- Medicare Secondary Payer Program
- Medicare's 50th Anniversary
- Medigap
- Mental Health
- Multiple Sclerosis & Medicare
- Nursing Home / Skilled Nursing Facility Care
- Nurse Staffing In Nursing Facilities
- Outpatient Observation Status
- Part B
- Part D / Prescription Drug Benefits
- Quality of Care
- Quick Medicare Facts & Stats
- Racial and Ethnic Health Care Disparities
- Rehabilitation Hospital Services
- Resources
- Self Help Materials
- Site Neutral Payment for Rehab. Care
- Speech Generating Devices (SGDs)

Related

Easy Access to Understanding Medicare

The Center for Medicare Advocacy produces a range of informative materials on Medicare-related topics. Check them out:

- CMA Blog
- CMA Webinars
- CMA *Alerts*
- *CMA Podcast*

Sign Up for the CMA *Alerts* today.

National Medicare Advocates Alliance

National Medicare Advocates Alliance

The Center for Medicare Advocacy's National Medicare Advocates Alliance provides Medicare advocates with a collaborative network to share resources, best practices, and developments of import to Medicare beneficiaries throughout the country. The Alliance is supported by the John A. Hartford Foundation. Learn more.

Font Controller

AAA

- Stay Connected:
-
- facebook
- twitter
- blog

CMA Blog | Contact Us | Sitemap | Products & Services | CMA Health Policy Consultants | Copyright/Privacy